PRESENTER'S BIO

Dr. Andrew Rosenblatt is a licensed Clinical Neuropsychologist at the Goldrich Center for Alzheimer's and Memory Disorders, in Departments of Neurology and Physical Medicine & Rehabilitation, at Cedars-Sinai Medical Center (CSMC). He earned his PhD in clinical psychology with a major area of focus in neuropsychology. He completed his clinical internship in neuropsychology at the VA Connecticut, West Haven, and he completed a two-year postdoctoral fellowship in clinical neuropsychology at the UCLA Semel Institute of Neuroscience and Human Behavior.

Dr. Rosenblatt's clinical expertise includes neuropsychological assessment, diagnosis, and treatment planning for individuals with Alzheimer's disease, frontotemporal dementia, Dementia with Lewy Bodies, and other conditions.

Dr. Rosenblatt's research focuses on Alzheimer's disease and related dementias among LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual as well as additional identities) older adults, including risk factors, clinical outcomes, and barriers to care. Other activities include education, community outreach, and advocacy initiatives to improve access to LGBTQIA+ affirming healthcare.

ALZHEIMER'S AND MEMORY DISORDERS IN LGBTQ+ COMMUNITIES

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DISCLOSURES

The following CME Planners and CME Faculty do not have any financial relationships with ineligible companies in the past 24 months:

- Leilanie Mercurio, L.A. Care PCE Program Manager, CME Planner.
- Jennifer Schlesinger, Alzheimer's Los Angeles Vice President, Healthcare Services & Professional Training, CME Planner.
- Alicia Villegas, Alzheimer's Los Angeles Director of Healthcare Client Services, CME Planner.
- Andrew Rosenblatt, PhD, Clinical Neuropsychologist, Jona Goldrich Center for Alzheimer's and Memory Disorders, Cedars-Sinai Medical Center, Los Angeles, CA, CME Faculty.

An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Commercial support was not received for this CME activity.

LEARNING OBJECTIVES

- Differentiate between sex, gender, sexual orientation and gender identity; and to gain familiarity with the terminology used to define one's sexual orientation and sexual identity.
- Identify the factors responsible for reduced access to LGBTQ+ affirming healthcare services, including discrimination (actual and anticipated), unavailability of specialized services, and mistrust of healthcare providers.
- List the risk and protective factors for cognitive impairment and dementia in LGBTQ+ individuals.
- Specify methods of providing an LGBTQ+ affirmative healthcare environment.

HOW MANY PEOPLE IDENTIFY AS SEXUAL AND GENDER MINORITIES (SGM)?

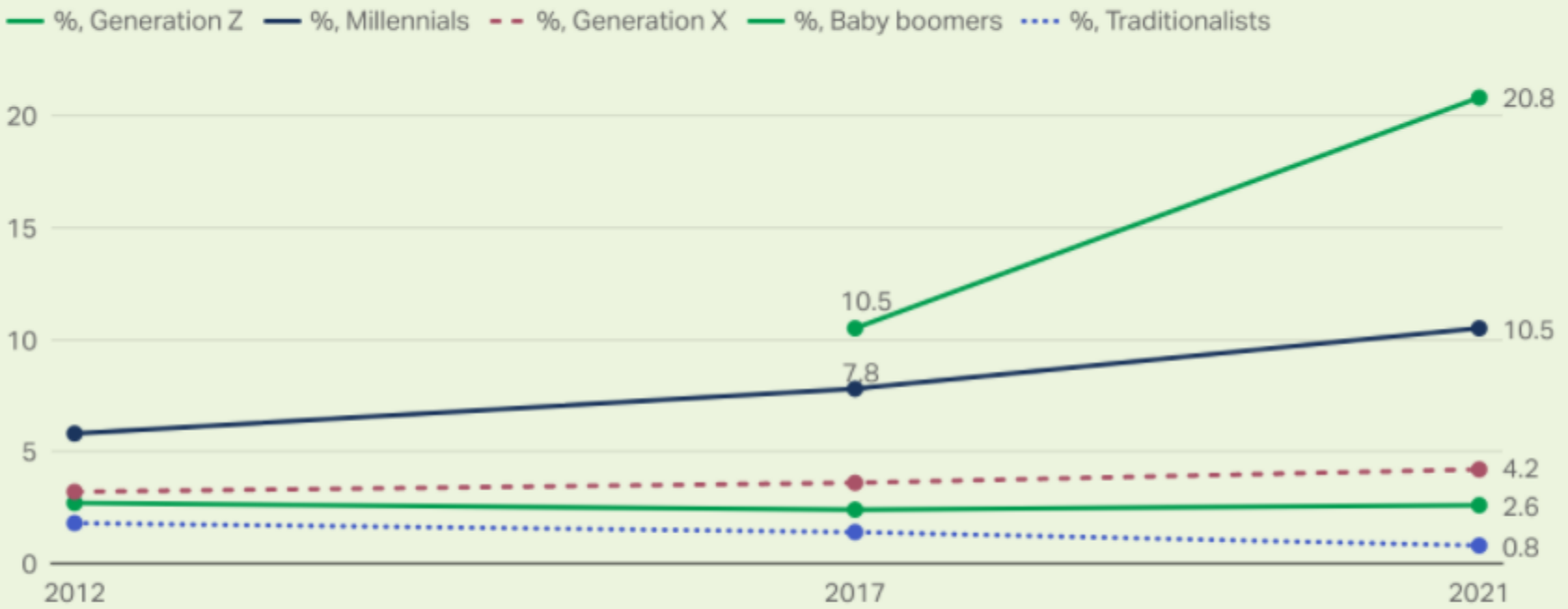
- 2021 report released by the HRC
  - 20 million + adults (7-8%) in the US identify as SGM
  - Almost double prior estimates
  - >1% identify as a gender minority
  - Bisexual people make up the largest contingent of the SGM community (~4%)
  - California has the highest number of SGM identifying adults (~2.6 million)

WE ARE HERE: UNDERSTANDING THE SIZE OF THE LGBTQ+ COMMUNITY

HUMAN RIGHTS CAMPAIGN FOUNDATION™

- SGM individuals live in every town, city, and zip code, in every ethnic, racial, and religious community

Trend in LGBT Identification by Generations of U.S. Adults, 2012, 2017 and 2021



--Generation Z are those born between 1997 and 2012. In 2017, only those born between 1997 and 1999 had reached adulthood. In 2021, only those born between 1997 and 2003 had reached adulthood.
--Millennials are those born between 1981 and 1996. In 2012, only those born between 1981 and 1994 had reached adulthood.
--Generation X are those born between 1965 and 1980.
--Baby Boomers are those born between 1946 and 1964.
--Traditionalists are those born before 1946.

GALLUP

Americans' Self-Identification as LGBT, by Generation

	LGBT	Straight/Heterosexual	No response
	%	%	%
Generation Z (born 1997-2003)	20.8	75.7	3.5
Millennials (born 1981-1996)	10.5	82.5	7.1
Generation X (born 1965-1980)	4.2	89.3	6.5
Baby boomers (born 1946-1964)	2.6	90.7	6.8
Traditionalists (born before 1946)	0.8	92.2	7.1

GALLUP, 2021

TERMINOLOGY REVIEW

SEX, GENDER, GENDER IDENTITY, GENDER EXPRESSION

So many letters… What does SGM mean?

- Lesbian
- Gay
- Bisexual
- Transgender
- Queer/questioning
- Intersex
- Asexual
- +
    - Many individuals prefer other terms to the ones listed above
    - Shifts in language over time
    - Identity often does not fit neatly into a box
    - THE BEST WAY TO KNOW ONE'S PREFERRED IDENTITY TERMINOLOGY IS TO ASK!

SEX, GENDER, GENDER IDENTITY, GENDER EXPRESSION

- Lesbian
- Gay
- Bisexual
- Transgender
- Queer/questioning
- Intersex
- Asexual
- +
- Society tends to group all sexual and gender minorities
  - There are commonalities, e.g., disenfranchisement
  - Within-community prejudices can occur
  - Medical and social needs are likely to differ between groups (and individuals within groups)

- What language to use?
  - Medical language may include “man who has sex with men” (MSM) or “woman who has sex with women” (WSW)
  - LGBT? LGBTQ? TGNB? TGNC? LGBTQQIAA2S?
  - Gender and Sexual Minorities
  - SOGI

THE BEST WAY TO KNOW IS TO ASK!!!!!

SEX, GENDER, GENDER IDENTITY, GENDER EXPRESSION

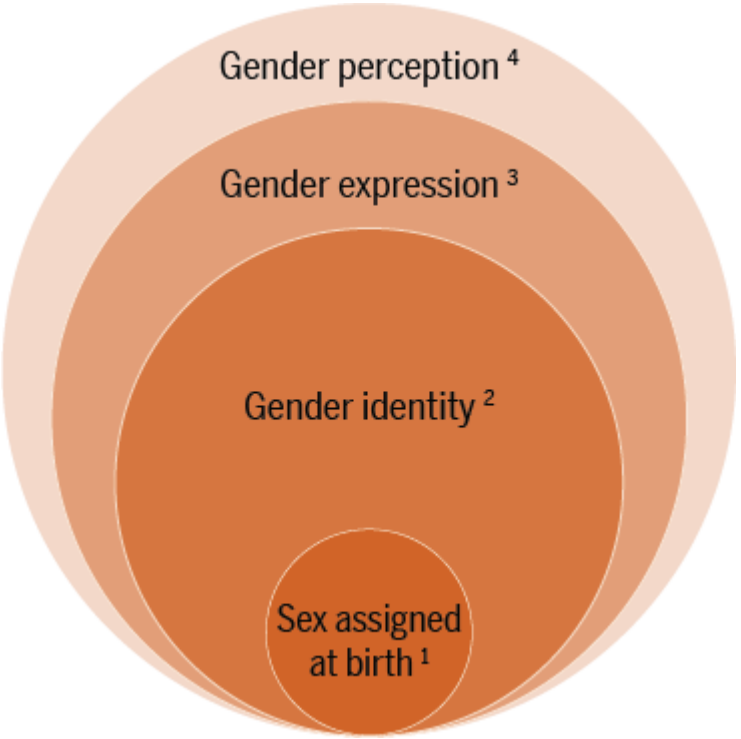
[1] Sex refers to the classification of individuals as female or male on the basis of their reproductive organs and functions. E.g., male, female, intersex

[2] Gender Identity refers to a person's inner sense of being a woman, man, gender queer, nonbinary, another gender, or having no gender. GI does not always align with sex assigned at birth

[3] Gender Expression refers to how one demonstrates or expresses their gender

[4] Gender Perception refers to how gender is perceived by others

Sexual Orientation is a distinctly different yet related term describing one's attraction toward another person

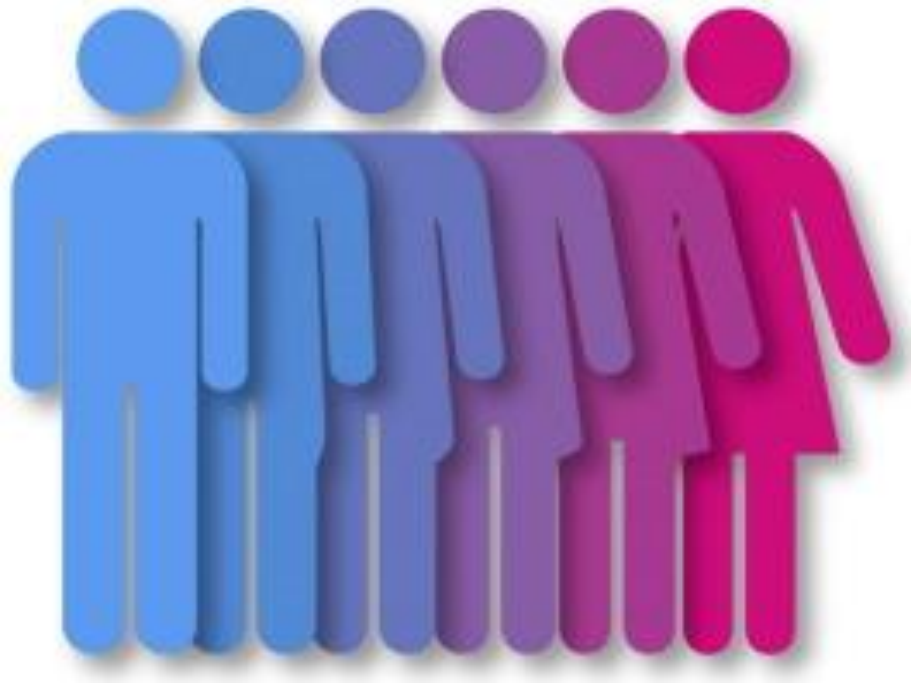


Harvard Medical School, 2020

SEXUAL ORIENTATION

Sexual Orientation is a distinctly different yet related term, how a person self-identifies their physical, emotional, and romantic attachments to other people

e.g., lesbian, gay, bisexual, straight, queer, and more



3 components:

1. Attraction
2. Behavior
3. Identity

These components may change over time for some people

ADDITIONAL RELATED TERMS

Gender non-conforming Appearance or behavior does not conform to what is traditionally expected

Non-binary Identity that is not exclusively masculine or feminine, outside the gender binary

Transgender man (*trans man, female-to-male*): Individuals assigned female at birth but who identify and live as men.

Transgender woman *(trans woman, male-to female):* Individuals assigned male at birth but who identify and live as women.

Cis-gender A gender identity that is congruent with what society would consider to be associated with ones birth sex

WHAT IS TRANSITIONING?

- Taking steps towards affirming one's gender identity
- Ranges from social, psychosocial, physical, medical…and is an individualized and unique process
- There are a multitude of treatments, therapies, and procedures that aim to better align a person's physical presentation and function with their gender identity. These may include:
  - Hormone replacement therapy (HRT) – masculinizing or feminizing
  - Gender affirming surgery (GAS)
  - Voice and communication training
  - Social skills training/modification
  - Hair styling, removal
  - Wardrobe
  - Couples/family therapy
  - Group/peer support

HEALTH DISPARITIES

NEUROLOGICAL RISK FACTORS IN SGM

- Health disparities that increase risk of neurological compromise have been identified in SGM individuals
- Behavioral/Mental Health:
  - Suicide/suicidal ideation
  - Depression
  - Anxiety
  - PTSD
  - Eating disorders
  - Alcohol and substance abuse
  - Tobacco use

Rosendale, et al. 2021

NEUROLOGICAL RISK FACTORS IN SGM

- Physical Health:
  - HIV/AIDS (cis-gay and bisexual men, trans women, Black/African American and Hispanic/Latinx men have highest risk)
  - Obesity (lesbian/bisexual women)
  - HPV infection, cervical or anal cancers
  - Breast cancer (lesbian and bisexual women, trans men and women)
  - Stroke – trans women, bisexual women (highest among Black bi women)

Rosendale, et al. 2021

SGM HEALTH DISPARITIES BY RACE/ETHNICITY

- Few studies in literature looked at neurological factors from an intersectional lens
- This is a significant gap in literature deserving of more attention
- Those that did found generally greater disparities in SGM individuals of color:
  - HIV/AIDS: Increased risk among Black and Latinx cis-gay and bisexual men, trans women
  - Stroke: higher risk among Black bisexual women than White bisexual women, Black/White heterosexual women
  - Mixed evidence of disparities in sleep quality for SM individuals of color
- We have significantly more data about health disparities among people of color overall, raising concern for multiple minority effect

Rosendale, et al. 2021

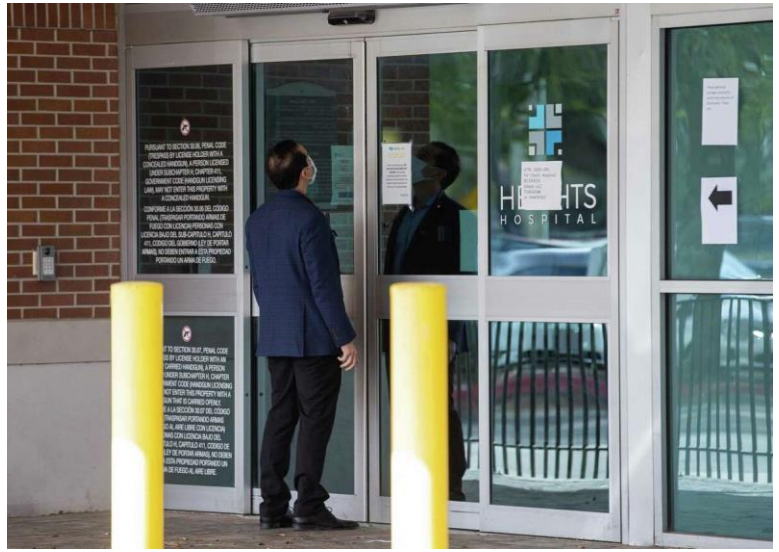
MINORITY STRESS, STIGMA, AND CONCEALMENT AFFECT HEALTH

- Minority Stress Model (Meyer, 1995, 2003):
  - Chronic stress levels experienced by members of stigmatized groups leads to physical and MH disparities
- SGM individuals often face a unique set of stressors that increase risk of physical and mental health conditions
  - Internalized stigma: Acceptance of negative views, stereotypes, and myths from mainstream culture
  - Identity concealment: discomfort with disclosure of SOGI status due to internalized stigma, discriminatory experiences.
  - Health disparities may be exacerbated further by psychosocial consequences of internalized stigma, e.g., disconnect from other LGBTQ+ individuals, discomfort with same-sex romantic relationships/sexual activities

Gold et al., 2007; 2009; O'Brien, et al., 2015; Correro et al. 2020

REDUCED ACCESS TO CARE

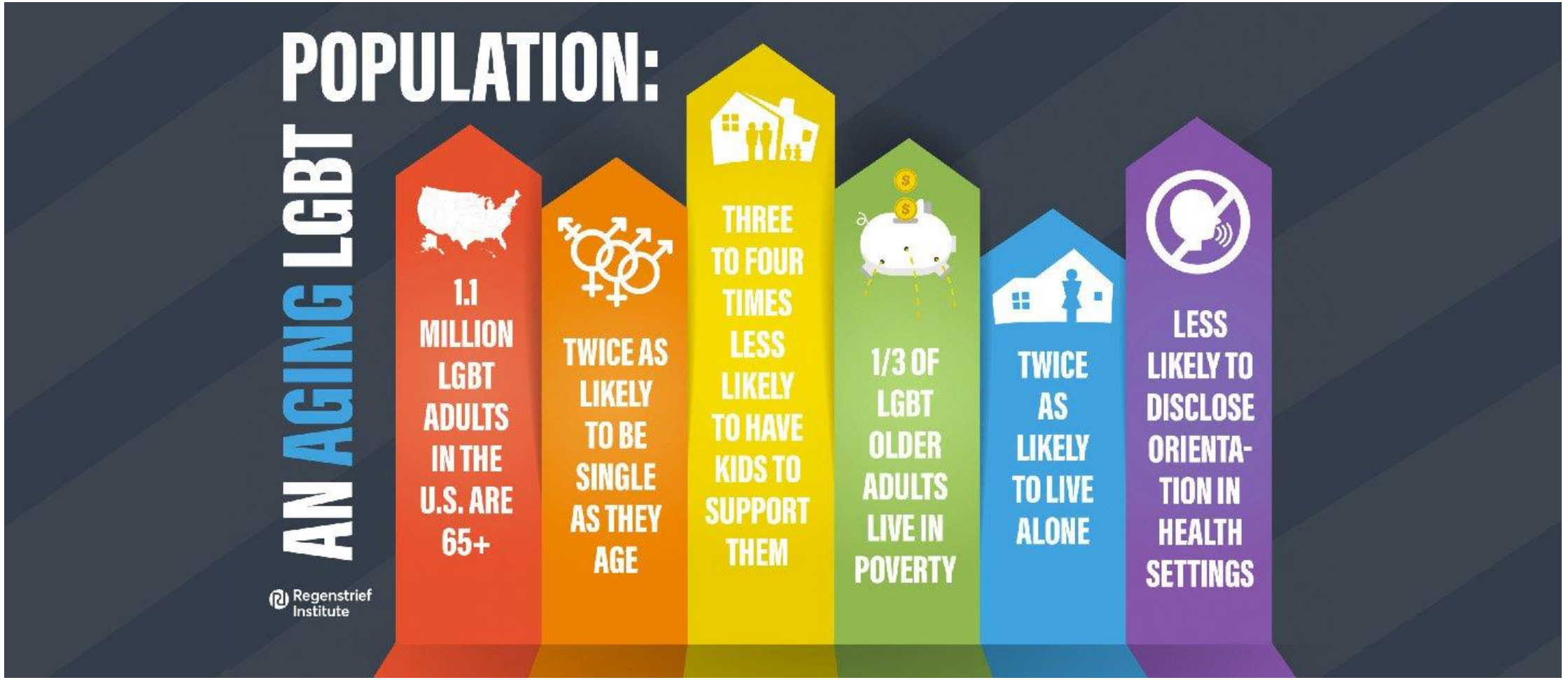
- Access to care may be affected by:
  - The availability (actual or perceived) of competent health care providers
  - Lack of specialized healthcare resources
  - Mistrust of healthcare providers, uncertainty about acceptance
  - Denial of care and services
- Sectors of SGM population (especially GMs, BIPOC) are more likely to be uninsured and experience poverty, unemployment, lack of housing



HEALTHCARE DISCRIMINATION

- Actual (and fear of) discrimination is a barrier to accessing care
- Evidence suggests SGM individuals may avoid some aspects of services due to concerns about stigma
- Fear of discrimination may lead to concealment of one's identity from medical providers
- Jones et al., (2016) found among transgender individuals
    - 23% avoided care due to harassment
    - 33% had previously been denied care

HEALTH DISPARITIES IN OLDER SGM ADULTS



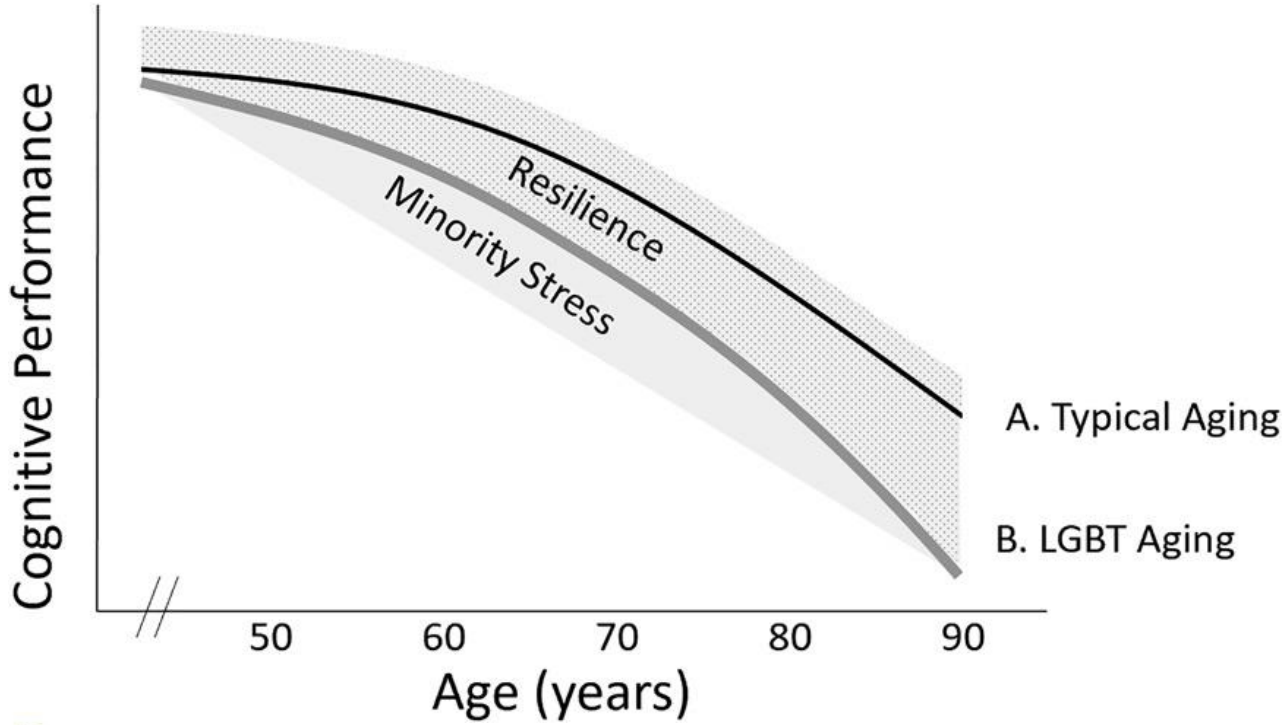
MINORITY STRESS AS A RISK FACTOR IN LGBT ELDERS

- Cognitive decline is accelerated in SGM aging due to the effects of chronic minority stress
- Resultant increase in:
  - physical and mental health risk factors
  - Neurotoxic effects of stress hormones on brain structure and function
  - Negative modifying factors include discrimination and social inequality
  - Protective factors can counter these effects

Correro & Nielson, 2019

PROTECTIVE FACTORS AND RESILIENCE

- Discussing aspects of identity can be a protective factor in medical settings (Mosack et al, 2013)
- Other protective factors may include having support from the LGBTQ+ community, family acceptance, communities of faith
- Sense of community pride
  - Celebration of sexual and gender diversity
  - Stance against prejudice and social stigma
    - e.g., LGBTQ+ rights movement



COGNITIVE IMPAIRMENT IN SGM

NEUROCOGNITIVE DISORDERS IN SGM

- Literature review of age-related cognitive impairment (CI) in SGM - Romanelli, Rosenblatt, Marcum, & Flatt, 2023 (*in revisions*)
  - 15 eligible studies
  - 13 of these studies rated as moderate-to-critical risk of bias, e.g.:
    - Information bias - use of non-validated diagnostic measures of CI
    - Selection bias – non-representative study sample
    - Study design – most studies were cross-sectional
- Working assumption – there is no direct relationship between SOGI and CI; relationship is mediated by indirect associations between risk factors attributable to SOGI status and lead to CI.

SOGI STATUS / SUBJECTIVE COGNITIVE IMPAIRMENT

- Subjective Cognitive Impairment (SCI) = Self-reported difficulties with memory and related cognitive symptoms
  - Note: there is a fairly weak, positive correlation between SCI and actual cognitive decline, and SCI measures are not considered valid diagnostic tools (Ibnidiris, et al. 2022)
- Studies have generally identified a positive association between SCI and SO/GI status

Subjective cognitive decline higher among sexual and gender minorities in the United States, 2015–2018

Jason D. Flatt[1] | Ethan C. Cicero[2] | Nickolas H. Lambrou[3] | Whitney Wharton[2] | Joel G. Anderson[4] | Erin D. Bouldin[5,6] | Lisa C. McGuire[5] | Christopher A. Taylor[5]

- Data from Behavioral Risk Factor Surveillance System survey
  - N = 119,128; Age 45+
    - SGM n = 3,520; heterosexual n = 115,608
  - Self-reported SOGI status
  - Subjective cognitive decline ratings for the previous 12 months; ratings of different cognitive domains summed and converted to 0-100 scale
    - Domains: reasoning and problem solving, memory, attention, concentration
- SGM individuals were more likely than heterosexuals to report:
  - Cognitive decline (15.7% v. 10.5%)
  - Functional limitations due to cognitive decline (60.8% v. 47.8%)
  - Interfered with work and social activities (47.9% v. 34.9%)

TABLE 5 Multivariable logistic regression model for subjective cognitive decline (SCD) for people aged ≥45 years from 25 states accounting for demographic, health, and social characteristics, BRFSS 20

Demographic adjusted

Adjusted for depression

	Model 1			Model 2			Model 3		
Variables	aPR	(95% CI)	*P*	aPR	(95% CI)	*P*	aPR	(95% CI)	*P*
Demographics									
Sexual and gender minority	1.26	1.05–1.51	.0160	1.23	1.03–1.47	.0283	1.15	0.97–1.37	.1162
60 years or older	0.72	0.66–0.79	<.0001	0.82	0.76–0.89	<.0001	0.94	0.87–1.02	.1162
Racial/ethnic minority	1.06	0.96–1.18	.2496	1.05	0.95–1.16	.3384	1.12	1.02–1.23	.0200
Not married	1.09	1.00–1.18	.0406	1.01	0.94–1.09	.7446	0.97	0.90–1.05	.4782
≤High school grad	1.21	1.12–1.31	<.0001	1.08	1.01–1.17	.0328	1.12	1.04–1.21	.0026
Unemployed	2.77	2.51–3.06	<.0001	1.70	1.54–1.87	<.0001	1.50	1.37–1.66	<.0001
Low income, < $20K	1.66	1.50–1.83	<.0001	1.24	1.12–1.37	<.0001	1.16	1.05–1.27	.0039
Uninsured	1.34	1.11–1.61	.0031	1.40	1.19–1.65	.0001	1.40	1.19–1.64	<.0001
Health									
Functional impairment (any)				2.74	2.50–3.02	<.0001	2.30	2.09–2.53	<.0001
Frequent physical unhealthy days (14+ days)				1.80	1.64–1.98	<.0001	1.60	1.46–1.75	<.0001
Depressive disorder							2.44	2.26–2.63	<.0001

Notes: Model 1 = Demographics; Model 2 = Model 1 + Functional Impairment and Unhealthy days; Model 3 = Model 2 + Depression.
Unweighted n = 96,912 (weighted n = 48,943,800).
Abbreviations: aPR, adjusted prevalence ratio; BRFSS, Behavioral Risk Factor Surveillance System; CI, confidence interval.

Flatt, et al., 2021

SOGI STATUS / SCI

- Other studies of SOGI status/SCI have found:
  - SM reported more SCI than heterosexuals, but effect was nullified when adjusting simultaneously for risk factors – most significantly anxiety, sleep problems, and number of stressful life events, among others (Jacob et al., 2021)
  - In a study of women age 65+, >SCD reported by bisexual women compared to heterosexual women, no significant effect for lesbian/gay women (Seelman, 2019)
  - In adults 18+, increased odds of SCI among GM compared to cisgender individuals, even after adjusting for depression and other risk factors (Streed, McCarthy, & Haas, 2017)

SOGI STATUS / OBJECTIVE COGNITIVE IMPAIRMENT

- Objective cognitive impairment (OCI) – encompasses studies with:
  - Administration of validated cognitive assessments (2)
  - Clinical documentation of neurocognitive disorder diagnoses from health records (2)
- Hsieh, et al (2021):
  - Adults age 50+, from the 2015-2016 US National Social Life, Health, and Aging Project
  - Used the 18-item survey-adapted Montreal Cognitive Assessment (MoCA)
  - Found higher odds of impairment based on MoCA scores in SM than heterosexuals (gender identity not investigated)

SOGI STATUS / OBJECTIVE COGNITIVE IMPAIRMENT

- Stinchcombe& Hammond (2022):
  - Adults 45-85 years; from 2010-2015 Canadian Longitudinal Study on Aging
  - Homosexuals and bisexuals performed better on memory tests than heterosexuals
  - No difference in executive functioning by sexual orientation (gender identity not investigated)
- Dragon et al (2017):
  - Utilizing 2015 Medicare claims data
  - Dementia diagnoses were more prevalent among transgender compared to cisgender individuals for adults <65 years of age and adults age 65
    - Adults < 65years: Transgender = 6.9%; Cisgender = 4.8%
    - Adults age 65: Transgender = 18.2%; Cisgender = 12.2%
  - *Analyses were not adjusted for potential confounders

SOGI STATUS / OBJECTIVE COGNITIVE IMPAIRMENT

- Guo et al (2022):
  - Electronic health records-based cohort, OneFlorida (2012-2020)
  - Higher prevalence of dementia diagnosis among transgender compared to cisgender individuals
    - Only statistically significant for age/race/ethnicity-matched adults 18-49 years, but not among adults 50+ years
  - Transgender individuals were more likely to have established risk factors for dementia, (e.g., History of smoking, alcohol use disorder, depression, diabetes, obesity)

CREATING AN AFFIRMING ENVIRONMENT

CULTURAL COMPETENCY MATTERS

Cultural competence and sensitivity of the care environment is vital to quality of service provided, patient outcomes, and your professional reputation

- Most common error in patient care with SGM patients is insensitive treatment
  - Thoughtless assumptions about sexual identity, sex of partner
  - Mis-gendering
- Tolerating humor, public comments, etc. among staff that demonstrate negative or prejudicial views can be especially harmful
  - Invalidation, sense of rejection
  - Offensive
  - Feeling unwelcome, “not belonging”
  - Can make people feel *unsafe*
  - *Significantly* erodes trust

CULTURAL COMPETENCY MATTERS (CONT).

- Other common errors in cultural sensitivity:
  - Invasion of privacy
  - Insensitive personal questions
  - Subtly hostile attitude, microaggressions from staff
  - Discussion of patients in public spaces away form the patient
  - Assumptions about relationship status
    - e.g., assuming someone's legal relationship status as "single" implies they have no life-partner

SOLUTIONS

- Self-assessment – what are *my* biases? How may my own identity and expression affect my interactions with a patient?
- Ensuring that all staff are educated on matters of SGM sensitivity
- Keeping records up-to-date and consistent with the patient's stated identity and preferences
- Reviewing all clinic forms and templates for sensitive language (whether patient will see it or not)
  - E.g., do forms contain preferred name, gender identity, preferred pronouns?
- Placing visual signifiers in all patient-areas of SGM inclusivity (e.g., signs, posters, art, informational pamphlets)
- Standardize communication with all patients (e.g., ask *all* patients for preferred pronouns)
  - Making assumptions about gender/sexual identity based on appearance or medical records *will* lead to errors
- Research – data collection on sexual/gender identity factors

FURTHER SUPPORT FOR SGM PATIENTS WITH ADRD

- **Work with the patient to establish any potential caregivers** – keeping in mind that this may encompass “chosen family” (e.g., unmarried partner, former partner, friend, etc.)
- **Connect patient with LGBTQ-inclusive long-term care** – Contact facilities, search websites for information on:
  - Non-discrimination policy covering sexual orientation and gender identity
  - Equal visitation policy
  - Gender-oriented policies on rooming, bathrooms, programming
  - Outreach efforts with the LGBTQ+ community
  - Long-Term Care Equality Index (LEI) – Listing of LGBTQ+ inclusive senior housing and long-term care facilities.

FAQS

1. What is the difference between sex, gender identity, and sexual orientation?

   - Sex refers to the classification of individuals as either male or female on the basis of their reproductive organs and functions (e.g., male, female, intersex). Gender identity refers to a person's inner sense of being a man, woman, nonbinary, gender-queer, or having no gender. Gender identity does not always align with sex assigned at birth. Sexual orientation is a distinctly different concept and describes how a person describes their physical, emotional, and romantic attachments to other people. Some common sexual orientation identities include lesbian, gay, bisexual, straight, queer, and asexual, but there are many more.

FAQS

2. Why are LGBTQ+ persons at greater risk of certain health conditions?

- Access to healthcare services is associated with health outcomes, and there are several societal factors that restrict access to healthcare for many LGBTQ+ persons. Many LGBTQ+ persons may not receive healthcare services due to reduced availability of LGBTQ+ affirmative healthcare providers, lack of specialized resources, and mistrust of healthcare providers due to past experiences of discrimination and/or fear of discrimination. Some LGBTQ+ individuals, particularly transgender and nonbinary persons, are also more likely to be uninsured, living below the poverty line, unemployed, and unhoused. Chronic stress from discrimination experienced by members of stigmatized groups increases risk of medical and psychological health conditions. LGBTQ+ individuals who belong to racial or ethnic minority groups are particularly impacted by these barriers to care and discrimination, resulting in increased risk for certain health complications.

FAQS

3. Are LGBTQ+ persons at greater risk of Alzheimer's disease and dementia?

- Studies have found that LGBTQ+ older adults tend to report experiencing more cognitive difficulties than heterosexual and cisgender individuals. The limited number of studies that have examined rates of Alzheimer's disease and related dementia (ADRD) in LGBTQ+ persons have had mixed results, and more research on ADRD in LGBTQ+ persons is needed. However, studies have found that some LGBTQ+ individuals have higher rates of medical and psychological conditions that increase risk for ADRD.

FAQS

4. How can healthcare providers ensure they are providing LGBTQ+ affirmative care?

- Cultural competence of health professionals and sensitivity of the care environment are vital for provision of quality healthcare services. Insensitive treatment is the most common error in patient care, which may include thoughtless assumptions about sexual orientation or gender identity, use of wrong gender pronouns, discussions of patients in public spaces away from the patient, tolerance of offensive or discriminatory comments, and many more. In order to create an LGBTQ+ affirmative healthcare environment, all healthcare professionals should undergo LGBTQ+ sensitivity training. Other actions can be taken to improve LGBTQ+ inclusivity, such as documenting preferred names and pronouns in electronic medical records, reviewing clinic forms for insensitive language, and placing visual signifiers in patient-areas that promote LGBTQ+ inclusivity (e.g., signs, posters, art, or informational pamphlets).

ADDITIONAL RESOURCES ON SGM HEALTH CARE

California LGBTQ Health and Human Services Network
https://californialgbtqhealth.org/resources/faqs/

National LGBT Health Education Center
https://www.lgbtqiahealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Front-line-Health-Care-Staff.pdf

Long-Term Care Equality Index LEI) – Listing of LGBTQ+ inclusive senior housing and long-term care facilities
https://thelei.org/

Many SGM Healthcare Standards Guidelines through USC Libraries:
https://libguides.usc.edu/healthsciences/LGBTQhealth/guidelines

ADDITIONAL RESOURCES FOR TGNB HEALTH CARE (CONT.)

World Professional Association for Transgender Health's Standards of Care for Gender Identity Disorders, Version 7, 2011. Available from www.WPATH.org

Endocrine Society Guidelines: https://www.endocrine.org/guidelines-and-clinical-practice/clinical-practice-guidelines/gender-dysphoria-gender-incongruence

Center of Excellence for Transgender Health http://www.transhealth.ucsf.edu/

Kauth, M. & Shipherd, J. C. (2017). *Adult transgender care: An interdisciplinary approach for training mental health professionals.* NY: Routledge

Erickson-Schroth (Ed). (2014). *Trans Bodies, Trans Selves: A resource for the transgender community*. NY: Oxford University Press

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality. http://www.ustranssurvey.org/