Moderator: Hello, and welcome to public health live, the Thursday breakfast broadcast, I will be your moderator today. Before we get started, I would like you to please fill out your online evaluation on the webcast, and your feedback is helpful in planning future programs. We encourage you to let us know what topics will serve you and serve your needs. Throughout the program, we will take your calls through the program. You can call or send your written questions by fax, the number is 518-426-0696. And we will take your questions by e-mail. Please e-mail at any time at PHlive@NewYork. Our program is Cancer and the LGBT Community: Special Issues and Concerns. Our guests are from the New York School of Medicine, Department of Gynecology Division, and the Program Coordinator for The Lesbian Campaign of Lesbian and Gay Center of New York.

Thank you for being here and covering this very important topic. To introduce this topic, we will start watching a video produced by the National LGBT Cancer Network, called, To Treat Me, You Have to Know Who I Am. And let’s take a look.

[Video]: To treat me, you have to know who I am. I identify as a Latino lesbian mother.

To treat me, you have to know who I am, I identify as a transgender man.

To treat me, you have to know who I am, I identify as a gay man.

At 15 years old, I remember going into the doctor office and I remember telling her when she asked about my sexual activity, if I used condoms or anything like that. I said no, I am gay. And I just remember her face changed very much. And her warm tone, her voice turned very harsh. And it seemed as though she was rushing me out as quickly as possible. I think that the LGBT community has special needs which is to be treated not LGBT people have been treated forever, which is to be asked about their sexuality and not be afraid of the answers. My partner and my children were on a family vacation and my oldest daughter was sick, and we got to the hospital and they asked who are the parents? I said she's got two moms. And they said she can't have two moms and we were traumatized by that. My partner went to the hospital, and the nurse would not allow me to accompany him, and I asked if I could if I was part of his family, and she looked the other way. At the hospital the care providers think about the fact that the patients have different orientation than the provider. And those dealing with me as midwife and nurses with them were not responsive to my identity and did not respect it. When diagnosed with breast cancer, I found my breast surgeon was unable to call me to give me my biopsy results. He told me that he had problems with my transgender status, and upon meeting me and learning of my Transgender status that his first result was to refer me. It's about respect and humanitarian response to a human being in general. To treat me, you have to know who I am. I identify as a lesbian. To treat me you have to know who I am, I identify as a Latino queer parent.

Moderator: That was a pretty incredibly powerful video, wouldn't you agree?

Dr. Blank: Absolutely. Absolutely, striking.

Christina Moldow: Clearly to treat me, you have to know who I am.

Moderator: And today's program would provide all of those viewing today with the skill base and the knowledge to really have that understanding of who these patients are. Let's begin; we will talk with Christina, the Program Coordinator for the Lesbian Cancer Initiative at the Lesbian, Gay, and Transgender Center in Manhattan.
Christina Moldow: And Christina that video, and some may wonder how it matters, and can you start talking about cultural competency and why it's important when dealing with cancer patients who are members of the LGBT community.

Moderator: Absolutely, and first I want to talk about the acronym LGBT, we will use a lot in this presentation, and it stands for lesbian, gay, transsexual and bigender.

Christina Moldow: Not everyone in the community uses one of those four labels to describe themselves. But we are talking about a group of people that are targeted in the society of their identity. And that's who we refer to as LGBT. And in our community we see greater risk factors for cancer among LGBT people and greater barriers to receive screening. When you put together increased risk factors and lower screening rates, we can only assume that cancer will be detected at later stages when it's harder to treat. And that is the key thing we want to shift in doing this program. Some key contributing factors is that no demographic data is gathered in health facilities or registries about sexual orientation or gender identity. And without that data we don't have a way to track cancer in LGBT communities and among these people. And there is a strong research to understand these.

Moderator: Clearly understanding that connection helps to illustrate the importance of this topic. Before we go further into the statistics, I think it would be helpful to define some terms we are using. Some members of our audience may have a different understanding. Can you provide some clarity to us?

Christina Moldow: I think that's a great idea. I will share a set of definitions that I think are useful to get everyone on the same page for this discussion. First I will talk about sex. With sex I am talking about biological markers that are sex specific, including chromosomes and genetics and anatomy and the like. And the examples of sex are female and male and those characteristics.

Moderator: When we talk about sexual orientation, how does that factor in?

Christina Moldow: That refers to a person's desires or attractions to others of many kinds, including sexual attractions and other kinds as well. So a couple of specific terms that are examples of sexual orientation, and pan sexual refer to people's attraction to all people regardless of their gender identity. And queer is a term that gender of male and female and is used by younger people. And the people understand the terms lesbian and gay.

Moderator: Take us through gender identity.

Christina Moldow: This is a term that people are less clear on. When I talk about gender identity, I am talking about a person's inner awareness of male and female. For most gender identity is the same but for transgender people it does not match. For example, a transgender woman is born with male sexual anatomy and chromosomes. But she experience as female, and identifies as female. And has a female name and refers to herself with the pronouns she and her. And this is regardless of any gender changing surgery. And a gender neutral person may not identify themselves as male or female. And may prefer to go by their name which may not have a gender association rather than by he and she.

Moderator: And gender woe?
Christina Moldow: This is a person's outward expression of themselves regardless of gender identity. And this can be expressed through dress and how they interact in the world and how they carry themselves. If you see someone and you think that person is masculine or feminine you are probably responding to their outward role.

Moderator: Is there a gender model?

Christina Moldow: Yes, I will walk you through two gender models that are the key of understanding that makes up the LGBT community. First we will look at the traditional gender model. And here we see a linear relationships, between gender and sex. And someone with female characteristics behaves in female ways and experiences attractions towards men. And you may notice that LGBT people don't fit into this model. And the truth is that not all non LGBT people do either. And now look at the authentic gender model. And when we look at this, we see there is a place here for everyone. LGBT people included and in particular. Here we don't have rigid and determining relationships between sex and gender roll and sexual orientation. But many possibly relationships between these categories. And if someone lands in one category doesn't preclude about the other three. You may know a lesbian with female characteristics who has more male outward characteristics and attracted to both but primarily to women. And a gender characteristic may identify as gender neutral and be attracted to women.

Moderator: That was helpful information and lays the foundation for today's discussion, it sheds lights on the terms and how they relate to each other. Now that we have that understanding, tell us more about the members of the LGBT community and how being a part of that community affects their risk for cancer.

Christina Moldow: Okay, many studies show significantly increased rates of alcohol and tobacco use in LGBT people. And we know that substance use is greater in discrimination. And we see higher rates of obesity in lesbians in particular, and higher risks of gender men and more particular in unprotected sex and anal and cancer and HIV cancers. And we see different patterns of reproductive behavior in those with female reproductive systems, but Dr. Blank will talk about that more in the program. And as far as gender hormone use, we don’t have long-term data that talks about risks. There are isolated studies that suggest some increased risk with both masculinizing and Femalizing hormones and more research is needed.

Moderator: Are there screening rates?

Christina Moldow: Yes, and this relates to screening rates. LGBT people are not engaged in health care and less likely to get cancer risk screenings and less likely to know what to be screened for. And LGBT people tend to have lower insurance rates, and hope to see change in New York with marriage equality but they may not change that risk. And cost factor for LGBT people that don’t have job flexibility and extra money for transportation. And this does not just relate to LGBT people, but important to remember that LGBT people exist in all strata, and many discriminate in engaging in health care and may have to be engaged in it and stay away. And there is a level of distrust and vulnerability around bodies and physical contact and nudity that are often circumstances that people have to be in, in medical appointments.

Moderator: Two more.
Christina Moldow: There is often a provider lack of awareness and some providers are not familiar with LGBT people and may eliminate them and some providers don't want to work with LGBT patients.

Moderator: Are there barriers to coming out?

Christina Moldow: Yes, there are, and the most risk statistic I have seen, indicates that 49% of LGBT patients come out to their providers. This statistic is about six years old and I think that the number has improved but no question that barriers still exist. I talked about fear as a barrier, so I will go right into don't ask, don't tell. If providers in facilities don’t ask about orientation, many LGBT people assume it means it's not safe to come out or not comfortable to take that risk. I have heard many providers say, I don't ask, I treat everyone the same. With the intention to create more comfort and safety. But the problem is that this is often experienced as the lack of unique concerns of LGBT patients. And providers actually miss an important opportunity to acknowledge respect and that's the opposite of what is intended. And finally some providers assume heterosexuality, and I think that's less true than it used to be. Although I hear many reports of lesbians asked what kind of birth control they use, and some providers alienate by their gender. And I don't know if this is specific, because I know that providers ask other things that are personal.

Moderator: And I am sure you see vulnerability and the other questions.

Christina Moldow: I do.

Moderator: Christina, given these barriers you pointed out to you us. Let's talk about successful strategies to engage LGBT people.

Christina Moldow: Sure, first I want to talk about opportunities for inclusion. Think about the language that is used in all points of contact. Intake forms and gathering information on the phone or scheduling appointments and handling issues and the medical appointment itself. And remember that any contact is an opportunity to build or break a patient's trust. So if you are asking things about marital status, what options on the form besides single, married, divorced or widows. It's us useful to ask about the partner's gender. And it's useful to ask questions about sexual orientation, you can ask if a patient is lesbian, gay and include a line for other, because some people may have a specific way to define themselves. And similar to asking about gender, you can ask male, female or other, and ask if there is a transgender experience. And encourage people to provide an inclusive environment. Make sure that magazines and art work and pictures reflects LGBP experiences. If there is a nondiscrimination policy that says you have to make sure that sexual orientation and gender identity are included. And if it can be made public, that's a great thing too. It's used to help people feel engaged and respect people’s choices. Marital language that they use to describe themselves and relationships. So if your female patient refers to their wife and don't refer to her as her friend. If your initial contact with the patient is over the phone, be familiar that a male sounding voice may have a female name.

Moderator: Are there additional strategies?

Christina Moldow: Yes, it's useful to supply materials with messaging designed for the needs and concerns of LGBT people. At the lesbian cancer center, we have a breast shower card that speaks to lesbians by sexual women and transgender people in particular. And we have cancer screening materials that refer to appropriate screenings by body part, and not by gender or gender-cancer information. And there are other materials available about LGBT cancer risks as well. We think it's
important to be open to people's uniqueness. Not all think about their sexual orientation. Be careful to use LGBT people you know to identify themselves. With regard to a provider's own biases. We understand that people have cultural or religious beliefs that require them not to accept LGBT life and choices. If this is you, we ask that you make an honest assessment about your ability to provide the same quality of care to an LGBT patient as to anyone else. And if the answer is honestly no, that you take on the responsibility to make referral to that patient to be sure they receive the level of care in spite of their identity. And that you continue to provide care and with facilities experiencing amount of turnover, and this is necessary to keep your staff in top shape to serve the needs of LGBT patients.

Moderator: Christina, thank you for that information and it's important to hear about why this is important not only for the LGBT community. But also for providers that are looking to engage their patients. You speak of inclusive and respectful and repeating training. All of these factors are key for successful provider/patient relationship. And I know that Dr. Blank will go more into that. As a quick reminder, we will be taking your questions by phone and by fax and by e-mail on the topic of engaging patients, we are going to hear from Liz Martlie, founder of the LGBT Cancer Network about the importance of these issues and some work that their organization has done around them. Let's take a look.

[Video]: Hi, I am the Founder and Executive Director of the LGBT Cancer Network. Increase risks are behaviors that can be traced at living in the stigma LGBT communities, and they use twice the tobacco and alcohol at higher rates. And what you see in the general population, alcohol tends to decrease with age. That's less true with LGBT people. And we see in lesbians, to be overweight and less likely to have children under the age of 40. And with men we see a higher rate that can lead to anal cancer. And we see people in the LGBT people as they are aging, they are getting cancer at a higher rate of the General population, and at a younger age. And treatment is complicated because of the medications they take. I am not talking about the AIDS defining cancers but lung cancer and anal cancer. That we see in the aging H.I.V. population.

And the second barrier to care is negative experiences in the health care system. And there is new research that came out this week, that even today the amount of LGBT time spent in medical education is five hours. That is not enough to talk about our unique health needs and risks and family structures, etc. There are lots of things that need to change, so that LGBT people will feel comfortable engaging in the health care system. And one of the basic things outside of our scope is that we need to make discrimination against LGBT people illegal. Because they carry that around with them and not feeling safe. The problem not feeling safe in the health care system, we can't be open about our lives and therefore our health risks. So a recently married man that may not be living with his wife but have a primary relationship with another man or having sexual encounters with another man. If he doesn't feel safe talking to his doctor about the kind of sex he's engaging in. His doctor didn't know to be tested for anal cancer and give an anal pap. If we can't say what is really going on, I think it affects treatment. It means we are less likely to get the screenings. We need to make it safe for us to be in the health care system. My organization was recently suggested by the Health And Hospital Corporation in New York City, which is the largest municipal system in the country, to create a training program. That is now mandatory for all 38,000 employees. And what makes HHC so special is that the mandate came from the top. And it will go from everyone. It's not one gay man that runs some department store who needs to make sure that everyone in his department knows how to speak respectfully to LGBT people, knows how to create them safe and a welcoming environment. But everyone person will be trained. And I like to think today it's HHC and tomorrow it's all of New York State and next week it's the entire country.
Moderator: Now we will hear from Dr. Stephanie Blank who is an oncologist who treats cancer patients and specifically in the LGBT community. And we will hear from her about barriers to overcome. And Dr. Blank there is so much information and start off by introducing us to the topics.

Dr. Blank: Yes, and thank you. And I want to say due to my specialty that is oncology that is cancer that is born in women. But I will speak in general terms.

Moderator: First speak of LGBT patients in your practice and who they are and who you need to know.

Dr. Blank: And I will talk about LGBT people in cancer risk and improving the care you provide.

Moderator: The first thing you mentioned was knowing who are the patients in your particular care are. Can you talk more about what you mean by that statement?

Dr. Blank: First, knowing your LGBT patients and what percentage of your patients are LGBT. First to know the following, you will have LGBT patients in your practice and how to know who they are. There are a number but none are perfect, and I will comment on how good they are. And perhaps the patient will tell you, and that’s pretty reliable. If you ask directly, this is the best way to get that information and done properly. There are other ways that are less good, rumors and assumptions, these are imperfect and may be based on clothing. Intake forms are flawed and do not yield itself for this information. It’s interesting to look and see what people have written. And I will talk about that but usually quite flawed. And other ways, maybe a nurse heard someone speaking on the phone or saw someone at a march. But in general the LGBT community is about 6%, but less than half of LGBT patients come out to their providers. And we have statistics for some but have no idea for transgender.

Moderator: Clearly for less than half coming out to the providers, we have a lot of work to do in this area. Any way to estimate the prevalence of cancer in the LGBT community?

Dr. Blank: We cannot estimate of the risk of cancer in the LGBT community because health providers do not bring this out.

Moderator: I understand you have information to share with us regarding a pilot review of oncology practice you did.

Dr. Blank: Absolutely, I care for a number of LGBT patients in my practice, and curious of the outcome with cancer. And I found there was no efficient way to search for LGBT patients and I basically tried to identify patients. And we surveyed five practitioners and we looked at hospital and 65% were cared for by one attendee. And that was one person that asked about their sexual orientation. And each patient revealed by a female partner. And in the marital status and half were single and 90% of the people had female partners actively involved in their care. So we found that sexual orientation was often misrepresented in charts and not directly assessed.

Moderator: You talked about what you have seen in your review of a practice. Can you talk about members of the LGBT community and their experience of talking about their sexual practices and gender identity?
Dr. Blank: In a survey found that more than one in five LGBT people withhold information about their sexual practices from their health care provider and either cites past experiences and concerns.

Moderator: Talk about a huge impediment.

Dr. Blank: Yeah, for many in the community it seems like a big warning sign of assessing a medical provider they can trust. And not worry about how they are judged. And this is a sample, and failing to include partner as a choice. And not to discuss about the possibility of LGBT. And to ask a lesbian how she is sexual active and not using condoms, or assuming that a lesbian doesn't want to become a partner. And a big one is not acknowledging or including the patient's partner. And talking to the transgender. And this is not just the provider but everyone in the office. It's something that needs to come from the top. And has to be reflected all the way down.

Moderator: Is there a way to kind of, for lack of better term, comfort the patients from the LGBT community as they come in and meet with their providers. Christina described it an opportunity to build or break the trust factor on the first initial discussions between patient and provider.

Dr. Blank: Absolutely, and I will restate, LGBT people report negative experiences with health care providers. And they feel that disclosure will negatively impact their care.

Moderator: I imagine having to worry about how your sexuality and gender identity affects your quality of care must be enormously stressful. It can sometimes be stressful going into a provider and knowing you have something wrong with your health. And you may have a diagnosis of cancer. And then to compound that with being afraid to come out. And to openly discuss your sexuality and gender identity, has to be tremendously stressful to the patients and quite frightening. Let's hear from a cancer survivor that talks candidly about his experience in this situation. Let's take a look.

[Video]: My name is Jay, I identify as a transgender man, and I lived in the first years as a woman and then regarded as a lesbian. And I have been a volunteer EMT working in disasters all over the country. I have been faced not just a patient but a provider. My cancer diagnosis came as a shock, I just had a mammogram not just six months before, and it come across very clean. And then I found a very small lump in my breast. And I took to do my primary care provider. And she gave me a referral for a mammogram. At the time when I had the mammogram, the physician immediately called me aside. And said there are highly suspicious things going on in the films. And I took a look and said, oh, my God. And she offered on the spot to do a biopsy, I agreed. And then I waited for weeks and weeks and didn't get the results back. The screening radiologist who had been warm and supportive to me, and she said, how are you feeling about your diagnosis, and I said, what diagnosis. She said, oh, doctor so-and-so hasn't called you. And he hadn't. And he was the person ahead of surgery at this major New York City hospital, and he set a time. And I give him credit; he spent a good hour talking to me.. He said right off the bat, I have tremendous problems with your transgender status, and he said, I don't know what to call you. And I said you are welcome to call my Jay or Joy, whatever you are most comfortable with. We talked; we talked for a good hour. And we discussed my surgical choice, which was because I had such dense breast and mammogram hasn't picked up my cancer. What I wanted was a double mastectomy, and he said to me, my first reaction when I knew you were transgender, I wanted to send you to psychology. To me despite his efforts to understand my condition, I couldn't handle having someone open up my chest who couldn't call me by my proper name. And who clearly had such deep seated troubles with my being transgender. It was terrifying to me. As a patient going for chemotherapy, what I face is you the medical professional coming at me with a bag of deadly poison and a needle. And I started to feel I trusted cancer more than I trusted the providers I was seeing.
Moderator: you know, to think that's just one example. Jay's story is one example. Dr. Blank can you talk about the impact of a person's gender identity from the provider's perspective?

Dr. Blank: Yeah, I will speak about why providers need to know. And Christina said that providers don't want to know, and treat everyone the same. But I believe that providers need to know. And some are not comfortable with the LGBT lifestyle but you need to know. And knowing that a patient is LGBT will allow you to take better care of them. That's part of the history, and you ask for their gender identity as it should roll off of your tongue. And you need to know for cancers and for care and as a client's system and accurate history. And important for a patient's trust. And many LGBT patients are likely to receive medical care if treated with full respect.

Moderator: What about health disparities in the LGBT community?

Dr. Blank: Remember, just seeing a doctor can be stressful in this community, and it involves coming out to your doctor. So there is a disparity in the LGBT community. They tend to underutilize health care and not receive prompt health evaluations. And in a 2010 survey, 7,000 people of the National Gay and Lesbian Task Force found that 28% patients postpone seeking care when sick or injured.

Moderator: That's an alarming percentage. And Christina, you spoke about a shift in the area of health care disparities.

Christina Moldow: Right; this is a health-care disparity that has the capacity to end, and one that we can do things about. So that we will see an end to it. And that's part of why we are doing this program. There are a lot of things that medical personnel and providers can do that we both have been talking about. And hopefully that will come about in the next period.

Moderator: I agree, and those health care disparities are a greater concern for the LGBT community, as I understand they have greater cancer risks. Can you talk about those risks and why they exist?

Dr. Blank: Absolutely, and Christina served to some, and so did Liz on the tape. But there is cancer risk in the LGBT community and due to social economic factors and behaviors. And the daily stressors for the LGBT community and as spoke about before. And this may contribute to poor health outcomes for the community. You have increased risk and decreased access and this is not model health care.

Moderator: Not at all and increases the risks of the community.

Dr. Blank: Right and as preluded to, there is cancer risk in the LGBT community and may be because of obesity and lesbians have fewer pregnancies and that allows for under progesterone and there is more smoking in the LGBT community and lower rate of oral contraceptives.

Moderator: What about unique screenings for men.

Dr. Blank: As we saw for Jay, there are unique situations for the LGBT community. There are unique concerns. When a person's sex and gender identity are different, appropriate screenings may not take place or reimbursed. And practitioners are not familiar with this population and misuse pronouns. And body parts that do not relate to gender identity. And most men don't get Pap smears and why should I.
Moderator: It seems obvious there are concerns for the LGBT community, what needs to be done to prepare providers for these conditions?

Dr. Blank: This is where we are moving ahead with medical school and those concerns. By medical institutions we mean every health care provider care for LGBT. It was examined in curriculum and five hours were devoted to LGBT concerns and one school allotted no time. And the reason why things are moving forward because this is an important part of care. And students and faculty are advocating for LGBT concerns. And these are competencies to be learned and this is a good thing again coming from the top.

Moderator: Would you summarize for us what providers need to do?

Dr. Blank: Sure. First providers should ask. Asking is acknowledging, and that should be as routine as asking for allergies. And saying, I can't ask, she's from Connecticut. And if a doctor has a negative concern and it could be that this patient has had a negative experience. And asking in a respectful manner is the proper thing to do. And intake forms, revise them. And include choices about married and single partner and same-sex partner, and pronounce -- pronouns, use the same pronouns you would use. Don't assume, and don't assume that a lesbian doesn't want to be a parent. And acknowledge and include the partner.

Moderator: What about recommendations on LGBT health?

Dr. Blank: It's important to note that the majority of health care providers want to provide for all patients. They may not have the knowledge to do this. And the government is recognizing this issue, and there is notable progress for LGBT health care and from the institute of medicine that makes reference to needs of the LGBT community.

Moderator: Thank you for sharing that information to us, and I want to take this opportunity to point out the Cancer Services Program. You can see the information on your screen. If you wonder what is available in New York, whether insured or uninsured, you can take to someone 24 hours a day. The cancer services program is a wonderful resource offered by New York State. And we have heard today about different barriers that assess care, and under insured is a barrier that exists for the LGBT community. This resource can help some individuals overcome that barrier and assess the services they need for their cancer treatment. Please know that's available. And let's move through some questions. Christina, this one's for you.

[Caller]: I am a Social Worker in a Catholic hospital setting. How do I recommend that I bring to them for support for LGBT?

Christina Moldow: That's an excellent question. And I don't know what the restrictions are that you have around this, being that you work in a Catholic hospital. There may be local support opportunities available in your area. Typically what happens is that hospitals make referrals to social service programs. And it would be good to find out what programs are around you. And there may be national programs that offer telephone support. And cancer care is a national organization that offers telephone support. And I know they are trying to get an LGBT telephone support group started. Liz from the Cancer Network is also connected with a number of organizations around the country that are offering...
LGBT related support services and she may have more information that is closer to you. If that exists. There is not as much near LGBT targeted support services.

Thank you for that, and here is an additional question from Wagner university in Pennsylvania, where can we find sample intake forms?

Moderator: And Dr. Blank you talked about the issues of the intake forms and other materials addressing the LGBT population.

Dr. Blank: Online there are several good places, now I don't remember the name of the organization, but specific model forms. And I can get back to you about that. And some institutions such as UCSF has a well-developed center and they have curriculum drawn out and competencies written out. These are available; you don't have to start from scratch. I think that the Motener Project in D.C. may be a place to go for that as well.

Moderator: Thank you, and this question is from the Harvard School of Public Health. Can one of you talk about the interaction of sexual orientation and race?

Christina Moldow: All right, I can say a little about that. And that is that we know that groups that are marginalized around race and ethnicity have disparity, and we have to assume there a greater disparity of LGBT communities of color. And it's an important issue, and it's something that we try to address at the cancer initiative. And I think that medical personnel have more competency training around race than LGBT communities. But there are similar and different factors and they all sort of need to be taught about at once. And I will say that the Motener Project produces-cancer related materials specifically for lesbians who are of color.

Moderator: Can you clarify what you see as UCSF?

Christina Moldow: Sorry, University of Cancer of San Francisco.

Moderator: Thank you, you mentioned risk factors for those variables?

Christina Moldow: You know I think that some of the LGBT social services programs offer LGBT specific alcohol-related resources. Either around prevention of substance abuse or substance abuse recovery services as well. You know there are still a lot of gaps that need to be covered here. And it's something -- just like any psycho-social issue that pertains to the LGBT community, there is not a lot -- there is some but not as work as needed being done to address LGBT unique concerns. Good to check with the LGBT community services that are local and around the country to find out more information about resources. I know at the LGBT community center at New York City where I work, we have an outpatient LGBT substance use recovery program. But I think these are sort of few and far between at the moment, unfortunately.

Moderator: I want to thank, Christina and Dr. Blank for being with us today. And covering this timely critical information in such a comprehensive manner. And with a great deal of expertise and passion. And we so appreciate you being here. And we are beginning to make inroads on this as it relates to health disparities and building the trust among the LGBT community. Thank you for being here.

Dr. Blank: Thank you for having us here and addressing this important issue.
Moderator: Thank you for watching. Thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is helpful to our programs and continuing education credits are available. An archived presentation of this broadcast will be on the website in two weeks, for credits, learners must visit WWW.PHlive.org. Please join us on December 15th, for the next broadcast of public health live on cancer and the clinical trials. Thank you for joining us on Public Health Live. Thank you.