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Addressing the intersection of sexual identity and sexual behavior for women who have sex with women: understanding risk and exploring options

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ADDRESSING THE INTERSECTION OF SEXUAL IDENTITY AND SEXUAL
BEHAVIOR FOR WOMEN WHO HAVE SEX WITH WOMEN:
UNDERSTANDING RISK and EXPLORING OPTIONS

A Thesis

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ABSTRACT

Variable inconsistencies and conflicting theories on female sexual orientation compromise women's sexual health research. Subsequently, health risks associated with female-to-female sex play are largely unknown and providers continue framing services for sexual identities. The study's focus was first, to establish whether discordance between sexual behavior and identity among women who have sex with women (WSW) correlates with risky sexual behaviors and then, to explore healthcare providers' and practitioners' methods for addressing the intersection of patients' sexual identity and reported behaviors. After WSW sexual health-related response outcomes from a NYC Community Health Survey sample were assessed, practitioners from three providers were interviewed on best practices. Quantitative research revealed associations between incongruent identity-behavior and high-risk behaviors, while qualitative research found four themes in optimal patient care (avoid assumptions, communicate confidentiality, inclusive language, let the client lead). Observations of sexual discordance among WSW strengthen the case against identity-based healthcare, while shared tactics between providers set a standard for prompting WSW patient satisfaction.

ACKNOWLEDGEMENTS

IN MEMORIAM:

Christina Santiago [1981 – 2011]

Activist | Leader | Inspiration

Howard Brown Health Center's
Lesbian Community Care Project

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CHAPTER 1 | INTRODUCTION

Some self-identified lesbians have sex with men and some straight-identified females have sex with other women. Thus, sexual identity is an unreliable indicator for sex-related risk. However, a sexual orientation-based binary divide (heterosexual or straight-identified vs. homosexual or lesbian-identified) persists throughout women's sexual healthcare and related intervention services. This two-part exploratory study first examines the issue of sexual discordance among women, and then assesses potential solutions in the form of female-focused sexual healthcare providers.

Though ineffective as an indicator for risk independently, self-described sexual identity combined with self-reported sexual behavior offer a comprehensive measure for assessing risk (Fromby 2011, Pathela et al. 2006). Researchers employing this measure to address the intersection of sexual identity and behavior suggest that observations of sexual discordance should be expected within any population. However, when incongruent identity-behavior combinations consistently correlate with increased sex-related risk there is cause for concern.

Female-focused research is limited and variable inconsistencies, along with conflicting theories on female sexual orientation, can be found throughout the few sources available. As a result, the behavioral patterns and associated risks for WSW are generally unknown, leaving healthcare professionals to subjectively interpret the information available. Meanwhile, the US Centers for Disease Control and Prevention (CDC) and earlier research indicate WSW remain vulnerable to HIV infection and other sexually transmitted infections (STIs). According to these sources, sex-related risks for

WSW exposed to a variety of pathogens (or infectious agents) through sexual intercourse with men or through intravenous drug use, increase significantly (GMHC 2009). Therefore, increased understanding of females' behavioral patterns is necessary for identifying risk. Most studies on incongruent sexual identity-behavior focus on men's response outcomes alone. Thus, the first focus in this two-part research initiative will be to verify discordance among women who have sex with women (WSW) and assess how discordance relates to risk. Though drug use is a significant concern in terms of female-to-female HIV and STI infection and transmission, this study does not address these risk-associated behaviors.

Though a number of articles frame WSW self-inhibiting behaviors (such as failing to seek healthcare due to fear of physician homophobia or ones own misperceptions of lesbian immunity) as their biggest barrier to care, other articles fault medical professionals' lack of understanding for issues in female sexual minority health (Meckler et al. 2006, Singh & Marrazzo 2009). Those latter sources implicate medical professionals' inadequate healthcare training, which is framed by findings from the female-focused research considered both limited in scope and conflicting in terms of content (Marrazzo & Gorgos 2012, Obedin-Maliver et al. 2011). Not surprisingly, the resulting, general approach to female sexual minority healthcare is overwhelmingly subjective on the part of the providers. Furthermore, resulting patient perceptions associated with the experiences of care-seeking WSW in present research are predominately negative (Meckler et al. 2006).

Amid the lack of satisfaction with women's sexual healthcare approaches seen in the literature, some providers in the city of Chicago are considered reputable for WSW-

inclusive and culturally competent care by patients and other providers. Their preferred service implementation frameworks detail best practices and illustrate approaches to optimal patient care. Identifying shared themes across three WSW-inclusive providers essentially offers instruction in serving female sexual minority patients specifically. Thus, after addressing the problem of sexual discordance and associated risk among women, the second initiative of this two-part study assesses three organizational approaches as potential solutions to WSW-inclusive care.

Two questions guide the quantitative and qualitative research initiatives in this study:

- 1. Do WSW who do not self-identify as lesbian or bisexual engage in more high-risk sexual behavior than women who do self-identify, and are the behavioral differences of WSW who do not self-identify placing them at greater health risk?*
- 2. What are the best practices for professional and trained healthcare practitioners at Chicago-based sexual health service organizations that specialize in serving WSW, and how do individual practitioners address the intersection of female sexual behavior and identity?*

In answering these questions, the goal or intent of this two-part study is also two-fold: First, this study aims to clarify the behavioral patterns of WSW and provide a basis for understanding associated sexual risk. However, to understand associated risks, one must first find a way to discern between participants within the WSW-specific research sample.

Highly sporadic, inconsistent patterns for defining variables throughout WSW-related research are considered problematic in the research (Bauer & Jairam 2008). In fact, some sources suggest variable inconsistencies are one of WSW patients' bigger barriers to competent care. As a preventive measure, this study utilizes a glossary of relevant terms created specifically for this research based on information from the World Health Organization (WHO) and the Association of Reproductive Health Professionals (ARHP). To avoid confusion, the terms WSW and female sexual minority are used interchangeably to describe data that captures women who have sex with women. Also, WSW includes women who have sex with women who may also acknowledge sexual partnerships with men. Sexual identity (including the terms "lesbian" and "bisexual"), however, was rejected as a means for variable measurement in large part due to its inability to adequately represent the full range of potential associated behaviors. A full glossary of relevant terms can be found in Appendix 1, page 118.

In this study, the context of risk is directly related to a woman's experience and behaviors, neither of which can be determined by the use of traditional labels for individual sexuality and sexual identity. However, just as inaccurate labels and language likely potentially compromise healthcare outcomes, comprehensive sexual health history details can protect against inadequate risk assessments. Moreover, healthcare professionals who diligently recognize reported behavior must still solicit comprehensive sexual health histories from clientele in order to accurately assess risk.

Medical professionals only know as much as their patients are willing to share and behavioral details enhance practitioner understanding. Thus, patient disclosure as an indicator for best practices is discussed in the second section of this two-part study.

Though the intent of the second initiative is to identify best practices from shared provider-perceptions, the shared (patient-practitioner) nature of the healthcare experience is also addressed. Essentially, the pressure to produce positive healthcare outcomes does not fall exclusively on providers and practitioners and satisfaction in service is not up to patients alone. In the following chapters, findings from research on the female sexual minority patient-practitioner relationship are addressed following results from research on the WSW identity-behavior relationship.

CHAPTER 2 | LITERATURE REVIEW

Amid the inconsistencies and differing opinions on how female sexuality should be perceived, the risk of infection with female-to-female sex play has been ignored (Arend 2005). The dearth of public-health research focused on women who have sex with women (WSW) stands in stark contrast to countless studies surrounding men who have sex with men (MSM) (Fromby 2011). While informational sources on health risks associated with male-partnered sex practices are reportedly widespread, risks linked with female-to-female exclusive sex play remain largely unknown (Kitzinger & Peel 2005).

In discussing female-to-female sex-related transmission and infection, an important distinction must first be made between risks associated with female-exclusive sex play and reported cases of Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STIs) among lesbian-identified women. Sexual identity is not the same as sexual behavior. Sexual behavior or sex play between women may include oral-genital sex, genital-genital contact, vaginal or anal sex using hands, fingers, or penetrative sex toys, and oral-anal sex (Marrazzo 2004). Though the rate of transmission of STIs and HIV between women is considerably lower compared with male-to-female sex, most lesbian-identified women (53%-99%) have had sex with men, and many (21%-30%) continue to do so—particularly younger lesbians who are most at risk for chlamydial infection (Bauer & Jairam 2008, Kitzinger & Peel 2005, Marrazzo 2004).

Studies on HIV-positive self-identified lesbians show subjects often acquire HIV through injection drug use or sex with men. According to GMHC.org:

Of the 109,311 cases of AIDS reported among women through 1998, 2,220 reported having sex with women. However, the majority of these women also reported other high-risk behaviors such as drug use and unprotected sex with high-risk men (gay and bisexual men). Of these cases, 347 women reported having sex only with women.

However, the US Centers for Disease Control and Prevention (CDC) reports that HIV can be transmitted by any of the following means:

- Blood (including menstrual blood)
- Semen (including pre-seminal fluid or “pre-cum”)
- Mother to child – perinatally (pregnancy, labor, delivery) and/or breast milk

With regard to blood, if one female partner is HIV-positive, the HIV virus will be in her vaginal secretions and menstrual blood. Exposure to these secretions through the mucous membranes (mouth and vagina) could lead to HIV transmission. Thus, the CDC contends that female-to-female sex play remains a possible means for HIV transmission (GMHC 2009).

Though there are no confirmed cases of female-to-female sexual transmission of HIV in the United States database to date (CDC 2011), information on AIDSMap.com contends five cases of female-to-female HIV transmission have been reported. The few cases include a 2003 female-to-female HIV transmission through shared sex toys in Philadelphia. Also, an earlier Italian study of 18 “HIV-discordant lesbian couples” is cited on AIDSMap.com as having found three-quarters of the study’s subjects had been sharing sex toys and nearly all had engaged in oral sex. Resulting risk factors identified in sex between women included, but were not limited to:

- Oral sex (cunnilingus)
- Sharing sex toys

- Fisting, particularly if blood is drawn

In female-to-female sex play, the risk for sexually transmitted diseases (STD) transmission varies significantly depending on the STD. According to the Seattle and King County website on Public Health, “Herpes, HPV (genital wart virus), and bacterial vaginosis are transmitted fairly easily between women during female-exclusive sex. HIV, hepatitis B, gonorrhea, and Chlamydia are much less likely to be transmitted—the risk is low but it is still possible” (Mautner Report 2005)

Furthermore, a 2009 study of more than 48,000 HIV-negative young women between the ages of 13 and 24 found that the diagnosis of an STD or STI carries a threefold higher risk for a subsequent HIV diagnosis within 10 years. There was also a significant trend in female subjects who were first diagnosed with gonorrhea or syphilis to be diagnosed with HIV later than those who were first diagnosed with Chlamydia (Bosh 2009).

Although men represent the majority of new HIV infections and AIDS diagnoses in the US, the CDC has reported a dramatically increased impact on infections reported among women (regardless of sexual orientation). Women represented 8% of the AIDS diagnoses in 1985, 20% in 1995 and 25% in 2009. A more recent study by the Women’s HIV SeroIncidence Study (ISIS) in 2012 found African American and Hispanic females represent 80% of the approximately 30% of new HIV infections among U.S. females, even though these racial minority groups stand for less than a quarter of the total U.S. population combined (ISIS 2012).

Research shows that there are many social and economic barriers for racial minorities that can increase the risk of HIV and other STIs. These barriers include but are

not limited to social and economic realities—such as poverty, racial discrimination, limited access to health care and housing, and incarceration. Also, “stigma, fear, and silence can increase the risk of infection while decreasing the willingness to get support, get tested, and get treatment, if needed” (CDC 2013).

In addition to reporting the highest increase in HIV infection in recent years, African American women are also frequently associated with sexual discordance in earlier research. For example, a 2003 study to assess the range of discrepancy in self-reported sexual identity and behavior between four racial/ethnic groups found African American females had the lowest rates of concordance, while Asian female had the highest. However, breakdown of the data to exclude those who reported sex trade work or illegal sources of income improved the concordance rates for African American and Hispanic subsamples (Ross et al. 2003).

Regardless of race or ethnicity, the CDC insists that the WSW demographic remains at risk for both HIV and other STIs. Meanwhile, inconsistencies in already limited research potentially excuse healthcare practitioner ignorance and fuel misinformation among care-seeking clientele (Bauer & Jairam 2008, Fromby 2011, GMHC 2009). This review seeks to highlight health disparities caused by compounded vulnerabilities among WSW clientele. Misconceptions about this sexual minority population are also explored in order to define the meaning of culturally competent sexual health services for WSW.

Kaiser Permanente’s guide for LGBT-inclusive (lesbian, gay, bisexual, and transgender-specific) healthcare defines “culturally competent care” as a term used by medical professionals, advocates, and public-health researchers to describe “health care

that is sensitive to the health beliefs and behaviors, epidemiology and treatment efficacy of different population groups” (Kaiser Permanente 2000). For patient-advocacy organizations like Kaiser, the end goal is inclusive or nonjudgmental and informed service delivery for all patients. Though research has yet to reveal a single causative link between sexual orientation and a person’s access to quality healthcare, sexual minority patient populations like WSW face a unique combination of personal, societal, and industry-related obstacles in seeking Kaiser-approved culturally competent care (Marrazzo 2004).

Sexual minority patients who encounter obstacles in *seeking* care represent one area of concern in earlier research, while those patients who encounter obstacles to *receiving* quality care after finding a provider or practitioner represent another. The personal barrier to seeking culturally competent care most frequently discussed in the literature is the frequent self-denial of appropriate and medically accurate care exhibited by WSW (Klitzman & Greenberg 2002, Marrazzo 2004). In 2005, Mautner Project, a leading organization on lesbian health, found that 75% of lesbians delayed seeking healthcare compared to 54% of heterosexual women (Mautner Project 2005). Meanwhile, studies involving WSW who do actively seek care often cite disclosure as the most common self-inhibited barrier to receiving culturally competent care (Meckler et al. 2006). Another study found a majority (53-72%) of WSW patients disclosed neither sexual identity nor behavioral details with their primary care physician (PCP) (Roberts & Sorensen 1999). Furthermore, the experience of many sexual minority patients receiving care whom had “come out” to their physician described the experience as overwhelmingly negative (Lehmann et al. 1998). More recent studies are showing higher

rates of satisfaction with healthcare providers and practitioners from patients who chose to disclose (Klitzman & Greenberg 2002).

In summary, motives behind WSW patient obstacles to both seeking and receiving culturally competent care include but are not limited to: Insecurities about “coming out” to PCP; Fear of discrimination or assumptions about shared sexuality, reported behaviors and subsequent needs; Concerns about the medical professional’s degree of familiarity with sexual minority females and competence with surrounding health issues; Feelings of confusion or uncertainty about sexuality; Geographical, social and/or cultural isolation; Lack of health insurance; Trust with ones medical practitioner (Dean et al. 2000, Fromby 2011, Johnson et al. 2008, Mautner Project 2005, Meckler et al. 2006, Politi et al. 2009).

Not every reason supplied by authors exploring disparities in WSW sexual healthcare centers on self-inhibiting behavior. Social conditions are also credited as major barriers to WSW patients both seeking and receiving care in varying degrees (Dean et al. 2000, Meyer & Northridge 2007, Johnson et al. 2008). Authors emphasized themes of heterosexism and homophobia in the majority of articles detailing WSW-reported barriers to care. Despite the fact that social stigma surrounding homosexuality in the United States has diminished considerably over the past two decades, women remain reluctant to disclose sexual behaviors and orientation to their healthcare practitioner (Singh & Marrazzo 2009). Proof that fears of heterosexism are not unfounded can be seen in a number of recent articles relaying complaints from WSW patients that their healthcare practitioner chose to operate on the assumption that they were heterosexual instead of asking directly (Mautner Project 2005, Meckler et al. 2006). Most of these patients also

mentioned unsolicited endorsements from the physician for specific oral contraceptives to guard against the unwanted pregnancy their physician had only assumed they were stressing. Most experts continue to ignore the need for more female-focused sexual health research, even when sufficient data for studying behavior and identity already exists. In 2006, Pathela et al. extracted male response outcomes associated with a New York City population-based health survey. In focusing on men's sexual health related practices, the study found that many New York City men who have sex with other men (MSM) do not identify as gay and men who did not self-identify were less likely to have undergone HIV testing in the past year. The MSM-focused study closed with the recommendation that medical professionals look to men's behavior when assessing sexual risk, but the implications these findings have on women's sexual health were never discussed (Pathela et al. 2006). Thus, WSW sexual health research remains limited and, as a result, the training for most healthcare professionals is inadequate leaving the perception of WSW (or lesbian and bisexual-identified) patients' sexual health needs and risk in an ambiguous state (Marrazzo & Gorgos 2012, Obedin-Maliver et al. 2011).

Specialized training for serving sexual minority populations could be beneficial on both ends, yet is rarely seen in traditional medical settings. A 2011 study measuring the extent to which 176 undergraduate medical-education programs explored lesbian, gay, bisexual and transgender-related content showed a median of five hours in the entire curriculum dedicated to LGBT-specific health issues (Obedin-Maliver et al. 2011). Assumptions and misconceptions behind medical professionals' general perception of lower risk or STI or HIV immunity for WSW are indicators of broader social attitudes

remaining unchallenged throughout the education process and following, with respect to sexual health policy (Fromby, 2011, Kitzinger & Peel 2005, Solarz 1999).

An assessment of sexual health services and programs within major metropolitan areas across the U.S. shows many providing services through what some authors refer to as a “narrow perception” of female sexuality (Bourne & Robson 2009, Kaiser Permanente 2000). As previously stated, medical professionals from traditional medical establishments are often reported by WSW clientele for making heteronormative assumptions regarding behavior, including persistent promotion of oral contraceptives for safeguarding against unwanted pregnancy (Marrazzo & Gorgos 2012). Incidentally, many sexual health organizations advertising minority-inclusive care offer sexual identity-specific programming framed on the assumption that the way in which a patient chooses to self-identity is always congruent with their reported sex practices (Diamond 2008, Dolan & Davis 2008). According to a number of recent studies, however, the intersection of sexual identity and behavior is anything but predictable (Marrazzo 2001, Pathela et al. 2006, Reece et. al 2010).

In 2010, researchers from the Center for Sexual Health Promotion at Indiana University’s School of Health, Physical Education and Recreation surveyed 5,865 adolescents and adults ages 14 to 94 with the National Survey of Sexual Health and Behavior (NSSHB) on sexual experience and condom-use behavior. While 7% of adult female respondents and 8% of men identify as gay, lesbian or bisexual, “the portion of individuals in the U.S. who have had same-gender sexual interactions at some point in their lives is (significantly) higher” (Reece et. al 2010). Another study revealed that between 80-95% of self-identified WSW had a sexual history that included men. These

findings aligned with their WSW-reported reproductive-health outcomes, which included that 23% to 35% reported pregnancies (Singh & Marrazzo 2009, Valanis et al. 2000). At the same time, some authors argue that this kind of fluidity in sex and sexuality is rare and that it only reveals a reason to challenge the authenticity of those study participants' sexual orientation (Obermeyer 2005, Tabatabai 2010). According to Diamond, convincing either side of the fluid-stagnant sexuality debate to see logic in the other side would be a challenge. There is an 'assumption among scientists and laypeople alike that authentic sexual orientation develops early and is consistent through one's life.' What is authentic is what is stable. 'So the familiar battlegrounds are drawn: fix=biological=deserving of acceptance, and protection, whereas variable=chosen=fair game for stigma and discrimination' (Diamond 2008).

The inconsistent, dynamic nature of reported sex and sexuality in research on the intersection of identity and behavior is also seen in the variable measures used throughout the already limited WSW-focused research. Bauer et al. discovered over 100 measures across 201 papers related to female sexual health. This highly sporadic, inconsistent pattern for defining variables exemplifies how commonplace it is for authors to pull from different dimensions of orientation, varying identities, time periods, and definitions of "sex," and occasionally compile categories that other authors many not compile (Bauer & Jairam 2008). Aside from their research model and the absence of a universal definition, authors Bauer and Jairam suggest factors that potentially influence measure selection. These factors may or may not include; a lack of cultural knowledge or knowledge only pertaining to a specific sub-group that does not apply to the broader demographic, lack of communication with other public-health experts, statistical leverage in combining smaller

groups or prioritizing higher prevalence groups, and terms used in previous projects (Bauer & Jairam 2008). Subjectively defined research variables draw ample criticism throughout the literature (Arend 2005, Diamond 2005, Fromby 2011). One author describes the use of the term “lesbian” to communicate information on all three axes (identity, attraction, and behavior) as “careless” (Singh & Marrazzo 2009). Another article points out how perceived interchangeability of “WSW” and “lesbian and bisexual women” calls into question whether the already limited research renders comparable results (Bauer & Jairam 2008). Undoubtedly, imprecise terminology and corresponding assumptions fail to account for the complexity of women’s sexuality and have contributed to the lack of data on the sexual health practices of this dynamic population.

If sexual identity and behavior are as unpredictable as the literature portrays them to be, and cues associated with specific sexual identities are truly unreliable, patient disclosure and definition plays a primary role in a medical professional’s ability to administer culturally competent healthcare. In fact, several authors underlined the importance of full patient disclosure and referred to a client’s comprehensive sexual health history as their prerequisite for sexual health-related care (Boon & Stewart 1998, Politi et al. 2009, Reece et al. 2010). According to these articles, a more comprehensive sexual-health history leads to a more accurate patient assessment, and a more accurate assessment means a more appropriate treatment and diagnosis from the medical professional. The patient’s trust in their provider or healthcare practitioner is also considered essential for obtaining a comprehensive health history and accurate assessment. In general, there are four primary influential factors on patient satisfaction

and outcomes: 1) Patient-centered care; 2) Cultural context; 3) Quality of care; 4) Trust. Of these, trust is the most important.

Soliciting health-history details from first-time patients is traditionally a two-part process that begins with the client's written intake form responses and ends with their verbal testimonials during the patient-practitioner discussion (King County). As indicated on the Public Health Website for Seattle and King County, the intake form is a paper document listing questions concerning everything from personal contact information and previous surgeries, to current relationship status and concerns about future wellbeing. While one-on-one patient-practitioner discussions are typically held behind closed doors, intake forms are administered to new patients as they enter a clinic's waiting room. The intake form must be completed by all new patients and submitted to a staff representative before an introductory in-person session with any new physician can begin. Intake form responses essentially offer physicians a cue card for prompting additional details from each new patient during the in-person discussion. The discussion is the final contextual opportunity a medical professional has to interact with a care-seeking client prior to administering a diagnosis and recommending treatment (Meckler et al. 2006, Politi et al. 2009).

Several authors place patient satisfaction in the hands of the patient by describing the intake form and patient-practitioner interview as two contextual opportunities where care-seeking clients can take control of their appointment (Boon & Stewart 1998, Tabatabai 2010). Some sources directly relate the extent to which sexual health history details are disclosed to the quality of the clinic visit outcomes. In this scenario, the pressure to obtain culturally competent care falls on the first-time clientele. Meanwhile,

patient-advocacy organizations and information bases, such as the Gay and Lesbian Medical Association (GLMA) and the Lesbian Health & Research Center (LHRC), argue that a negative or positive tone for the patient experience can be determined long before any new client enters a clinic waiting room. So while the first set of authors emphasize patient disclosure for ensuring competent assessment and diagnosis, some organizations place the onus for successfully prompting comprehensive disclosure back on the medical professional (GLMA 2006, Kaiser Permanente 2000, LHRC). In other words, GLMA supports the argument that detailed responses to intake form questions can be beneficial to client care, but also stresses the importance of effectively wording the questions so as to successfully prompt the kind of personal details that will aid in a more accurate diagnosis. In fact, a 2008 *Journal of Homosexuality* supplemental issue entitled, “HIV Testing Among Lesbian Women: Social Contexts and Subjective Meanings,” supports the perception that the medical professional has the majority of control over new-patient appointment outcomes. To that end, the article encourages that sexual health service organizations use inclusive forms and languages, and that the discussions led by organizational staff do not assume the individual’s identity, orientation, behavior or relationship status—as all points are crucial for facilitating optimal delivery of care and services (Dolan & Davis 2008).

In the absence of an enforced universal standard for WSW-specific healthcare, such recommendations for LGBT-inclusive care are highly beneficial to those medical professionals who actively serve, or anticipate serving, a sexual minority patient population. Culturally competent and nonjudgmental recommendations for service organizations’ marketing materials, clinic environments, intake forms and patient

interviews can and should be as inclusive as an-expanding patient population demands (Wilson-Stronks et al. 2008). A patient's willingness to disclose sexual health history details does not guarantee a physician will have been adequately trained to treat them. In fact, continued education for medical professionals is supported in the literature as a means to keep physicians current on any recent sexual health service delivery frameworks seeing gains in patient satisfaction (Obedin-Maliver et al. 2011).

Ultimately, no additional information can guarantee gains in cultural competency when medical professionals feel stigma toward same-sex practices. A 2000 survey of medical students found that 25% believed homosexuality to be immoral and felt negatively about interacting with this population; 9% thought homosexuality was a mental illness and 14% reported increased feelings of homophobia since the rise of AIDS (GLHR 2000). As the next generation becomes sexually active and begins to explore their sexual identities, their wellbeing depends on whether healthcare professionals are both accepting and equipped to handle everything from coming out to safe sex counseling. From school nurses to primary care physicians, everyone should be properly trained and culturally competent if their role entails addressing sexual-minority health needs (Johnson et al. 2008). Though contextually different, the same thorough training is needed for those medical professionals addressing the sexual-health needs of the increasingly older generation of baby boomers. A 2006 Met Life study of lesbian and gay baby boomers entitled "Out and Aging" found that although the typical LGBT baby boomer is well-educated, middle-class, employed, in a committed relationship, and more likely to be "out" than the previous generation, 26% of lesbians said discrimination was their greatest concern about accessing health services more frequently with age and 20%

had little to no confidence that healthcare practitioners would treat them with respect (MetLife 2006). It is important to note, however, that even medical professionals motivated to do more can do little with insufficient funding, inaccurate information or a limited outreach model (Johnson et al. 2008, Klitzman & Greenberg 2002).

CHAPTER 3 | METHODOLOGY

This chapter outlines this two-part study's quantitative research approach to assessing the issue of WSW sexual discordance and the qualitative research approach utilized to explore organizational solutions for WSW-competent care.

PART 1 | QUANTITATIVE RESEARCH — *Assessing the Problem*

RESEARCH QUESTION | Do WSW who do not self-identify as lesbian or bisexual engage in more high-risk sexual behavior than women who do self-identify, and are the behavioral differences of WSW who do not self-identify placing them at greater health risk?

QUANTITATIVE | **HYPOTHESES**

If high-risk is defined as two or more sex partners in the past 12 months, infrequent HIV and Pap testing, or no condom used at last sexual encounter, straight-identified women who have sex with women (WSW) are more likely than their lesbian or bisexual-identified counterparts to have had two or more sex partners (H1), but less likely than lesbian or bisexual-identified WSW to have been tested for HIV in that time, or ever (H2). Straight-identified WSW are also less likely than lesbian or bisexual-identified WSW to have had a Pap test in the past 3 years (H3). Multiple sexual partners in conjunction with less primary (Pap test) or secondary (HIV test) care make straight-identified WSW the most at-risk female identity-behavior demographic (H4).

Nonexclusive WSW who report sex with at least one male partner in the past year (WSWM), regardless of sexual identity, are more likely to report high-risk behaviors than female respondents who have sex exclusively with other women (WSWX) (H5). If high-risk is defined as two or more sex partners in the last year, infrequent HIV, or no condom

used at last sexual encounter for WSWM, straight-identified WSWM are more likely than lesbian and bisexual-identified WSWM to report high-risk behaviors (H6).

QUANTITATIVE | **SAMPLE DATA SOURCE**

The quantitative analysis and evaluation of existing data from a NYC Community Health Survey (CHS) addresses the intersection of sexual behaviors and identity. From 2002 to 2009, 10,000 adults aged 18 and older participated in the cross-sectional survey. Based on the National Behavioral Risk Factor Surveillance System (BRFSS) and conducted by the Centers for Disease Control and Prevention, the CHS gathers data on a sample population comparable in size to Chicago. CHS administrators ask both male and female respondents a number of questions related to sexual health each year. As a prior study has examined male sexual identity and behavior (Pathela et al., 2006), this study, only considers response outcomes from sexually active female respondents.

The CHS uses a stratified random sample to produce neighborhood and citywide estimates. Strata are defined using the [United Hospital Fund's \(UHF\)](#) neighborhood designation, modified slightly for the addition of new zip codes since UHF's initial definitions. There are [42 UHF neighborhoods in NYC](#), each defined by several adjoining zip codes and a [computer-assisted telephone interviewing \(CATI\)](#) system is used to collect the survey data.

CHS did not sample groups that could not be reached by the telephone survey. Data are weighted to account for households without telephones. CHS began including a cell-phone-only sample in 2009, which is reported to have had only a nominal affect.

Detailed information about the CHS sampling methodology is available at (<http://www.nyc.gov/html/doh/html/survey/chsdata.shtml>).

Although inconsistencies in questions surrounding female sexual health could be found across all CHS surveys, a cross-comparison of codebooks revealed thirteen common variables between 2007, 2008 and 2009. Descriptive statistics showed a limited number of female respondents in each year reported sex with other women (WSW). Thus, all three years were combined to produce a sufficient study sample of 7,520 total sexually active females, which included 288 WSW respondents.

QUANTITATIVE | ANALYTIC SAMPLE RESPONSE RATES BY YEAR

CHS documented response and cooperation rates every year that data was collected. According to the CHS Website, cooperation rates represent the number of those who participated in the survey, divided by the number of individuals in the sample who were contacted and identified as eligible. Response rates represent the number of individuals who participated in the survey, divided by the number of individuals in the sample who were contacted and identified as eligible, as well as those never contacted and those with unknown eligibility. In 2007, an analytic sample of 9,554 respondents produced a 32.8% response rate and 90.4% cooperation rate. In 2008, an analytic sample of 7,554 respondents produced a 33.3% response rate and 80.7% cooperation rate. In 2009, responses were weighted to account for the distribution of the adult population. With data from 2008's New York City Housing and Vacancy Survey, participants were separated into one of three categories for telephone use (landline only, landline and cell, cell only). The resulting analytic sample of 9,934 produced response rates that were 34%

landline and 50% cell only, and cooperation rates that were 88% landline and 97% cell only.

QUANTITATIVE | VARIABLES

CHS variables for female sexual behavior (women who reported sex with women) and sexual identity (heterosexual or straight; homosexual or lesbian; and bisexual) were combined to produce 3 analytic identity-behavior groups of WSW, straight-identified (heterosexual), lesbian-identified (homosexual), and bisexual-identified. One new variable combining sexual identity and sexual behavior, in addition to 13 other CHS-defined variables utilized for this study, provided a multivariate representation of all three WSW identity-behavior groups. Response outcomes revealing the number of WSW who reported exclusively female sex partners split each identity-behavior analytic group into two analytic subgroups; female respondents who reported sex with other women only and female respondents who reported sex with at least one male partner in the past 12 months.

CHS representatives questioned participants about their sexual identity in the middle of the survey amidst demographic characteristics questions. All other survey questions related to sexual behavior were asked toward the end. These questions included history of testing for HIV, Pap tests and total number of sexual partners of either sex and can be seen below in **Figure 1**. The survey questions about sex partners were inconsistent, as the survey told interviewers to always define “sex” with a man, but only to define “sex” with a woman if asked for clarification. This inconsistency may have affected the reported prevalence of sex with men and women.

The CHS survey also asked respondents age, education level, marital status, race or ethnicity, and place of birth.

FIGURE 1 | Chart of Questions in CHS Survey 2007 – 2009

1 | DEMOGRAPHIC Module:

Sexual Identity | Q. Now I'll read a list of terms people sometimes use to describe themselves -- heterosexual or straight; homosexual, gay or lesbian; and bisexual. As I read the list again, please stop me when I get to the term that best describes how you think of yourself.

1. Heterosexual (straight)
2. Gay or Lesbian
3. Bisexual

2 | SEXUAL BEHAVIOR Module:

Male sex partners | Q. During the past 12 months, with how many men have you had sex? By sex we mean oral, vaginal or anal sex, but not masturbation.

Female sex partners | Q. During the past 12 months, with how many women have you had sex?

(If asked: "By sex we mean oral, vaginal or anal sex, but not masturbation."*)

**No record of how many respondents called for clarification of the term "sex."*

Ever female sex | Q. Have you ever had sex with a woman?

(If asked: "By sex we mean oral, vaginal or anal sex, but not masturbation."*)

**No record of how many respondents called for clarification of the term "sex."*

1. Yes
2. No
3. Don't know/Not sure
4. Refused

Sex partners | Total number of sex partners of either gender in the past 12 months**

***Combination of response outcomes with number of male and female partners reported in prior questions (For this study, response outcomes were recoded to narrow the categories to three and exclude all responses of < 1 sex partner)*

1. One
2. Two
3. Three+

HIV test in past 12 months | Q. Have you had an HIV test in the last 12 months?

1. Yes
2. No

HIV test ever | Q. Have you ever had an HIV test?

1. Yes
2. No

Pap test in past 3 years | Q. Have you had a Pap test in the past 3 years?

1. Yes
2. No

Condom use | Q. The last time you had sex with a man, did you use a condom?
(If asked: "This includes the female condom.")

1. Yes
 2. No
-

QUANTITATIVE | **DEPENDENT / RISK-RELATED VARIABLES**

Four dependent variables relating to sexual health were considered while assessing concordant and discordant sexual behaviors between WSW identity-behavior groups:

- Number of sexual partners of either gender
- Testing for HIV in the past 12 months
- Testing for HIV ever
- Pap test screenings within the past 3 years

A fifth dependent variable was used that related only to respondents who report sex with at least one male partner in the past 12 months:

- Condom use at last sex

CHS only questioned female respondents reporting sex with at least one male partner in the past 12 months whether they had used a condom at last sex. If prompted, interviewers could clarify that condom refers to both female and male condoms. Despite

this sex-partner-exclusive framework, **condom use** response outcomes remain relevant to this WSW-specific study for two reasons; condom use plays a significant role as an effective and accessible method for preventing risk and questions about condom use solicited CHS survey responses in each WSW identity-behavior group, resulting in two subgroups for each WSW category. Risk behavior among women who report exclusively female sex partners (WSWX) is illustrated in **Table 1c** (page 39), while response outcomes associated with women who report sex with at least one male (WSWM) are explained in **Table 1d** (page 41), which includes a look at reported condom use.

QUANTITATIVE | STATISTICAL ANALYSIS

A One-Way ANOVA was used to find variance between groups in regards to other demographic and behavioral covariates such as age, ethnicity, marital status, education level, condom use among WSW reporting male partners, and place of birth. A post-hoc Tukey Test was used to find statistically significant differences across groups regarding four response outcomes relating to female sexual health. The identity-behavior group reporting fewer sexual partners and more frequent HIV and Pap tests are considered less at-risk for sexually transmitted disease and infection in this particular study.

PART 2 | QUALITATIVE RESEARCH — *Assessing the Solution*

RESEARCH QUESTION | *What are the best practices for professional and trained healthcare practitioners at Chicago-based sexual health service organizations that specialize in serving women who have sex with women (WSW), and how do these providers address the intersection of female sexual behavior and identity?*

QUALITATIVE | SAMPLE SELECTION PROCESS

In an informal consensus survey of public health professionals and self-identified members of the lesbian community, four sexual health service practitioners were credited time and again with culturally competent, WSW-specific services: All Women's Health (AWH), Chicago Women's Health Center (CWHC), Howard Brown Health Center (HBHC), and Planned Parenthood of Illinois (PPIL). Consensus survey participants reported high levels of patient satisfaction, defined by provider and practitioner competency and patient inclusiveness. After PPIL's administrators clarified that legal restrictions prevented any interviews with clinic staff, this exploratory focused in on three of the four in an effort to distinguish differences between WSW-friendly approaches. Background information on each organization selected for this qualitative study is provided below:

All Women's Health (AWH)

(<http://www.allwomenshealth.net/>)

AWH in Chicago's Bucktown neighborhood opened in 2005 and is one of three clinics (Seattle, WA and Tacoma, WA) privately owned and operated by an all-female staff. Services include, but are not limited to men's and women's primary and gynecological care, surgical & non-surgical abortions, pregnancy tests, STD testing, annual exams, contraception, and ultrasounds. As an organization, employees are trained to empower patients by keeping them informed and encourage patients to take control of their bodies by keeping them involved in the healthcare process.

Chicago Women's Health Center (CWHC)

(<http://chicagowomenshealthcenter.org/>)

CWHC, started in 1975 by female medical professionals and activists, is a collective of healthcare professionals, counselors, outreach health educators, and physicians who offer a wide range of gynecological and mental healthcare services for female and transgender clientele. Services include, but are not limited to, gynecology, counseling, acupuncture, massage, alternative insemination, TGAP (Trans Greater Access Project), outreach and education, and fertility awareness. The organization prioritizes affordable and accessible healthcare in a nonjudgmental environment where preventative, alternative, and holistic care are encouraged and supported.

Howard Brown Health Center/Lesbian Community Care Project (HBHC/LCCP)

(<http://howardbrown.org/>)

Founded in 1974, Howard Brown Health Center is a nonprofit healthcare organization that offers services and programming created to promote and address issues relating to lesbian, bisexual, queer and transgender health. Founded by female activists and providers in 1990, LCCP is female-specific initiative of HBHC that promotes the health of lesbian, bisexual, queer and transgender individuals through health services, advocacy, public education, research and programming. Services include, but are not limited to, alternative insemination and parenting workshops, primary and gynecological care, Pap tests and breast/chest exams, STD/HIV testing, outreach and education, behavioral health services, and a variety of support programs for sexual minority-specific needs.

QUALITATIVE | RESEARCH METHODS

CONTEXT-BASED ASSESSMENT

For the qualitative portion of this two-part study, contextual opportunities in which patient-practitioner interactions occur provided a guide for cross-comparing

organizational approaches within AWH, CWHC, and HBHC. Contextual themes for assessing patient-provider interaction in this study are as follows:

1. Outreach and Marketing
2. Physical Clinic Environment
3. Clinical Intake Form
4. Patient-Practitioner Discussion

The order of the four above-mentioned contexts intentionally parallels the chronological steps taken by any new care-seeking client.

IDENTIFYING BEST PRACTICES

According to the Gay and Lesbian Medical Association (GLMA), the client's first impression of a service provider sets the tone for all patient-practitioner interactions to follow (at that clinic and, potentially, others, regardless of location) (GLMA, 2006). Therefore, the group offers provider-focused recommendations for each interactive context, which will frame each organizational assessment:

OUTREACH & MARKETING

- Participating in provider referral programs through LGBT organizations (e.g., www.glma.org, www.gayhealth.com, or local LGBT organizations) or advertising your practice in LGBT media can create a welcoming environment even before a patient enters the door.
- If your office develops brochures or other educational materials, or conducts trainings, make sure that these include relevant information for LGBT patients.
- Open dialogue with a (prospective) patient about their gender identity/expression, sexual orientation, and/or sexual practices means more relevant and effective care.

CLINIC ENVIRONMENT

- Rainbow flags, pink triangles, unisex bathroom signs, or other LGBT-friendly symbols or stickers
- Exhibit posters showing racially and ethnically diverse same-sex couples or transgender people. Or posters from nonprofit LGBT or HIV/AIDS organizations.
- Display brochures (multilingual when possible and appropriate) about LGBT health concerns, such as breast cancer, safe sex, hormone therapy, mental health, substance use, and sexually transmitted diseases (STDs—also called sexually transmitted infections or STIs such as HIV/AIDS, syphilis, and Hepatitis A and B).
- Disseminate or visibly post a nondiscrimination statement stating that equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, or gender identity/expression.
- Acknowledge relevant days of observance in your practice such as World AIDS Day, LGBT Pride Day, and National Transgender Day of Remembrance
- Display LGBT-specific media, including local or national magazines or newsletters about and for LGBT and HIV-positive individuals.

INTAKE FORMS

GLMA also provides service organizations with a recommended standard version of the intake form (GLMA 2006). In summary, they recommend intake forms offer more inclusive choices for answers to questions, open-ended questions, and use “partner” wherever the word “spouse” is used instead. A comprehensive list of all sample question suggestions can be found in Appendix 2, page 120.

PATIENT-PRACTITIONER DISCUSSION

In regard to the patient-practitioner discussion, GLMA recommends the following for healthcare practitioners:

Express empathy; Avoid assumptions and intrusive questions; Use inclusive and gender-neutral language; Prepare for all possible patient concerns with current and comprehensive education; Follow the patient's lead on preferred terms or labels; Request clarification when needed (GLMA 2006)

A comprehensive list of GLMA-recommended suggestions an optimal patient-practitioner interview can be found in Appendix 3, page 122.

QUALITATIVE | DEFINING OPTIMAL PATIENT CARE

Based on a 2008 clinical fact sheet from the Association of Reproductive Health Professionals (ARHP), optimal (reproductive or sexual) healthcare for WSW patients can be best described as confidential, comprehensive and appropriate healthcare free from any assumptions or bias that a patient can access, as well as understand (ARHP 2008). In this section, transcripts from interviews with clinical and administrative staff members at AWH, CWHC, and HBHC will be gathered and explanations for optimal patient care, cross-compared. The two sets of interview questions used to prompt personal accounts of optimal patient care from practitioners can be seen in Appendix 4, page 123.

Findings from this qualitative research—as well as those resulting from the previously discussed initiative—are outlined in the following chapter.

CHAPTER 4 | DATA ANALYSIS and RESULTS

The quantitative portion of this research showcases a statistical pattern in the intersection of sexual behavior and identity, while the qualitative portion reveals shared themes across three distinctly different organizational approaches to inclusive and competent (or optimal) patient care.

PART 1 | QUANTITATIVE RESULTS

Female CHS Survey Participants

Of the 7,575 sexually active women surveyed annually between 2007 and 2009, a total of 288 female respondents reported sex with other women. Among the 288 WSW respondents, 158 (55%) described themselves as homosexual or lesbian, while 42 (14%) preferred bisexual. Of the 88 (31%) WSW who self-identified as straight or heterosexual, 46.6% were married when the survey took place and 19.4% had been previously married. Lesbian and bisexual respondents reported much lower marriage rates with only 7% married in each category. According to New York City's website for the City Clerk's Office, same-sex marriage was not declared legal in New York until July of 2011. Therefore, the CHS survey question about marital status in 2007-2009 referred to a legal union between two people, one from each sex.

A multivariate analysis of covariate response outcomes (including age, education, ethnicity, marital status, and place of birth) can be seen in **Table 1a** (page 33).

TABLE 1a

WSW

ALL sexually active female respondents who reported sex with at least one female partner in the past 12 months

MULTIVARIATE ANALYSIS OF VARIABLES ASSOCIATED WITH WSW REPORTED NUMBER OF SEXUAL PARTNERS, REPORTED HISTORY OF TESTING FOR HIV & REPORTED HISTORY OF PAP TESTS

*NYC Community Health Survey — Public Use Data : <http://www.nyc.gov/html/doh/html/survey/chsdata.shtml>

ALL Women Who Have Sex With Women (2007-2009; n=288)

| COVARIATES | n= | Straight-identified WSW | Lesbian-identified WSW | Bisexual-identified WSW | = | TOTAL BASE | VS. Straight-identified Women Who Do Not Have Sex with Women (n= 7232) |
|--|------------|-------------------------|------------------------|-------------------------|---|--------------|--|
| | | | | | | | |
| Age: <i>Age-bracket for respondent when surveyed</i> | 88 | 158 | 42 | 288 | | | |
| 18-24 y | 7 (8.0%) | 13 (8.2%) | 10 (23.8%) | 30 (10.4%) | | 374 (5.2%) | |
| 25-44 y | 37 (42%) | 61 (38.6%) | 24 (57.1%) | 122 (42.4%) | | 3562 (49.3%) | |
| 45-64 y | 35 (39.8%) | 80 (50.6%) | 8 (19%) | 123 (42.7%) | | 2776 (38.4%) | |
| 65+ y | 9 (10.2%) | 4 (2.5%) | 0 (.0%) | 13 (4.5%) | | 513 (7.1%) | |
| Education: <i>Highest level of school completed</i> | 87 | 158* | 42 | 287 | | | |
| < high school | 12 (13.8%) | 8 (5.1%) | 8 (19.0%) | 28 (9.8%) | | 807 (11.2%) | |
| high school grad | 27 (31.0%) | 21 (13.3%) | 10 (23.8%) | 58 (20.2%) | | 1611 (22.3%) | |
| some college | 17 (19.5%) | 43 (27.2%) | 6 (14.3%) | 66 (23%) | | 1621 (22.5%) | |
| college grad | 31 (35.6%) | 86 (54.4%) | 18 (42.9%) | 135 (47%) | | 3181 (44.1%) | |
| Ethnicity: <i>Self-selected race of respondent</i> | 88 | 158 | 42 | 288 | | | |
| White | 24 (27.3%) | 80 (50.6%) | 10 (23.8%) | 114 (39.6%) | | 2820 (39%) | |
| Black | 21 (23.9%) | 41 (25.9%) | 17 (40.5%) | 79 (27.4%) | | 1934 (26.7%) | |
| Hispanic | 39 (44.3%) | 26 (16.5%) | 11 (26.2%) | 76 (24.4%) | | 1907 (26.4%) | |
| Asian | 0 (.0%) | 5 (3.2%) | 2 (4.8%) | 7 (2.4%) | | 419 (5.8%) | |
| Other | 4 (4.5%) | 6 (3.8%) | 2 (4.8%) | 12 (4.2%) | | 152 (2.1%) | |
| Marital Status: <i>Relationship status when surveyed</i> | 88 | 156 | 42 | 287 | | | |
| Married | 41 (46.6%) | 11 (7.1%) | 3 (7.1%) | 55 (19.2%) | | 3534 (49.0%) | |
| Divorced | 10 (11.4%) | 14 (9.0%) | 3 (7.1%) | 27 (9.4%) | | 776 (10.8%) | |
| Widowed | 2 (2.3%) | 3 (1.9%) | 0 (.0%) | 5 (1.7%) | | 232 (3.2%) | |
| Separated | 5 (5.7%) | 4 (2.6%) | 5 (11.9%) | 14 (4.9%) | | 404 (5.6%) | |
| Never Married | 23 (26.1%) | 62 (39.7%) | 22 (52.4%) | 107 (37.3%) | | 1749 (24.3%) | |
| Partnered | 7 (8.0%) | 62 (39.7%) | 9 (21.4%) | 78 (27.2%) | | 512 (7.1%) | |
| US Born: <i>Yes if born in U.S.</i> | 88 | 158 | 42 | 287 | | | |
| YES | 56 (63.6%) | 138 (87.3%) | 34 (81%) | 228 (79.2%) | | 4410 (61.1%) | |

*Significantly different from the other 2 identity-behavior groups at p < .05

Differences between each WSW identity-behavior group are summarized below:

Lesbian-identified WSW (*congruent identity-behavior*) are disproportionately older with the majority aged past 45 years (53.1%), more educated with more than half having graduated from college (54.4%), mostly white (50.6%) and U.S.-born (87.3%) with very few married or ever having been married (78.4%).

Bisexual-identified WSW (*congruent identity-behavior*) are much younger than lesbian and straight-identified WSW with a majority below age 44 (80.9%) and most describe themselves as black or African American (40.5%).

Straight-identified WSW (*incongruent identity-behavior*) are primarily Hispanic (44.3%) and were disproportionately married (46.6%) when surveyed. Over one-third of straight-identified respondents were born outside the U.S. (36.4%).

The 7,232 straight-identified WSM (women who have sex with men) and 88 straight-identified WSW (women who have sex with women) CHS surveyed between 2007 and 2009 showed similar response outcomes on age, education, ethnicity, marital status, and place of birth.

Multivariate models were also used to showcase four independent risk factors used to define high-risk sexual behavior in this study and how these factors relate to each identity-behavior analytic group. Differences between all WSW groups' risk-related response outcomes are illustrated in **Table 1b** (page 35).

TABLE 1b

WSW

ALL sexually active female respondents who reported sex with at least one female partner in the past 12 months

PERCENTAGES OF SEXUAL BEHAVIORS OF CONCORDENT & DISCORDANT WSW IDENTITY-BEHAVIOR GROUPS

*NYC Community Health Survey — Public Use Data : <http://www.nyc.gov/html/doh/html/survey/chsdata.shtml>

WOMEN WHO HAVE SEX WITH WOMEN (WSW)

| DEPENDENT VARIABLES | n= | Straight-identified WSW | Lesbian-identified WSW | Bisexual-identified WSW | = TOTAL BASE | VS. Straight-identified Women Who Do Not Have Sex with Women (n= 7232) |
|--|----|-------------------------|------------------------|-------------------------|--------------|--|
| | | | | | | |
| sexpartner: Number of sex partners within the past 12 months (male or female) | | 19 | 150 | 14 | 183 | |
| 1 | | 13 (14.8%) | 137 (86.7%)* | 7 (16.7%) | 154 (53.5%) | 6676 (92.3%) |
| 2 | | 31 (35.2%) | 10 (6.3%)* | 15 (35.7%) | 56 (19.4%) | 389 (5.4%) |
| 3+ | | 44 (50.0%) | 11 (7.0%)* | 20 (47.6%) | 75 (26%) | 167 (2.3%) |
| hiv12months: Has had an HIV test within the past 12 months | | 19 | 150 | 14 | 183 | |
| YES | | 34 (40.0%) | 47 (29.7%) | 29 (69.0%)* | 110 (38.6%) | 2557 (35.9%) |
| everhivtest: Has had an HIV test within their lifetime | | 19 | 149 | 13 | 181 | |
| YES | | 62 (72.9%) | 111 (70.7%) | 39 (95.1%)* | 212 (75%) | 4906 (69.5%) |
| paptest3yrall: Has had a Pap test within the past 3 years | | 19 | 150 | 14 | 182 | |
| YES | | 67 (79.8%) | 130 (82.3%) | 34 (81.0%) | 231 (81.3%) | 6445 (89.6%) |

*Significantly different from the other 2 identity-behavior groups at p < .05

**HIGH RISK BEHAVIOR
HIGH-RISK RESPONSE OUTCOMES**

WSW

WSW IDENTITY-BEHAVIOR GROUPS

| COMBINED HIGH-RISK RESPONSE OUTCOMES <i>(Responded yes to both questions listed below)</i> | Straight-identified WSW | Lesbian-identified WSW | Bisexual-identified WSW | = TOTAL BASE |
|---|-------------------------|------------------------|-------------------------|--------------|
| Two or more sexual partners in the past 12 months + NO HIV testing past 12 months | 60.0% | 70.3% | 31.0% | 61.4% |
| Two or more sexual partners in the past 12 months + NO HIV testing ever | 27.1% | 29.3% | 4.9% | 25.1% |

Mean differences between identity-behavior groups are statistically significant at p < .01

In summary, the fewer number of sex partners reported by lesbian-identified respondents in the sample is reflective of the general population at a 95% level of confidence (H1). The high response outcomes from bisexual-identified respondents' HIV testing within the past 12 months is also a reflection of the general population at a 99.9% level of confidence (H2). Though not statistically significant, all three identity-behavior groups reported high response outcomes to Pap tests within the past 3 years (H4), and bisexuals revealed the highest percentage of condom use at last sex with a male partner (H5).

HYPOTHESIS 1 | The first hypothesis (*Straight-identified WSW are more likely than lesbian or bisexual-identified WSW to have had two or more sexual partners within the past 12 months*) is **somewhat supported by the data.**

Straight-identified WSW (85.2%) are more likely than lesbian-identified WSW (13.3%) to have had two or more sexual partners in the past 12 months. Bisexual-identified females (83.3%) are just as likely to report two or more sexual partners as the straight-identified respondents.

HYPOTHESIS 2 | The second hypothesis (*Straight-identified WSW are less likely than lesbian or bisexual-identified WSW to have had an HIV test in the past 12 months or ever*) is **somewhat supported by the data.**

Straight-identified WSW (40%) are less likely than bisexual-identified WSW (69%) to have been tested for HIV in the past 12 months, but more likely than lesbian-identified WSW (29.7%). Straight-identified WSW (72.9%) are less likely than bisexual-identified WSW (95.1%) to have had an HIV test in their lifetime, while straight-

identified WSW and lesbian-identified WSW (70.7%) showed similar response outcomes to testing for HIV ever.

HYPOTHESIS 3 | The third hypothesis (*Straight-identified WSW are less likely than homo or bisexual-identified WSW to have had a Pap test in the past 3 years*) is **not supported by the data.**

There was no statistically significant difference among straight-identified WSW (79.8%), lesbian-identified WSW (82.3%), and bisexual-identified WSW (81%).

HYPOTHESIS 4 | The fourth hypothesis (*Straight-identified WSW are the most at-risk female identity-behavior demographic*) is **supported by the data.**

In general, lesbian-identified WSW were overwhelmingly monogamous (86.7%) in the past year and reported significantly higher incidence of monogamy than straight (14.8%) or bisexual-identified (16.7%) WSW at $p < .05$. Bisexual-identified WSW showed significantly higher incidence of HIV testing in the last year (69%) and ever (95.1%) than lesbian (29.7% last yr., 70.7% ever) and straight-identified (40% last yr., 72.9% ever) WSW at $p < .05$ respectively.

For the purpose of testing H4, however, this study quantifies high-risk sexual behavior as a combination of the following response outcomes:

- Two or more sexual partners in the past 12 months
- NO HIV test in the past 12 months or no HIV test ever

Fewer sexual partners and higher incidents of testing, therefore, denote lower risk in this study.

With this new definition of risk, differences between the three identity-behavior groups were found to be statistically significant at $p < .01$. The first combination of response outcomes, which indicated two or more sexual partners in the past year and no HIV testing in that same frame of time, saw a mean percentage of 60.0% straight-identified WSW, 70.3% lesbian-identified WSW, and 31.0% bisexual-identified WSW. The total mean percentage for all three groups in this first high-risk combination was 61.4%. The second combination of response outcomes, which indicated two or more sexual partners in the past year and no HIV testing ever, saw a mean percentage of 27.1% straight-identified WSW, 29.3% lesbian-identified WSW, and 4.9% bisexual-identified WSW. The total mean percentage for all three groups in this second high-risk combination was 25.1%.

HYPOTHESIS 5 | The fifth hypothesis (*WSW who report sex with at least one male partner in the past year (WSWM), regardless of sexual identity, are more likely to exhibit high-risk behaviors than women who have sex exclusively with other women (WSWX)*) is **somewhat supported by the data** (See **Table 1c**, page 39).

TABLE 1c

WSWX

Sexually active female respondents who reported exclusively female sex partners in the past 12 months

PERCENTAGES OF SEXUAL BEHAVIORS OF CONCORDANT & DISCORDANT WSWX IDENTITY-BEHAVIOR GROUPS

*NYC Community Health Survey — Public Use Data : <http://www.nyc.gov/html/doh/html/survey/chsdata.shtml>

WOMEN WHO HAVE SEX WITH WOMEN ONLY (WSWX)

| DEPENDENT VARIABLES | | Straight-identified WSWX | Lesbian-identified WSWX | Bisexual-identified WSWX | = TOTAL BASE | VS. Straight-identified Women Who Do Not Have Sex with Women (n= 7232) |
|--|---|--------------------------|-------------------------|--------------------------|--------------|--|
| | | n= | | | | |
| sexpartner: Number of sex partners within the past 12 months (male or female) | n= | 19 | 150 | 14 | 183 | |
| | 1 | 12 (63.2%) | 135 (90%) | 7 (50.0%) | 154 (84.2%) | 6676 (92.3%) |
| | 2 | 7 (36.8%) | 9 (6.0%) | 4 (28.6%) | 20 (10.9%) | 389 (5.4%) |
| | 3+ | 0 (.0%) | 6 (4.0%) | 3 (21.4%) | 9 (5%) | 167 (2.3%) |
| hiv12months: Has had an HIV test within the past 12 months | n= | 19 | 150 | 14 | 183 | |
| | YES | 6 (31.6%) | 42 (28.0%) | 7 (50.0%) | 55 (30.1%) | 2557 (35.9%) |
| | everhivtest: Has had an HIV test within their lifetime | n= | 19 | 149 | 13 | 181 |
| YES | 11 (57.9%) | 104 (69.8%) | 12 (92.3%) | 127 (70.2%) | 4906 (69.5%) | |
| paptest3yrall: Has had a Pap test within the past 3 years | n= | 19 | 150 | 14 | 182 | |
| | YES | 8 (44.4%) | 123 (82.0%) | 10 (71.4%) | 141 (77.5%) | 6445 (89.6%) |

*WSWX respondents were not questioned about condom use.

**HIGH RISK BEHAVIOR
HIGH-RISK RESPONSE OUTCOMES**

WSWX

WSWX IDENTITY-BEHAVIOR GROUPS

| COMBINED HIGH-RISK RESPONSE OUTCOMES <i>(Responded yes to both questions listed below)</i> | Straight-identified WSWX | Lesbian-identified WSWX | Bisexual-identified WSWX | = TOTAL BASE |
|---|--------------------------|-------------------------|--------------------------|--------------|
| Two or more sexual partners in the past 12 months + NO HIV testing past 12 months | 68.4% | 72.0% | 50.0% | 70.0% |
| Two or more sexual partners in the past 12 months + NO HIV testing ever | 42.1% | 30.2% | 7.7% | 30.0% |

Mean differences between identity-behavior groups are NOT statistically significant.

In general, **Table 1c** shows the WSWX majority (84.2%) reported monogamy for the past year, while nonexclusive WSW, or WSWM, have had at least two sex partners by definition. However, Table 1c also shows that, in addition to reporting fewer sex partners, WSWX also reported less frequent HIV testing (12 months: 30.1%; ever: 70.2%) and Pap tests (77.5%) than WSWM (HIV 12 months: 56%; ever: 83.5%; Pap: 87.6%). Therefore, it is conclusive that while WSWM show higher risk behaviors regarding number of reported partners, the WSWM respondents also show higher reported rates of HIV and pap testing than WSWX, who exhibit lower risk in terms of partner count.

HYPOTHESIS 6 | The sixth hypothesis (*Straight-identified WSWM respondents are more likely to exhibit high-risk sexual behaviors than lesbian and bisexual-identified WSWM*) is supported by the data (See **Table 1d**, page 41).

TABLE 1d

WSWM

Sexually active female respondents who were questioned about condom use at last sex after reporting at least one male sex partner in the past 12 months.

PERCENTAGES OF SEXUAL BEHAVIORS REPORTED BY WSWM ACROSS CONCORDENT & DISCORDENT IDENTITY-BEHAVIOR GROUPS

*NYC Community Health Survey — Public Use Data : <http://www.nyc.gov/html/doh/html/survey/chsdata.shtml>

WOMEN WHO HAVE SEX WITH WOMEN & MEN (WSWM)

| DEPENDENT VARIABLES | | Straight-identified WSWM | Lesbian-identified WSWM | Bisexual-identified WSWM | = TOTAL BASE | VS. Straight-identified Women Who Do Not Have Sex with Women (n= 7232) |
|--|-----|--------------------------|-------------------------|--------------------------|--------------|--|
| | | n= | | | | |
| sexpartner: Number of sex partners within the past 12 months (male or female) | n= | 66 | 6 | 28 | 100 | |
| | 1 | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 6676 (92.3%) |
| | 2 | 22 (33.3%) | 1 (16.7%) | 11 (39.3%) | 34 (34%) | 389 (5.4%) |
| | 3+ | 44 (50.0%) | 5 (83.3%) | 17 (60.7%) | 66 (66%) | 167 (2.3%) |
| hiv12months: Has had an HIV test within the past 12 months | n= | 63 | 6 | 28 | 97 | |
| | YES | 28 (44.4%) | 4 (66.7%) | 22 (78.6%) | 54 (55.7%) | 2557 (35.9%) |
| everhivtest: Has had an HIV test within their lifetime | n= | 63 | 6 | 28 | 97 | |
| | YES | 62 (72.9%) | 111 (70.7%) | 39 (95.1%) | 81 (83.5%) | 4906 (69.5%) |
| paptest3yrall: Has had a Pap test within the past 3 years | n= | 63 | 6 | 28 | 97 | |
| | YES | 67 (79.8%) | 130 (82.3%) | 34 (81.0%) | 85 (87.6%) | 6445 (89.6%) |

HIGH RISK BEHAVIOR (+ CONDOM USE/- PAP TESTS)

WSWM

WSWM IDENTITY-BEHAVIOR GROUPS

| COMBINED HIGH-RISK RESPONSE OUTCOMES <i>(Responded yes to both questions listed below)</i> | Straight-identified WSWM | Lesbian-identified WSWM | Bisexual-identified WSWM | = TOTAL BASE |
|---|--------------------------|-------------------------|--------------------------|--------------|
| Two or more sexual partners in the past 12 months + NO HIV testing (past 12 months or ever) | 55.6% | 33.3% | 21.4% | 44.3% |
| Two or more sexual partners in the past 12 months + NO condom use at last sex | 34.0% | 16.7% | 3.6% | 23.7% |
| NO HIV testing (past 12 months or ever) + NO condom use at last sex | 61.3% | 33.3% | 46.4% | 55.2% |
| NO condom use at last sex ONLY | 38.7% | 66.7% | 53.6% | 44.8% |

Mean differences between identity-behavior groups are NOT statistically significant.

In general, response outcomes from straight-identified WSWM exhibited more risk with reported rates of HIV testing (no test in past 12 months: 44.4%; no test ever: 72.9%) and condom use at last sex (no condom: 66.7%). Comparatively, lesbian (no test in past 12 months: 66.7%; no test ever: 70.7%; no condom use at last sex: 6.5%) and bisexual-identified (no test in past 12 months: 78.6%; no test ever: 95.1%; no condom use at last sex: 30.1%) WSWM reported fewer high-risk behaviors. **Table 1d** illustrates response outcomes associated with WSWM.

For the purpose of testing H6**, however, this study quantifies high-risk sexual behavior as a new combination of response outcomes that pertain only to those WSW who reported sex with at least one male partner in the past year (WSWM). The definition of high-risk sexual behavior within the WSWM demographic can be identified as one the following response outcomes or outcome combinations:

- Two or more sexual partners in the past 12 months + NO HIV testing (past 12 months or ever)
- Two or more sexual partners in the past 12 months + NO condom use at last sex
- NO HIV testing (past 12 months or ever) + NO condom use at last sex
- NO condom use at last sex

***Pap test response outcomes were not considered in testing H6 due to the similar and insignificant response outcomes the Pap test variable solicited in testing H4.*

With this new definition of risk, differences between the three identity-behavior groups were not found to be statistically significant. The first combination of response outcomes, which indicated two or more sexual partners in the past year and no HIV testing in the past year or ever, saw a mean percentage of 55.6% straight-identified

WSWM, 33.3% lesbian-identified WSWM, and 21.4% bisexual-identified WSWM. The total mean percentage for all three groups in this first high-risk combination was 44.3%. The second combination of response outcomes, which indicated two or more sexual partners in the past year and no condom at last sexual encounter, saw a mean percentage of 34.0% straight-identified WSWM, 16.7% lesbian-identified WSWM, and 3.6% bisexual-identified WSWM. The total mean percentage for all three groups in this second high-risk combination was 23.7%. The third combination of response outcomes, which indicated no HIV testing in the past year or ever and no condom at last sexual encounter, saw a mean percentage of 61.3% straight-identified WSWM, 33.3% lesbian-identified WSWM, and 46.4% bisexual-identified WSWM. The total mean percentage for all three groups in this third high-risk combination was 55.2%. The fourth and final measure for high-risk among WSWM was based on a single variable outcome. Exclusive consideration for condom use at last sexual encounter saw a mean percentage of 38.7% straight-identified WSWM, 66.7% lesbian-identified WSWM, and 53.6% bisexual-identified WSWM. The total mean percentage for all three groups in this final high-risk indicator was 44.8%.

Findings from the qualitative research are addressed in the following section.

PART 2 | QUALITATIVE RESULTS

OPTIMAL PATIENT CARE: DEFINED

Interviews with medical professionals employed at each organization provided further insight on varying interpretations of optimal patient care. Commonalities between respondents' transcripts include preferred means for ensuring patient satisfaction. The

resulting guide for optimal patient care is supported by first-hand accounts in the following sections of patient satisfaction (measured in competency, inclusivity, trust, and respect) from the practitioners' perspective.

In summary, from the ten, semi-structured interviews with clinical and administrative staff, four themes for understanding or interpreting optimal patient care emerged. According to respondents, if patient satisfaction is the end goal (as measured in competency, inclusivity, trust, and respect) practitioners must adhere to the following optimal care themes:

- *Avoid assumptions*
- *Communicate confidentiality*
- *Use inclusive language*
- *Let the client lead*

To clarify, though respondents had slightly different perceptions of the relationship between themes in optimal care and measures for patient satisfaction, there was some overlap in the correlations made. In general, while providers and practitioners who avoid assumptions about clientele are conveying *respect* for each patient's health-related concerns, communicating confidentiality to clientele is a one way for providers and practitioners to establish *trust*. Use of inclusive language conveys client *competency* and providers and practitioners who let the client lead are conveying *inclusivity* through allowing patients to play an active role in their healthcare.

Because all four themes were consistently mentioned by interviewees—regardless of context—optimal care themes offer a framework for introducing findings within three of the four following context-based sections (outreach and marketing, clinic environment,

and patient interview). The fourth context is formatted differently to allow for a cross-comparison of each organization’s intake form against the GLMA-recommended standard. Direct quotes from the ten interview transcripts introduce and explain the four themes in each context. The resulting guide, or list of recommendations, for ensuring patient satisfaction with respect to the themes in optimal care can be seen in **Table 2a**.

TABLE 2a

RECOMMENDATIONS FOR INCLUSIVE, CULTURALLY-COMPETENT SEXUAL HEALTH SERVICES

| OPTIMAL PATIENT CARE THEMES | PATIENT-PRACTITIONER INTERACTIVE CONTEXTS | | | |
|------------------------------------|---|--|--|--|
| | OUTREACH & MARKETING | CLINIC ENVIRONMENT | INTAKE FORM | PATIENT-PRACTITIONER DISCUSSION |
| AVOID ASSUMPTIONS | Engage potential patients at the local level; Discern community needs from perceived needs by directly connecting with those you serve or intend to serve | Nontraditional clinic setting; Nonjudgmental and welcoming front desk or reception area | Blank spaces allow clients to expand responses beyond existing options; More check box options conveys an acceptance of a wider range of lifestyles and behaviors | Ask lots of questions; Do not stereotype patients because no two are alike |
| COMMUNICATE CONFIDENTIALITY | All marketing materials should emphasize a patient’s right to privacy; Encourage prospective patients to consider your clinic as a safe haven for health history disclosure | Patient privacy rights or the clinic’s commitment to confidentiality should be prominently displayed in the waiting area or at the front desk (or any high-traffic area) | Bold, legible, prominently displayed statement of patient privacy rights or the clinic’s commitment to confidentiality | Display patient privacy rights in each office; Verbally remind any patient encountered of their right to privacy |
| INCLUSIVE LANGUAGE | Use the most all-inclusive terms when addressing an audience unless otherwise specified | Unisex restrooms; Broader terminology in marketing materials (including the mission statement) that welcome any demographic for which services are applicable | Extensive gender options that include trans and other; Partner options that are not heterosexist and reflect a wide range of combinations | Refer to the clients as they prefer to refer to themselves; Use language that is contextually appropriate |
| LET THE CLIENT LEAD | Maintain a list of credible, outside referrals to which you feel comfortable sending those clients you are unable to serve | Avoid reprimanding those clients who arrive late for appointments and leave room to accommodate those clients who stay later than expected with unplanned inquiries or additional concerns | Allow additional space for clients to ask any additional questions; Prompt additional inquiries by encouraging the client to note any areas of concern not already mentioned on the form | Let the client steer the appointment; Work with them; Communicate to the client that you are available to listen and discuss, not lecture. |

The following four sections detail the recommendations in optimal patient care that are outlined above.

Outreach and marketing is the first of four contexts explored.

SECTION 1 | OUTREACH and MARKETING

OUTREACH & MARKETING | AVOID ASSUMPTIONS

AWH, CWHC, and HBHC each boast an ever-expanding WSW patient population and a shared, staff-wide approach to outreach. Grassroots outreach and marketing tactics are staff-lead, internal initiatives organized to promote services and spread information with few limitations on content and extra emphasis on “creativity.” According to respondents, this approach is about soliciting new clientele without the assistance of professional agencies or formal platforms such as newspapers, television and radio. In addition to offering an answer to budget limitations and establishing a connection with the surrounding community, organizational representatives credited grassroots outreach and marketing as instrumental safeguards against organization-wide assumptions surrounding patient needs.

A limited budget also requires more time, energy and effort from already committed organizational staff. For this reason, not all respondents voiced support for grassroots outreach. The PCP at AWH explains her own concern for the marketing approach:

Marketing is a full time job! Who do you see in this office that has time to schlep around the city in a sandwich board? NOBODY. We're all too busy helping the patients we already have. However, I talk about my practice to as many people as I can and the majority of WSW that I serve here at my clinic tends to be people that I knew outside of my clinic that had trouble finding a physician that they liked. So, I say, come in and I'll take care of you...

For an administrator from HBHC's LCCP, the limited budget that requires her to spend extra hours away her desk may be bothersome, but controls that potentially come with outreach funding are even less desirable:

I mean, we clearly don't reach millions of people...and my schedule is completely full all the time—ALL the time. But the less money you have, the more hats you wear, ya know? This is about connecting with the community how we want to and being able to provide help in the way that we think it should be provided. So yeah, we don't have money but that means we get to make the rules. We don't have any major funders or grants dictating the way we present our services, so I don't have anyone telling me how to talk to people about what we do—Everyone just wants me to keep talking and to more people and the way I'm talking seems to be working so far.

In addition to being the more affordable approach, grassroots outreach and marketing allows organizational staff to interact regularly with potential clients and build recognition and familiarity in the surrounding community. By personally engaging individuals around their clinic and prospective clients from needy communities, staff members hear questions first-hand and personalize a service pitch to each care-seeking person. Establishing a presence at neighborhood events, distributing condoms during local parades, and passing out informational pamphlets in nearby neighborhoods are just a few ways the interviewees reportedly engage community members. These informal opportunities to advocate for their organization and solicit new clientele were described as “irreplaceable,” “sincere,” “priceless,” “wonderful,” and “humane.”

A number of interviewees warned against waiting for clients to come to “you, the provider (or practitioner).” They emphasized the importance of interacting with potential clientele outside clinic walls and the likelihood that assumptions may form among those

organizations who opted to sit back and wait for clients to come, instead. According to a clinical staff member from HBHC:

I mean, I'm not going to sit here in an office with my colleagues and wait to see who walks in the door. No! I'm getting out there and meeting people and finding out what they want from a PCP, because if what I'm offering has nothing to do with what they want or need, why should they listen to me or pay me a visit? There is a queer women's ethnic community in Chicago and we see that it's not linked to any agencies or any support group, really. This is and [will] be problematic and if anyone is going to do something about it, it should be us.

For the AWH PCP, combating assumptions during grassroots outreach that people have about her clinic is just as important as safeguarding against her own assumptions about clientele. The physician recalled an incident of successful client solicitation that occurred the morning of her interview:

Just this morning, a guy walked in here off the street and told [our receptionist] at the front desk, 'I gotta get a wart cut off my dick.' That's a pretty comfortable setting where a straight male can walk into a clinic called all women's health and ask that casually...and people may think that's crazy that a guy would walk into a women's clinic in the first place, but really...it's not about who your clinic is for...it's your approach to it. As far as getting new patients goes...I actually bumped into him on the street. He was putting up an art exhibit and I think I actually said to him, 'Do you need condoms?' and they said, 'Yeah.' So he and his buddies took some condoms and then I handed him my business card and he looks at it and says, 'Well, what good is that for me? I'm not a woman.' And so I said, 'Well, you're part of women's health. Either you have sex with women or you've got a mother.' That's the kind of patients that I tend to bring in here...they typically don't have a provider and don't have any type of insurance and often times they've been disenchanted with their previous providers.

Several interviewees mentioned that their image or brand as a sexual health organization does not accurately portray their range of services. AWH, for example, offers general healthcare for both men and women, yet staff members report that they are often asked whether or not they welcome males. Outreach initiatives provide staff with an

opportunity to clarify these assumptions they say are often based on the organization's sex-specific title. According to one AWH nurse practitioner (NP):

Men often come into the clinic on referrals and that's mostly because [our PCP] is out there talking it up. She's known by so many people and liked by so many people—they trust her, so they tell their friends and their friends tell their friends, etc.

The group CWHC was also named with women in mind and CWHC medical professionals say they look to patients to clarify any misconceptions that their clinic serves women exclusively. A fertility awareness coordinator at CWHC elaborates:

Because of our name and our focus primarily in gynecological care, we don't have many males coming into the clinic. Our outreach team leads a lot with female-specific services like our Artificial Insemination program, which (percentage wise) seems to be the most popular among WSW. We will, however, have people asking to bring their male partners in for testing and STD screenings and our goal has really always been a safe and respectful space for everyone. So we always encourage them to bring in their male friends, their male partners and let them all know they're welcome.

CWHC's recent initiative to become more trans-inclusive (for both trans women *and* men) has inspired several members of the collective to question the exclusivity of the organization title with its feminine branding. The organization recently received a grant for rebranding and a physician at CWHC explains how the current website and logo are weighted with assumptions:

Everything from our name and logo to our colors are very highly gendered and I think very exclusive to some of our clients and even some staff and volunteers. We need to not assume that just because we have this rich history of serving members of the surrounding community that everyone feels comfortable approaching our clinic for help. We need to recognize our rich history but we also need to make sure all those things I mentioned—our title, our brand—reflect who we are and who we can serve today.

HBHC staff, on the other hand, recognize that the general public assumes services offered within their organization are LGBT-exclusive and do not report the need to clarify. According one HBHC interviewee, the pressure on the organization to preserve a reputation for LGBT-inclusive and competent care is multiplied by the severely limited number of outside medical professionals who are properly trained to treat these particular patient populations:

So few classes touch on the sexual health issues of sexual minorities or really anything LGBT. They're not common and almost always offered as an elective. I think most medical providers would say that they provide for the LGBT community but in reality they don't know a whole lot about what that entails. So, as a staff committed to our cause, we actually do a lot of educating outside of HBHC. We go to Masonic and we educate other healthcare providers. We do as much education as much as we're equipped to provide, but I really think we're batting a thousand because there are way more medical providers than there are HBHC staff and hours available to train them.

OUTREACH and MARKETING | **COMMUNICATE CONFIDENTIALITY**

According to the ten clinical and administrative staff interviewed for this study, patient privacy plays a lead role in outreach and marketing for AWH, CWHC, and HBHC. All three organizations operate on a similarly clear and concise commitment to patient confidentiality set in place to protect the privacy of all patients and the personal information they disclose. These commitments to confidentiality apply to any staff or volunteer engaging with clients both in and outside the physical clinic space. Written permission from the patient is required to share information with the client themselves, or any approved third party, or in the incident that the physician has legitimate reason to suspect the patient may harm themselves or others.

Outreach-specific pamphlets and flyers at each clinic display printed promises to privacy, yet interviewees insist distributing a paper statement is not enough. Respondents from AWH, CWHC, and HBHC emphasized the need for verbally communicating this commitment during outreach initiatives. Whether soliciting new clients or introducing new people to sexual health services, staff with outreach experience offered similar reasons for reading or reciting the patient privacy policy aloud. All interviewees recognized that people rarely took the time to read the printed statement on paper and some respondents remembered times when they had discussed services with illiterate community members. Three reasons consistently surfaced in conversations with the medical professionals about opening all outreach efforts (one-on-one or with larger audiences) with an audible explanation of patient privacy rights. According to the interviewees, verbally communicating a patient's right to privacy lends credibility to any organization representative (staff or volunteer) and sets a professional tone for all topics to follow. It also lays the groundwork for all subsequent patient-practitioner interactions to be based in trust and presents all outreach staff and volunteers as secure extensions or representatives of a larger non-judgmental, safe-space initiative.

An outreach instructor from HBHC explains how definitively stating a patient's right to privacy helps her ease tension and gain confidence:

My training is in sex therapy, so it's very natural for me to be able discuss all sorts of topics most people would squirm through and I don't forget that. Some of the areas I have training around are sexual health, sexual dysfunction, pain, intimacy, couple's work, what feels good vs. what doesn't feel good, why or why not...etc. These are super personal subjects that, once people know who I am and what I do—no matter how they find out—I'm often approached with outside clinic walls... and I always keep in mind that, ya know, I may be the first person they've ever told. Ever. And I need them to know they can trust me. That's why

I'm so careful to remind people of their right to privacy—I am their trusted confidant.

For HBHC's outreach instructor, a patient's right to privacy should also be seen as their right to share those sexual health concerns society deems private or tends to shame. She was one of three interviewees who reported a preference for addressing the issue of privacy in outreach by making the traditionally private seem much less personal:

When I'm working with women who might have sex with women—groups or individuals—they often pretend to be very closed off to the idea of talking about sex up front—not always—but I think [it's] because, ya know, culture says you're not supposed to be sexual. Although, once I put it on the table—once they know that that's an option—those folks who come from a background where it's ok and permissible to talk about sex will talk about sex.

After introducing themselves as a sexual health professional and sharing their organization's policy on patient privacy, many respondents had encountered individuals eager to share personal stories and struggles related to sexual health. Interviewees were careful to explain how a stranger's willingness to share intimate details with a professional should not be confused with a willingness to share with just anyone. Anyone who chooses to engage with a representative from one of the three organizations is entitled to privacy.

Several respondents recalled one or more occasions when someone requested more information about services related to specific sexual behaviors that did not coincide with their stated sexual identity. Self-identified lesbian women, for example, sometimes request information on abortion services at AWH. Several staff insisted that communicating confidentiality first and foremost has had a calming effect on individuals

and crowds in that it sets a nonjudgmental tone for receiving questions and addressing their concerns.

OUTREACH and MARKETING | **INCLUSIVE LANGUAGE**

According to respondents, the three organizations in focus are all continually working toward expansion and diversification of their patient populations. During the interviews, most participants explained their organization’s approach to outreach, specified the group’s intent, made speculations about the potential outcome, and considered alternative approaches. Though their outreach-related experiences and desired end goals somewhat differed, an underlying theme emerged from a shared perception of best practices—the implication of inclusive language on successful patient solicitation.

In explaining their outreach efforts, interviewees necessitated the use of language that conveys inclusiveness in public speaking and marketing materials, and the group’s mission statement. According to The Joint Commission’s 2008 *Hospitals, Language, and Culture* study, a healthcare organization's “policies, procedures, and overall practice are often driven by its mission, vision, or values.” The study recommends incorporating “a commitment to cultural competence in these guiding principles, especially in the mission statement,” as an organization’s mission statement could be considered its most comprehensive and succinct marketing tool (Wilson-Stronks et al. 2008, 16).

By definition, the mission is a statement of purpose or brief summary of why and for whom the organization exists (Johnson et al. 2008). Typically no more than a single paragraph, the mission statement provides a quick glimpse inside the group’s operations often used by prospective patients to determine whether available services apply to them

and their needs. Mission statements for AWH, CWHC, and HBHC (LCCP) are as follows:

ALL WOMEN’S HEALTH | At All Women’s Health, we are committed to making sure every patient receives the respect, guidance, and compassion they deserve while offering the comprehensive and quality care expected from a professional healthcare practitioner. We strive to create an environment where patient rights are promoted, where diversity is celebrated, and where you will always receive non-judgmental, top quality healthcare. We encourage patients to get involved and become an informed participant in the care of their health. We believe patients have the right to understand and evaluate information about their bodies, and be empowered by knowledge they gain and the choices they make.

CHICAGO WOMEN’S HEALTH CENTER | CWHC facilitates the empowerment of women and trans people by providing access to gynecological healthcare, alternative insemination, health education, and counseling services in a respectful environment where clients pay what they can afford.

HOWARD BROWN HEALTH CENTER / LESBIAN COMMUNITY CARE PROJECT | The Lesbian Community Care Project, a program of Howard Brown Health Center, promotes the health of lesbian, bisexual and queer women and transgender individuals through healthcare, advocacy, public education, research and programming.

The mission of Howard Brown is to promote the wellbeing of gay, lesbian, bisexual and transgender persons through the provision of healthcare and wellness programs, including clinical, educational, social service and research activities. Howard Brown designed these programs to serve gay, lesbian, and bisexual persons in a confidential, supportive, and nurturing environment. Howard Brown Health Center is committed to working cooperatively with other community-based organizations serving and contributing to the gay, lesbian, bisexual and transgender community.

Howard Brown is the largest sexual health service provider of the three in this study and is an umbrella organization for the Lesbian Community Care Project (LCCP). LCCP is a program of HBHC specializing in what their mission statement describes as “lesbian sexual health.” However, the LCCP staff members interviewed for this study

prefer the term “queer” when conducting outreach or personally self-identifying. WSW is considered too formal for the organization’s typical outreach audience. In keeping with the inconsistencies in sexual health variables revealed in a review of the literature, the HBHC medical director considers how the organization’s identity-based terms are for females, while terms surrounding male patient populations emphasize behavior:

Howard Brown tends to use the terms ‘lesbian,’ ‘bisexual,’ and ‘queer’ more than ‘WSW,’ which is really interesting because we use the term ‘MSM’ way more often than we use ‘gay male.’ I think this could partly be the influence from the public health perspective. For instance, yesterday I saw in a publication read primarily by clinicians: ‘HIV Still on the Rise Among MSM.’ You just don’t see publication titles saying things like, ‘Chlamydia—or—‘Bacterial Vaginosis Outbreak Among WSW!’ It just doesn’t sit. If those types of headlines do appear, they’ll usually use the terms ‘lesbian’ and ‘bisexual.’

As one of just seven LGBT-centered healthcare providers recognized nationwide, HBHC’s mission statement, outreach materials, and program titles utilize language targeted specifically toward sexual minorities. LCCP caters to female sexual minorities who self-identify along what the organization describes as the “queer-spectrum” (LGBT). An outreach facilitator from HBHC explains the marketing materials and mission statement:

If you go onto any of the Howard Brown websites, pages or brochures, the common language is LGBT. We actually, even in our mission, don’t have Q added. However, in-house we try to focus on saying “queer” as being a more umbrella term as being more inclusive because it’s a term that encompasses all of the identities with in the LGBT...Q...LMNO...S [laughing], and that community at large. The only time we really use [the term] WSW is in our research or in our grant proposals because that’s the only time we’re really being specific about the community that we are trying to reach, or the community that we are currently working with. I am willing to bet, though, that within the next 10 years or so, the Q will be added because that’s the way that more and more folks are identifying.

While one HBHC staff member looks forward to a more specified mission statement that includes the term queer, another notes the obstacles specific terms cause in mission statements. For this particular HBHC interviewee, CWHC's more vague approach to patient demographics in their mission statement are the way to go:

[CWHC is] the only other place I think about when it comes to serving WSW and they still don't state WSW in their mission statement—they just state 'women's.' And I think that's great because when it comes to specifying the demographic you serve, an organization can probably cover more ground when they say they serve 'women's needs,' versus 'lesbian' and 'bisexual' needs. A trans woman, for instance, might feel more comfortable accessing services specified for 'women.' Unfortunately, because HB is not a private organization and because we receive state and government funding we can't just do what we want with the terms we currently use to specify who we serve.

Interviewees from AWH and CWHC also prefer the term “queer” for its overarching, all-encompassing implications within the sexual minority community—especially among youth. Four of the ten people interviewed for this study self-identified as “queer” at least once during their interview. When these interviews were conducted, the four queer-identified respondents were all under age 40 and held roles within their organizations that required them to interact with youth populations regularly. All four queer-identified respondents recognized that, although they preferred the term “queer” to lesbian, bisexual, or even WSW, it may not always be well received by sexual minority audiences. An LCCP program facilitator explains:

We took it back, ya know? We took queer back... 'cause it used to be this negative thing and then we took it back—we reclaimed it—and now it's used so loosely that to be honest, I'm not entirely sure if my 'queer' is your 'queer' or her 'queer'...I think it just means whatever it needs to mean to that person. Well, I mean...I think we can all agree that queer does not mean straight...I see queer as people being like... 'Look, I've got kinks and I know I'm not the norm and what I like now might not be what I like later, BUT that's O.K. 'cause I'm open to the

possibility of changing what and who I like. I'm O.K. with that.' Does that make sense?

Meanwhile, AWH's PCP agrees that younger patients react positively to her use of "queer," but also mentioned that older generations of "lesbian-identified" patients often find the term queer to be "offensive." She theorized that people prefer the terms that are relative to their age. She also predicted that future generations following the youth of today will accept and identify widely with the term queer. She, however, self-identifies in a unique way based on her own personal perception of what it means to be a lesbian in modern times:

To me, lesbian is more of a culture and not really your sexuality. So, my friends will tell you, I'm a heterosexual lesbian—I'm a total lesbian, but I'm heterosexual. In many circles, lesbian is now synonymous with feminist. I mean, if you think about the notion of the younger generation calling themselves queer, it's kind of like black people calling themselves 'nigger.' The thought process seems to be the same: 'You can't say anything to me because I've already called myself that!'

While HBHC and LCCP's mission statements center around those who self-identify on the queer spectrum (LGBT), CWCH, a collective founded by women to serve women more than three decades ago still focuses on an individual's gender or sex. Recent expansion in services and programming targeted toward a demographic not formally served by CWCH has led to recent changes in the organization's outreach materials and tactics, as well as their mission statement language. The organization has added "trans" into their mission statement following "women" as a patient identifier. No other sexual identity is mentioned because, as one CWCH staff member mentions, they have seen no shortage of lesbian, bisexual and queer-identified clientele. A significant expansion in

their trans patient population combined with a reportedly “noticeable” increase in trans-specific questions and concerns called for an integration of new terms. A CWHC physician explains how inclusive language has affected business:

This is a collective established by women for women and we’ve been around for 36 years and because we want to do stuff right, it’s been a slow growth. Our new patients and the potential patients we encounter doing outreach introduce us to new terms and any small changes we make in language or whatever is to ensure everyone we encounter feels comfortable. Just recently, our outreach team had been framing sexual health info by asking people if their partners were men, women, or both men and women. Calling out to women clearly worked for us because we had straight, lesbian, bisexual and queer-identified clients already. But we didn’t even bring up trans in our outreach language. So we changed up the mission and outreach framework to call attention to our trans folk and saw a huge jump in trans clientele who took our mention of the term to mean we’re equipped to meet their needs—and we can and do.

All Women’s Health (AWH) is also known for serving WSW clients regularly, but the organization does not base their mission or outreach efforts in sexual-identity like HBHC or emphasize gender like CWHC. Instead, AWH connects with patients on the basis of consequences resulting from unprotected or high-risk sexual behaviors, particularly those relating to pregnancy. AWH’s mission statement makes no mention of gender or sexual identity, but emphasizes inclusion, comfort and nonjudgmental care. Some interviewees credited including specific sexual identities or mentioning the female gender in their mission statement with successfully attracting those particular demographics. At the same time, AWH’s mission statement is comparatively vague and staff report serving a wide-range of patients in terms of both sexual identity and gender.

AWH’s clinical and administrative staff members, unlike staff from CWHC and HBHC, continue to avoid categorical terms relating to gender or sexual identity when conducting outreach. Prospective patients who self-identify as lesbian or homosexual are,

according to staff, just as likely as potential straight-identified female patients to receive information on the abortion services and birth control methods available. Several staff from AWH, including the primary care practitioner, shared stories of incongruent sexual identity and behavior among patients and therefore argue that information on abortion services should always be shared when engaging lesbian-identified audiences. AWH's PCP is only particular with language when engaging persons of the male sex in discussions about applicable services. AWH's PCP reportedly avoids using the group's gendered title and emphasizes services that bridge the binary gender gap, while specifically mentioning services offered exclusively for male sex (ie., vasectomies).

Ultimately, the opinion that each organization would benefit from a more diversified patient population was unanimous and everyone agreed that inclusive language is important in new patient outreach. In defending their preferred terms, however, participants split between two somewhat conflicting definitions for "inclusive language." For some interviewees, inclusive language is about connecting a specific population to a provider they may not have otherwise considered an option. CWHC, for example, specifies trans patients in the mission statement and marketing materials to personally invite that patient population to care. Others insisted that calling out a specific population is indirectly excluding all other groups not mentioned. Furthermore, listing all terms or labels associated with sex and sexuality is not a realistic option for providers as the list is fluid (or ever-changing) and the terms, subjective. These respondents admit that even broader terms such as "women" are somewhat exclusive (in that case, with men), but a much more inclusive direction than use of specific terms like "lesbian."

HBHC is one organization framed by sexual identity and LGBT patient populations are specified in the mission statement and all marketing materials. Known nation-wide for LGBT-inclusive service and programming, HBHC's rainbow-covered brochures and pamphlets boldly boast LGBT-specific care. Though they accurately portray some significant aspects of the organization and the services available, a member of the clinical staff blames the language on these materials and language used in any forum where the organization is referenced for the difficulty she has had with soliciting heterosexual or straight-identified clientele. Studies show straight patients are much more likely to have health insurance than their LGBT counterparts and more patients with health insurance would be vastly beneficial to HBHC as a whole. The clinical staff member explains:

The queer community is largely uninsured for a number of reasons and the funding we receive helps cover uninsured patients who can't afford their programming, treatments, etc. Our lesbians aren't having a whole lot of babies and government programs like Medicaid favor pregnant women and children. So, people with health insurance are a huge help to us. We're trying to get them in here anyway we can because what it boils down to is—and this is really crazy but— basically, the return we get from patients who are insured and can pay their bills is enough to serve almost three other patients without insurance. Crazy, huh? I wish more people knew...

She did not see the benefit in adding new terms to outreach materials or attaching additional after "LGBT." Instead, this HBHC staff member speculated on her organization's ability to convince straight-identified populations that "LGBT-inclusive" is not "straight-exclusive" by leading outreach efforts with the wide range of universally described services relevant to all. Language associated with the organization is not the only language she reports "neutralizing" in outreach. Addressing a group with vague,

general terms that specify neither gender nor sexual identity, in her opinion, leave less room for error.

On the other hand, another respondent from HBHC said that cautiously circumventing the obvious terms in her outreach experience has limited her ability to connect with the audience and entice potential patients with personalized service pitches. So instead, the respondent said she typically opts for a more dynamic approach. “Lesbian, bi, queer and questioning women” (“LBQ” for short) is preferred because it welcomes and recognizes a range of identities. Though her approach is more specific and could be considered as exclusive by some, this HBHC staff member chooses to dismiss her critics in advance by accepting the likelihood of offending someone no matter the terms considered of the sincerity with which they are delivered.

OUTREACH and MARKETING | LET THE CLIENT LEAD

Another HBHC’s staff member’s reported outreach approach is all about shifting people’s focus away from exclusive words in titles, to numerous services and program initiatives relevant to their sexual health needs. To do so, she brings every possible identity to the table and asks many questions much like AWH interviewees. Outside clinic walls, interviewees said people seemed less inhibited about discussing their sexual health. By asking many questions in a comparatively more comfortable context, this HBHC staff member is requiring future clients to meet her halfway. From their responses, she builds a better understanding of who they are as people and how they might benefit from HBHC’s mission. She explains how her questions-based approach is all about letting the client take the lead.

We help queer women realize the importance of getting engaged in healthcare and that it is a huge obstacle. First just getting a healthcare provider. Often we use the term PCP when asking people (at community events), ‘Do you have a PCP, which means do you have a primary care provider? When you get sick, where do you go? For your annual exam, who do you call?’ If they don’t have someone that’s their, like, go-to person, we help them realize that that means they don’t actually have a primary care provider. So when I say getting women engaged in healthcare here, it’s about linking them to an HB provider and getting them to think of Howard Brown as their medical home. I’m building our community by reaching out into the community.

Several respondents used inclusive language and asked many questions when directly engaging community members, in hopes of prompting a response that might guide recommendations for obtaining relevant care. Interviewees said that they could form a rough, but immediate verbal patient file from people’s responses to questions, admitted curiosities, concerns, and body language. According to the respondents, the extent of sexual health history details the care-seeking individual decides to disclose directly correlates with the quality of the advice/recommendation they are able to provide. Thus, a basic set of questions administered by organization staff in an outreach context lets the client take the lead and control the quality of the staff member’s response.

Some interviewees shared stories about times when letting the client chart their own personal pathway to care led them in the opposite direction or to another clinic. Some clients requested services that their particular clinic was not equipped to provide, while others simply did not respond well to a particular service provider’s approach. Because AWH, CWHC, and HBHC offer nontraditional approaches to sexual health services, the latter of these two reasons for exiting an arguably capable clinic had occurred in all three lobbies. An HBHC staff member touches on why this care-seeking

client might lead herself elsewhere—even before seeing what is past the waiting room space—and the best way to respond to this situation:

For whatever reason, a client may not be satisfied with what we do here and how we do it...or more specifically, they may need something that no matter how much restructuring we do, is just not within our scope of services. In any case, there's no way I'm sending someone out our doors without even just a name of someone I know could give them that sound care they can't for whatever reason get from us.

In the chance that the HBHC staff member did need to send a client somewhere else, she would most likely consult the HBHC or LCCP's referral list. AWH and CWHC also have referral lists and all three are located behind the clinic's receiving or front desk. The referral lists include names, locations and contact information for several other culturally competent Chicago-based physicians, trusted pharmacists, relevant support services, and like-minded programming. Interviewees also reported keeping informal versions of their organization's list on their person whenever they engaged in outreach efforts so that if and when they encountered a need the organization was not equipped to handle, staff members could at least meet their most immediate need (to find a healthcare practitioner) and suggest a credible clinic. A physician at CWHC explains:

We've been known to refer clients to Howard Brown and All Women's Health, and a few specific doctors operating out of traditional places like hospitals. As a collective known for queer female care, there's a pretty limited scope of what we do. Our clients rely on us and trust us for these quality referrals that we can say with confidence, 'You'll be treated well there.' There are gaps with specialized care especially for people without insurance. Even after we know we can't meet a patient's needs at CWHC, we'll sit down with them and help sort out the financial aspects. In other words, once we refer someone outside our clinic, we don't just wash our hands of that individual. We still treat them as if we're the primary provider ensuring that their next step toward better care is a good one and they're not going to get some overwhelming bill set to their house after.

Abortion services are the most frequently mentioned reason why staff at CWHC and HBHC referred WSW clientele to outside healthcare providers. Of the three organizations in focus, only AWH offers surgical abortion and had made it onto the other two clinics' referral lists. CWHC clinical staff said they were familiar with AWH and had a lot of respect for the specialty services they provide. Meanwhile, an AWH staff member explains how referrals link her clinic's clients to HBHC:

WSW that we serve here at my clinic, were referred by their heterosexual friends who said, 'You should check out AWH!' A lot of these people who said they were uncomfortable with their previous provider had been to Howard Brown and even though they liked it for all the reasons that made it more of a community health center, they found it to be more impersonal for the exact same reasons.

Two HBHC administrative staff members, however, were not familiar with AWH and the exclusive services available to women there. The two HBHC respondents theorized that not knowing about AWH could be attributed to the fact that they work with primarily lesbian-identified women who, according to one staff member, "are considerably less likely to need access to abortion services." After a more detailed description of the services that distinguish AWH from HBHC, another HBHC staff member argued why she believes HBHC is the most unique organization of the three in focus:

There are other providers that are LGBT competent and that have queer friendly providers and serve many queer women—like CWHC. Lots of queer women go there and it's probably because it's an all-women's space, but we're the only ones that are LGBT specific. There are something like 7 LGBT specific health centers in the entire United States. There used to be like 9, but then ya know, a couple went under [...]We're certainly the only one in the Midwest.

This respondent correctly identifies HBHC as the only organization in this study built on a fundamental need to provide LGBT-specific sexual health services. However, interviewees at all three organizations serve WSW clientele. Respondents theorized which services drew this particular demographic to each clinic. Most primary care services advertised in pamphlets and online for HBHC were also offered at AWH and CWHC. The unique, female-focused programming and WSW-specific services distinguishing each of these three sexual healthcare providers from their counterparts are listed below:

AWH | surgical and non-surgical abortions; ultrasounds

CWHC | acupuncture, massage, (alternative medicine and treatments)

HBHC/LCCP | LGBT-themed programs and services

Interviewees from each organization recognized and appreciated that the other two organizations in this study were successful in serving WSW-specific sexual health needs that their clinic could not. Respondents also recognized the fluidity in female sexuality and more than one person argued that their organization would never be capable of providing a truly comprehensive clinic for WSW in the face of women's ever-evolving sexuality and sexual health needs. As one staff CWHC staff member said, "These other two organizations you're evaluating are not our competition. They're our allies."

Interviewees agreed, however, that no patient should be sent elsewhere until the first service organization has exhausted all relevant resources in-house. According to medical professionals at AWH, CWHC, HBHC, this genuine commitment to service is likely to resonate with patients and inspire a return to the first clinic for services the

sexual health service organization is equipped to provide. A program facilitator from HBHC's LCCP offers an example:

Let's say we're having a lesbian sexual health event to promote LCCP and the male to female trans woman walks in our door. Information we're currently offering may not fit them exactly, but I'll be sure and let them know what parts do. I don't turn anyone away. Sometimes it's not about the services we offer but about creating a safe space here where women can get together and just talk. We recognize this. Then we use this as a way to gain their trust to eventually engage in care here.

SECTION 2 | CLINIC ENVIRONMENT

The Gay and Lesbian Medical Association (GLMA) argues that any new patient to enter a non-inclusive, unwelcoming clinic environment will most likely make that first visit their last. Lesbian, gay, bisexual, and transgender (LGBT) patients are said to be particularly sensitive to first time clinic visits and often “scan” an office for clues to determine whether full disclosure of their sexual health history will be welcomed or ridiculed.

GLMA's recommendations benefit lesbian and bisexual-identified patients, most specifically. Yet, the guide remains relevant in all sexual health service organizations. Studies show straight-identified women have sex with other women and disregard for the potential incongruence in sexual identity-behavior incapacitates a clinic set up to provide female patients with quality, comprehensive sexual healthcare (GLMA 2006).

GLMA encourages medical professionals to give equal attention to same-sex sexual behaviors and risks while promising the same positive response from all sexual minorities who enter GLMA-approved clinics. The significance GLMA places on simple

physical details and the assumption that similar adjustments across clinics can bring about the same benefits, calls for exploring the intent behind all informational materials found in waiting rooms.

Regardless of how familiar a sexual health service organization is with GLMA, most waiting rooms' details and materials were carefully selected to provide comfort, promote service, and prompt disclosure. According to staff interviewed for this study, anything hanging from a wall, covering a coffee table or crowding a magazine stand in AWH, CWHC, or HBHC was selected to suit current clientele needs. The following section explores the physical environment of all three organizations. In cross-comparing waiting room details, supplemented by direct quotes from staff, each organization's assumptions about current clients and those they intend to serve are revealed.

CLINIC ENVIRONMENT | **AVOID ASSUMPTIONS**

In keeping with GLMA's recommendations, "queer-affirming" magazines, posters, brochures and graphic décor can be found in all three sexual health service organizations. The number of LGBT-inclusive indicators in each waiting room, however, differs dramatically between clinics. A brief exploration of the queer affirming materials in each waiting room reveals three unique approaches to communicating cultural competency. Finally, a physical description of each nontraditional space explores how each organization defies traditional assumptions surrounding standard health clinic environments.

A patient entering HBHC would encounter the most signs of LGBT-inclusivity. Same-sex stock photography, rainbows, pink triangles, and identity-specific event

promotion (such as flyers for Chicago's Dyke Parade) in HBHC's waiting room outnumber the other two dramatically. On the other end is AWH, which is the smallest of the three organizations in terms of budget, number of patients, and wall space for queer-affirming propaganda. AWH's limited selection is restricted to a few rainbows and some sexual health information for same sex couples. These items are, for the most part, more difficult to find among a seemingly endless supply of information on pregnancy prevention and abortion services.

Only CWHC's quantity of "queer-affirming" materials can compare with HBHC's, especially with their more recently expanded programming for transgender patients. The primary difference between the posters, pamphlets, flyers, and flags at CWHC and those in HBHC appears to be a difference in underlying themes. While nearly every HBHC poster or pamphlet calls out a specific sexual identity, queer-affirming materials in AWH take a broader approach with a consistent emphasis on female empowerment. HBHC consistently associates community with the specific sexual-identities of their patients, while the majority of information posted in CWHC's waiting room centers on service and support for fellow females. Though CWHC and HBHC offer waiting room occupants disproportionately more cultural competency clues than AWH, one HBHC respondent insisted that one rainbow or equal sign prominently displayed is sufficient for inciting discussion and guarding against discrimination:

To say that all queer women should have access to a culturally competent provider feels pretty idealistic. I mean, I know that not everyone is going to ask all the right questions every single time, but a provider who makes it a point to hang up a rainbow flag or something like that in their clinic or stick some rainbow sticker on their front door is letting all queer people who enter their clinic know that they are open to having the kinds of conversations that these patients need to have...And maybe, ya know, for the provider who is already known for treating

queer people it's important too. Even that provider and the rest of the organization can benefit from putting up a couple symbols. You never know when a brand new patient who has no idea about your services is going to change their mind about coming into your clinic after seeing one small rainbow.

HBHC's clinic represents an identity-specific approach to providing a WSW-inclusive environment spectrum, while AWH and CWHC atmospheres emphasize female-empowerment and a more sex-specific approach. Materials in HBHC's lobby illustrate the organization's primary focus on serving self-identified sexual minorities, while the lobby of AWH provides information on pregnancy prevention with birth control samples, male condoms, and information on abortion rights.

Aside from the prominently placed front desk for receiving patients, AWH and, even more so, CWHC defy any traditional assumptions or expectations one might have about sexual health service environments. AWH and CWHC are suited to those more comfortable with a nontraditional clinic environment. Bright periwinkle walls meet AWH patients after a steep stairway climb from a discrete street-side door. AWH staff members reportedly chose the color to create a more soothing atmosphere. This second floor office can be difficult to find with no more than a single glass decal indicating its whereabouts amid the bustling boutiques and bars of Chicago's Bucktown neighborhood. Extra details like wall color are reportedly prioritized by staff who anticipate these added tensions when the clients arrive.

Every inch of the small office serves a purpose and crafty touches by the outgoing and close-knit staff would distract any anxious or nervous patient. For example, a boldly colored, translucent, fish-filled underwater scene is taped across the ceiling of one room to soften fluorescent-white lighting. One AWH nurse rationalized the enhancement with

another question: “Would you want to stare at a light bulb while someone was poking around your vagina? Frankly, I’d rather imagine I’m in the ocean.”

Thank you cards and photos from clients, supporters, family and friends camouflage otherwise blank walls, while a generous offering of hard candy serves a multitude of purposes at the receiving counter. One AWH staff member reported the sweets helped calm client nerves, and another said it helped combat the bitter taste of medicine administered prior to an abortion procedure. A third member of the AWH staff exclaimed, “It’s an all female office! What do you expect?”

AWH is composed of 8 rooms and close quarters means casual conversation can be heard throughout. From 9am to 4pm, Monday through Friday, an FM radio empties top 40 pop and hip-hop hits into a lobby so narrow it nearly forces front desk/waiting room conversations. AWH staff reported seeing their clients sing along with the radio and appear visibly comforted by the music while they wait to see the physician. In addition to the music, one interviewee believed the cross-office chitchat and playful interaction among staff put clients at ease. Another AWH nurse said she makes an effort to invite patients into her casual conversations with staff to make the client feel welcome and put any anxieties to rest:

We’re constantly talking about sex with people—our patients—and it really makes you think about your own life and your own situation. Everyone who works here spends a ton of time here together and we’re not just providers, ya know? We’re people too. These are my friends and we’re always discussing the most personal details of our own sex lives with one another. I know everything going on with them and they know everything going on with me.

Interviewees from AWH used the words “friendly” “casual” “colorful” and “cozy” to describe their clinic environment, while CWHC staff echoed these same sentiments then added the adjectives “quirky” “eccentric” and “vintage.” No three words could more adequately distinguish this collective from the rest. CWHC’s wood-paneled walls are reminiscent of a grandparent’s basement and the complicated maze of angled offices extends from a dated floral-print chair and couch-crowded waiting room.

Posters crowding bulletin boards like a college town coffee shop showcase a wide variety of events that include scheduled protests and calls to action, in addition to the sexual health related items. Bulletins about massage and holistic treatment pamphlets are the first indication that CWHC offers, provides, and supports alternative healing practices. In terms of distinguishing services exclusive to each organization, AWH has abortion services while CWHC offers many Eastern treatments like massage and acupuncture.

Informational signage on AWH’s walls and side tables highlights scientific subjects like the female anatomy and several pharmaceutical solutions for living life baby-free. Like a more playful version of Planned Parenthood, a woman waiting in AWH’s lobby could pick up a pamphlet on Illinois abortion laws, but from under a rock that says “DREAM” to the tune of Beyonce’s latest hit. CWHC, focuses more on communicating a theme of female empowerment throughout their second-floor clinic. CWHC has a street-level, glass door entry with a single decal that, just like AWH, can be difficult to find for first-time clients. The clinic is nestled into a busy corner of Chicago’s Lakeview Neighborhood, less than a block from Wrigley field.

Howard Brown Health Center's prominent stand-alone, street-level location is just a few blocks North of CWHC. Located in Chicago's Uptown neighborhood, occupies not one floor, but an entire two-level building with visible outdoor signage. Thus, while AWH and CWHC rarely report walk-ins, HBHC's lobby sees prospective patients daily. Though the bright-colored murals and high ceilings make the waiting area feel more like a community recreation center, the crowded pharmacy counter to the left is just one reason HBHC feels most like a traditional hospital. Representatives from AWH and CWHC pointed out that this is not necessarily a "good thing" and offered a short lesson on assumptions with regard to clinic environment. While a staff member from HBHC praised their hospital-like atmosphere, saying it communicated a sense of "credibility" to new clients, respondents from the other two organizations relayed the negative feedback they had heard from HBHC former clients. One client had reportedly felt discouraged by HBHC's "impersonal" interior, while another regarded the organization's hospital-like setting as "sterile" and "cold."

According to interviewees from all three organizations and despite GLMA's emphasis on the power of creating an inclusive atmosphere with pink triangle posters, the one person who sits behind the receiving desk has the ability to change the mood completely. The person behind the front desk is most likely the first human interaction any new client will encounter and how well they are received will set the tone for the remainder of the visit. A nurse from AWH explains that this is why one of their most outgoing and "bubbly" staff members sits at reception. A positive new-patient exchange benefits both the medical professional and client. According to the AWH staff member who manages the front desk:

We never know what kind of baggage people are walking in with. Maybe they had a bad day or they could be super nervous about the visit or maybe they're here to take care of something not even their closest friends know about...either way, one weird look on my face when I hand them their intake form could send them running, but that's why I was taught to be relaxed. If I'm relaxed, they're relaxed...and by relaxed I don't mean sloppy. I just treat patients like [our doctor] treats them. I take my cues from her.

Another AWH nurse illustrated the necessity of a nonjudgmental front desk by recalling her reaction in other clinics where it was "clearly not a priority." She learned what not to do while recounting visits to the dentist and doctor at other facilities with her two young children:

Man, I would never speak to anyone the way some of those people have spoken to me...like, not even looking up and yelling at my kids to sit down. I mean, excuse me, but those are my kids and why are you all frustrated. I mean, this is your job...And, ya know, I know it can get frustrating because I work in public health, but I don't forget those people because remembering them helps me keep my attitude in check at work. I may be tired some days, but I always welcome people when they come in and we always remember our clients' names. I greet them...I treat people like family. That's how it is here.

CLINIC ENVIRONMENT | **COMMUNICATE CONFIDENTIALITY**

In addition to warmly welcoming new patients and setting appointments, the person behind the front desk is presumably first to verbally communicate a clinic's statement of confidentiality. AWH, CWHC, and HBHC all have an official statement of privacy prominently displayed near the front desk or reception area which, according to some respondents, is treated like a cue card whenever necessary.

For some interviewees, effective front desk staff members watch for and adequately interpret new patients' behavioral cues. Anxiety over disclosing personal information and apprehension about seeking advice from a new source could all be put to

rest with an effective front desk. This type of person would encourage the new client to consider the clinic as a safe haven and reassure them about their right to privacy. An AWH NP explains how her organization deals with nervous new clientele:

There are the clients who refuse to share all their personal details out of sheer indifference or apathy, but then there are those who are so nervous when they reach our front desk that they're sweating. It's not like they have some legal obligation to share all the gory details, but these are the patients who always seem to calm down after a reminder about their privacy rights. Of course, we also tell them that exercising their right to remain silent isn't too great in terms of helping us solve what's otherwise a sexual health mystery...

Patients entering AWH, CWHC, and HBHC are all reminded of their right to privacy on signs and intake forms, and verbally at least once, but concern for maintaining patient confidentiality takes on new meaning with HBHC's support programming. Clinical and administrative staff working for HBHC's Lesbian Community Care Project dedicated significant time and effort to researching, planning and hosting programs for female sexual minorities. From their research, the staff discovered group themes or discussion topics meant little to queer women. The majority of program attendees told LCCP staff they had joined the group programs, not for the benefit of sexual health education and resources, but for the sense of community they felt among their fellow females. An outreach instructor at HBHC explains:

Getting queer women engaged in healthcare can be difficult—period—and me and the other LCCP staff wanted queer women engaged in care here! LCCP advocates for queer women's health out in the community and in-house, as well. And our in-house group programming is offered in the same space as clinic services. Programs help us attract women who might not have ever entered our clinic and give a place to slowly introduce them to all kinds of important services that they need and we have. The more group meetings these women attended, the more familiar they felt with us and the easier it was for us to connect them with primary care providers here. We were patient, but we were determined to get

them to think of Howard Brown as their medical home—their one stop shop for all things sexual health.

By offering an all-female, secure space in which women can share their stories, seek advice, and express empathy, HBHC’s clinic acts as a physical representation of the group’s commitment to patient privacy. HBHC programming includes a bisexual women’s support group and a group for women in the process of coming out or exploring their sexuality. Word-of-mouth advertising and paper flyers encourage women from across the city and the surrounding suburbs to gather at HBHC monthly. During meetings, staff facilitators guarantee attendees an all-female, safe space to share experiences and offer advice. Meeting dates, time, and location stay consistent so that no personal information need be exchanged.

HBHC interviewees say protecting participant identity is key for maintaining high attendance at meetings. Some participants reportedly remain closeted and exposing a person’s identity potentially places their reputation and relationships at risk. Regular meeting attendance is considered by staff facilitators to be a first step toward “taking control of your own sexual health” and a perfect opportunity to introduce prospective patients to applicable services.

CLINIC ENVIRONMENT | **INCLUSIVE LANGUAGE**

In terms of inclusive language in the clinical environment, GLMA emphasizes the need for unisex or universal restrooms in addition to specific signage and indication of inclusion in the waiting room. Every bathroom in the three organizations is presented to patients as unisex and labeled as such.

Aside from the unisex bathrooms, most interviewees mentioned language on posters and brochures prominently displayed in each lobby when questioned about inclusive language throughout the clinic. To use GLMA's term, "queer-affirming" language can be found on signage throughout each organization known for serving sexual minority females. Organizational titles, perhaps, offer the largest example of inclusive language in each clinic. While one organization offers services beneath the umbrella of a specific sexual identity, the other two organization titles are gender-specific, yet all three serve patients outside the population targeted in their titles.

Howard Brown Health Center is officially categorized and funded as an LGBT-specific provider, which is why the sexual health program focused specifically on female health has the word "lesbian" in the title (Lesbian Community Care Project). The other two organizations choose to lead with gender, not sexual identity. All Women's Health and Chicago Women's Health Center have the benefit of operating beneath gender-specific titles that make it easy for new clients to summarize the likely purpose of the organization without ever entering the two clinics.

CLINIC ENVIRONMENT | **LET THE CLIENT LEAD**

For one AWH nurse, the most effective training she received was the example set by the head physician at AWH. She said AWH's PCP had demonstrated an ability to frame services to meet specific patient needs by allowing the patients to verbalize concerns and ask questions. Interviewees from other organizations credited organization-wide formal training (including sensitivity training) for teaching them ways to guide clients to care without dictating to them every next step.

At CWHC, there is an organization-wide policy on scheduling requiring staff set aside one full hour of time for each appointment, regardless of appointment purpose. Staff members relayed stories from previous patients who reported feeling discouraged in traditional medical settings after being rushed in and out of the office by both the PCP and their supporting staff. CWHC clients are not required to use the entire time allotted for their visit, but staff appreciate the extended opportunity to obtain a more thorough sexual history. Stories of patients apologizing for taking up too much time and apologizing for asking questions outside the narrow purpose for the visit they had originally stated on their intake form reportedly bothered each staff member interviewed. AWH's PCP explains why a patient's concern about time limits during their session is so bothersome:

Just now I had a young woman come in who mentioned to the [nurses] that she didn't want to ask any questions because she didn't want to take up too much of my time. That's so sad to me because we always see these women who are so astute and aware of the time and the only reason I'm here is for them and their questions, but she didn't ask any. She was just here for her abortion and a follow up isn't necessary, but I'm hoping she'll come back. I bet she will.

A CWHC clinical staff member explained how addressing the intersection of behavior and identity becomes somewhat simpler when more time is permitted for each patient. She credited generous scheduling to patients sharing a more thorough sexual history and her consistently accurate patient diagnoses. The extra 30 minutes or more she gets with each client allows her to build relationships while engaging them in their own risk-prevention plan:

At CWHC, we're trained to believe that additional time is what we really need to kill the mystery—and it's the honest truth. What I mean by that is, if someone says I don't like my pregnancy prevention method, I'll say let's pull out the box

of all the different methods and let you look and touch and dig through all these different options. The whole hands-on experience takes away the mystery and often lifts stigma surrounding certain methods. I mean, no one knows what a diaphragm looks like. No one really knows where it goes, but if you pull out a diagram and take the time to explain, they may be like, ‘Perfect!’ They could also say, ‘Nope. Not for me.’

Throughout the CWHC clinic are visuals and verbal reminders to remind the client that they are in control of their session. Both inside the waiting room and behind closed clinic doors, CWHC staff members are trained to encourage and empower all patients. CWHC’s PCP explains:

The way that we work with our clients is as partners in their care and on equal grounds, which can feel VERY revolutionary to people, but—and I still get chills when I talk about it like this—it shouldn’t be this way. I mean you see this on people’s faces and then they say it at the end of our visit or in our surveys and stuff that they’re surprised they had such a positive experience at a gynecological exam. It’s funny but this is so important in terms of continuity of care. I think it’s that bit about feeling like they’re actually participating in their visit and that they have ownership over their body at every moment of their session and it’s an empowering experience working with equal partners, rather than feeling like you’re getting something done to you that you don’t quite understand. From the first time you walk in and pick up an intake form, to the last question you answer on the post-session feedback survey you get on your way out, you’re a whole human that’s respected throughout the entire process. This is huge—I know it.

SECTION 3 | INTAKE FORMS

*To provide a succinct, cross-comparison of intake forms from AWH, CWHC, and HBHC against the GLMA-recommended version (Appendix 2, page 120), section 3 is formatted differently than the previous two sections. Recommendations for intake forms with respect to the four themes in optimal care are included in **Table 2b** (page 79), although the themes are not used to frame this particular context-based section.*

TABLE 2b

SEXUAL HEALTH SERVICE ORGANIZATION INTAKE FORM COMPARISON:
Response options offered on each organization's intake form are listed in the boxes in the order they appear on forms

| RECOMMENDED INTAKE FORM STANDARD: GLMA* | ALL WOMEN'S HEALTH | CHICAGO WOMEN'S HEALTH CENTER | HOWARD BROWN |
|---|---|---|---|
| NAME: Legal name; Preferred name; Preferred pronouns | Legal name; | Legal name; Preferred name; Preferred pronouns | Legal name; Preferred name/nickname; Preferred pronouns |
| GENDER: Female; Male; Transgender (female to male or male to female); Other w/ blank space | N/A | Woman; Trans; Intersex; Man; Gender queer; Describe gender w/ blank; Preferred pronoun w/ blank | Male; Female; Trans Male; Trans Female; Gender Queer; Intersex; blank |
| SEXUAL PARTNERS: Men; Women; Both (regarding current and past partners) | Are you currently sexually active Y/N; Do you currently partner with Men, Women, or Both; In the past, did you partner with Men, Women, or Both | Are you currently sexually active with a partner/partners?; If no, have you ever had sexual contact with a partner in the past?; If yes, is/are your current partner/partners Female; Male; Trans; Intersex | N/A |
| RELATIONSHIP STATUS: Single; Married; Domestic partnership/civil union; Partnered; Multiple partners; Separated from spouse/partner; Divorced; Other w/ blank space | Current marital status w/ blank | N/A | Single; Partnered; Married; Widowed; Divorced/Separated |
| SEXUAL IDENTITY: Bisexual; Gay; Heterosexual/straight; Other w/ blank space; Not sure; Don't know | N/A | N/A | Bisexual; Gay; Heterosexual; Lesbian; Queer; Questioning |
| CONFIDENTIALITY STATEMENT ON FORM : (YES or NO) | YES | YES | YES |

N/A = section not included on the form

In the absence of a universally accepted, research-based guide for framing intake forms, jurisdiction over everything from section topics, preferred language and page length is left up to each clinic. All three clinics explored in this study administer a unique version of a single or multi-page paper questionnaire to new patients. As indicated on the Public Health Website for Seattle and King County, intake form responses should

provide background information sufficient for ensuring more efficient patient assessment. This paper questionnaire is the first set of health-related questions any new care-seeking client encounters. It is the printed approach to obtaining private information about a patient's personal health that precedes the verbal approach encountered during the patient-practitioner interview.

The dramatically different intake forms available to first-time clients at AWH, CWHC, and HBHC illustrate the variety that occurs when guidance is limited and standards are not enforced. According to respondents, this exemplified variety in language, content, and page length is also a reflection of the degree of significance each organization places on the role of the intake form. While some interviewees regarded patient responses to intake form questions as a potentially beneficial source for medical professionals striving for efficient diagnosis, most considered the forms as no more than "a receipt for care." One interviewee offered this description of the intake form because aside from holding a place in the organization's files, it served no other purpose than offering proof that the client was once there.

At AWH, CWHC, and HBHC intake forms are administered during the patient's initial visit, thus providing a starting point for each new medical file. Changes to the information the patient first provides are made on an ongoing basis by clinical staff. Thus, most patients encounter their clinic's intake form once or twice, at most.

Due to the personal nature of the form's questions and the fact that these inquiries precede their introductory physician meeting, The Gay and Lesbian Medical Association (GLMA) insists that patients' first impression of an intake form is indicative of all

subsequent patient-practitioner interactions. GLMA argues that an effective intake form has the potential to calm new-client nerves and prompt full health-history disclosure, while a misstep in language or content can confirm client doubts and decrease the likelihood of a follow-up visit.

Although no formal or regulated standards exist, GLMA and the Lesbian Health and Research Center (LHRC) recommend sexual health service providers treat clinical intake forms as a platform for exhibiting competency and establishing a non-judgmental atmosphere (GLMA 2006, LHRC). The website for the Lesbian Health and Research Center (LHRC) offers a list of recommendations for culturally competent questions featured on intake forms, while GLMA provides a sample intake form against which all three clinic forms are measured in this study (Appendix 5, page 125). LHRC's suggestions for writing culturally competent intake forms for sexual minority females are as follows:

- Patient intake forms should be free of heterosexual assumptions. Include options such as "Living with domestic partner" as well as standard options such as "Married" and "Single". Instead of "husband/wife" use gender-neutral terms such as, "partner."
- Whenever there's a sex or gender question, add a third category for transgender with space for people to elaborate. Don't list transgender as an alternate sexual orientation. Gender identity and sexual orientation are distinct.
- Questions about families should allow for alternative families including two parents of the same sex and more than two parents.
- Intake forms should include an explanation about how confidentiality will be protected and who has access to medical records. Offer the patient the right to refuse to answer a question on the intake form if he or she is concerned, knowing you can discuss it in your office.

GLMA's recommended intake form sample is a reflection of the suggestions above. Intake forms from All Women's Health, Chicago Women's Health Center, and Howard Brown Health Center were obtained from each clinic's front desk and evaluated according to above-listed criteria and GLMA-recommended sample intake form. **Table 2b** illustrates how each form compares with GLMA's standard. Hard copies of all four intake forms used in this study can be found in Appendix 5, which begins on page 125.

GLMA's intake form sample offers a checklist of inclusive language and suggested order for covering such topics as: *Name; Gender; Sexual Partners; Relationship Status; Sexual Identity; Visible Confidentiality Statement.*

The three intake forms under evaluation introduced the above topics in three unique orders. While one organization covered every topic in a single double-sided document, another took seven pages to address each one. This seven-page form comes from HBHC, and multiple disclaimers, waivers and opt-in forms for participating in clinic-run research explain the length. The clinic's decision to make a majority of HBHC's questions multiple choice was, according to interviewed staff, intended to help speed-up patient-response time and make the multi-paged document less daunting. Based on the long list of choices following each multiple-choice question, HBHC's strategy for soliciting the most information from new patients centered on making all possible responses available. Only one or two blank lines were left for clarification or write-in purposes. AWH, on the other hand, appears to have taken a more open-ended approach with single blank lines below each intake question. Single spaces and fewer topics helped keep AWH's intake form to one double-sided page. At three single-sided pages, CWHC's

intake form is a median length and a combination of multiple choice and fill-in-the-blank questions combine patient-friendly aspect from both forms just described. CWHC's intake form covers the widest range of health topics (allergies to physical handicaps), while AWH's questions focus primarily on reproductive health and related topics. Detailed descriptions of each form are provided below.

Howard Brown Health Center's intake form, which is seven pages in length, is stapled and handed to every new patient who enters the clinic (Appendix 5a, page 125). The first page (client registration form) requests basic contact information including name, address, and emergency contact, as well as information on the patient's insurance provider and a request for their signature to release all medical information to their insurance carrier. The second page is the patient demographic survey that requires clients to once again state their legal and preferred names and answer the same questions included on GLMA's sample intake form (See **Table 2b**, page 79). Questions about language, race, ethnicity, education and living status are also on the second page, followed by a request from HBHC for the patient's signature permitting use of their personal information in future research initiatives. The consent for treatment is outlined on page three and the patient's signature authorizes all treatments and procedures. The fourth page, which also requires the patient's signature, details patient privacy, rights and responsibilities with an acknowledgment for HIPAA Privacy Practices, Client Rights and Responsibilities, and Grievance Policy. A lengthy list of 16 "patient rights" cover page five, and 11 "patient responsibilities" occupy page six. The seventh page offers a brief explanation of what to expect in each of the four HBHC service areas available: *Primary Medical Care; Therapy and Counseling; Case Management; Research*. The bottom half

of the final page is reserved for all the fine print associated with the organization's Grievance Policy. Although this seven-page version is not HBHC's only intake form, it is, according to clinical staff, the organization's most generic version and the one handed out most frequently to new patients.

The three single-sided pages of **Chicago Women's Health Center's** standard intake form (Appendix 5b, page 125) seem considerably shorter after exploring HBHC's. The single double-sided page satisfaction survey is an optional form that accompanies each required intake form. While HBHC opted to make most health inquiries a multiple choice question, CWHC's form offered many more blank spaces and room for clients to elaborate. Several blank lines follow the section on sexual history and a section inquiring about a variety of physical health problems asks respondents to explain past problems including dates of surgery. The CWHC intake form is the only intake form with a section on emotional health and also the only form that provides ample space and a prompt for patients to add their own questions and concerns.

All Women's Health has the most basic intake form (Appendix 5c, page 125). The single, double sided questionnaire also assumes respondents are of female sexual orientation, evidenced by several sections pertaining only to physical female-bodied patients: Gynecology History; Menstrual History; Pregnancy History; Contraceptive History. Also, no section requests specification of gender.

GLMA emphasizes the need for visible, legible, and comprehensible privacy statements on intake forms for clinics interested in seeing more sexual-minority

inclusive. Though fonts and font sizes vary on each form, the privacy or patient confidentiality statement is printed big and bold across all three clinics' forms.

In summary, the majority of interviewees reported that their intake form was neither useful nor necessary in their effort to determine patient risk. One interviewee referred to the form simply as a “merchant’s copy of the receipt for care.” It should be noted that the respondent who felt having the form readily available kept her patient interview “on track” was also the most recently employed staff member working within her organization less than one year. For her, this information served as a “checklist” during one-on-one sessions and was quick to add her growing anticipation for mastering the interview process, which she defined as the point at which she would no longer require a written reference.

In fact, the general response to questions regarding the level of significance placed on intake form responses was that while broad, open-ended questions saved clinics from having to carry numerous forms, these types of questions could never possibly provide enough personal information on each patient to accurately determine all their sexual health risks. Another reason many preferred not to rely on the written responses was fear of measuring risk by assumptions associated with responses to questions on identity and sexual behavior.

SECTION 4 | PATIENT-PRACTITIONER DISCUSSION

After a new client answers all intake form questions and returns the information to the front desk at AWH, CWHC, or HBHC, the interviewee’s form is returned to the organization’s front desk and filed to serve as an immediate reference for clinic staff.

Information from the intake form, for some clinical staff, acts as a cue card for care when it comes time an immediate guide to the staff members responsible for assessing and diagnosing the patient in the fourth and final context: the patient interview. This one-on-one interaction is the first formal opportunity for the client to express concerns and ask questions of their physician in a private space.

Respondents from each organization reported that the staff member responsible for engaging the patient at this point is most often a nurse practitioner (NP) or primary care physician (PCP).

The majority of interviewees referred to this one-on-one follow-up time with clients as “the patient interview.” Traditionally, the purpose of the intake form within the patient interview context is to serve as a reference for client care and potentially acts as a prompt for healthcare practitioners faced with the challenge of addressing a particular patient’s sexual health risk. In actuality, few medical professionals interviewed paid much attention to the intake form responses and instead, focused on getting to know the patient through the fourth and final interaction type: *the patient-practitioner discussion*.

PATIENT-PRACTITIONER DISCUSSION | **AVOID ASSUMPTIONS**

Negative consequences of assuming too much were often exemplified by stories of patients who reported heterosexism from previous physicians. Meaning, after confirming they were sexually active, the physician immediately inquired about pregnancy prevention methods. A clinical staff member from CWHC explains how important it can be to reference the intake form as a means to avoid assumptions:

Most providers simply assume that birth control is going to be part of every visit and you know, percentage-wise says it's going to be, but the way in which it's introduced into the conversation should respect the patient's previous disclosure regarding partners and sexual behavior.

Assuming that a female who is sexually active is only engaging in hetero-normative sex likely closes the small window of opportunity in which a patient feels comfortable coming out to their healthcare practitioner. While the most interviewees mentioned the significance of not making hetero-normative assumptions about patients, AWH's PCP underlines the importance of not making behavioral assumptions about those patients self-identifying as lesbians:

The issue of someone [calling themselves] a lesbian is the same issue in saying, 'Well, you're black, so you're all the same.' That's just totally untrue. Lesbians in fact will say whether they're comfortable or uncomfortable within the lesbian community because like every other community it's a smaller community and it's judgmental [...] I'm fine with women having sex with men and calling themselves lesbian. Whatever. But that's my own opinion. Medically, however, I can't just assume your behaviors match your identity.

Two interviewees acknowledged the difficulty they faced in avoiding assumptions with patients who looked or acted in a particular manner, but direct statements professing a conscious effort to avoid assumption-based care could be found in every respondent's transcript.

To expand on the significance of the interview process as a follow up to any intake form, one interviewee reported several of her previous patients with drastically different sexual histories had had "surprisingly similar" intake forms responses. The interviewee stated that only after the patient interview process—the opportunity to expand upon the behaviors assumed to be in accordance with their checked boxes—was

she made privy to distinguishing aspects of each client's sex life. The CWHC interviewee elaborates on her own approach to avoiding assumptions; including assuring each client that she is not making assumptions about them:

The way our organization trains us to assess need—the way we all assess need—is by asking lots and lots of questions. I assume nothing. Knowing who you're sleeping with now does not dictate your entire sexual history in the same way that knowing you're not sexually active at the time of our visit says nothing of your past practices. So, I make it clear to all my clients that I'm not here to lecture you or dictate how you should behave. I'm not here to undercut your autonomy in any way. This experience is and will be different.

That same CWHC respondent adds that an “accidental benefit” to this inquisitive approach during which she is able to introduce a multitude of lifestyles has allowed her to promote awareness in the fluidity of sexual behavior:

So I'll say, 'Are you currently sexually active, with how many partners, what is your partner or partners' gender identity, and do your partner(s) identify as male, female or trans.' First, I'm watching out for the health and wellbeing of our clients in making sure that they feel all options are on the table and they can be fully present. However, an added bonus in doing this is when the patient oftentimes asks, 'Why did you ask in that way?' Maybe they're not queer-identified or unfamiliar with all the options I've just exposed them to, but either way, I'm presented with an opportunity to inform them that sexual identities can shift and that we shouldn't assume behaviors will remain the same...and they'll say, 'Oh...I didn't know' or 'Yeah, I guess you're right.'

Medical professionals illustrated that no two patients are ever alike, nor do they always behave as the healthcare practitioner might have expected based on intake form responses. One interviewee admittedly expressed how the challenge of obtaining a complete sexual history would be a considerably simpler task if each patient acted in congruence with the way they had identified on their form. New challenges surface when medical professionals attempt to move beyond the patient's initial disclosure and uncover

details regarding practice. AWH's PCP explained how a stubborn, unwavering declaration of sexual identity could become a patient's greatest barrier to care. Services she provides at her clinic require a more detailed approach to care, especially when they are lesbian-identified women entering AWH for an abortion procedure:

When someone announces from the get go that they're a lesbian, I can't just take them at their word...but it's not like I can launch immediately into asking if they have sex with men, either. Taking that kind of careless approach is sure to make the client feel like I'm not listening or taking them seriously, or that I consider their identity to be a phase. All options are on the table with every patient. Do you have sex with men women or both—it's that simple. I know to do this from my experience, not training, because if I went with what my biomedical training I wouldn't give someone who identifies as a lesbian a pregnancy test. However, I don't care if you're a lesbian or not, I'm doing a pregnancy test. My job is to identify risks, not just respond to whatever you've written on your intake form. I know the risk in playing the name game because I see the patients of providers who did and failed to address the true risks of that client.

The AWH physician went on to say that although her clients are often initially frustrated with her persistence, they eventually come to the general understanding that this "isn't about a lecture. It's about their health and well being." She elaborates:

Most women getting abortions at say, Planned Parenthood, go into the abortion clinic on a designated day for abortion procedures. I always say to my patients, 'Ya know, you can come back here. I don't just do abortions. I can be your PCP.' There's always this look of surprise, like they're not used to seeing the two intersect. I'll bet they didn't even know their abortion doctor's name before and I'll bet they don't want to know. But I know their names and they all know mine and they know they're welcome back—and many of them come back! I'm still talking about abortions now because I think it's important to let you know that I perform abortions on lesbians. That's why I don't play the name game anymore. It doesn't work.

The PCP's point regarding persistence is important because every physician interviewed reported having to remind patients about services at their organization outside the realm of sexual health. Staff from each clinic said that the majority of their

patients seemed to view sexual health services and general healthcare as being mutually exclusive. This, however, was no more than an assumption about service capacity on the part of the patient.

According to the interviews, assumptions are a problem for both healthcare practitioners and patients alike. The best lesson shared by those interviewees who had overcome assumptions in their personal experience on the job stressed the significance of maintaining an open and honest dialogue with all clients. A comfortable conversation is more likely to include personal details or private health concerns on the part of the patient, making it easier for the medical professional to diagnose need. Within the context of an open dialogue, healthcare practitioners are also able to pitch other appropriate services with which the patient may not be familiar.

In reality, studies show that the majority of care-seeking WSW clientele (53-72%) keep pertinent details about their identity or sexual behaviors from their physician (Marrazzo 2004, Mautner Project 2005). The importance of creating a more comfortable clinic atmosphere to prompt patient disclosure has already been discussed, but interviewees also mentioned the significance of ensuring a patient's privacy—especially within the context of the patient-practitioner discussion.

PATIENT-PRACTITIONER DISCUSSION | **COMMUNICATE CONFIDENTIALITY**

Communicating confidentiality, or the existence of privacy policy is another subtheme consistently reported helpful for gaining a patient's trust. Means by which they communicate this policy, however, were found to be unique to each transcript. It should be noted that all three organizations evaluated in this study have explicit, transparent

patient privacy policies, but some individuals were quick to point out that just the existence of a verbal or written privacy reminder does not necessarily guarantee client comfort. They also added that closing the office door for the one-on-one patient interview process only implies privacy.

One PCP from HBHC, prefers a more uniform, universal approach. She describes how she feels as though she is speaking for all her staff when she explains patient privacy protections to new clients. Although she may be explaining privacy to patients in a one-on-one setting initially, she explains how these clients may then engage with additional staff, which is why she must be clear that their feeling of security carries throughout the clinic. She refers to herself as a “translator” because she chooses her words carefully; tailoring her language so that each client understands their right to privacy in full. She explains her goal is to ensure each patient seems “to feel safe and secure when disclosing very private information” in both their initial appointment and all appointments thereafter. This way, if colleagues fail to address privacy aloud during subsequent visits, all her clients are sure to remember where they stand.

HBHC’s PCP explains how frequently she witnessed the importance of patient privacy played out in her clinic:

Many people don’t want to use their insurance and choose to pay out-of-pocket instead. I believe that this is because of stigma surrounding HIV testing. They keep it separate from their insurance because if the test ever does come back positive—even if they’re eventually going to have to disclose to the insurance company anyway—they’re left with some shred of authority or control over when and how they disclose their HIV status to everyone. They make the decision about when and how they’ll engage in care, and if and when they’ll let their HR department at work know all the details. People just feel like [HIV/STI] testing is going to be a great big red flag to their insurance provider. Even though the reality is that it’s not going to be, it’s still something they want to keep very separate. Ya

know, some people feel like their entire sex life should be very separate. Some people have insurance with their spouse and they may not only be having sex with their spouse. Those people will come here for testing and say, “Oh, well, I don’t want my wife to see that I got tested for Chlamydia and Gonorrhea.’ Sometimes their family physician knows their wife or their partner—that’s something we actually get a lot. They’ll say, ‘Yeah I know they said it’s confidential over there, but they also see my wife and so that’s information I’m not comfortable with disclosing.

According to HBHC’s PCP, the reason why a particular patient does not wish to leave a paper trail in the wake of HIV or STI testing should never be a concern for her or her staff. The organization’s role, as she sees it, with respect to these patients’ needs, is administer the quality care they are after and ensure HBHC upholds its reputation for protecting patient privacy—the reputation that brought these patients to her clinic in the first place. For this particular physician, gaining a patient’s trust begins the provider trusting their patient.

PATIENT-PRACTITIONER DISCUSSION | **INCLUSIVE LANGUAGE**

One HBHC clinical staff member has successfully gained clients’ trust by leading with her expertise and academic qualifications. In the one-on-one interviews, she often sees women who were not lesbian-identified, but who “might” have sex with women. She watches patients’ body language as they are disclosing sexual history and orientation. “Women who identify one way, but behave another,” she says, “often pretend to be closed off to the idea of talking about sex entirely up front.” She explains that unless she gains that patient’s trust immediately, the chance of addressing all their needs is off the table for good. When female clients seem or appear to be withholding, she reminds them that she is a certified sex therapist. While listing the areas in which she specializes, the

HBHC interviewee says she is simultaneously implying there is “no way they can shock me because there is no such thing as weird in the world of sexual health.”

Like the HBHC staff member, an interviewee from CWHC said she also watches the patient’s body language. Informal training that her organization provides taught this interviewee that a large part of gaining patient trust is allowing the patient to take control in the interview process. The CWHC respondent insisted body language is her best cue for effectively navigating clients’ sexual history, but also acknowledged that it is much easier to observe discomfort or “telling” body language than it is to know the best way to react.

Meanwhile, a staff member at HBHC explained how she reacts to negative body language. According to her, a client’s distrust, or feelings of lost control, is often much more visible in their physical reactions to interview questions than written responses on an intake forms.

If I ever dive into patient history and I sense discomfort, which often translates to mumbling or body language that seems to be closing me off—and we get this a lot from our trans patients as soon as the questions about gender come up—I don’t just rush through to my next question. I know that I need to remind them that this is a safe space. I stop what I’m doing and look directly at the patient and say, ‘if this is making you uncomfortable we can do it at another time or we can just not do it because this is about you and it’s not hurting anything not to continue.’ Just then, I’ve put the power back in their hands. By acknowledging that this is their visit and they call the shots, the power dynamic has been shifted, and most likely, a sense of comfort restored.

Assuming a more casual tone and making the conversation feel more informal are ways CWHC’s PCP and AWH’s PCP address a scenario where a patient is visibly uncomfortable. As mentioned previously, AWH’s PCP emphasizes how her comfort with

discussing “dildos” and “anal sex” at length with patients has played a major role in her ability to prompt patient disclosure. CWHC’s PCP said her casual approach to discussing sexuality and sexual health is the reason for her patients’ high return rates.

My patients tend to ask more questions about vaginal sex than anal sex and are often surprised that I refer to anal sex as a normal activity that anyone can be engaging in. It’s after I bring it up casually or within a context that says not just gay men have anal sex that they’re then able to trust they can ask me the more personal questions—and they do.

AWH’s PCP takes what she refers to as a “sex-positive approach” when discussing sexual health history details with clients. No topic or term is considered too embarrassing, distasteful or shameful for her or any of her clinical staff. As she explains it:

You got to be fine with talking about the dick in vagina or the fingers in the vagina or the dildos in the asshole—whatever. It really takes a certain personality to work in sexual health and I don’t know if it can be trained, but there [are] lots of quirky people in sexual health. I just think you can train people all you want—you can tell people the questions to ask—but can you really teach a bedside manner?

This AWH physician reportedly provides plenty of opportunities to learn this “bedside manner” through training days for residents at her clinic. The way she describes a typical medical student’s reaction to her interview approach supports the list of differences from CWHC’s PCP and an AWH staff member’s description of how her organization and the other two compare with traditional hospital care settings.

The candid approach to discussing personal details with patients seen across all interview transcripts from this study is, according to a review of the literature, seemingly rare for service providers on the whole. All interviewees stated the importance of using

appropriate language for gaining client trust and prompting disclosure, including patient-preferred pronouns. This includes ease with using the same names as the client when the client refers to sexual practices and body parts.

PATIENT-PRACTITIONER DISCUSSION | **LET THE CLIENT LEAD**

For determining preferred pronouns (he, she, or both) or sexual-identity (hetero, lesbian, bisexual, or queer) the transcripts showed strong similarities in approach: Listen first and then reflect, but always (as with avoiding assumptions): Let the client lead. HBHC's medical director explains how her clinical staff is trained to approach the patient interview:

At Howard Brown we do try to do some informal trainings for all staff to teach them to let the patient guide the conversation as much as possible. Everything from sexual history to gender pronoun to name preferred are important to look at, not in terms of placing them into boxes or categories, but instead—ya know—listening to the person and letting them lead. It's important also to start off very open ended—before asking about sexual partners, asking if they're even sexually active and, if they say yes, then going on with, 'When you're sexually active, do you sleep with...' So, allowing the patient to determine the flow or direction of the conversation.

Allowing the client to guide the conversation is considered by most interviewees to be an effective tactic for prompting disclosure. However, maintaining control as the “expert” throughout the patient-practitioner discussion is crucial for keeping the patient assessment accurate. The HBHC medical director explains how she reminds patients of her experience and broader patient knowledge:

Let's say my patient identifies right off the bat as lesbian. Then I would say, 'Well, studies have shown that even though women identify as lesbians—which, by definition, you may say means you only sleep with women—it does not always turn out to be the case. So even though you're telling me you're a lesbian, I still need to ask [if] you sleep with men, as well as whether you are using

condoms. And when you sleep with women, do you use toys...etc.’ I just don’t ever assume that if they say they’re one thing that they don’t ever do the other thing or that they’re in zero risk. People always feel more comfortable after I provide them with some kind of statistical basis for my questioning.

Interviewees described letting the client take the lead during the patient-practitioner discussion as a “preventative measure” for medical professionals. In other words, one AWH staff member referred to this approach for determining appropriate inquiries and language as a physician’s “verbal insurance.” By opening up dialogue so the client takes control of the conversation is a safety measure for clinical staff to ensure less opportunity for verbal misstep. According to the clinical and administrative staff at all three organizations, the clients will refer to particular behaviors or self-identity with whatever language they feel most comfortable using in that space and at that time. The physician need only hear these preferences and follow their patients’ lead. A member of HBHC’s clinical staff explains how some “cues” that clients give are nonverbal:

In my role at the clinic, I usually see patients after the fact—as in, after they’ve disclosed to one of the nurses their [sexual health] needs. I am often called in when the nurse relays something like, ‘I asked the patient a question about penetration and the patient broke down weeping.’ At that point, it’s my role to come in and see what’s going on. In that kind of case, it’s fairly easy to engage in a dialogue around ‘OK. What’s going on? What’s triggering these emotions for you?’ I try to reach some sort of understanding by asking questions, but by asking questions I’m also getting to the root of what is bothering the patient and assuring them that they have control over what is and isn’t discussed.

The issue of “heterosexism” is something every staff member was eager to discuss. Clinical staff relayed numerous stories from female patients reporting incidents of homophobia or heterosexist assumptions on the part of their previous physician. Nearly every time a staff recounted such a story, reassurance of organization-wide

trainings followed visible and verbal frustration with failed doctor-patient relations elsewhere. One member of HBHC's staff volunteered this story:

One patient said that after going over several birth control methods with her provider she said told him that the type of sex she was having didn't require birth control and the awkward silence that followed was bad enough that neither provider, nor patient ever really recovered and she ended up coming to us for help. As far as the physician's behavior goes, if we ever do hear of anything worth reporting about previous doctor experiences from our patients, there is a compliance line with each institution. So, we would report to the Masonic compliance line that there was an issue with a particular provider and what the issue was. Then, we would encourage the patient to report it themselves if they felt comfortable doing so.

One HBHC interviewee mentioned that her clinic faces a similar, but unique version of the challenge most organizations face in preventing homophobia. The interviewee noted that, in her clinic, colleagues often report that the patients are the ones exhibiting signs of heterosexism. HBHC staff members, on the other hand, are much more concerned with their own "homosexisms":

Often times I'll have women say after I've asked them if they sleep with men, women, or both, 'Well men of COURSE!' And I don't say, 'We're an LGBT health center. So, why are you here?' I instead say, 'Well, this is how I do my sexual history.' So, I think that's a hugely important point because there are LGBT providers who get so integrated [with LGBT patients] that they forget that it's not about that we serve just this community. It's about [the fact that] we serve [the LGBT community] because they're underserved. As a primary service provider for mostly LGBT [patients], we need to be careful not to forget our large hetero-identified clientele who happen to live across the street and sleep with men.

In the following section, the implications that these qualitative findings have on future research and programming efforts are discussed in conjunction with results from the quantitative research.

CHAPTER 5 | CONCLUSION

The purpose of this female-focused study was two-fold: first, to assess the intersection of female sexual self-identification and applied sexual practices and then, to explore means by which reputable, WSW-inclusive sexual healthcare providers address this intersection with female clientele. After defining the problem of incongruent identity-behavior in the introduction and literature review, this study assessed the problem in a sample population and explored ways in which service providers are addressing the problem. Many findings from the present quantitative and qualitative research supported those found in the literature. However, results from both sections of this study have important implications for medical professionals engaging female patient populations on the topic of sexual healthcare and risk management.

Overall, the quantitative analyses of women who reported sex with women (WSW) in a NYC Community Health Survey (CHS) sample can be summarized in two central themes: (1) sexual identity and sexual behavior are not always congruent; (2) identity-behavior discordance is an indicator for risk. From the qualitative research section three distinctly different—but analogously important—organizational approaches to WSW-inclusive healthcare emerge. Because each approach targets a different market segment of WSW clientele, the three healthcare organizations are not mutually exclusive. Further explanation resulting from the cross-comparison of All Women’s Health (AWH), Chicago Women’s Health (CWHC), and Howard Brown Health Center (HBHC) is provided following an explanation of thematic findings from the quantitative research.

THEME 1 | INCONGRUENT ID/BEHAVIOR

Although some discordance between self-described sexual identity and self-reported sexual behavior can and should be expected in any population, this study focused specifically on women who reported sex with at least one other woman in the past year, as well as their sexual self-identity. Of the 288 WSW from the sample, 88 participants (31%) self-identified as “straight” or “heterosexual.” Consistent with findings from Pathela et al. (2006), present research suggests straight-identified WSW are disproportionately married and of *minority racial/ethnic status* (in this particular sample, Hispanic).

In fact, the scope of behavioral combinations observed among women in this study’s sample suggests that a traditional three-part system for labeling women (straight, lesbian, bisexual) cannot adequately capture the potential range of combinations in the population. Ultimately, terms preferred by individuals are not sufficient for predicting behavior, which means public health researchers must adopt a standard system for variable measurements and classifications in sexual health. Otherwise, healthcare practitioners should focus more on developing trusted relationships with their patients to elicit full descriptions of their behaviors, rather than rely on labels alone.

THEME 2 | SEXUAL DISCORDANCE and RISK

To discern which WSW identity-behavior group is most at-risk for HIV infection and STIs (straight-identified WSW, lesbian-identified WSW, and bisexual-identified WSW), differences in response outcomes from sexual health-related questions were compared. Based on similar research initiatives, fewer sexual partners and higher

incidents of testing for HIV as well as Pap tests denoted lower health risks for respondents in this study (Meyer & Northridge 2007, Pathela et al. 2006). Condom use was also considered in assessing WSW who were not exclusive about the sex of their partner. High-risk behavior, for the purpose of this study, was defined as two or more sexual partners in the past year and less frequent HIV testing.

In general, sexual health-related outcomes reported by straight-identified WSW differ most from those reported by lesbians and are somewhat similar to reports from bisexuals, with some exceptions. Straight-identified WSW engaged in the highest-risk behavior in that they reported lower rates of testing for HIV and multiple partners. Meanwhile, lesbian-identified had lower HIV test rates as well but were primarily monogamous, and bisexual WSW had multiple partners but lower HIV test rates. WSW Current findings suggest differences between each identity-behavior group are statistically significant at $p < .01$.

VARYING APPROACHES TO SEXUAL HEALTHCARE

The quantitative results, in combination with prior research, make it somewhat easier to understand why sexual health issues for female sexual minorities are typically misunderstood or altogether unknown by medical professionals (Arend 2005, Fromby 2011, Obedin-Maliver et al. 2011). Articles on increasing disparities in women's healthcare, reports on inadequate provider training, and personal stories of negative healthcare experiences all suggest that quality healthcare services are not the norm for WSW clientele (Klitzman & Greenberg 2002, Marrazzo & Gorgos 2012, Meckler et al. 2006). An informal consensus survey of WSW patients and professionals for this study,

however, produced evidence to the contrary. The survey identified three highly recommended sexual healthcare providers, reputable for WSW-inclusive, quality healthcare. Findings from the exploratory study that ensued are discussed in the following section.

In general, All Women's Health (AWH), Chicago Women's Health (CWHC), and Howard Brown Health Center (HBHC) are three healthcare providers that boast ever-expanding WSW patient populations and reputations for WSW-friendly care. Though the results of this study are clearly context specific, a comparison of transcripts from interviews with clinical and administrative staff employed at each revealed a shared perception on basic requirements for optimal patient care. Reports of patient satisfaction (measured in competency, inclusivity, trust, respect, and effusiveness) can be linked to interviewees' personal accounts of avoiding assumptions, communicating confidentiality, using inclusive language, and letting the client lead. However, additional details from the interviews coupled with first-hand observations of each clinic, indicate that this is where similarities between healthcare organizations end.

Inconsistencies across nontraditional healthcare initiatives for WSW should be expected in the absence of universal healthcare standards and describing each unique physical environment would be sufficient confirmation. However, understanding the truly significant differences between providers requires recognizing their underlying themes in service delivery, programming, and new patient solicitation. In exploring these themes, three effective, though somewhat conflicting interpretations for WSW-inclusive care emerge.

At AWH, staff members focus on behavior in service delivery and stress risk management in the marketing materials. Sexual identity is of little significance at an organization where abortions are performed on lesbian-identified patients regularly. Furthermore, information on birth control is available throughout the clinic and an important topic of discussion, again, regardless of patient identity. Interviewees argued that birth control can be used to address a range of medical issues and that, therefore, it should be discussed with all patients regardless of potential risk for pregnancy. The smallest organization in focus is a private practice owned and operated by women. When addressing WSW clientele, staff members are direct in a manner that underlines efficiency and conveys honesty. Staff members are trained to keep patients informed and actively encourage their participation. No questions go unanswered or issue unaddressed. Emphasis is on patient understanding and provider transparency. The organization's outreach efforts take the same direct approach and interviewees insist the title All Women's Health implies all-inclusive care. As AWH's PCP says, "Everyone either comes from a woman, is a woman, or will have sex with a woman at some point in their lifetime. That's what we mean by All Women's Health." The extensive list of primary care services available to patients of either sex is often used to strengthen her pitch.

CWHC, on the other hand, is a collective of medical professionals, therapists and healthcare practitioners who emphasize ongoing, preventative care. As the second largest organization in focus, CWHC is the only organization to show strong support for nontraditional, holistic approaches to healthcare. Instead of focusing on negative outcomes associated with high-risk behavior, staff members are trained to stress the importance of personal healthcare management. CHWC staff members strive to empower

patients to take control of their own healthcare instead of looking exclusively to medical professionals to gain understanding. While the AWH approach is best described as direct and transparent, CWHC could be described as approachable and encouraging. The clinic environment is completely informal with vintage couches and wood-paneled walls, with employees dressed no differently than patients. Though the organization was built on services and programming framed specifically for females, recent service expansion has an added focus on transgender healthcare. Because specific sexual identities are rarely addressed in all aspects of the organization, the cohesive perception of female clientele maintains the female-focused solidarity at the organization's origin.

Unlike AWH and CWHC, HBHC emphasizes sexual identity in every service and programming initiative. LGBT (lesbian, gay, bisexual, transgender) inclusivity is emphasized on all marketing materials and throughout the physical clinic. Of all the organizations in focus, HBHC is the biggest and designed to look most like a traditional hospital. In fact, the only major difference between a typical hospital and HBHC are all the rainbow flags and same-sex couples seen throughout the clinic. HBHC is a nonprofit healthcare organization created to provide healthcare services to sexual minorities at the same level as traditional medical providers, if not better. The wide range of programming for sexual minorities distinguishes HBHC from all other healthcare providers in Chicago. The organization also hosts LGBT-focused research and advocacy initiatives surrounding LGBT equality. Though the sexual identity-specific focus may seem exclusive to some WSW, HBHC staff insist that LGBT-inclusive is not synonymous for heterosexual-exclusive. Interviewees argue that, on the flip side, the communal aspect of sexual

identity has been beneficial for directly connecting with those patients who cannot relate to care offered in more traditional healthcare frameworks.

In summary, there are three distinctly different emphases represented throughout AWH, CWHC, and HBHC most likely appeal to different identity-behavior combinations of WSW. All three approaches are valuable in that each appeals to a different segment of the WSW healthcare market. For example, HBHC's emphasis on sexual identity is likely to resonate with lesbian or bisexual-identified WSW, while straight-identified WSW may not recognize the relevancy in HBHC's services for that same reason. Thus, additional research from the patient-perspective is one of many suggestions included in this chapter's section on implications for future research. Limitations of the research and implications for future practice, however, will be addressed first.

RESEARCH LIMITATIONS

Population survey data is scarce and due to the more recent release of articles highlighting fluidity in sexual identities and behaviors, these sources are not yet publically accessible. Moreover, data on female sexual behavior within the city of Chicago could not be found. NYC Community Health Survey (CHS) data offered sexual health-related data on an urban population comparable to Chicago's. However, the CHS surveyed sample excluded two potentially significant sample groups in which younger, sexually active respondents are likely in the majority. These two groups are persons who could not be reached using residential telephone services and anyone living in institutional group housing, such as college dormitories.

CHS variables relating specifically to female sexual health were only consistent across three survey years (2007, 2008, and 2009). Also, survey questions relating to sexual health were limited in number as well as topic and addressed at the very end of what averaged out to be 25 minute-long phone interviews. Though this section included questions on condom use, they were only presented to sexually active female respondents who reported sex with one or more male partner in the last year. Women reporting female-exclusive sex partners in that same time frame were not questioned about condom use.

Though NYC's CHS sample is somewhat comparable to Chicago in terms of population size and some response outcomes associated with WSW survey participants are significant reflections of the general population, quantitative findings are still regionally specific. New York City's foreign-born population is considerably larger and growing much faster than the immigrant population in Chicago or in any other major U.S. city. In 2000, more than one-third (36%) of NYC's population was foreign born and from a wide range of countries and by 2010, the population was three times the size of Chicago's, where most come from Mexico (Pathela et al. 2006, U.S. Census Bureau 2010). Findings from this study's qualitative research are regionally specific as well, but not the same region. Organizational assessments of All Women's Health (AWH), Chicago Women's Health Center (CWHC) and Howard Brown Health Center (HBHC) revealed a diverse female patient population on the basis of sexual orientation, but additional demographic details on each respective patient population were not made available for this study. However, it should be noted that all three clinics are located within a less than five-mile radius (CWHC and HBHC are less than a mile apart) and

occupy only two of Chicago's 77 communities total. Thus, findings from assessing each clinic's approach could be considered as specific to the small cluster of communities that represent Chicago's north side. Of note, Chicago's north side is primarily white, educated, and upper middle class (U.S. Census Bureau 2010).

Interviewing clinical and administrative staff from each group for the qualitative portion of this study presented several challenges. Scheduling conflicts due to hectic work schedules of employees within each organization, for example, meant fewer staff available and able to accommodate the time needed for questioning. Also, though all interviewees interacted with WSW clientele, the combination of professional titles and relevant responsibilities reported by each staff member differed across clinics. Thus, a cross-comparison of important clinic roles could not be made. Shared themes in provider or practitioner approaches, however—regardless of professional titles—could be identified across interview transcripts. The following section, therefore, addresses the implications these findings have for the future of women's sexual healthcare.

IMPLICATIONS FOR FUTURE PRACTICE

All information on sexual identity and behavior from this study can be useful for targeting case-based interventions. However, the statistically significant data on different identity-behavior groups' potential for risk can be particularly useful for framing broader outreach efforts—especially in communities wherein differing demographic characteristics may be more likely. For example, present findings suggest an increased likelihood of sexual discordance among racial minorities—a finding consistent with existing research (Bosh 2009, Pathela et al. 2006). With sexual discordance consistently

observed among a patient demographic that also represents the highest rates of female-reported HIV infection, the effectiveness and relevance of current outreach and intervention tactics for racial minority females must be reassessed.

Present findings suggest traditional identity-based categories in sexual health services and programs are exclusive to a fault. Straight-identified WSW in particular are frequently forced to choose between programming that reflects their identity or behaviorally relevant risk interventions. In general, a binary, identity-based organizational approach to healthcare perpetuates the problem of high-risk sexual discordance. However, Howard Brown Health Center exemplifies a sexual identity-based focus in service and has seen success in simultaneously celebrating the nontraditional patient's needs. According to HBHC employees, the group's approach centers on warmly welcoming all those whose sexual identity and behavior would most likely be perceived as nontraditional or atypical anywhere else. In seeking to provide for specific sexual minority populations, HBHC is filling a healthcare niche rather than attempting to offer universal care. HBHC's organizational approach themed in LGBT-empowerment is particularly helpful in guiding medical professionals who are operating in regions where services or support for sexual minorities do not currently exist.

Providers and practitioners who are seeking to offer universal or comprehensive clinic care should focus on flexible intervention frameworks that evolve with new findings in research, as well as new client needs. This calls for using more inclusive language and flexibility with all services offered. In other words, program themes should be fluid in way that welcomes and reflects the potential for changes in patient demographics. The organizational approach observed within Chicago Women's Health

Center offers guidance to other medical professionals seeking to tailor resources to their patients, as opposed to forcing clients to conform to strictly structure services available. CWHC's emphasis on personal healthcare management and shared or collective patient-provider responsibility is perhaps the most progressive of the three clinics in focus. The reported success of CWHC's alternative and ever-changing organizational approach to healthcare can simultaneously guide and encourage the more apprehensive healthcare providers facing recent healthcare reform.

To clarify, the implications that healthcare themes resulting from this study's organizational assessments have on the future of healthcare services have increased significance with the recent implementation of the Patient Protection and Affordable Care Act (PPAC). This healthcare reform has ignited the intended shift from traditional fee-for-service healthcare approaches to team-based, patient-centered services with bundled payments to be based on specific population healthcare outcomes.

When healthcare success is measured in community-wide service outcomes, a provider's understanding of their patient population is essential. Because certain characteristics such as their race, sexual orientation or place of birth can be indicative of a client's culture, these details offer clues for understanding risk and framing intervention. However, in order for these details to prompt more accurate assessments the patient, medical professionals must educate themselves on the innate health disparities within the communities they serve. Healthcare practitioners who recognize these obstacles for care-seeking clientele will be able to create intervention initiatives that either circumvent potential patient barriers or respectfully address them head-on.

On the topic of race, the white or Caucasian WSW majority in this study self-identified as lesbian, while Hispanic and African American WSW were far less likely to self-describe as anything other than straight—in spite of having also self-reported sex with other females. Such response outcomes suggest that while intervention programming thematically framed for lesbian patients (in program language, promotional content, or associated graphics) will most likely appeal to white WSW, the WSW from ethnic minority populations may not recognize the relevance in said programming. In addition, straight-identified, racial minority WSW may fear that any association with lesbian-themed services would expose the same-sex behavior they have struggled to keep private.

The potential for straight-identified WSW racial minorities to misinterpret or misunderstand the term lesbian based on their own culture and experiences is another reason why racial minority WSW may not access lesbian-themed services. Several interviewees from each organization explained ways in which definitions for labels and language preferences surrounding WSW differ between communities and evolve with each new generation. The staff members interviewed within All Women's Health acknowledged that their organization's title undoubtedly influences misconceptions about the patients they serve and the services they offer. Thus, it no surprise that AWH's organizational approach emphasizes educating patients and keeping clients informed about relevant healthcare services and sources. Whether in spite of or inspired by misperceptions stemming from the word female in their group's title, AWH staff members strive to connect what are oftentimes atypical clientele to all applicable and available AWH services. Because this organizational approach to client care prioritizes

information communication and simplifying otherwise intimidating or complex issues for all patients as opposed to specific populations, AWH offers the most basic and approachable guide to inclusive care of the three. Any medical professionals apprehensive about making changes within their clinic to create a more culturally competent healthcare environment should look to the AWH approach.

Observational findings suggest that when practitioners prioritize patient-reported behaviors above any other information offered (this includes self-described and self-defined identity labels), assumptions about risk and risk profiles are shattered for practitioners and patients alike. Thus, AWH would be the best option for Hispanic WSW who were most likely to self-identify as straight. AWH might also be the best option for recent immigrants, as they may not understand the terms lesbian or bisexual. Because African American WSW were most likely to self-identify as lesbian or bisexual, HBHC might be the best source for services. Meanwhile, data on Asian WSW were insufficient for making conclusions about best organizations for care.

In summary, to improve the likelihood for WSW-inclusive, culturally competent healthcare services in clinics beyond the three in focus here, healthcare organizations must prioritize culturally competent health education, prevention, diagnosis, treatment, and care. Secondly, though no two clients are the same, federal agencies and public healthcare organizations must disseminate guidelines for best practices in WSW-inclusive and quality healthcare to establish a basis for understanding. These guidelines should evolve with new findings in female sexual health research and these up-to-date findings should shape basic training for all healthcare providers, practitioners, program facilitators, and all other medical professionals who interact with female patients on a

daily basis. Without adequate training, WSW clientele will continue to face providers within a healthcare system that is both unaware and unprepared to meet their needs.

Additional research initiatives on organizational approaches that show support for the present findings with consistent terminology are also required for ensuring WSW-inclusive care is both understood and practiced in healthcare organizations nationwide. The nature of these additional endeavors and the implication of present findings on future research are discussed in the following section.

IMPLICATIONS FOR FUTURE RESEARCH

Exploring associations between consistently noted social characteristics and sexual discordance is beyond the scope of this study. However, the emerging profile for sexual incongruence is a reflection of the population that represents the most significant increase in recently reported HIV infections. Parallels between high-risk behavior profiles and sexual discordance add a sense of urgency to studying the intersection of these issues among female sexual minorities (CDC 2011, CDC 2013). Also, because clinics explored in this study operate in primarily white, upper middle class areas of Chicago, healthcare organizations serving racial minorities and/or operating in low-income communities should be observed.

In summary, additional research on the sexual identity and behavior of WSW in the general population is needed. Future data collection should focus exclusively on sexual health as opposed to offering a sexual health-related section within a larger body of questions on personal health. Also, an effort must be made to include data from younger, 18 to 24-year-old sample groups that are likely in college and therefore living in

communal housing. Though consistency with survey questions is significant for compiling research outcomes, questions about condom use should not be reserved exclusively for those WSW reporting male-partnered sex as they are with CHS. Further, female condoms should be recognized as a qualifying alternative to the male condom (which is primarily associated with heterosexual behavior) within the actual question so as to avoid the need for clarification. Though dental dams (a rectangular sheet of latex used as a barrier method in oral sex) are not comparable to male or female condoms in terms of scope of prevention, inquiring about their use in surveys is significant as well in that responses offer insight on risk with particular practices.

Future analyses of this study's organizational approaches or service styles in other clinics should include detailed descriptions of the roles within each clinic. Understanding each position and the extent of their interaction with WSW clientele could be helpful for discerning between approaches and identifying best practices. Organizational assessments should also include demographic information (i.e., age, race, sexual identity) on each group's respective patient population. More descriptive information on the WSW patient populations associated with each clinic could be helpful for understanding or verifying the market segmentation observed in this study's assessments.

In terms of understanding patient satisfaction, the present research offers a provider-perspective; therefore, future research initiatives should address the patient-perspective. Findings from this study indicate that patient satisfaction strengthens the practitioner-patient relationship and enables more competent and relevant information, education, care and services. By exploring patient satisfaction from the point of view of the patient, future research could potentially offer a more thorough definition of what it

entails. An improved understanding of patient satisfaction could potentially benefit public health research initiatives and healthcare services addressing other issues for women (such as cardio-vascular issues, cancers, mental health, smoking, exercise, alcohol and drug abuse, domestic violence, nutrition). However, studies should consider measuring patient health outcomes (i.e. changes in health status as a result of healthcare system) as well as patient satisfaction in that an organization's perceived success and ability to survive depends upon both.

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APPENDIX

APPENDIX 1 | GLOSSARY OF RELEVANT TERMS

SOURCES:

World Health Organization (WHO); Association of Reproductive Health Professionals (ARHP)

...

Healthcare practitioner (or **medical professional** or **healthcare provider** or **primary care practitioner (PCP)**): any individual with a degree/license in their healthcare field and scope of practice

HIV/AIDS: Acquired immune deficiency syndrome (**AIDS**) is a chronic, potentially life-threatening condition caused by the human immunodeficiency virus (**HIV**)

Optimal patient care (or **culturally competent care**) Confidential, comprehensive and appropriate healthcare free from any assumptions or bias that a patient can access, as well as understand

Patient (or **client**): A person receiving or registered to receive medical treatment

Patient satisfaction: For the purpose of this study, patient satisfaction is measured in competency and inclusivity on the part of the practitioner, mutual patient-practitioner trust and respect, and effusiveness on the part of the patient

Pap test (or **Pap smear**): A procedure in which a physician scrapes cells from the patient's cervix or vagina to check for cervical cancer, vaginal cancer, or abnormal changes that could lead to cancer

Sex: Refers to the biological and physiological characteristics that define men and women; Example: "male" and "female" (For this study, "sex" is not synonymous with "gender," which refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women; Example: "masculine" and "feminine")

Sexual behavior (or **sex practices**): Actual sexual acts performed by the individual and/or actions associated with or resulting from sexual acts

Sexual behavior-based terms:

- **WSW**: Women who have sex with women
- **WSWX**: Women who have sex exclusively with other women
- **WSWM**: Women who have sex with women and men

Sexual health: Sexual health is a state of physical, mental and social wellbeing in relation to sexuality. This includes relationships and sexual practices or sexual behaviors. There are three main focus areas in sexual health: Infectious diseases; Relationships and intercourse; Family planning and contraception

Sexual healthcare: Education, prevention, diagnosis, treatments, cures/and or frameworks for managing issues related to sexual health

Sexual healthcare organization: A medical group or institution that offers services and programming for enhanced or improved sexual health

Sexual identity: A term or label used to describe a individual's sexual and romantic attractions

Sexual self-identity: A self-selected term or label used to conceptualize one's own sexual and romantic attractions

Sexual identity-based terms:

- **Straight** (or heterosexual): A label associated with persons who engage in sex practices with members of their opposite sex; *Female-to-male* or *male-to-female*
- **Lesbian** (or homosexual): A label associated with persons who engage in sex practices with members of their same sex; *Female-to-female* or *male-to-male*
- **Bisexual:** A label associated with persons who engage in sex practices with members of both sexes; *Female-to-female and male* or *male-to-female and male*

Sexual orientation: Describes an enduring pattern of attraction—emotional, romantic, sexual, or some combination of these—to persons of the opposite sex (heterosexual), the same sex (homosexual), or to both sexes (bisexual)

STI (or STD): Sexually transmitted infection (or disease)

APPENDIX 2 | GLMA GUIDELINES | INTAKE FORM SAMPLE QUESTIONS

GLMA-Recommended Standard Sample Intake Form Questions (GLMA 2006)

- **Legal name**
- **Name I prefer to be called (if different)**
- **Preferred pronoun?**
 - She
 - He
- **Gender: Check as many as are appropriate (An alternative is to leave a blank line next to Gender, to be completed by the patient as desired)**
 - Female
 - Male
 - Transgender
 - Female to Male
 - Male to Female
 - Other
 - Other (leave space for patient to fill in)
- **Are your current sexual partners men, women, or both?**
- **In the past, have your sexual partners been men, women, or both?**
- **Current relationship status (An alternative is to leave a blank line next to current relationship status)**
 - Single
 - Married
 - Domestic Partnership/Civil Union
 - Partnered
 - Involved with multiple partners
 - Separated from spouse/partner
 - Divorced/permanently separated from spouse/partner
 - Other (leave space for patient to fill in)
- **Living situation**
 - Live alone
 - Live with spouse or partner
 - Live with roommate(s)
 - Live with parents or other family members
 - Other (leave space for patient to fill in)
- **Children in home**
 - No children in home
 - My own children live with me/us
 - My spouse or partner's children live with me/us
 - Shared custody with ex-spouse or partner
- **Sexual Orientation Identity**
 - Bisexual
 - Gay
 - Heterosexual/Straight
 - Lesbian
 - Queer
 - Other (state "please feel free to explain" and leave space for patient to fill in)
 - Not Sure
 - Don't Know
- **What safer sex methods do you use, if any?**

- **Do you need any information about safer-sex techniques? If yes, with:**
 - Men
 - Women
 - Both
- **Are you currently experiencing any sexual problems?**
- **Do you want to start a family?**
- **Are there any questions you have or information you would like with respect to starting a family?**
- **Do you have any concerns related to your gender identity/expression or your sex of assignment?**
- **Do you currently use or have you used hormones (e.g., testosterone, estrogen, etc.)?**
- **Do you need any information about hormone therapy?**
- **Have you been tested for HIV?**
 - Yes : most recent test (space for date)
 - No
- **Are you HIV-positive?**
 - Yes: when did you test positive? (space for date)
 - No
 - Unknown
- **I have been diagnosed with and/or treated for:**
 - Bacterial Vaginosis
 - Chlamydia
 - Gonorrhea
 - Herpes
 - HPV/human papilloma virus (causes genital warts & abnormal Pap smear)
 - Syphilis
 - None
- **Have you ever been diagnosed with or treated for hepatitis A, B, and/or C?**
 - Hepatitis A
 - Hepatitis B
 - Hepatitis C
- **Have you ever been told that you have chronic hepatitis B or C, or are a “hepatitis B or C carrier?”**
 - If yes, which and when?
- **Have you ever been vaccinated against hepatitis A or B?**
 - Vaccinated against hepatitis A
 - Vaccinated against hepatitis B
- **Below is a list of risk factors for hepatitis A, B, and C. Check any that apply to you.**
 - Sexual activity that draws blood or fluid
 - Multiple sex partners
 - Oral-fecal contact
 - Sexual activity during menstrual period
 - Travel extensively
 - Dine out extensively
 - Tattooing, piercing
 - Use intravenous or snorted drugs
 - Ever been diagnosed with or treated for an STD
 - Close contact with someone who has chronic hepatitis B or C
 - None apply
 - Not sure if any apply

APPENDIX 3 | GLMA GUIDELINES | PATIENT-PRACTITIONER DISCUSSION

GLMA'S GUIDELINES FOR A POSITIVE PATIENT OUTCOME (GLMA 2006)

- As with all patient contacts, approach the interview showing empathy, open-mindedness, and without rendering judgment.
 - Prepare now to treat a transgender patient someday. Healthcare providers' ignorance, surprise, or discomfort as they treat transgender people may alienate patients and result in lower quality or inappropriate care, as well as deter them from seeking future medical care.
 - Transgender individuals may have had traumatic past experiences with doctors causing fear or mistrust. Therefore, developing rapport and trust with transgender patients may take longer and require added sensitivity from the provider.
 - When talking with transgender people, ask questions necessary to assess the issue, but avoid unrelated probing. Explaining why you need information can help avoid the perception of intrusion, for example: "To help assess your health risks, can you tell me about any history you have had with hormone use?"
 - Be aware of additional barriers caused by differences in socioeconomic status, cultural norms, racial/ethnic discrimination, age, physical ability, and geography. Do not make assumptions about literacy, language capacity, and comfort with direct communication.
 - When talking about sexual or relationship partners, use gender-neutral language such as "partner(s)" or "significant other(s)." Ask open-ended questions, and avoid making assumptions about the gender of a patient's partner(s) or about sexual behavior(s). Use the same language that a patient does to describe self, sexual partners, relationships, and identity.
 - When discussing sexual history, it is very important to reflect patients' language and terminology about their partners and behaviors. Many people do not define themselves through a sexual orientation label, yet may have sex with persons of their same sex or gender, or with more than one sex. For example: some men who have sex with men (MSM), especially African American and Latino men, may identify as heterosexual and have both female and male partners.
 - When assessing the sexual history of transgender people, there are several special considerations:
 1. Do not make assumptions about their behavior or bodies based on their presentation;
 2. Ask if they have had any gender confirmation surgeries to understand what risk behaviors might be possible; and
 3. Understand that discussion of genitals or sex acts may be complicated by a disassociation with their body, and this can make the conversation particularly sensitive or stressful to the patient.
 - Ask the patient to clarify any terms or behaviors with which you are unfamiliar, or repeat a patient's term with your own understanding of its meaning, to make sure you have no miscommunication.
 - It is important to discuss sexual health issues openly with your patients. Non-judgmental questions about sexual practices and behaviors are more important than asking about sexual orientation or gender identity/expression.
-

**Semi-Structured Interview Outline: Administrative Staff
Sexual health services for women who have sex with women**

Thank you for agreeing to participate in an interview that will address sexual health services for women who have sex with women (WSW). The interview questions will discuss ways in which you address and determine client need while working for your organization. The interview will be recorded using an audio device. The interview is completely voluntary and you may decline to answer any question that you do not feel comfortable addressing. I will start the audio recording now.

1. Describe what sexual and reproductive health services and programs your agency provides.
2. How does your agency define “WSW”, “lesbian”, “bi-sexual”, “queer women”?
3. People use many different terms to describe sexual identity and behavior, including “homosexual,” “bisexual,” “lesbian,” “queer,” and “women who have sex with women.” Which terms does your agency use? How does it define them?
4. What would you identify as the sexual and reproductive health needs of WSW?
5. What services do/might women who have sex with women (WSW) access at your agency? Are any of them specifically targeted to WSW?
6. Within the population of women who have sex with women, there are groups that might have special needs or different issues. Are there any such groups that your organization is aware of? [*Once they respond, or if they want an example, provide prompts.*] For example, WSW of color, transsexual WSW, WSW with disabilities, and newcomer WSW.
7. Can you identify any barriers for WSW accessing sexual health services in Chicago?
8. Can you identify any gaps in sexual health services for WSW in Chicago?
9. Can you describe any programming for WSW that you have been involved in and if so, what made it work/not work?
10. Are you aware of any/other sexual/reproductive health work/programs offered specifically for WSW living in Chicago?
11. If you could have any program/service for WSW in Chicago on sexual/reproductive health, what would it look like? What would be the most important elements of such a program?

Thank you very much for your time and comments. If you have any additional questions or comments, please do not hesitate to contact me (Joan Pinnell) at 316.734.7650 or by email at joan.pinnell@gmail.com.

Semi-Structured Interview Outline: Clinical Staff
Sexual health services for women who have sex with women

Thank you for agreeing to participate in an interview that will address sexual health services for women who have sex with women (WSW). The interview questions will discuss ways in which you address and determine client need while working for your organization. The interview will be recorded using an audio device. The interview is completely voluntary and you may decline to answer any question that you do not feel comfortable addressing. I will start the audio recording now.

How do you determine a person's risk for HIV/STIs?

1. Do you have a written questionnaire or verbal intake form for interviewing your patients about risk?
2. Whether written OR verbal, do you do a history with specific questions about STDs in addition to the comprehensive medical exam?
3. Do you use general questions to elicit questions or concerns from the patient? For example: *Are you worried about STIs?* or *Any questions about safe sex?* OR do you wait to respond to questions or concerns patients raise about STIs and HIV?
4. Do you take cues from your patient's appearance, medical history, social situation and/or lifestyle that they may be at increased risk and ask specific questions if and when appropriate OR do you pursue a discussion of risks for all patients in certain groups that may be at increased risk such as on the basis of age, sex, marital status, race? OR do you stick to a script when questioning about risk to ensure all patients are asked the same questions?

Thank you very much for your time and comments. If you have any additional questions or comments, please do not hesitate to contact me (Joan Pinnell) at 316.734.7650 or by email at joan.pinnell@gmail.com.

APPENDIX 5 | INTAKE FORMS

5a | Howard Brown Health Center

5b | Chicago Women's Health Center

5c | All Women's Health



Howard Brown Health Center

Client Registration Form

Today's Date

____/____/____

CLIENT INFORMATION (PLEASE GIVE YOUR PHOTO IDENTIFICATION TO THE RECEPTIONIST)

| | | | | | | |
|---|--------------------------------|---|------------------------------------|--------------------------------|-------------------------------|-------------------------|
| Legal Name: Last | First | Middle | <input type="checkbox"/> Mr. | <input type="checkbox"/> Ms. | <input type="checkbox"/> Mrs. | Preferred Name/Nickname |
| | | | <input type="checkbox"/> Dr. | <input type="checkbox"/> None | | |
| Birth Date | ____/____/____ | | Social Security Number | | | |
| | | | ____ - ____ - ____ | | | |
| Gender Listed on Insurance | <input type="checkbox"/> Male | <input type="checkbox"/> Female | | | | |
| Street Address | City | | | State | Zip | |
| Email Address | Home Phone | | Cell Phone | | | |
| | | | () | | () | |
| You may contact me by (check all that apply): | <input type="checkbox"/> phone | <input type="checkbox"/> voice mail message | <input type="checkbox"/> U.S. mail | <input type="checkbox"/> email | | |
| Occupation | Employer | | | Work Phone | | |
| | | | () | | | |
| Emergency Contact | Phone | | Relationship to Client | | | |
| | | | () | | | |
| Street Address | City | | State | Zip | | |

INSURANCE (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

| | | | | | | |
|---|--|------------------------|------------------------|------------|-----|--|
| Legal Name of Person Responsible for Bill | <input type="checkbox"/> Same as Above | Relationship to Client | | | | |
| Birth Date | ____/____/____ | | Social Security Number | | | |
| | | | ____ - ____ - ____ | | | |
| Street Address (if different) | City | | State | Zip | | |
| Email Address | Home Phone | | Cell Phone | Work Phone | | |
| | | | () | | () | |
| Primary Insurance Company | Subscriber's Name | | ID# | Group# | | |
| Secondary Insurance Company | Subscriber's Name | | ID# | Group# | | |

DISCLAIMER STATEMENT

I authorize Howard Brown Health Center to submit claims to my insurance carrier and to release any medical information necessary to process all claims. I also authorize payment for any medical benefits to Howard Brown Health Center for all services provided until further notified for this account. I agree that I am financially responsible for any co-pay and self-pay balance at the time of service, and any balance that may be due after the claims have been submitted to my insurance.

Client Signature _____ Date ____/____/____

Howard Brown Health Center

Description of Services and Grievance Policy

Howard Brown Health Center (HBHC) promotes the health and well-being of gay, lesbian, bisexual, and transgender people and enhances their lives through health care and wellness programs. Howard Brown offers primary medical care, therapy and counseling, and case management services. Howard Brown also has a range of research opportunities in which clients can participate. Our services are designed to serve gay, lesbian, bisexual and transgender people; people impacted by HIV/AIDS and allies in a confidential, supportive environment.

DESCRIPTIONS OF SERVICES

Primary Medical Care: Anyone is eligible to receive care based on availability. Services include: comprehensive primary care, STD testing and counseling; free HIV testing and counseling.

Therapy and Counseling: Anyone is eligible to receive care based on availability. Services include: individual, couples, family and group counseling, substance abuse counseling, support groups, therapy groups, smoking cessation groups, workshops, and referrals.

Case Management: Anyone who is living with HIV is eligible to receive care based on availability. Services include: needs assessment, development of service plan, medical case management, treatment adherence, support with accessing benefits and entitlement programs, resource referral, emergency financial aid (based on need), transportation, legal assistance, and Department of Rehabilitation Services (DRS) home services coordination.

Research: Eligibility to participate in research opportunities depends on the specific needs of each research study. Research participation might include: behavioral interventions, surveys, and clinical trials focused on health issues, such as HIV/AIDS, STDs, cancer screenings, and smoking cessation.

GRIEVANCE POLICY

We appreciate client feedback and encourage you to offer us the opportunity to address any concerns you may have. If you feel that you have not been treated fairly, that your rights have been violated or that the quality of the services you received were poor, please consider taking one of the following steps:

- If you feel comfortable, please discuss your concern with the staff member offering your services.
- If you are not comfortable speaking directly with the staff member or if you are still dissatisfied after speaking with the staff member, you may request to speak with that staff member's supervisor.
- If you are uncomfortable speaking to the supervisor or you are still dissatisfied after speaking with the supervisor, you may speak with Howard Brown Health Center's Grievance Officer by calling (773) 572-8361. Please leave a message and the Grievance Officer will contact you directly.

We encourage clients to raise their concerns as soon as they occur. However, clients can submit a grievance at any time. Clients will not be penalized for raising a complaint or concern. If a staff member or supervisor receives a grievance that is related to another department, the grievance will be forwarded to the Grievance Officer.

Howard Brown clients who have a concern about our services funded through Ryan White Part A or B can contact The Center for Conflict Resolution (CCR) for free at 1-866-CARE-212. CCR provides conciliation and mediation services by a neutral person to help you and Howard Brown discuss and problem solve your concerns in hopes of finding resolution. Clients can call CCR at any point in the grievance process and do not need to follow the steps above before calling CCR.

Case management clients receiving services funded through the AIDS Foundation of Chicago who continue to be dissatisfied after taking the steps above can call the Care Team at the AIDS Foundation of Chicago at (312) 922-2322.

Revised August 9, 2010



Howard Brown Health Center

Howard Brown Health Center

Receipt of Privacy Practices, Client Rights & Responsibilities, and Grievance Policy Documents

Legal Name of Client: _____

Preferred Name of Client: _____

Date of Birth: ____ / ____ / ____

HIPAA Privacy Practices Acknowledgement

Notice of Privacy: Howard Brown Health Center's Notice of Privacy Practices was provided to you upon registration. By initialing and signing below, you acknowledge that you have received the Notice of Privacy Practices.

Initial Here _____

Client Rights and Responsibilities Acknowledgement

Rights and Responsibilities: Howard Brown Health Center's Client Rights and Responsibilities statement was provided to you upon registration. You have read the Rights and Responsibilities statement. It has been explained to you and you understand it. By initialing and signing below, you acknowledge that you have received a copy of the Rights and Responsibilities statement.

Initial Here _____

Grievance Policy Acknowledgement

Grievance Policy: Howard Brown Health Center's Grievance Policy was provided to you upon registration. By initialing below, you acknowledge that you have received the Grievance Policy.

Initial Here _____

Client Signature _____ Date _____

Guardian Signature _____ Date _____
(if different from the client listed)

Employee Witness to Signature _____ Date _____



Howard Brown Health Center

Howard Brown Health Center

Consent for Treatment

Legal Name of Client: _____

Preferred Name of Client: _____

Date of Birth: _____ / _____ / _____

Consistent with Howard Brown Health Center's Client Rights and Responsibilities, I consent to and authorize the performance of all treatment, procedures, and the administration of all medicine which my health care provider and/or behavioral health provider believes may be considered necessary or advisable for diagnosis and/or treatment at Howard Brown Health Center for myself or for the client named on this form.

I understand that no guarantee has been made as to the results that may be obtained from the treatment, procedures and medicine I receive.

I also understand that Howard Brown Health Center provides integrated health care services. This means that Howard Brown Health Center's health care staff work together to provide me or the person named on this form high quality health care. To accomplish that, health information about me or the person named on this form may potentially be shared with Howard Brown Health Center staff involved in my care or the care of the person listed on this form for the purposes of quality health care.

I understand that information I offer to Howard Brown Health Center is confidential and cannot be shared without my permission. I also understand that, on occasion when required by law, Howard Brown Health Center may be required to release information about me without my permission. If Howard Brown Health Center finds out about or suspects child abuse, elder abuse or abuse of someone that is disabled, Howard Brown Health Center is required to take action necessary to protect the person being abused. If Howard Brown Health Center believes that you are at serious risk of hurting or killing yourself or someone else, Howard Brown Health Center is required to take action to help ensure the safety of you and/or that other person. Please refer to Howard Brown Health Center's Privacy Policies for additional information.

Client Signature _____ Date _____

Guardian Signature _____ Date _____
(if different from the client listed)

Employee Witness to Signature _____ Date _____



Howard Brown Health Center

Receipt of Privacy Practices, Client Rights & Responsibilities, and Grievance Policy Documents

Legal Name of Client: _____

Preferred Name of Client: _____

Date of Birth: ____ / ____ / ____

HIPAA Privacy Practices Acknowledgement

Notice of Privacy: Howard Brown Health Center's Notice of Privacy Practices was provided to you upon registration. By initialing and signing below, you acknowledge that you have received the Notice of Privacy Practices.

Initial Here _____

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Rights and Responsibilities: Howard Brown Health Center's Client Rights and Responsibilities statement was provided to you upon registration. You have read the Rights and Responsibilities statement. It has been explained to you and you understand it. By initialing and signing below, you acknowledge that you have received a copy of the Rights and Responsibilities statement.

Initial Here _____

Grievance Policy Acknowledgement

Grievance Policy: Howard Brown Health Center's Grievance Policy was provided to you upon registration. By initialing below, you acknowledge that you have received the Grievance Policy.

Initial Here _____

Client Signature _____ Date _____

Guardian Signature _____ Date _____
(if different from the client listed)

Employee Witness to Signature _____ Date _____



Howard Brown Health Center

Howard Brown Health Center

Statement of Client Rights and Responsibilities

You have the right:

- ◆ To access services which will not be denied on the basis of economic status, disability, national origin, ethnicity, race, religion, gender, gender presentation or gender identity, sexual orientation or HIV status (in accordance with the Americans with Disabilities Act).
- ◆ To be treated as an important member of your health care team and to have your choices and needs valued.
- ◆ To receive care in a safe and secure environment, free from physical, verbal or sexual harassment, swearing or disorderly conduct.
- ◆ To have all information about you, including HIV status, treated in a confidential manner in accordance with Federal and State laws.
- ◆ To receive information about your diagnosis, medical condition and treatment in language you understand.
- ◆ To request a copy of your medical records.
- ◆ To be informed of services, research opportunities and programs available to you at Howard Brown.
- ◆ To receive services from other organizations with or without the assistance of Howard Brown staff.
- ◆ To refuse service or end your participation in any or all services provided by Howard Brown and to have the consequences of this decision explained to you without punishment or penalty.
- ◆ To know where and how to register a complaint or concern, and to know that your complaint or concern will be taken seriously.
- ◆ To know that you will not be penalized for registering a complaint or concern.
- ◆ To ask for the services of an interpreter and to know that Howard Brown will provide one.
- ◆ To request a meeting with a financial counselor when your financial circumstances or insured status have changed to have your assessed payments reevaluated.
- ◆ To continue to receive services if your financial circumstances or insured status has changed.
- ◆ To contact Howard Brown's billing agency to raise concern about any errors in your bill.
- ◆ To be aware that Howard Brown is a teaching institution and that resident physicians, medical students, student nurses, psychology and social work students and other supervised health care providers-in-training may be involved in your care.



Howard Brown Health Center

Statement of Client Rights and Responsibilities

You have the responsibility:

- ◆ To be an active member of your health care team and to follow the treatment plan that you and your provider agree upon.
- ◆ To ask questions and tell us when you do not understand a treatment option or decision being considered.
- ◆ To help your provider understand your concerns and the way your life circumstances may impact your care.
- ◆ To keep your provider informed of all services you are receiving from outside agencies or individuals.
- ◆ To notify Howard Brown immediately if your contact or personal information and/or if your insured status or financial circumstances change.
- ◆ To come to your appointment without being under the influence of alcohol or illicit drugs. If you are under the influence of alcohol or other illicit substances, you will not be seen and you will be asked to reschedule your appointment.
- ◆ To attend your appointment and to arrive 10-15 minutes before your scheduled appointment time. Please provide at least 24 hours advanced notice if you need to cancel your appointment.
- ◆ To answer all questions and fill out all paperwork completely and honestly, including (but not limited to) information about your financial status, health conditions and care received elsewhere.
- ◆ To treat everyone at Howard Brown with respect. Physical, verbal or sexual harassment of staff or other clients, swearing or disorderly conduct will not be tolerated. This type of behavior may result in immediate termination from Howard Brown services.
- ◆ To pay your bills or make arrangements with Howard Brown to meet your financial obligations in a timely manner.
- ◆ To share your compliments and concerns, and provide suggestions that will help us provide you the best care possible.

Effective August 5, 2010



Howard Brown Health Center



W o m e n M a k i n g H e a l t h C a r e A c c e s s i b l e

MEDICAL RECORD

Today's Date _____

Legal Name _____ Birth date _____ Age _____

Preferred Name _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone #1 _____ (c/h/w) Phone #2 _____ (c/h/w)

Occupation _____ Employer _____

Birthplace _____ Primary Language _____

Your medical record is CONFIDENTIAL. Please answer the following questions briefly. If there are questions you wish to omit, feel free to do so. This document is for our use only. It will not be released with your medical records.

HAVE YOU EVER HAD OR ARE YOU HAVING PROBLEMS WITH ANY OF THE FOLLOWING?
IF YES, PLEASE NOTE IF THE PROBLEM IS CURRENT OR PAST

- | | |
|--|---|
| _____ 1. Skin Problems | _____ 13. Bladder or Kidney Infections |
| _____ 2. Eyes, Ears, Nose, Throat Conditions | _____ 14. Urinary Pain or Burning |
| _____ 3. Asthma | _____ 15. Diabetes |
| _____ 4. Tuberculosis | _____ 16. Thyroid Problems |
| _____ 5. Lung Problems | _____ 17. Anemia or other Blood Disorder |
| _____ 6. Heart Disease | _____ 18. Hepatitis or Liver Disease |
| _____ 7. Rheumatic Fever | _____ 19. Cancer (specific organ) |
| _____ 8. Chest Pain | _____ 20. Joint or Muscle Pain |
| _____ 9. High Blood Pressure | _____ 21. Severe Headaches or Migraines |
| _____ 10. Blood Clots or Vein Problems | _____ 22. Fainting or Dizzy Spells |
| _____ 11. Breast Problems (lumps, soreness, discharge, cancer) | _____ 23. Immune System Disorders (HIV, Lupus, CMV, Multiple Sclerosis) |
| _____ 12. Gastrointestinal Pain or Problems | _____ 24. Other: _____ |

EXPLAIN (DATES OF PROBLEMS AND TREATMENT): _____

ALLERGIES: Do you have any allergies to any medications or substances (penicillin, sulfa, aspirin, iodine, gluten, doxycycline, latex, etc.)?

CURRENT MEDICATIONS (INCLUDING HORMONES): Please list: _____

CURRENT SUPPLEMENTS/VITAMINS/HERBS: Please list: _____

HOSPITALIZATIONS/ SURGERIES: List dates, condition, treatment: _____

DISABILITIES: Please list _____

Have you had a cholesterol test in the past 5 years? _____ If so, when? _____

Have you had any of the following vaccines? (Check if yes) _____ Hepatitis B _____ HPV

FAMILY HISTORY: Have any members of your family had (write in relationship and age of onset):

| | |
|---------------------------------|---------------------------------------|
| _____ Heart Disease _____ | _____ Breast Cancer _____ |
| _____ Stroke _____ | _____ Other Cancer (what type?) _____ |
| _____ High Blood Pressure _____ | _____ Diabetes _____ |
| _____ High Cholesterol _____ | _____ TB _____ |
| _____ Blood clots _____ | |
| _____ Other _____ | |

(_____ Family health history unknown _____ Father's history unknown _____ Mother's history unknown)

EMOTIONAL HEALTH:

Do you have any unusual stress in your life at this time?

Do you have a history of emotional health problems? _____

Have you recently been in a situation that feels unsafe or harmful to you? _____

Have you in the past or are you currently experiencing emotional, sexual or physical abuse or violence? _____

Are you interested in counseling or other well-being referrals? _____

HABITS: Smoke tobacco _____ / day Alcohol _____ Other drug use _____
Coffee/tea/soda _____ / day Sleep _____ hrs./night

Describe your eating habits. _____

Do you have or have you had an eating disorder? _____

Is food or eating a source of anxiety for you? _____

Exercise (type and amount): _____

GENDER:

How do you identify? (check one or more)

_____ Woman _____ Trans _____ Intersex _____ Man _____ Gender queer (or describe your gender) _____ Preferred pronoun: _____

SEXUAL ACTIVITY:

Are you currently sexually active with a partner/partners? _____
If no, have you ever had sexual contact with a partner in the past? _____
If yes, is/are your current partner/partners: _____ Female _____ Male _____ Trans _____ Intersex
If having vaginal sex with males, do you use contraception? _____
Do you have any sexual concerns or problems? _____
Do you have any questions or concerns regarding sexual pleasure or orgasm? _____
Do you use any methods to protect yourself from sexually transmitted infections? _____
Have you ever had a screening for sexually transmitted infections? _____

WHAT (IF ANY) CONTRACEPTIVE METHODS HAVE YOU USED? WHEN/HOW LONG? PROBLEMS?

GYNECOLOGICAL:

Age menstrual periods began _____ Menopause at age _____
First day of last menstrual period _____ Are periods regular? _____
How many days from the first day of one period to the first day of the next period? _____
How many days do you bleed? _____ Do you ever bleed between periods? _____
During your period do you have excessive bleeding, pain, cramping, or vomiting? _____
Has there been any recent change in your menstrual period? _____
Do you have pre-menstrual symptoms or problems? Describe: _____

Number of pregnancies _____ Live births (dates) _____
Miscariages/stillbirths (dates) _____ Abortions (dates) _____
Any complications related to pregnancy? _____

Date of last PAP smear _____ Result _____
Date of last Mammogram _____ Result _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? CHECK IF YES.

- | | |
|--|---|
| _____ Abnormal Pap Smear | _____ Ovarian Cysts |
| _____ Colposcopy | _____ Vaginal Infections (Yeast/Bacterial) |
| _____ Cryosurgery | _____ Sexually Transmitted Diseases or |
| _____ Cone Biopsy, LEEP or Laser Surgery | Infections (Chlamydia, Gonorrhea, Herpes, Genital |
| _____ Uterine Fibroids | Warts, Syphilis, Hepatitis, Trichomonas) |
| _____ Endometriosis | _____ Pelvic Inflammatory Disease |

EXPLAIN (GIVE DATES OF PROBLEMS AND TREATMENT): _____

IS THERE ANYTHING ELSE YOU WANT TO TELL US? _____



All Women's Health^{PS}

This form is part of your permanent medical record. Please answer as completely as possible; all information is strictly confidential.

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Alternate Phone: _____

Have you ever been a patient here before? Yes No

If no, how did you hear about us? _____

Today's Visit

Reason for Visit Today : _____

Any concerns you would like to discuss with the doctor: _____

Gynecology History

Have you had:

| Yes | No | When? | Yes | No | When? |
|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Annual pap test _____ | <input type="checkbox"/> | <input type="checkbox"/> | Surgery on your uterus or cervix _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal pap test _____ | <input type="checkbox"/> | <input type="checkbox"/> | Syphilis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia _____ | <input type="checkbox"/> | <input type="checkbox"/> | Trichomoniasis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital warts _____ | <input type="checkbox"/> | <input type="checkbox"/> | Yeast infection _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea _____ | <input type="checkbox"/> | <input type="checkbox"/> | Bacterial Vaginosis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes _____ | <input type="checkbox"/> | <input type="checkbox"/> | PID _____ |

Menstrual History

Date last period began: _____ Was it normal? Y N

Are your periods: regular irregular?

Social History

Do you smoke tobacco? Y N Are you using recreational drugs? Y N

Have you used any drugs in the past 24 hours? Y N If yes, what? _____

Demographic Information (Required by IDPH)

Race: White Black/African American American Indian Asian
 Hispanic Other _____

Highest Grade Completed in School: _____

Married? Y N

Pregnancy History

Age at first pregnancy: _____ Total number of times pregnant: _____

Year of last pregnancy: _____ Years of past pregnancies: _____

of children _____ # of cesarean sections: _____

of ectopics: _____ # of miscarriages _____

of abortions (not including today): _____ # of still births: _____

Are you currently breast feeding? _____

Have you had complications with any birth abortion, miscarriage, or cesarean section? Y N

Contraceptive History

What birth control have you taken in the past?

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Oral contraceptives (birth control pills) | <input type="checkbox"/> IUD |
| <input type="checkbox"/> Depo Provera (3 month injection) | <input type="checkbox"/> Nuvaring |
| <input type="checkbox"/> Ortho Evra (the patch) | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Plan B (emergency contraception) | <input type="checkbox"/> Condom |
| | <input type="checkbox"/> Other |

Why did you stop using the method(s)? _____

What birth control are you currently using? _____

What are you interested in now? _____

Medical History

List any allergies to drugs or seafood: _____

Any medical problems (now or in past): _____

Any surgeries: _____

Do you take any medications? (circle one) Yes No

List: _____

Are there any medical problems in your family history? _____

Sexual History

Current marital status

Are you currently sexually active? Yes No

Do you currently partner with men women both?

In the past, did you partner with men women both?

Have you:

Used Condoms with all new partners? Y N

Had two or more sex partners in the last 60 days? Y N

Had a new sex partner in the last 60 days? Y N

Had a partner with symptoms or infection in the last 60 days? Y N

Had any sexually transmitted infections in the last 12 months? Y N

Are there any concerns about sexuality, sexual assault, rape, drugs/alcohol, or domestic violence you would like information about or to discuss with the doctor? Please circle any areas you would like more information about and/or describe below.

I certify that the medical information above is true and accurate to the best of my knowledge.

Signature

Today's Date

(For office use only)

Medical History Reviewed: _____

Physician

Date