Dr. Mitchell Lunn
We do know things like people having real experiences of discrimination or stigma that make people reluctant and anxious in the experiences of their daily life. And so, all these things are where if they can get a positive and affirming experience in health care and a positive and affirming experience at school or at their place of employment, those things help, we know, improve people's mental health outcomes and their physical health outcomes.

LuAnn Heinen
That's Dr. Mitchell Lunn, a physician scientist who serves as co-director of the Pride Study, a research initiative that assesses the general health of over 30,000 sexual and gender minority adults in the U.S. Dr. Lunn's work focuses on understanding factors that positively and negatively influence the health and well-being of sexual and gender minority adults, which primarily includes members of the LGBTQ community. When he's not actively engaged in his research role, you'll find Dr. Lunn consulting with patients at Stanford Hospital or teaching in the Stanford University School of Medicine.

I'm LuAnn Heinen, and this is the Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers.

The LGBTQ community experiences disparities in both health and health care. In conversation with Dr. Lunn, we dive into what these disparities are, why they exist, and what employers need to know.

Today's episode is sponsored by Aon’s health solutions, transforming insights into actionable strategies, crafting innovative and financially sustainable solutions. Aon is your visionary ally to elevate your employees' health and benefits. Aon focuses on affordability, accessibility, and inclusivity, reducing health and benefits disparities, because they believe caring for your people means caring for your organization.

Dr. Mitchell Lunn from Stanford University, welcome to the Business Group on Health podcast.

Dr. Mitchell Lunn
Thank you so much for having me. I'm delighted to be here.

LuAnn Heinen
I'm really glad you're here. I'm going to switch to Mitch and give you maybe a curveball. From your work portfolio, it seems you're one of the lucky and no doubt gifted people who kind of get to have it all, academic and clinical roles in your specialty area, nephrology, plus you get to spend over half your time on a passion project, LGBTQ-related research. So, in 90 seconds, where did you come from and how did this happen?

Dr. Mitchell Lunn
Sure. Great question. I'm originally from Bismarck, North Dakota, where I grew up. Then I eventually went to the East Coast for undergrad, and it was there that I really started to get involved in LGBTQ+ advocacy and activism. But it really wasn't until medical school that I fell in love with research and fell in love with studying topics that were important to me and to my community as a gay cisgender man. It was at that same point that I also discovered kidney disease and loved nephrology. So, I was really able to thankfully find a career that allows me to do both of them, both nephrology patient care and LGBTQ+ research. That project has become more than just a passion project, but really is now the primary focus of my work, is working towards LGBTQ+ health equity, is now what I spend most of my time on and brings me great joy. I feel like I really have a duty to improve the health of LGBTQ+ people, given the positions of privilege and influence that I currently have.

LuAnn Heinen
I'm excited to get into the various research efforts that you have underway and studies. But first, can you explain SGM as a term and why it's useful?

Dr. Mitchell Lunn
So, SGM, which stands for sexual and gender minorities, is actually a term that is primarily used by academia. Let's break that term sexual and gender minorities apart a little bit. Sexual minorities are people who are not heterosexual, people who are not straight. So, I am a gay man, so I would be classified and I identify as a sexual minority person. Gender minority person is somebody who is not cisgender. And so, the term cisgender people may or may not be familiar with, but cisgender refers to people whose gender identity is aligned or what is commonly expected with somebody's sex assigned at birth. For folks who are assigned male sex at birth, society commonly associates them to have a gender identity as man and for people who are assigned female at birth, society commonly expects them to have a gender identity as woman. But people who are transgender, for example, may have been assigned male sex at birth and now identify as a woman or have been assigned female sex at birth and now identify as a man. So, those folks, along with folks who are non-binary, all fit into that gender minority category. Over the years, we've had more and more letters being added to the LGBTQ+ acronym. Now we say plus, right, to include a whole bunch of other letters. But really, SGM is this overarching or umbrella term that describes everybody within the LGBTQ+ community. But it is, I think, also really important to note that the LGBTQ+ or SGM community is not a monolith, but that we have oftentimes very, very different health experiences and very different experiences in society as well.

LuAnn Heinen
Well, one of the things SGM calls out for me relates to the Office of Minority Health, which is the place in the federal government where a lot of work on health disparities is funded and done and advocated for. But of course, that's a focus on racial and ethnic minority, African American and Latino. Is it a goal that SGM be part of that?

Dr. Mitchell Lunn
To a certain extent, we are in various ways. So, the National Institutes of Health, or NIH, has a variety of communities that have been designated as health disparity populations for research. And it actually was in October of 2016 when SGM people were formally designated as a health disparity population for research. And so, what this brought about then was specific funding opportunities or funding priorities for the SGM communities. So that was really a groundbreaking moment in the federal funding landscape because it really started to diversify the research portfolio that related to LGBTQ+ people. Prior to that designation, almost 100% of NIH research that was classified as being SGM related was HIV related. This designation really opened the door to start studying smoking and diabetes and high blood pressure and a whole bunch of other health conditions within the SGM community and provided the prioritization to make those funding opportunities possible.

LuAnn Heinen
I was struck by your words, you said SGM people are underserved, understudied, and vulnerable to poor health. Can you dive a little deeper into that and why that's so?

Dr. Mitchell Lunn
We think that they're understudied largely because we've been made invisible in health research. We oftentimes, in medical journals or medical articles or scientific articles, you'll see the first table in the paper usually describes the participant characteristics, the people who participated in the particular study. And very rarely, if ever, are sexual orientation and gender identity listed in those demographics. There's things like age and race and ethnicity and maybe geography or education and income, but rarely do we have sexual orientation and gender identity. So, while SGM people have undoubtedly been participating in studies for a long time, we have largely been made invisible. We don't know, for example, in some of these large, say, heart disease studies that have been done, we don't know the number of LGBTQ+ people who actually participated in them. So that makes it pretty challenging. The other aspects are that we're vulnerable to poor health because of things in society. One of the key things that I like to reiterate to people is it is not being an LGBTQ+ person that causes poor health. It is homophobia, transphobia, racism, sexism, etc., that really impacts people's health. Many, many, many LGBTQ+ people, even those with the most privilege and most power in the world, have had varying amounts of discrimination and stigmatizing experiences in their lifetimes. Oftentimes, those experiences have happened in the health care setting or in

the research setting. That really makes people shy away from, one, getting health care, and two, participating in research. Why would you want to go to a place where you've been discriminated against when you can avoid it, right? Those aspects, along with the way that society treats people, the way that there are varying laws and protections that are either present or absent to help protect LGBTQ+ people, all those aspects really influence people's health. Some of the work that we're trying to do is to increase the visibility, increase the representation by building trust with LGBTQ+ communities so that we can start seeing SGM people represented in health studies, and that's in studies that are not just SGM specific. I would love to see sexual orientation and gender identity in a table one on a paper about diabetes, right, in a big study about diabetes or heart disease or a certain type of cancer. That's really, I think, the end goal is to really have this representation permeate itself throughout the scientific research community.

LuAnn Heinen
Thank you. That's just a great intro and transition to The PRIDE Study at Stanford that you've been an integral part of for many years. Let's go there. What it is, why it matters.

Dr. Mitchell Lunn
The PRIDE Study is a national online longitudinal prospective cohort study, which is a lot of adjectives, but really this is a study that was started by me and my dear friend and co-director, Dr. Juno Obedin-Maliver, who is an obstetrician and gynecologist at Stanford. We actually started this study when we were fellows, when Juno was a women's health fellow and I was a nephrology fellow at the University of California, San Francisco. We started working together actually in medical school and research that we did in medical school primarily focused on how much is being taught about caring for LGBTQ+ patients in medical school. We did a big national study when we were medical students and then when we were fellows, we decided to pivot and start looking at health outcomes in the LGBTQ+ community. We found ourselves not too far from Silicon Valley and decided to do this in a technology-rich way. In addition to using technology to reach large amounts of people, it also provides some safety. So again, LGBTQ+ people oftentimes have had various transgressions against them or periods of stigmatization and discrimination in medical settings, especially academic medical centers, that they may not feel safe participating in a research study by showing up at Stanford or at any of these large academic medical centers. And so instead, a digital way allows folks some safety because if they start to feel uncomfortable or discriminated against, they can just close their browser window. So we decided to take this online approach so that we could reach large numbers of people, not have it be just another San Francisco Bay Area LGBT study, but instead to be a national study. We created The PRIDE Study. It initially was an iPhone app only and that was really a pilot phase that we launched in June of 2015 and lasted about 22 months or so. It was about a two-year long pilot. The purpose of that really was to gather research questions and research ideas that the community had that they would want us to study. We also wanted to make sure that people would actually even think about participating in an LGBTQ+ health study.

LuAnn Heinen
One of the things I've loved reading about this is how feedback from the users, the community, is used to personalize and update the survey. It's so not the typical mindset of survey designers. Clearly you have something else in mind.

Dr. Mitchell Lunn
We consider The PRIDE Study and really all the work that we do, it goes by the term of community-engaged research. So people may have heard of things like community-based participatory research or participatory action research. There's a variety of terms, but community engaged is a way where we involve the community really in everything that we do, every step of the research process from the very beginning. Again, that research question generation to how should the study be designed, what should the recruitment materials look like, and then of course, during data collection, we of course want community members to participate, but then it doesn't really end there. We really want to make sure that community members are involved in the analysis and interpretation of the data. And of course, importantly, that they are involved in the dissemination of the results and that they, of course, receive the results of their participation. I think all of us have taken studies or surveys online and we never hear the results of the surveys that we've taken and we've spent a lot of our own time volunteering our time to these surveys and

the loop isn't closed. So one of the things that we really care about is the closing of that loop. And that loop though, is not just about the study itself and the research questions of that study, but also how it's conducted and that's the feedback that you're mentioning. We get feedback every week from participants telling us of things that they wish we would do differently or how they like things that we were doing. Our science committee in The PRIDE Study reviews those, any feedback that comes in, we review it actually every two weeks and make decisions going forward. Some of those decisions include, ooh, did we make a mistake and maybe say something in a way that could be viewed offensive and we need to make a live change right now? Or do we get feedback that says, you know, I really wish that you would study topic X and we then take that into consideration and say, hey, is this a topic that's either a hot topic right now, something that's important to the community broadly, and something that we should either incorporate into the next year's annual questionnaire, which is the primary instrument in The PRIDE Study, an annual questionnaire, or is this something so important that we should create more in-depth survey just on this particular topic? That may be a shorter survey, something somewhere from 10 to 20 minutes to complete, but it really takes a deep dive into that particular topic. We really value participant feedback, you know, all the time. We also have a set of groups. We have a participant advisory committee, which is anywhere from 12 to 15 members of community members across the country that we meet with every month. They are paid and they advise us on our work. We also have a set of paid ambassadors. These are oftentimes spokespeople or people who are really well connected either to local LGBTQ+ communities or digital LGBTQ+ communities. Those groups really advise us in our work and review a lot of our materials and say, no, you need to do this differently, or the way you've done this here is very good and to continue doing that. We really try to have community members involved everywhere and that also includes as authors on our papers as well.

LuAnn Heinen
Do you have advice or lessons learned for others who are developing surveys when it comes to a focus on, you know, centering on the participant as you do and avoiding othering, as you put it?

Dr. Mitchell Lunn
Yeah, yeah, absolutely. I think that's really important to avoid othering. People need to feel themselves represented and thought about in the survey design. I can tell every survey that I take where they didn't make any thought about LGBTQ+ people, so I can usually suss that out pretty quickly. Part of it is, you know, making sure that you have LGBTQ+ people involved in the survey design, but also think about some simple, rather simple tricks in terms of survey design. One of them is to avoid, when you're giving a question that has fixed answer choices, that you do simple things, like put those answer choices in alphabetical order, instead of listing, for example, in a race and ethnicity question, instead of listing white first. We do that with our race and ethnicity questions. We do it with our sexual orientation and gender identity questions. We do it with virtually everything to avoid any either conscious or unconscious opinions that you might be sharing that the most popular or what is most expected should be first.

LuAnn Heinen
Okay, so if you had gay, lesbian, queer, trans, you wouldn't put something else?

Dr. Mitchell Lunn
Yeah, yeah. We always do still have write-ins, but we don't usually use the term something else, or we don't use the term other. We use the term another sexual orientation with please specify in parentheses or another gender identity. Those are a little softer words to use than just saying, you know, well, you're something else or you don't fit any of these boxes. Instead, it might just be something that we missed. And in fact, one prime example of how we've taken participant feedback is we used to have fewer answer choices related to sexual orientation than we do now. What we did is we took a look at all those write-ins, and we had several hundred people who wrote in pansexual as a sexual orientation, which was not one of our checkboxes in our survey and as a result of that, plus some written feedback that we got from participants, we've now added pansexual as a checkbox.

LuAnn Heinen
Okay, got it.

Dr. Mitchell Lunn
So now people are not writing that in and they're able to see themselves in the answer choices. This also just makes it easier as a researcher, right, because now I don't have free text. I have several hundred fewer free text responses that I need to review and analyze and try to categorize.

LuAnn Heinen
I've been speaking with Dr. Mitch Lunn, co-director of The PRIDE Study at Stanford University. When we come back, we'll dive into learnings.

Aon
Soaring health care costs and the urgent need to improve employee health, engagement, attraction, and retention mean inaction is no longer an option. It's time to disrupt the status quo and embrace a bold commitment to your people and ultimately to the future of your organization. The time for convention is over. The time for better health and benefits decisions is now. Visit www.aon.com, to learn more.

LuAnn Heinen
How good is our data saying that about 7% of the U.S. adult population belongs to the SGM community?

Dr. Mitchell Lunn
Yeah, great question. That's data that I'm assuming you got from Gallup, because they are really the only place right now that provides some estimates. They do that by random digit dialing, so this reaches people with landlines and cell phones. It doesn't reach people who don't have either of those. You know, a random stranger calls you on the phone and asks you if you are part of the LGBTQ+ community. So we think that that number is actually a floor. Some people, of course, will not necessarily disclose that to Gallup calling them for polling. The real issue here is that sexual orientation and gender identity has never been collected in the U.S. census. So I don't know where LGBTQ+ people live, what their races and ethnicities are, what their ages are, what their religions are, what their jobs are. We obviously know that LGBTQ+ people are not uniformly distributed geographically, right? I grew up, as I mentioned, in Bismarck, North Dakota, and I live now in San Francisco, California. There are more LGBTQ+ people in San Francisco than there are in Bismarck. We don't have a national accounting of LGBTQ+ people. That then limits actually the health data that the federal government collects. So they conduct a variety of national studies every year or in various waves to actually say that X percent of the population has diabetes or X percent of the population has glaucoma. They do that by sampling, by picking a certain number of folks from each county or each census tract to send them some health questions and they know that they'll get X number of African American people and X number of Asian American people and X number of Latinx people. They don't have that for LGBTQ+ people, so our numbers, our estimates of the actual percentage of the population are likely rather correct, but they have some probably pretty big error bars around them. In terms of health status of LGBTQ+ people, we're stuck back in the 1950s or 60s describing just even the prevalence of certain health conditions.

LuAnn Heinen
Well, that is a great tee up for the All of Us Research Program, which is NIH supported part of the Precision Medicine Initiative, I believe, and their aim is to collect health data from at least 1 million people that does reflect the full diversity of the country. And you're involved with that project as well, so tell us a little bit more.

Dr. Mitchell Lunn
Sure, yes. Our community engagement network, which we call PrideNET, PrideNET really has these two major projects that it does community engagement for. The community engagement process again is our participant advisory board, our ambassadors. What I didn't mention earlier is that we have between 20 and 30 nonprofit LGBT serving organizations across the country that are partners with us that are community partner organizations. So PrideNET has this big overarching community engagement structure. It does community engagement for The PRIDE Study. We're also the national community engagement partner for the All of Us Research Program. The All of Us Research Program is really different because number one, it is

a federal study that has thought about LGBTQ+ people from the very beginning. That in and of itself makes it historic. It's also, as you mentioned, going to recruit more than 1 million people from across the country. Also very, very ambitious and historic. And at least 75 to 80% of all the participants in All of Us are going to be from communities that are underrepresented in biomedical research or sometimes called UBR communities in the NIH parlance. That includes racial and ethnic minority communities. That also includes sexual and gender minority communities and many others, people living in rural areas, people with lower amounts of education, etc. It will be 50% racial and ethnic minorities. So again, really going to be a diverse dataset and will be, we think, one of the largest datasets of LGBTQ+ people in the world. That includes not only survey related data, but participants in All of Us can also share their electronic health record data and they can also donate biospecimens, so these include things like saliva, blood, and urine.

LuAnn Heinen:
And wearables, right?

Dr. Mitchel Lunn
Yes, there will be wearable data. There is wearable data that can be shared as well. So Fitbit and others are part of that and more will be coming in the next year, actually. A new system will be launching. I think the other really exciting thing from All of Us is that all 1 million people will have their entire genome sequenced. So every single letter of their DNA will be sequenced and that really will start to open many new doors into either things that may cause disease or make people more susceptible to certain diseases. It also will start to tell us about how our bodies react or metabolize various medications. People may be familiar with the medication Warfarin, sometimes called Coumadin. It's a blood thinner. For some patients that I have, I can give them one milligram a day and their blood gets appropriately thinned to the level that I want it to be. Other patients that I have need 10 milligrams a day. And this is all actually little changes in our genetic code that affect the way that the enzymes that metabolize these drugs work. We're really looking forward to this kind of field of pharmacogenomics, it's called, to see if we can have a better understanding of the way each of our own bodies react and process certain medications so that we can actually start being, again, a little more precise, a little more tailored, a little more individualized for each person.

LuAnn Heinen
What would you like to share about findings to date from All of Us research and/or The PRIDE Study? What are some of the things you're excited about and watching?

Dr. Mitchell Lunn
Yeah, I think there's a couple things that we're trying to do. Let's start with The PRIDE Study first. We've done several things that I think are really starting to be, you know, impactful. One of them is discussing eating disorders or the disordered eating within the LGBTQ+ community. Typically, most eating disorder literature is largely focused on cisgender women, usually in adolescence and that's kind of it. There's very little on eating disorders in men, and very, very little, if any, eating disorders in the LGBTQ+ community. Because The PRIDE Study, which has now recruited more than 30,000 people, LGBTQ+ people, has such large numbers, we're able to kind of disaggregate those letters of LGBTQ and start looking at how do, you know, cisgender lesbian women compare to cisgender bisexual women in terms of eating habits? Or how do gay men compare to bisexual men compared to transgender men, for example. And so, basically, the size of The PRIDE Study, along with the kind of granular sexual orientation and gender identity data that we collect, has allowed us to really take a more nuanced approach to looking at eating disorders within the community. We've also tackled some topics that some people may consider controversial. They include things like transgender men and their pregnancy experiences. So, again, transgender men are people who are assigned female sex at birth and now identify as men, and that they are at risk for pregnancy, we've shown. We've also shown that many of them want to have babies and build their families that way and so, looking at those experiences. One of the things that we also showed was that there's kind of this lore in the community that when you're a trans man taking testosterone for gender-affirming purposes, that that is adequate contraception, because people's menses, people's periods usually stop. We actually showed that people actually did indeed get pregnant while taking testosterone, so kind of evidence to debunk the myth that it's an effective contraceptive. Then, similarly, we also looked at trans people's experiences with

abortion, another potentially controversial topic. In that case, trans people, as we've heard, get pregnant, and so they, of course, also have abortions. I think the most maybe disturbing finding that we had was that about 20% of the trans people who were having an abortion, 20% of them did that without clinical supervision. This is doing an abortion on their own at home or other means, and that, of course, is dangerous and unhealthy. This really just shows that people are afraid of getting care or may not have the resources or the access, depending on where they live, to gender-affirming abortion care. Those statistics actually come from before the Supreme Court's Dobbs decision. We expect those to actually be worse now, you know, or harder to have access. Then the last part from The PRIDE Study that I talk about would be this experience of what sometimes gets called conversion practices or conversion "therapy." These are oftentimes either religious or mental health-based groups that are meant to change somebody's sexual orientation or gender identity to be straight and cisgender. These are outlawed now in about 23 states because they have been shown to be nothing but harmful. But the longitudinal nature of The PRIDE Study has allowed us to look at people's experiences, oftentimes in adolescence or early adulthood, of experiencing conversion practices and then there are the experiences of mental health symptoms later. So, looking at anxiety, depression, PTSD, suicidality, you know, most of them having an association later in life with being exposed to conversion practices as a young adult. We think that those are actual things that will be used, hopefully, in fighting for legislation to ban conversion practices at the federal level or other health policy-related changes.

LuAnn Heinen
What do you see as the role of social determinants, particularly in LGBTQ+ health? The idea that where you live is key.

Dr. Mitchell Lunn
Yes, I think this is a key component. The phrase is that your zip code tells you more about your health than your genetic code, having just discussed DNA. But I think that's exactly right. There's multiple, multiple determinants of health, including social cohesion or the ability to get along with your neighbors and have kind of a neighborhood network versus things that are oftentimes unhealthy, violence, or lots of traffic, or no sidewalks, and no parks, and food deserts, and all these things that impact health. You then overlay that with experiences of stigma and discrimination in society, and you overlay that with other aspects, policies, and laws or more structural things. So the social determinants of health, we know this is obviously a very hot topic in the past maybe decade or two where people are starting to actually study these various components. You can imagine that if you are living in a state that doesn't have certain protections and you can be fired from your job for being an LGBTQ+ person, that you might find yourself being marginally housed or even homeless. All those aspects, of course, have profound and detrimental effects on health. This is really an area that we are actually just getting started studying in The PRIDE Study. We're going to be doing a particular study looking at the effects of neighborhood disorder and neighborhood cohesion and social cohesion, people's social support networks within a neighborhood, and looking at how those impact both their physical health and their mental health. That is one of the reasons why there are these what sometimes get called gayborhoods. The gay neighborhoods of various cities. So think about the Castro in San Francisco, or North Halstead in Chicago, or kind of previously Chelsea and now Moorehouse Kitchen in New York City are areas where LGBTQ people have largely concentrated because they have LGBTQ owned businesses, they know they're going to be safe and not discriminated when they either live in or patronize some businesses in those neighborhoods. So some of those things are other aspects that are important.

LuAnn Heinen
Yes, absolutely. I do think that one of the things that your work has really focused on, I've seen some of your lectures and videos that you've given to other health professionals, emphasizing that kind of the human side of all of this, I mean, the stress, the microaggressions, the things that the community experiences, with lack of acceptance from family members or colleagues, or the stress about coming out, all the reasons why their behaviors, for example, tobacco use, there was a whole study on tobacco use disorder. Many folks start in college, and maybe you get to college, you discover a gay community where smoking's already prevalent. You want to belong, you get addicted, the advertisers target this market and there we have a much higher prevalence of smoking.

Dr. Mitchell Lunn
The tobacco industry, for one, has been one that actually has marketed to the LGBT community for a very long time. They were actually the ones that were actually prior to marriage equality, were conducting ads in support of equality and targeting the LGBT community. And of course, you're exactly right, it is this concept of minority stress, both internalized and externalized stressors, that of being a minority person that contribute to people having negative health outcomes and negative health behaviors. The increased smoking, alcohol use, things like that, have largely been coping mechanisms for those experiences of stigma and discrimination and then couple that with the gay bar scene of places that you could be yourself and be accepted. Those, of course, were places that were rich in tobacco and alcohol use.

LuAnn Heinen
I was really impressed by the series of videos that you had illustrating the challenges that someone from the SGM community could have in the health care system. It was kind of a what not to do, then, you know, here's how to do it better. It had little video vignettes on approaching the registration desk and not being recognized because your name has changed, or getting to the exam room and looking for the appropriate restroom, or being in the exam room and how you're treated. I thought they were really compelling and it struck me that you've spent a lot of attention on this, the humanity of it all, and trying to translate.

Dr. Mitchell Lunn
Yeah, yeah, absolutely. Again, it's because the LGBT community kind of gets billed as the single monolith, like, we're all the same, that it's really easy to lose the humanity part. We're kind of obsessed with labels in this country. Everybody has to be put into a little bin or a little box in some way and it's really easy to lose the fact that these are real human beings, actually that we're talking about. Everybody's experience is different and so even the anecdotes or stories that I've shared today are not true for everybody. Some cases have more severe or different outcomes. So yeah, keeping the humanity, I think, is a really important part of it and that, again, really is why we do the community engaged aspect of our work. Because that allows us to also be a little bit grounded by real community members telling us, what are you doing or, you know, you should do it this way. Because we can sometimes be a little in the books as academic researchers and lose sight of the fact that there are real human beings whose lives are truly affected there. I think we do know things like people having real experiences of discrimination or stigma, then result in this kind of anticipated stigma or discrimination, right, where you're always a little hyper vigilant, on edge, that you're going to be called some name, denied services, somebody is going to use the wrong name, you know, misgender you use the wrong pronouns, those sorts of things that make people reluctant and anxious in the experiences of their daily life. So all these things are where if they can get a positive and affirming experience in health care, and a positive and affirming experience at school, or at their place of employment, those things help, we know, improve people's mental health outcomes, and their physical health outcomes. Those are, I think, really big factors for employers, for businesses, for organizations, for nonprofits, for everybody to think about to make sure that folks are welcoming and affirming their employees fully for the entirety of who they are, not just because they're good at whatever their job duties are, but also that they are welcomed, appreciated, and supported in their own identities.

LuAnn Heinen
That was terrific, a terrific summation. Is there any double click on specifically on health benefits and well-being initiatives that companies might offer their employees and families?

Dr. Mitchell Lunn
Yeah, I think it's really, really important for companies to think about what benefits they offer LGBTQ+ people, and really what benefits they offer everybody, but specifically, do they offer coverage of gender-affirming care and that includes more than just getting prescribed hormones for transgender or non-binary people who may be taking them to affirm their gender. That includes coverage of oftentimes very expensive gender-affirming surgeries, both top surgery, which refers to chest or breast surgery, bottom surgery, which refers typically to genital surgeries, but there's also things like hair removal, laser hair removal on your face, for example, or in other parts of your body that can be done for gender-affirming purposes, or a variety of other procedures. I think it also includes things like what family building options

does your company provide or cover, so things like invitro fertilization or any other of the reproductive endocrine types of family building. That includes things like so-called second parent adoption or surrogacy, having child through a surrogate. Those are all very, very expensive things that some companies cover and other companies don't, and interestingly enough, some companies only cover it for folks who are married and don't for folks who are not. So thinking about are you actually offering this equitably to people of different sexual orientations and gender identities, I think, is important. Many big companies also have employee resource groups or ERGs. Some of those may be focused on LGBTQ+ people, and almost every company nowadays has a chief diversity officer or somebody who's in charge of diversity, equity, inclusion, and belonging. It's important that every company actually includes LGBTQ+ people under that umbrella of diversity. I'd like to just emphasize the importance of visibility, and so many, many companies conduct kind of climate surveys or other aspects, kind of internal surveys about how their culture and climate is inside their organization, and I would encourage the inclusion of are you assessing how well your company does for LGBTQ+ inclusion as well, and part of that involves actually asking your employees, do you identify as an LGBTQ+ person. We used to be very anxious about asking things like race and ethnicity, fearful that nobody would answer it or that it was too invasive or that it was inappropriate to ask. We now know that people are actually more likely to disclose their sexual orientation and gender identity than they are their race and ethnicity when they're asked that on surveys. We need to get over our fear that it's an inappropriate thing to ask. I think people think it's inappropriate because they often think just equate it only with sex, and in actuality, being an LGBTQ+ person is so much more than just who you have sex with or who you love and really impacts many aspects of health, of company's culture and climate, and really their dedication to welcoming people of all different backgrounds and experiences.

LuAnn Heinen
If an employer is interested in looking at your research, where can they find it?

Dr. Mitchell Lunn
Yeah, great question. Thank you for asking. There are a couple places, so probably the easiest place is going to https://pridestudy.org/, and you can actually view all of the studies, all the papers that we've done. In addition to having access to the scientific paper that's there, we also create what we call community-friendly summaries, and these are really plain language summaries written to be accessible by everybody, and they really just provide a very brief synopsis of the key takeaways of the study of the paper to be really digestible by everyone.

LuAnn Heinen
Thank you so much for this conversation. I've learned so much. Loved it.

Dr. Mitchell Lunn
Great. It was really a pleasure to be here, and again, thank you so much for inviting me.

LuAnn Heinen
I've been speaking with Dr. Mitchell Lunn about The PRIDE Study, which includes LGBTQ+ participants from all 50 states, ranging from age 18 to those in their 90s. For more information, including how you can participate, visit www.pridestudy.org.

I'm LuAnn Heinen, and this podcast is produced by Business Group on Health, with Connected Social Media. If you liked the episode, please rate us and consider leaving a review.