



# High Rates of Access to Health Care, Disclosure of Sexuality and Gender Identity to Providers among House and Ball Community Members in New York City

Sean Cahill, Sarah Trieweler, John Guidry, Nelisa Rash, Layla Stamper, Kerith Conron, Nicole Turcotte, Ilana Gratch & Paige Lowry

To cite this article: Sean Cahill, Sarah Trieweler, John Guidry, Nelisa Rash, Layla Stamper, Kerith Conron, Nicole Turcotte, Ilana Gratch & Paige Lowry (2017): High Rates of Access to Health Care, Disclosure of Sexuality and Gender Identity to Providers among House and Ball Community Members in New York City, Journal of Homosexuality, DOI: [10.1080/00918369.2017.1328221](https://doi.org/10.1080/00918369.2017.1328221)

To link to this article: <http://dx.doi.org/10.1080/00918369.2017.1328221>



Accepted author version posted online: 24 May 2017.



Submit your article to this journal [↗](#)



View related articles [↗](#)



View Crossmark data [↗](#)

## **High Rates of Access to Health Care, Disclosure of Sexuality and Gender Identity to Providers Among House and Ball Community Members in New York City**

### **Authors:**

**Sean Cahill, PhD,<sup>1,2</sup> Sarah Trieweler,<sup>1,3</sup> John Guidry, PhD,<sup>4</sup> Nelisa Rash,<sup>1</sup> Layla Stamper,<sup>1</sup> Kerith Conron, ScD,<sup>1</sup> Nicole Turcotte,<sup>4</sup> Ilana Gratch, BA,<sup>1,5</sup> and Paige Lowry<sup>4</sup>**

1. The Fenway Institute, Boston, Massachusetts, USA
2. School of Public Policy and Urban Affairs, Northeastern University, Boston, Massachusetts, USA
3. Department of Sociology, Northeastern University, Boston, Massachusetts, USA
4. Gay Men's Health Crisis (GMHC), New York, New York, USA
5. Middlebury College, Middlebury, Vermont, USA

#### *Corresponding author:*

Sean Cahill, Health Policy Research, The Fenway Institute, 1340 Boylston St., Boston, MA 02215, USA. E-mail: [scahill@fenwayhealth.org](mailto:scahill@fenwayhealth.org),

#### **Abstract**

The House and Ball community is an important cultural manifestation of resiliency for Black and Latino gay and bisexual men and transgender women. Participants at the August, 2013 House of Latex Ball in New York City were surveyed about insurance coverage, health care access, experiences in health care, and housing instability. The sample (n=367) was 58% Black/African American and 20% Hispanic/Latino, with a mean age of 31. Fifty-five percent were gay and bisexual men. While only 6% identified as transgender, nearly half were gender nonconforming. Strong majorities had health insurance, were in regular medical care, and were “out” to their providers. Some were unstably housed and had recently exchanged sex for shelter or money.

High rates of health care access and disclosure indicate resiliency and agency. Unstable housing and income insecurity may be structural drivers of vulnerability for this population to HIV infection and other health risks.

**Keywords:** sexual orientation, gender identity, House and Ball, health care, disclosure, Black, Latino, gay, bisexual, transgender

## Introduction

The House and Ball community (HBC) in New York City (NYC) emerged as a population of interest in public health research following the discovery of high prevalence rates of HIV infection among members in 1998 (Murrill et al., 2008).

Rooted in the Harlem Renaissance of the 1920s, and possibly dating back as far as the Civil War era, the HBC in NYC began as a supportive community for primarily Black homosexual men and women who were marginalized due to racism, anti-gay prejudice, and rigid gender norms. Harlem in the 20s and 30s was a social hotspot for homosexual and bisexual men and women, both Black and White (Chauncy, 1994). The HBC has since grown into an extensive support network, spanning multiple cities across the United States, with participants consisting primarily of Black and Latino gay and bisexual men and transgender women who experience discrimination due to their race/ethnicity, sexual orientation, and gender identity (Murrill et al., 2008).

The HBC of NYC includes “Houses,” which function as distinct groups of individuals directed by a house “mother” and “father,” and “Balls,” which refer to elaborate events featuring dance competitions performed “in drag” that reward winners with cash prizes and the attainment of “ball status” (Schrager, Latkin, Weiss, Kubicek, & Kipke, 2014). Today in NYC, there are approximately 40 active houses that participate in the ball scene (Murrill et al., 2008)

The NYC HBC is an important community for HIV prevention (Kubicek et al. 2013). Men who have sex with men (MSM) have consistently been identified as having disproportionately high rates of HIV infection. In 2009, MSM in the U.S. were at least 44 times more likely to become HIV-infected than heterosexual men, and were the only group of people among whom the rate of new infections was increasing (CDC, 2014; Prejean et al., 2011). Among MSM who were newly infected in 2009, 42% of them were African American (CDC, 2014). Young Black MSM (YBMSM) age 13-24 are most heavily burdened by new HIV diagnoses. From 2006 to 2009 new HIV infections in this group increased by 48% (CDC, 2011). However, previous research has indicated that Black MSM do not engage in risk-behavior at rates greater than other MSM (Millett, Peterson, Wolitski, & Stall, 2006).

Researchers have consistently sought to determine what accounts for the discrepancies in HIV incidence among YBMSM and other YMSM, as well as between MSM and heterosexual populations (Kipke, Kubicek, Supan, Weiss, & Schrager, 2013). One difficulty associated with this task is that YBMSM have been designated a “hard-to-reach” population (Galindo, 2013). Because of its inherent structure and organization, the NYC HBC provides an opportunity to

explore some of these health disparities in an accessible subset of YBMSM (Schrager et al., 2014).

A study conducted in the NYC HBC in 2008 found that 17% of house members tested positive for HIV. Seventy-three percent of those infected were unaware of their HIV status, so HIV prevalence was associated with a lack of HIV testing (Murrill et al., 2008). Previous research has shown that one correlate of HIV testing is disclosure of one's same-sex orientation or behavior to a healthcare provider (Bernstein et al., 2008). In 2004-2005, the National HIV Behavioral Surveillance system discovered that 61% of MSM had not disclosed their same-sex orientation or behavior to their healthcare providers. Additionally, Latino and Black MSM were less likely to disclose than White non-Hispanic MSM (Ibid). Those who didn't disclose their same-sex behavior to health care providers were less likely to be offered an HIV test. If this trend holds among House and Ball participants (Murrill et al., 2008), this could mean that NYC House and Ball participants are at greater risk of not being screened for HIV, syphilis, and other STIs.

Despite the correlation between disclosure of same-sex behavior and HIV risk, no research has evaluated the extent to which House and Ball participants in NYC disclose sexual orientation and gender identity (SO/GI) to healthcare providers. Because of the potentially disproportionate rate of unknown HIV infection among House and Ball participants, particularly YBMSM, we sought to explore House and Ball participants' access to health care, as well as their relationships and experiences with their healthcare providers.

LGBT people and Black and Latino people in the U.S. are less likely, on average, to be insured (Ranji, Beamesderfer, Kates, & Salganicoff, 2014; Pearl, 2015) or to access preventive health

care (Pearl, 2015, Valanis et al., 2000; Institute of Medicine, 2011). This is changing thanks to the implementation of the Affordable Care Act, key provisions of which took effect in 2014, and federal support for training health care providers in LGBT cultural competency (Cahill & Vargas, 2015). However, it is important to understand the degree to which House and Ball participants are covered by health insurance and access routine health care. Data on insurance coverage, access to routine care, and disclosure of sexual orientation and gender identity to providers can indicate resilience and agency among House and Ball participants. Data on housing instability and exchanging sex for shelter or money can indicate risk factors that increase vulnerability to HIV infection.

## **Methods**

### ***Setting, Sample & Recruitment***

Recruitment for the survey took place August 17, 2013 at the House of Latex Ball in Manhattan, New York City. This is the largest House and Ball community event in the world. The Fenway Institute Institutional Review Board waived the written informed consent requirement. Attendees were approached while waiting in line to enter the event and were asked to participate in the survey by volunteer research assistants affiliated with the Fenway Institute or Gay Men's Health Crisis. The anonymous survey, with no identifying information gathered, was described to each potential participant and informed oral consent was obtained from each. Information regarding risks and benefits, privacy and confidentiality, and who to contact for further questions was provided upon request. There was no compensation to participate in the survey, nor did the

decision to participate or not affect admission to the event. Those who took the survey were given a wristband that allowed them to enter a VIP section. Attendees were instructed not to participate if they were under 18 years of age. Of an estimated 1,700 attendees at the ball, 369 opted to participate in the survey, a response rate of about 22%. Of these 369, two surveys had to be discarded due to a lack of any legible responses, which resulted in a final sample size of 367.

### ***Instruments***

Data for this study was collected using self-administered, anonymous participant surveys. Questions fell into the following groups:

- Demographic characteristics: these included questions about age, race, ethnicity, and area of primary residency.
- Gender and sexuality: in addition to questions on sexual orientation and gender identity, the survey also asked about sex assigned at birth (SAB) and gender expression<sup>1</sup> (here measured using a seven-point scale).
- Risk factors: these survey questions asked about trading sex for money and housing instability.

---

<sup>1</sup> Gender identity refers to a person's internal sense of their gender (do I consider myself male, female, both, neither?) Gender expression refers to how one presents his- or herself through behavior, mannerisms, speech patterns, dress, and hairstyles.

- Access to healthcare: participants were asked about insurance status, typical place of care and affordability of care.
- Experiences in healthcare: these survey questions asked about discrimination, being out to a provider and provider knowledgeability, among other things.

Survey questions were both closed and open ended. Additionally, any written comments participants made (whether or not they were instructed to do so) were recorded and included as a post-survey variable.

## ***Analysis***

Stata 12 was used to recode variables and to generate univariate descriptive statistics for the sample. The following recoded variables were created:

- Gender non-conformity was a dichotomous variable that categorized participants based on whether their response to a question about gender expression, “Most of the time, my gender presentation (how I look and act) is...” converged or diverged from their assigned sex at birth (“What sex were you assigned at birth, on your original birth certificate?” Male, female, decline to state). Natal males who described their gender expression as completely, mostly, or somewhat masculine, or butch, or aggressive (AG) were categorized as gender conforming, whereas natal females who selected any of the masculine response options were categorized as gender nonconforming. Participants who selected “androgynous, not specifically masculine or feminine,” regardless of sex assigned at birth, were categorized as gender non-conforming. Natal



males who selected somewhat, very, or completely feminine as their gender expression response were categorized as gender nonconforming, whereas natal females selecting any of these responses were classified as gender conforming.

- Sexual orientation identity: based on their responses to questions on sexual orientation and gender identity, participants were categorized as gay men, bisexual men, lesbians (lesbian women), bisexual women, unable to categorize within binary, straight (heterosexual) man, or straight woman.
- Sexual orientation, gender identity, and expression status: based on their responses to questions on sexual orientation identity, gender identity (“Which of the following describes your gender identity, how you think about yourself?”), and gender expression, participants were categorized as heterosexual-cisgender<sup>2</sup>, lesbian, gay or bisexual (LGB)-cisgender, transgender and gender non-conforming (T/GNC), and all others (including those who were unsure about both their sexual orientation and gender identity, as well as those who skipped one or more items.)
- Two new variables were also created for residency: NYC resident or not, and national (U.S. resident) or international (non-U.S. resident). This was done to acknowledge the more liberal nondiscrimination and health policies extant in New York City (e.g. gender identity nondiscrimination in public accommodations, which does not exist in the rest of New York state or in some nearby states like Pennsylvania; Medicaid expansion and LGBT-affirming and

---

<sup>2</sup> Cisgender means not transgender.

competent healthcare, for example at the Callen-Lorde Community Health Center in Chelsea, New York City).

A new race variable was also created in order to compress this data into categories that could be more easily compared with other variables. In the original survey, participants could select as many racial and ethnic classifications as they wished. In this new variable, categories were created to be mutually exclusive.

## **Results**

### ***Demographics***

Most respondents were from New York City (61%<sup>3</sup>) or New York State (66%). The vast majority (80%) were from the Northeast or Eastern Coast, and nearly 5% were international. Respondents ranged in age from 18-63 years, although 15% declined to state. The mean age of those who did respond was just over 31 years.

The sample was primarily Black and Hispanic/Latino: 58% identified as Black or African American, 20% as Hispanic or Latino, 18% as White, 3% as American Indian or Native American, 4% as Asian, 2% as Pacific Islander, and 1% were unsure. Survey respondents could choose as many as applicable, but when the data were sorted into mutually exclusive categories for the purpose of analysis 52% identified as Black or African American only, 16% as White

---

<sup>3</sup> Figures are rounded up or down except when less than 1%.

only, 16% as Hispanic or Latino only, and 13% as multiracial, Asian, American Indian, or unsure. Overall, 4% of respondents skipped the question of race entirely.

## ***Gender and Sexuality***

When asked about their sex assigned at birth, on the original birth certificate, 68% reported that they were male-assigned at birth, 26% were female-assigned at birth, 2% declined to state and 4% did not answer.

Respondents were allowed to select as many gender identities as applied: most only selected one or two, however. Some 43% selected boy/man, 29% male/masculine, 17% girl/woman, 10% female/feminine, 1 % genderqueer, 1% transman, 5% transwoman, and 0.82% picked other. Respondents were also free to write in a gender; and three elected to do so. Of those three, the answers were “myself”, “masculine woman” and an illegible response (*Table 1*).

For gender expression, respondents selected their place on a seven-point scale that ranged from completely masculine to completely feminine. In order to facilitate comparisons with other variables, these were compressed into masculine (33%), androgynous (38%) and feminine (20%). About 9% skipped this question.

Fifty-four percent of respondents said they are gay, lesbian, or same-gender loving, 24% straight or heterosexual, 13% bisexual, 6% no response, and 4% unsure.

Post-survey, two new variables were created—gender non-conformity (GNC) and sexual orientation identity. The GNC variable compared sex assigned at birth and gender *expression*:

43% were gender-conforming, and 46% were gender non-conforming, while 12% of respondents skipped either the question on sex assigned at birth, gender expression or both (*Table 2*). The sexual orientation identity variable combined reported sexual orientation with gender *identity*; its categories were gay man (46%), bisexual man (9%), lesbian or gay woman (5%), bisexual woman (4%), straight man (7%), and straight woman (17%). Some 13% of respondents could not be categorized because they answered “other” to one or both questions, or because they skipped one or both questions on gender identity and sexual orientation.

### ***Access to Healthcare***

The vast majority (81%) of respondents had one usual place for healthcare, and only 7% has no usual place. Eight percent had more than one usual place, and 5% did not know. The most frequent place was a clinic or health center (41%), followed by a doctor’s office or health maintenance organization (HMO) (35%). Only 5% of respondents said that a hospital emergency room was their usual place to go for health care, and only 3% said a hospital outpatient department.

When asked if they had ever gone without care because of cost, 19% said yes, and the majority, 78%, said no. Some 82% had talked to a doctor about their health in the last six months, while 16% had not.

When asked about insurance coverage, 40% reported having coverage through an employer, 25% reported having public insurance like Medicare, Medicaid or CHIP, 10% had individual insurance purchased privately, and 3% had insurance through the US military. In sum, 78% of

respondents were covered by a specific insurance, while 13% had none at all, and 9% either did not know or skipped the question

### ***Experiences with Healthcare***

Among respondents who identified as LGBT, a large majority, 78%, were out to their providers. Eighteen percent were not out, and 4% were unsure. Of all respondents, 49% had had a provider ask about their sexual orientation or gender identity (SO/GI), while 43% had not been asked about their SO/GI by a provider, 5% did not know and 4% skipped the question. When asked if they had received care from a provider who didn't know about the needs of LGBT people, 26% of all respondents said yes, 53% said no, and 18% said they did not know.

About a third (35%) of all respondents reported that they had experienced discrimination in healthcare *because* they were LGBT, the other two-thirds had not. The most common type of discrimination reported was being treated differently than other patients (15%), followed by being refused care entirely (10%), having staff use harsh or abusive language toward them (6%) and having providers refuse to touch them or taking excessive precautions (5%). Participants could select more than one response (*Table 3*). It's important to note that 67% of our sample is gay, lesbian or bisexual (GLB). Six percent is transgender, and there is some overlap between the GLB and transgender groups. About half of the LGBT respondents reported experiencing anti-LGBT discrimination in healthcare because they were LGBT.

## ***Risk Factors***

Respondents were asked where they slept most nights and whether or not they had traded sex for money, drugs, a place to sleep, or food in the last 6 months. A little over half (55%) of respondents stayed primarily in their own place, while 26% lived with parents. The next most frequent response was a friend's place (6%), followed by someplace else (4%), a relative's place (3%), no one place most often/varied a lot (2%), a public place (1%) or a shelter (0.82%). The remainder either picked multiple responses or skipped the question (*Table 4*).

Based on these responses, a housing stability variable was created. Respondents who stayed primarily at home with parents, in their own place or at a relative's were categorized as housing stable, while those who stayed with friends, couch surfed, or stayed at a public place or shelter were categorized as housing unstable. Eighty four percent of respondents were categorized as housing stable, while 14% were unstable, and 2% could not be determined because they skipped the question. A large majority of respondents had not traded sex in the last 6 months (87%), but more than one in ten (11%) had done so at least once. Of those who had traded sex in the last 6 months, it had happened twice on average.

## **Discussion**

The results of this survey have significant implications for public health and the ability of Black and Latino gay and bisexual men and transgender women to access culturally competent and affirming care. The significant rate of reported experiences of anti-LGBT discrimination in

health care (about one half of the LGBT respondents in a city where such discrimination is illegal) underlines the need for cultural competency training of health care providers and other clinical and nonclinical staff and enforcement of nondiscrimination laws. The Joint Commission requires health care institutions it accredits to have a sexual orientation and gender identity nondiscrimination policy (Joint Commission, 2011a). The high rate of gender nonconformity underlines the need for nondiscrimination protections for LGBT people in health care and in society more broadly. Among transgender people, visually gender nonconforming (GNC) individuals (i.e. respondents who agree that “people can tell that I am transgender”) experience higher rates of discrimination than those who can “pass” (Reisner et al., 2015). Gay, lesbian, and bisexual people who are GNC may also experience discrimination at higher rates than those who are gender conforming (Gordon & Meyer, 2007). Nondiscrimination laws covering real or perceived sexual orientation and gender identity are needed to protect the rights of LGBT people. Laws and regulations should protect against discrimination in employment, housing and public accommodations (Reisner et al., 2015), as well as in health care (Cahill & Vargas, 2015), schools (Cianciotto & Cahill, 2012), and other settings. While New York City protects against discrimination on the basis of sexual orientation and gender identity in employment, housing, and public accommodations, outside New York City transgender people in the rest of New York State have no explicit legal protection against discrimination (American Civil Liberties Union, n.d.). Black transgender women are especially vulnerable to discrimination and hate violence (Grant, et al., 2011; National Coalition of Anti-Violence Programs, 2016).

The HBC is an important culture that provides an opportunity to reach Black and Latino gay and bisexual men and transgender women with HIV/STI prevention education, testing, and health

promotion information (Holloway et al., 2012). The HBC also represents a vibrant example of creativity and resiliency (Kubicek et al., 2013). This survey of participants at a recent House and Ball event in New York City indicates resiliency regarding health care access and self-agency. While LGBT people and Black and Latino people in the U.S. are less likely to be insured or to access preventive health care (Gates, 2014; Hayes, Rile, Radley, & McCarthy, 2015), four fifths of the House of Latex Ball sample said they had a usual place to access health care, and less than one in ten had no place to access health care. While one in five had gone without care due to prohibitive cost, four in five said they had not had to forego care due to cost. This may reflect the northeastern states' relatively generous access to Medicaid and the free/sliding scale care offered by urban health centers. Despite barriers such as a lack of culturally competent care, participants at the House of Latex Ball are finding ways to access routine care.

Nearly four fifths of LGBT respondents participating in the Ball who completed the survey reported being "out" about their sexual orientation or gender identity (SO/GI) to their health care provider, even as half reported experiencing discrimination in health care settings on the basis of their sexual orientation and/or gender identity. The Institute of Medicine (IOM, 2011), the U.S. Department of Health and Human Services (U.S. DHHS, n.d.), and the Joint Commission have encouraged health care providers to discuss SO/GI with their patients (Joint Commission, 2011b). A number of federal health agencies have taken steps to promote SO/GI data collection in health care settings, and its use to inform appropriate preventive screenings (Cahill, Baker, Deutsch, Keatley, Makadon, 2016). LGBT health advocates and providers have also encouraged patients to disclose their SO/GI to improve patient care (National LGBT Health Education Center, 2015) as a critical step toward accessing preventive screenings, such as prostate exams



for transgender women and HIV/STI screenings for gay and bisexual men (Cahill & Makadon, 2013). Given that research has shown Black and Latino gay and bisexual men in New York City to be less likely to disclose their sexual orientation to providers than White non-Hispanic gay and bi men, the fact that an overwhelming majority of respondents in a mostly Black and Latino gay and bisexual male and transgender female sample are out to their providers indicates that disclosure of SO/GI in health care settings is a practice of many Black and Latino LGBT people, at least in New York City and environs. This practice could help improve patient-provider communication and patients' access to preventive screenings. It could also help reduce racial/ethnic health disparities that exist within gay and bisexual male and transgender female communities, a critical public health imperative.

Finally, most respondents were stably housed and had not exchanged sex for money, a place to stay, or something else. However, 14% were unstably housed, and 11% had exchanged sex within the past 6 months. These are both risk factors for HIV and STIs. Often these two factors are linked, as young people “couch surf” to put a roof over their heads, and may exchange sex in exchange for shelter. The need for employment, affordable housing and social services for LGBT youth, especially in cities like New York with high and rising housing costs, cannot be overstated.

## **Recommendations**

Policy makers should take steps to reduce victimization and discrimination against LGBT people, including passing gender identity nondiscrimination laws that cover public

accommodations. Cultural competency training for health care providers is needed to reduce discrimination in health care settings. Significant reported housing instability and exchange of sex for commodities including housing indicate that House and Ball participants, particularly youth, experience income insecurity that may contribute to their risk of HIV infection. Innovative structural interventions, including affordable housing, employment, and support services for LGBT youth of color, are needed to support resiliency and reduce risk for the House and Ball participants.

## **Limitations**

Important limitations of this study must be noted. First, the number of House of Latex Ball participants who completed the survey represent only 22% of those who attended the ball. Because the House and Ball community is primarily comprised of Black gay and bisexual men and transgender women, as well as Latino gay and bisexual men and transgender women and individuals of other racial/ethnic background, our sample was reflective of the diversity of participants in House and Ball events in New York City. However, the experiences of House and Ball participants in other states and cities may be different, in part reflecting different public policies (for example, non-expansion of Medicaid). Also, the House and Ball community is an international one, with houses in Europe and Canada. Experiences of House and Ball participants may differ in those countries compared to what we found in New York. Second, we recruited individuals to complete the survey at the door. Volunteers reflected some diversity, with Black and White, transgender and cisgender, male and female volunteers, including gay men and transgender women. We do not know the extent to which individuals connected to specific social

networks might have been over selected for participation in the study. Third, because of time constraints, we did not ask about other issues that could affect health, such as anti-transgender discrimination in public accommodations (Reisner, Hughto, Dunham et al., 2015).

## **Conclusion**

The House and Ball community is a manifestation of resiliency for communities that have experienced multiple forms of prejudice, stigma, and violence. Its members exhibit many forms of resiliency, including accessing healthcare and disclosing their SO/GI to providers, despite significant barriers to both. Reaching participants in House and Ball community events such as balls and Kiki functions is important to reduce HIV infections and promote population health among Black and Latino/a gay and bisexual men and transgender women. High rates of gender nonconformity (46%) and reported anti-LGBT discrimination in health care indicate that House and Ball participants may be at elevated risk of discrimination and violence. Training of health care providers, and expansion and enforcement of nondiscrimination protections that explicitly include sexual orientation and gender identity can ensure more culturally competent and affirming health care for Black and Latino/a gay and bisexual men and transgender women.

### **Acknowledgements:**

Thank you to Slavik Milberg for his assistance with survey collection, and thank you to Marjorie Hill and Janet Weinberg of Gay Men's Health Crisis for assistance with this project.

## References

- American Civil Liberties Union. (No date). Nondiscrimination law map. <https://www.aclu.org/map/non-discrimination-laws-state-state-information-map>
- Berstein, K.T., Liu, K.L., Begier, E.M., Koblin, B., Karpati, A., & Murrill, C.. (2008). Same-sex attraction disclosure to health care providers among New York City men who have sex with men. *Arch Int Med* 168(13):1458-1464.
- Cahill, S., Baker, K., Deutsch, M., Keatley, J., & Makadon H.. (2016). Inclusion of sexual orientation and gender identity in Stage 3 Meaningful Use guidelines a huge step forward for LGBT health. *LGBT Health* 3(2): 100-102.
- Cahill, S., & Makadon, H.. (2013). Sexual orientation and gender identity data collection in clinical settings and in Electronic Health Records: A key to ending LGBT health disparities. *LGBT Health* 1(1): 1-8.
- Cahill, S., & Vargas, H.. (2015). Policy and legal issues affecting LGBT health. In: H. Makadon, K. Mayer, J. Potter, and H. Goldhammer (eds.). *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. Philadelphia: American College of Physicians. Second edition. 519-538.
- Centers for Disease Control and Prevention. (2014). *HIV and Young Men Who Have Sex With Men*. Fact sheet. [http://www.cdc.gov/healthyyouth/sexualbehaviors/pdf/hiv\\_factsheet\\_ymsm.pdf](http://www.cdc.gov/healthyyouth/sexualbehaviors/pdf/hiv_factsheet_ymsm.pdf)
- Centers for Disease Control and Prevention. (2011). *HIV among Youth*. Fact sheet. 2011, [http://www.cdc.gov/hiv/pdf/library\\_factsheet\\_HIV\\_amongYouth.pdf](http://www.cdc.gov/hiv/pdf/library_factsheet_HIV_amongYouth.pdf)

Chauncy, G.. (1994). *Gay New York: Gender, urban culture, and the making of the gay male world, 1890-1940*. New York: Basic Books.

Cianciotto, J., & Cahill, S.. (2012). *LGBT youth in America's schools*. Ann Arbor: University of Michigan Press.

Galindo, G. R.. (2013). A loss of moral experience: understanding HIV-related stigma in the New York City House and Ball Community. *Am J Public Health* 103(2): 293-299.

Gates, G. J.. (2014). In U.S., LGBT More Likely Than Non-LGBT to be Uninsured. Gallup. <http://www.gallup.com/poll/175445/lgbt-likely-non-lgbt-uninsured.aspx>

Gordon, A.R., & Meyer, I.H.. (2007). Gender nonconformity as a target of prejudice, discrimination, and violence against LGB individuals. *J LGBT Health Res* 3(3): 55-71.

Grant, J., Mottet, L., Tanis, J., Harrison, J., Herman, J.L., & Keisling, M.. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*.. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force. [http://www.thetaskforce.org/static\\_html/downloads/reports/reports/ntds\\_full.pdf](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf)

Hayes, S., Rile, P., Radley, D., McCarthy, D.. (2015). *Closing the Gap: Past Performance of Health Insurance in Reducing Racial and Ethnic Disparities in Access to Care Could be an Indication of Future Results*. New York: The Commonwealth Fund. [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/mar/1805\\_hayes\\_closing\\_the\\_gap\\_reducing\\_access\\_disparities\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/mar/1805_hayes_closing_the_gap_reducing_access_disparities_ib_v2.pdf)

Holloway, I.W., Traube, D.E., Kubicek, K., Supan, J., Weiss, G., & Kipke, M.D.. (2012). HIV prevention service utilization in the Los Angeles House and Ball communities: Past experiences and recommendations for the future. *AIDS Educ Prev* 24(5):431-444.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

Joint Commission. (2011a). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Oak Brook, IL: Joint Commission Resources.

<http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>

The Joint Commission. (2011b). *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender Community: A Field Guide*. Oak Brook, IL: Joint Commission Resources.

[http://www.jointcommission.org/assets/1/18/LGBTFieldGuide\\_WEB\\_LINKED\\_VER.pdf](http://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf)

Kipke, M. D., Kubicek, K., Supan, J., Weiss, G., & Schragger, S.. (2013). Laying the groundwork for an HIV prevention intervention: a descriptive profile of the Los Angeles House and Ball communities. *AIDS Behav* 17(3): 1068-1081.

Kubicek, K., Beyer, W.H., McNeeley, M., Weiss, G., Ultra Omni, L.F.T., & Kipke, M.D.. (2013). Community-engaged research to identify house parent perspectives on support and risk within the house and ball scene. *J Sex Res* 50(2): 178-189.

Millett, G. A., Peterson, J., L., Wolitski, R. J., & Stall, R. (2006). Greater risk for HIV infection of black men who have sex with men: A critical literature review. *Am J Public Health*, 96, 1007-1019.

Murrill, C.S., Liu, K.L., Guilin, V., Colón, E.R., Dean, L., Buckley, L.A., Sanchez, T., Finlayson, T.J., & Torian, L.V.. (2008). HIV prevalence and associated risk behaviors in New York City's house ball community. *Am J Pub Health* 98(6): 1074-1080.

National Coalition of Anti-Violence Programs. (2016). *Lesbian, gay, bisexual, transgender, queer, and HIV-affected hate violence in 2015*. 2016 release edition. New York: NCAVP. [http://www.avp.org/storage/documents/ncavp\\_hvreport\\_2015\\_final.pdf](http://www.avp.org/storage/documents/ncavp_hvreport_2015_final.pdf)

National LGBT Health Education Center. (2015). *Do ask, do tell: Talking with your health care provider about being LGBT*. Boston: National LGBT Health Education Center, The Fenway Institute. [http://www.lgbthealtheducation.org/wp-content/uploads/COM13-067\\_LGBTHAWbrochure\\_v4.pdf](http://www.lgbthealtheducation.org/wp-content/uploads/COM13-067_LGBTHAWbrochure_v4.pdf)

Pearl, R.. (2015). Why health care is different if you're Black, Latino or poor. *Forbes*. <http://www.forbes.com/sites/robertpearl/2015/03/05/healthcare-black-latino-poor/>

Prejean, J., Song, R., Hernandez, A., Ziebell, R., Green, T., Walker, F., Lin, L. S., et al.. (2011). Estimated HIV incidence in the United States, 2006–2009. *PLOS ONE* 6(8): e17502.

Ranji, U., Beamesderfer, A., Kates, J., & Salganicoff, A.. (2014). *Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S*. Washington, DC: The Henry J. Kaiser Family Foundation. <http://kff.org/report-section/health-and-access-to-care-and-coverage-for-lgbt-individuals-in-the-u-s-health-challenges/>

Reisner, S.L., White Hughto, J.M., Dunham, E., Heflin, K., Begenyi, J.B., Coffey-Esquivel, J., & Cahill, S.. (2015). Legal protections in public accommodations settings: A critical public health issue for transgender and gender nonconforming people. *Milbank Q* 93(3):484-515.

Schrager, S.M., Latkin, C.A., Weiss G., Kubicek, K., and Kipke, M.D.. (2014). High-risk sexual activity in the House and Ball Community: Influence of social networks. *Am J Pub Health* 104(2): 326-331.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (no date) Healthy People 2020. Lesbian, gay, bisexual, and transgender health. [www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25](http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25),

Valanis, B.G., Bowen, D.J., Bassford, T., Whitlock, E., Charney, P., & Carter, R.A. (2000). Sexual orientation and health: comparisons in the women's health initiative sample. *Arch Fam Med* 9(9):843-53.



**Table 1. Gender Identity**

	<b>Frequency (n)</b>	<b>Percentage (%)</b>
Gender identity (all selections)		
Boy/Man	157	42.78
Male/Masculine	106	28.88
Girl/Woman	63	17.17
Female/Feminine	37	10.08
Genderqueer	5	1.36
Transman	5	1.36
Transwoman	18	4.90
Other	3	0.82

**Table 2. Gender Non-conformity**

	<b>Frequency (n)</b>	<b>Percentage (%)</b>
Gender non-conformity		
Gender conforming	156	42.51
Gender non-conforming	167	45.50
Skipped	44	11.99

**Table 3. Health Care Experiences**

	<b>Frequency (n)</b>	<b>Percentage (%)</b>
Out to providers (LGBT only)		
Yes	229	77.89
No	54	18.37
Unsure	11	3.74
Provider did not understand LGBT needs (all respondents)		
Yes	95	25.89
No	194	52.86
Unsure	66	17.98
Skipped	11	3.00
Reported anti-LGBT discrimination (all respondents)		

Yes	128	34.88
No	239	65.12
Type of anti-LGBT discrimination (all respondents)	38	10.35
Refused healthcare	54	14.71
Treated differently	20	5.45
Extreme precautions	23	6.27
Harsh/Abusive language		

Accepted Manuscript

**Table 4. Risk Factors**

	<b>Frequency (n)</b>	<b>Percentage (%)</b>
Slept most nights (last 30 days)		
Home with parents or guardians	95	25.89
Relative's place	10	2.72
Own place	203	55.31
Friend's place	22	5.99
Varied a lot	6	1.63
Shelter	3	0.82
Public place	4	1.09
Other place	13	3.54
Skipped	6	1.36

Traded sex (last 6 months)		
Never	319	86.92
Once	14	3.81
2 times	10	2.72
3 times	8	2.18
4 times	2	0.54
5 or more times	6	1.63
Skipped	8	2.18