



GATHERING SEXUAL ORIENTATION DATA ON STATEWIDE BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEYS:

A CALL TO ACTION FOR STATES

INTRODUCTION

We learn a great deal about health disparities that different populations face by including demographic measures on national health-related surveys. While qualities such as age, race, and gender are consistently measured on national health surveys, data on sexual orientation have largely not been collected, although this is changing. Including sexual orientation measures on Behavioral Risk Factor Surveillance System surveys—conducted in all 50 states—would allow for systematic data collection and analysis of health risks, protective factors, and outcomes of lesbian, gay, and bisexual (LGB) people.

The Behavioral Risk Factor Surveillance System (BRFSS) is a national public health monitoring system that gathers data through state-level surveys administered to over 500,000 individuals annually. The Centers for Disease Control and Prevention (CDC) funds and provides guidance to state health departments in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam to administer BRFSS surveys.¹ Each state invites a random sample of households to participate in the survey every year. Survey teams call selected households and use the survey to collect a variety of health-related information from one adult member of the household. BRFSS data are subsequently used to identify emerging health problems, track health trends, and develop and evaluate public health strategies.

CDC provides states with a standardized core questionnaire annually, which forms the bulk of the survey; CDC requires states to ask all questions on the core questionnaire of each respondent. Additionally, CDC provides several optional question sets, or modules, that states can choose to incorporate into their BRFSS surveys. Beyond the optional modules, each state may choose to incorporate additional questions at its own discretion. Through 2013,

sexual orientation measures were not included on the core questionnaire or any of the optional modules, but some states added sexual orientation measures as additional questions to gather information on LGB people, which helps document health disparities faced by this community.

BRFSS serves as an invaluable tool for states and the nation to assess the health needs of residents and tailor health programs and services accordingly. Information gleaned from the core questionnaire provides an overview of the nation's health status. Importantly, it is also used to track progress toward achieving national public health goals, including reducing health disparities across different groups. Furthermore, states can use their BRFSS data to assess how their residents' health behaviors in particular areas, such as tobacco use, compare to national benchmarks and the health behaviors of residents in other states. Only some states have included their own questions about sexual orientation, which poses a considerable challenge to understanding LGB health risks and disparities across the country, for if LGB people cannot be identified in the data, it is impossible to compare their health behaviors to those of other groups. Without this information, states may miss the opportunity to develop programs, policies, and services to address local health disparities.

Sexual orientation is complex to define and can be measured in a variety of ways. For the purposes of this policy brief we focus on capturing data about sexual orientation by using a measure of sexual identity, or whether one identifies as heterosexual (straight), homosexual (gay or lesbian), or bisexual, particularly because research shows that health risks and outcomes differ based on self-identification by sexual orientation. One major drawback to only using a measure of sexual identity on BRFSS is that some individuals may not self-identify as lesbian, gay, or bisexual but may engage in sexual

behaviors with members of the same sex. These behaviors may indicate specific health-related risk factors. Thus, because BRFSS collects information about the population's health risk behaviors in order to assess their role in disease morbidity and mortality, we also discuss using a measure of sexual behavior. A sexual behavior measure indicates whether one has sex with both men and women, only men, or only women. Together these two measures align with the goals of BRFSS to capture health disparities and monitor health risk behaviors.

This policy brief aims to educate state health department staff and other policy makers--such as elected officials and advocates concerned with LGB issues--about the importance of collecting sexual orientation data, and provides a strategy for how to accomplish this specifically through BRFSS surveys. Ultimately, we advise states to include, at a minimum, a sexual identity measure, and, whenever possible, to also include a sexual behavior measure. Moreover, we encourage states to consider including a measure of gender identity on BRFSS surveys; however, due to the nuances and complexity of measuring gender identity, and the unique and understudied health disparities transgender people face, a comprehensive assessment of these issues is outside of the scope of this brief and should be addressed separately.^a

HEALTH DISPARITIES OF SEXUAL MINORITIES

The national conversation about LGB health is growing, in part, because research shows that significant health disparities exist for LGB

individuals (Table 1). This body of knowledge continues to grow, but wide gaps still exist.²⁻⁴

Structural barriers, in part, drive LGB health disparities. Some of these barriers include a reluctance of LGB patients to disclose their sexual identity, often due to fear that they will experience discriminatory treatment⁵; providers being inadequately trained to address the specific health care needs of LGB people⁶ and provide culturally appropriate care²; and much lower rates of health insurance coverage for same-sex couples.⁷

Some research draws upon BRFSS data to examine the health of LGB people. In a few studies using BRFSS data, researchers found that the LGB population is on some measures healthier than heterosexuals. For example, a study utilizing BRFSS data indicates that gay men in Massachusetts are less likely than heterosexual men to be overweight or obese.⁸ However, most studies of this nature indicate health disparities that negatively impact sexual minorities.

Health Care Access and Utilization

Analysis of BRFSS data reveals several sexual orientation health disparities with regard to health care access and utilization. Lesbian women are less likely to have received a Pap test in the past 3 years,^{9,10} less likely to report a recent physical check-up, and more likely to report unmet medical needs than heterosexual women.⁹ Lesbian and bisexual women report lower rates of health insurance coverage and are less likely to receive mammography screening than heterosexual women.⁹ Similarly, gay men experience lower rates of insurance coverage and higher rates of unmet medical

a. For more on gender identity measurement in surveys, see GENIUSS Group (Gender identity in U.S. surveillance). Gender-related measures overview. Los Angeles, CA: The Williams Institute. February 2013. <http://williamsinstitute.law.ucla.edu/wp-content/uploads/GenIUSS-Gender-related-Question-Overview.pdf>.

needs than heterosexual men.⁹ Bisexuals are more likely to report having no health insurance, no regular health care provider and no dental care within the prior year compared to heterosexuals.⁹

Risk Factors

Analysis of BRFSS data indicates that sexual minorities experience higher rates of many risk factors that lead to negative health outcomes compared to heterosexuals. For instance, several studies note higher rates of smoking among lesbian women, gay men, and bisexuals compared to heterosexual women and men.¹¹

¹³ Lesbian and bisexual women report higher

rates of binge drinking, heavy drinking, and being overweight than heterosexual women.^{10,11} Lesbians are also more likely to be obese than heterosexual women.¹¹ Bisexual men report higher rates of insufficient exercise and heavy drinking compared to heterosexual men.¹⁰

Self-Perceived Health Status and Health Outcomes

BRFSS analyses demonstrate that LGB individuals report higher rates of poor self-perceived health status and poor health outcomes. Research suggests that one's self-perceived health status may predict health outcomes³⁰ and serves as an indicator of

Table 1. Documented health disparities of LGB populations

LGB Community	Higher rates of tobacco use ^{14,15} Higher rates of alcohol and drug use ¹⁶ Higher rates of psychiatric disorders and mental health service use ¹⁷ More likely to lack health insurance ⁷
Gay Men	Higher rates of alcohol and drug use ² Increased risk of HIV for men who have sex with men ¹⁸
Lesbians	Increased risk of being overweight or obese ^{11,19} Lower likelihood of receiving certain screenings for cancer ²⁰
Bisexuals	Experience more barriers to health care ¹¹ Higher rates of alcohol use among bisexual women ²¹ More likely to experience mood or anxiety disorders ²²
LGB Youth	More likely to be bullied and victimized ²³ Increased risk of attempted suicide ^{24,25} Increased risk of homelessness ²⁶ Increased risk of substance use ²⁷
LGB Older Adults	Increased risk of disability ^{28,29} Increased risk of poor mental health ^{28,29} Increased risk of smoking ²⁸ Increased risk of excessive drinking ²⁸

quality of life.³¹ Bisexuals are more likely to report fair or poor perceived health compared to heterosexuals, as well as to report a physical, mental or emotional disability causing activity limitation.^{11,32} Frequent tension and worry or sadness, as well as past-year suicide ideation are more likely to occur in bisexuals and lesbian women than heterosexuals.^{11,33} Gay men experience higher rates of poor physical health and higher rates of poor mental health and health problems causing activity limitation compared to heterosexual men.^{10,32} Lesbians also experience higher rates of those same factors than heterosexual women as well as higher rates of asthma.¹⁰ In addition, rates of hypertension and diabetes are significantly higher in bisexual women compared with heterosexual women.¹⁰ Finally, sexual minorities report higher rates of sexual assault.^{11,34}

WHY STATES SHOULD GATHER SEXUAL ORIENTATION DATA

Track and Eliminate Health Disparities Nationally and Locally

The call for inclusion of sexual orientation in national data collection efforts spans over a decade.^{35,36} In the early 2000s, the federal government recognized that health disparities exist for LGB people when the U.S. Department of Health and Human Services pledged to monitor and eliminate health disparities with regard to sexual orientation in Healthy People 2010, a 10-year strategic plan of science-based objectives for improving the health of all Americans.³⁶ With the release of this plan advocates highlighted gaps in federal data systems and made recommendations for improvement.³⁵ Unfortunately, these recommendations went unheeded and the Department was forced to report that data by sexual orientation were

unavailable to measure progress related to the objectives outlined in the plan.³⁷ Presently, the U.S. is working toward achieving goals and objectives of a new strategic plan set for 2010-2020, which includes improving the health and safety of LGBT individuals and eliminating LGBT health disparities.³⁸ While federal data collection efforts to capture sexual minorities have improved, sexual orientation measures have yet to be incorporated systematically across all federal health surveys, hindering the nation's and states' ability to assess progress on these public health goals. National efforts to incorporate these measures are slowly moving forward, particularly because of a decision made by the Secretary of the Department of Health and Human Services, who indicated in 2011 that public health programs, activities, and surveys should collect data about sexual orientation and gender identity to track health disparities.³⁹ While federal initiatives are being implemented, states can also act to include sexual orientation questions in their surveys. Collecting sexual orientation data at the state level can propel the federal initiative forward and enhance states' ability to document and work toward eliminating health disparities experienced by their own populations.

Enhance States' Capacity to Improve Health Care Quality

Capturing data on sexual orientation can help improve health care quality, which aligns with national health reform goals. Knowing more about disparities faced by LGB people in a particular state can improve quality of care by giving health care providers access to information that allows them to better care for their patients. For example, if providers know that sexual minority youth in the state are more likely to use drugs, they may be more likely to ask their young patients about their sexual orientation and use that information to appro-

privately screen for drug and alcohol problems. To provide the highest quality of care providers must consider the health disparities and unique needs of their patients and comfortably deliver culturally competent care. Evidence suggests providers are frequently uncomfortable providing care to LGB people. One study found that 18% of doctors in California are “sometimes” or “often” uncomfortable caring for gay patients.⁴⁰ Surveys of both patients⁵ and providers⁴⁰ indicate that prejudicial treatment occurs in clinical settings and that anti-LGB attitudes among providers are widespread. Also, many LGB people report discriminatory or culturally incompetent care, or fear such substandard care.⁵ Access to information guides culturally competent practice, which improves the quality of care delivered and the experiences of LGB people presenting for care. This, in turn, may improve health care utilization and early detection of disease among the LGB community.

Enhance States’ Capacity to Improve Health Systems Efficiency

Tracking health behaviors and outcomes such as smoking, obesity, depression, and health care utilization locally among LGB populations provides useful information about where to target health system improvements and suggests where states should focus limited resources. States can develop targeted public health interventions based on gaps highlighted in the data. For example, if the data show lesbians in the state are less likely to be screened for certain cancers, such as mammography for breast cancer, health departments may choose to launch a public marketing campaign that encourages more lesbians to seek these services. After the state uses this data to inform development and implementation of public health strategies, it can then use the data to measure the effectiveness of these new initiatives by tracking improvements in the subpopulation’s health as

reported through the same data system. Collecting data on sexual orientation can enable more cost-effective decision making.

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LGB people who reside in states that choose not to administer CDC’s sexual orientation optional module may face even greater health disparities that worsen each year, remain hidden, and go unaddressed.
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OVERVIEW OF SEXUAL ORIENTATION DATA COLLECTION ON NATIONAL HEALTH SURVEYS

A handful of federally-funded, national health surveys include or have included sexual orientation measures, as shown in Table 2.⁴ Some national health surveys noted in the table included sexual orientation measures sporadically, hindering our ability to monitor trends in data over time. Those surveys also vary in terms of the measures used to record sexual orientation.

Progress at the Federal Level to Collect Sexual Orientation Data

In 2011 the Institute of Medicine commissioned a team of experts to review the available science on LGBT health and determine the challenges to better understand LGBT health disparities.⁴ In a final report, the team cited a need for more data on sexual and gender minority populations, recommended inclusion of sexual orientation as part of demographic data collection, and called for the development and usage of standardized sexual orientation measures across all federally-funded health surveys.⁴ In response to the report, the federal government made progress in collecting better

Table 2. National surveys that have included sexual orientation measures (i.e., sexual identity and sexual behavior) in comparison to BRFSS

Survey	Sample Size	Sexual Orientation Measures Used	Survey Purpose
General Social Survey	2,000	Identity, behavior	Tracks societal trends, including behavioral and attitudinal topics
National Epidemiological Survey on Alcohol and Related Conditions	43,100	Identity, behavior	Measures alcohol, tobacco and illicit drug use
National Health and Nutrition Examination Study	10,149	Identity, behavior	Assesses health and nutritional status through interviews and physical examinations
National Health Interview Survey	33,856	Identity	Monitors overall health of the nation through household interviews
National Survey of Family Growth	12,600	Identity, behavior	Collects information regarding family life, marriage status, contraception and fertility.
Behavioral Risk Factor Surveillance Study	506,000	Identity, behavior	Measures prevalence of behaviors that increase risk of health outcomes, such as diet, physical activity, smoking, immunization, and sleep.
<i>Inclusion of sexual orientation varies by state</i>	<i>Total respondents across all states</i>	<i>Not included in all states</i>	

sexual orientation data, yet it is far from including it systematically across all health surveys. In a major success, the Department of Health and Human Services included a sexual identity measure on the National Health Interview Survey in 2013. Also, the Substance Abuse and Mental Health Services Administration is piloting sexual orientation questions on its National Survey on Drug Use and Health. Most notably, CDC recently released an optional module on sexual orientation for BRFSS, providing states with a standardized sexual orientation measure to use on BRFSS. Leaders within the Department of Health and Human Services have indicated that

as many as 17 states have taken steps to ask sexual orientation and gender identity questions on their BRFSS, and many other states are considering adopting these questions. However, a major drawback to adding these measures as an optional module rather than adding them to the core questionnaire is that disparities impacting LGB populations will remain largely unknown in states that choose not to administer the optional module. Thus, LGB people who reside in states that opt out may face even greater health disparities that worsen each year, remain hidden, and go unaddressed.

Figure 1. States that included a sexual identity and/or sexual behavior measure on BRFSS at least once between 1995 and 2012.^b

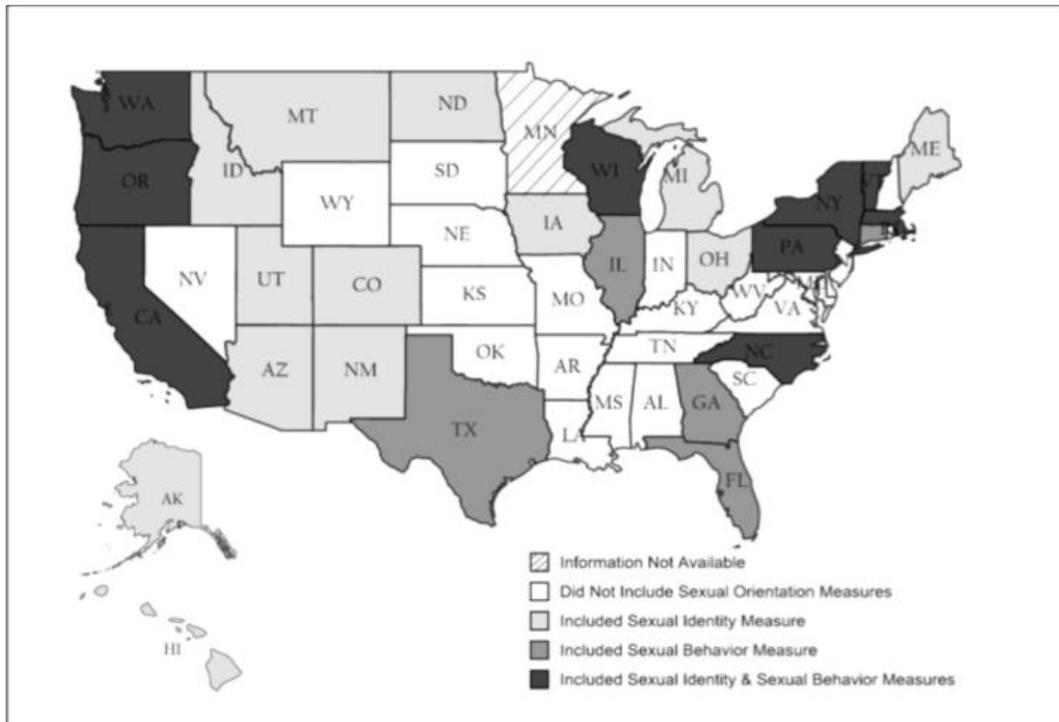


Figure 2. States that included a sexual identity and/or sexual behavior measure on BRFSS in 2009.^b



b. Figures 1 and 2 represent information gathered through the Centers for Disease Control and Prevention's BRFSS webpage, state health department webpages and contacts, and 2009 BRFSS surveys we obtained from each state. We updated the maps with all publicly available information we could find. Some states may have included sexual orientation identity and/or behavior measures that are not included on these maps. For the most current information on each state's use of these measures, contact the BRFSS State Coordinator listed here http://www.cdc.gov/brfss/state_info/coordinators.htm.

States' Efforts to Include Sexual Orientation Measures on BRFSS

As the correlation between sexual orientation and health disparities becomes clearer, many states have chosen to collect sexual orientation information from respondents in a variety of ways through BRFSS surveys. Between 1995 and 2012, 27 states and Washington D.C. asked about sexual orientation (i.e. sexual identity and/or behavior) utilizing a state-added measure at least once (Figure 1). Of these states, 6 are located in the Northeast region of the country, 6 in the Midwest, 4 in the South, and 11 in the West. Some states did not include a measure every year. For instance, data collected from states' 2009 BRFSS surveys show that only 13 states and Washington D.C. included a sexual orientation measure that year (Figure 2). These maps prove that states in all regions of the country recognize the importance of collecting data on sexual orientation and that including such measures on BRFSS is feasible. If more states collect this data we would have a better understanding of LGB health across the country and across particular LGB subpopulations.

Despite success including sexual orientation measures on BRFSS throughout all regions of the country, LGB people in some areas and some LGB subpopulations are grossly underrepresented. For instance, the majority of Southern and Midwestern states have yet to ask any questions about sexual orientation on BRFSS. Moreover, according to the 2010 census, Southern and Midwestern states have the highest proportions of rural residents.⁴¹ This means that LGB people who reside in rural areas, who may have unique health needs and risks compared to LGB people who reside in urban areas, are disproportionately underrepresented in the limited amount of BRFSS data

available on sexual minorities. Another example of underrepresentation resides in the gap in data on LGB older adults. Some states that do collect information about sexual orientation only collect it from respondents between the ages of 18 and 64, and therefore miss information on older LGB adults. We advise all states to include sexual identity and sexual behavior measures on their BRFSS surveys and to ask them of all BRFSS respondents to fill these gaps in knowledge and to ensure comprehensive representation of LGB subpopulations in BRFSS datasets.

LGB people who reside in rural areas, who may have unique health needs and risks, are disproportionately underrepresented in the limited BRFSS data available at this time.

WHY STATES SHOULD USE BRFSS TO COLLECT SEXUAL ORIENTATION DATA

Information gathered from national health surveys has the capacity to inform research and federal policy in various areas. The BRFSS health survey is unique in several ways. First, it enlists all states to collect information on behaviors that determine risk factors unique to populations within a state. So, not only does BRFSS contribute to development of research and policy at the national level; it also informs state-level public health initiatives. Second, the sample size of BRFSS far exceeds that of most other health surveys that collect sexual orientation data. In this way, BRFSS can provide significant data about LGB individuals with regard to health measures such as tobacco and alcohol use, HIV/AIDS prevention, health care access and utilization, receipt of HPV vaccinations, cancer screenings, and prevalence of

mental illness. Third, since many states have experience using sexual orientation measures on BRFSS, and some have included them consistently for years, we have substantial information from these states' experiences to draw upon to implement sexual orientation data collection through BRFSS.

Using a standardized question or set of questions on BRFSS across states would allow us to pool data from several states, count the number of people who identify as sexual minorities across the country, understand geographic variation in LGB health disparities and risk behaviors, and build our knowledge base to develop successful strategies to reduce these disparities. As stated in the previous section, states vary in their history of including sexual orientation items on BRFSS surveys with regard to frequency, type of question or questions used (sexual identity and/or sexual behavior), and question content or wording. The variability makes cross-state comparisons challenging and inhibits our ability to detect trends from year to year. Furthermore, lack of standardization can result in different estimates of health risk behaviors for certain populations depending on how sexual orientation is defined.⁴² Using standardized sexual orientation measures on national surveys is ideal and we offer suggested questions for states to use on their BRFSS surveys. However, including any sexual identity or behavior questions on BRFSS allows states to locally measure and track health disparities faced by their sexual minority residents.

HOW STATES HAVE UTILIZED SEXUAL ORIENTATION DATA COLLECTED FROM BRFSS

Several states have a long history of utilizing BRFSS data to implement new programs and

policies. The following examples show how states have used sexual orientation data from BRFSS to document important health disparities among LGB individuals and drive policy and programmatic changes in response.

Arizona used BRFSS data to highlight disparities of tobacco use in *Arizona's Statewide Substance Abuse Epidemiology Profile 2009* and found that 31% of lesbian women who responded reported current smoking behavior, a rate twice that of the general female population.⁴³ The Arizona Department of Health Services has included sexual orientation on other statewide surveys and in analyses for their sexually transmitted disease control program. The Department's Office of Prevention also recorded a 20-part webinar series on different LGBT topics, including health disparities, in 2010. Tobacco Free Arizona works with the Department and targets LGBT smokers through its programs and partnerships with LGBT organizations.

Colorado BRFSS data, which included sexual orientation measures, were analyzed in conjunction with data from the One Colorado Education Fund LGBT Health Study for a comprehensive understanding of LGB health disparities. Results showed higher rates of smoking, binge drinking, drinking and driving, and asthma in lesbian, gay, and bisexual people compared to heterosexual people.⁴⁴ One Colorado, the state's LGBT advocacy group, subsequently outlined goals for health systems, providers, and the community. In response, Governor Hickenlooper signed a bill (HB13-1088) to ensure that health data in Colorado would consistently include sexual orientation.⁴⁵

After discovering significant health disparities in the LGB population ages 18-64 through the BRFSS, Massachusetts decided to include a sexual identity question on the BRFSS for

those over the age of 65 as well.⁴⁶ The state also developed a new survey specifically for the LGBT community to create a more comprehensive data set for this population.⁴⁷ Massachusetts now collects sexual orientation data from Tobacco Quit Line callers. The Massachusetts state government funds direct services targeted at LGBT people based on data from BRFSS and other surveys that show the disparate impact of certain health risk behaviors, including social isolation among older gay men. These services include suicide prevention, domestic violence prevention and services, homeless services, congregate meals for LGBT elders, and youth services for teens as well as young adults 18-25.

New Mexico released a report in 2010 entitled *New Mexico's Progress in Collecting Lesbian, Gay, Bisexual, and Transgender Health Data and its Implications for Addressing Health Disparities*, which describes the importance of collecting such data, the methodology, results and recommendations.⁴⁸ New Mexico gears tobacco prevention and cessation programs toward lesbian, gay, and bisexual people based on disparities found through BRFSS. New Mexico school districts have also begun LGB cultural competency training for staff and health care providers.⁴⁹

Washington's Spokane Regional Health District released a report entitled *Health Care Needs and Resources of the Gay, Lesbian, Bisexual, Transgendered, Intersexed, and Questioning Community* in 2006.⁵⁰ After identifying LGB health disparities in BRFSS data, the district chose to collect sexual orientation data from other sources, including from its Tobacco Quit Line callers, to identify more specific needs and disparities.⁵¹ In 2009 Spokane released its *Tobacco Prevention and Control Program 5-Year Strategic Plan*, which identifies the LGB community as a top priority population for targeted programs.⁵²

WHAT STATES CAN DO

1. Capture sexual orientation on BRFSS surveys though use of a standardized measure of sexual identity.

We urge all states to adopt and use the optional BRFSS module of sexual orientation measures once available, and to use it consistently each year. We encourage states to use the following sexual identity measure on their BRFSS surveys, which is consistent with what CDC proposes in the optional module.

Do you consider yourself to be:

- 1 Straight
- 2 Lesbian or gay
- 3 Bisexual
- 4 Other
- 7 Don't know/not sure
- 9 Refused

While other measures exist, and some states may currently use a different measure, we strongly encourage standardization for data pooling and comparison, and therefore urge states to include this question on their BRFSS.

Collapsing all sexual minorities into one "LGB" category assumes lesbians, gay men, bisexual women and bisexual men have the same experiences and needs.

2. Capture sexual orientation on BRFSS by also including a measure of sexual behavior.

Sexual behavior does not always align with sexual identity, and states are encouraged to also include a sexual behavior measure to gain more comprehensive data on sexual orienta-

tion. Some individuals identify as heterosexual or straight but also engage in sexual activity with same-sex partners. Behavior data tell us who is homosexually active, and what differences we see between those who are homosexually active (either exclusively with same-sex partners or with both opposite-sex and same-sex partners) and those who are exclusively heterosexual. Self-identity as gay, lesbian, or bisexual and same-sex behavior sometimes overlap, but not always. A 2006 study of more than 4,000 men in New York City found that 9.4% of men who identified as “straight” reported having sex with another man in the past year.⁵³ A recent survey of sexually active adolescents showed that 76% of self-identified lesbians reported having had sex with a male at some point during their lives.⁵⁴ Therefore a sexual behavior question is essential to capture data on people whose sexual behaviors do not align with identity. While the suggested sexual identity measure will capture significant information to identify LGB people within the data, it will not identify all those at risk for specific health outcomes based on behavior. A suggested sexual behavior measure states can use is that from Massachusetts and Vermont’s BRFSS surveys:

*[If respondent reports sex in past 12 months]
During the past 12 months, have you had sex with only males, only females, or with both males and females?*

- 1 Only males
- 2 Only females
- 3 Both males and females
- 7 Don’t know/Not sure
- 9 Refused

3. When analyzing these data, resist the urge to lump all lesbian, gay, and bisexual people together.

Although certain health disparities affect the LGB community as a whole, like access to health care services, important differences exist between groups and between subpopulations within each group and therefore should be considered when analyzing BRFSS data.⁴² Collapsing all sexual minorities into one “LGB” category assumes lesbians, gay men, bisexual women and bisexual men have the same health-related experiences and needs. For example, lesbian women may face different barriers to receiving routine Pap smears than bisexual women. Lumping lesbians and bisexual women together in analyzing cervical cancer screening data may hinder the exploration of such important differences. In another example, lesbians are more likely to be overweight or obese than heterosexual women, while gay men are less likely to be overweight or obese than heterosexual men. If data from lesbian women and gay men are analyzed together, these disparities may never be discovered.

There likely exist even more disparities unique to LGB subpopulations that research has not yet identified. For example, gay white men may have different experiences with the health care system than gay black men or gay Hispanic men. To capture these distinctions, states and researchers must not only capture sexual orientation on BRFSS, but also distinguish between different LGB subpopulations when analyzing the data and considering policy and programmatic changes. A more comprehensive understanding of factors affecting LGB subpopulations will not only help illuminate health disparities, but enhance the development of customized programs, services, and interventions to reduce these disparities. Beyond that, a more detailed look at the data could lead to more efficient use of public health resources, particularly because effective public health strategies require tailored messaging to indi-

viduals most at risk for a particular health outcome. Some states may not have the capacity to conduct this type of advanced analysis with BRFSS data. Therefore, CDC should consider funding for states to undertake this.

4. Advocate for inclusion of sexual orientation measures on the BRFSS core questionnaire.

While we advise states to include sexual orientation questions or the specified optional module on their BRFSS survey, we also encourage state health departments and other stakeholders to advocate for inclusion of sexual orientation measures on the BRFSS core questionnaire. This will make great strides in better sexual orientation data collection nationally, standardize sexual orientation measures on BRFSS, and enhance the ability to pool data across states. Additionally, if sexual orientation is asked on the core questionnaire, states would avoid the burden of adding these measures each year. Most importantly, it would represent a national recognition of sexual minorities as a population with unique health risks and needs and signify a commitment to improving the health of LGB people.

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ADDITIONAL RESOURCES

For technical assistance and support when adding a sexual orientation measure to BRFSS, or to find out if your state has included sexual orientation on BRFSS, contact your CDC BRFSS State Coordinator.

A list of State Coordinators can be found here: <http://apps.nccd.cdc.gov/BRFSSCoordinators/coordinator.asp>

You may also contact the following individuals at The Fenway Institute for more information on scientifically tested measures of sexual orientation, and to learn more about policies and strategies to improve data collection on sexual minorities:

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