Special Considerations - Cancer Concerns For and Of Sexual Gender Minority

May 15, 2018 | 2pm ET

Moderator: Earl Nupsius Benjamin, DrHSc, Community Advisory Council Member

Presenters:
Dr. Keisa Fallin-Bennett, M.D., University of Kentucky
Dr. Christine Brennan, Ph.D., FNP Louisiana State University
Tony Burns, Cancer Survivor
Michael L. Robinson, MSW, LCSW
CenterLink

✓ Nonprofit founded in 1994

✓ Helps develop strong, sustainable LGBT community centers with a national network of 190+ organizations

✓ Builds a thriving network of centers for healthy, vibrant communities

✓ Recognized by the White House as a “Champion of Change”
LGBT HealthLink

- One of eight CDC-funded cancer and tobacco disparity networks
- Advance LGBT wellness by addressing LGBT tobacco and cancer health disparities
- Link people with information and promote adoption of best practices
- We promote tobacco prevention & cessation, decreased second-hand smoke exposure, cancer prevention and screening and improved quality of life for those with cancer

Become a member at
www.MyLGBTHealthLink.org
LGBT HealthLink Provides:

- Technical Assistance
- Trainings/Webinars/Presentations
- Needs Assessment Tool
- Sample non-discrimination policies
- Other resources such as educational materials
- Tobacco Census

- Cancer Assessment of Community Level of Readiness
- Cross-sectoral connections between health systems, providers, community centers, and departments of health
- Linkages for information and best and promising practices
Today’s Presenters

Earl Nupsius Benjamin  Keisa Fallin-Bennet  Christine Brennan  Tony Burns  Michael L. Robinson
Special Considerations
Cancer Concerns for and of Sexual Gender Minority

*Moderator:* Dr. Earl Nupsius Benjamin, Dr.H.Sc.
Goal

Increase attendees’ awareness of information, skill sets and resources relating to SGM

a) cancer screenings,
b) tobacco related-cancers and
c) patient experiences
Workshop Speakers

Dr. Keisa Fallin-Bennett, MD, MPH
Family & Community Medicine; University of Kentucky

Dr. Christine Brennan PhD RN NP-BC
Louisiana State University (LSU) - Health School of Public Health &
South Central (SC) AIDS Education and Training Center

Tony Burns, Peer Mentor and Advocate
LGBTQ Community Cancer Research Advisory Board Member,
George Washington University Cancer Center

Michael Louis Robinson, MSW, LCSW
The BACH GROUP & BACH Therapeutic Counseling Services
Cervical Cancer Prevention

Dr. Keisa Fallin-Bennett, MD, MPH
Family & Community Medicine
University of Kentucky
Outline

• Why Cervical Cancer?
• Reasons people do not get prevention and screening.
• Guidelines
  • HPV vaccine
  • Cervical screening (Paps)
• What can you do?
Jamie

What testing and preventive care would you recommend?
Persistent HPV infection is the most common cause of cervical cancer

# Persistent HPV infection is the most common cause of cervical cancer

- Normal epithelium
- HPV infection
- Koliocytosis
- CIN1
  - Low-grade squamous intraepithelial lesion (ASCUS/LSIL)
- CIN2
  - High-grade squamous intraepithelial lesion (HSIL)
- CIN3
- Invasive carcinoma

**Progression**

**Regression**

* Probability increases with viral DNA integration. CIN: cervical intraepithelial neoplasia; ASCUS: atypical squamous cells of undetermined significance.

Cervical Cancer

~ Detectable ~
A pap smear is a preventative screening test for cervical cancer.

~ Preventable ~
The Gardasil vaccine protects against HPV, the main cause of cervical cancer.

~ Treatable ~
When caught in the early stages, you have an 80% chance of beating the cancer. This is why it’s so important to keep up with your annual exams.

FpaWomenshealth.com
Why is cervical cancer an LBTQ issue?

- Lower rates of HPV vaccine
- Higher rates of smoking
- Lower rates of screening
Guidelines: Pap

- 21 and over with a cervix
- Every 3 years in 20’s
- Every 5 years 30-65 with HPV cotest
- HPV self test?
Guidelines: HPV vaccine

4-valent or 9-valent

- Age 11-14: 2 shot series
- Age 15-26: 3 shot series
- Age 9-10: start if at risk
What Can You Do?
Cervical Cancer Screening Tips Trans* Men

- May have particular difficulty with the exam
- Use extra sensitivity with terminology comfortable to patient
- Be as efficient as possible with exam
Resources

http://www.lgbthealthlink.org/Projects/Cancer-Best-Practices

https://www.cdc.gov/hpv/hcp/for-hcp-tipsheet-hpv.html
Jamie

• Start 3-shot HPV vaccine series today
• Motivational interviewing for smoking cessation
• Consider STI screening
• Discuss and prepare for Pap
Queer women need Paps too!

WE BOTH GET PAPS

cHECK it OUT

clickitoutguys.ca

If you're over 25, check out www.checkitoutguys.ca for more information and support lines to help getting into care.

Check it outguys.ca

www.LGBTCenters.org  954-765-6024  information@LGBTCenters.org
Cancers in the LBGT Community

Dr. Christine Brennan PhD RN NP-BC
LSU Health SPH
SC AIDS Education and Training Center
Cbrenn1@lsuhsc.edu
Learning Objectives

• Identify the difference/disparity in cancers occurrences types and survival in LBGT population verses the general population
• Described what may be the causes of this disparity.
• Identify how these disparities may be addressed including best practices to address tobacco cessation (3A’s Brief Intervention)
Cancer Disparity within LGBT Population

• Each sub group within “LGBTQ” community has its own unique set of health/cancer risk factors/disparities within the shared experiences of discrimination and stigma

• Limited data available on LBGTQ community
  - NO SOGI data is included in large national cancer registries/surveys of cancer incidence
  - The data that LGBTQ people have a unique “cluster of risk factors” leads to conclude there is disparity in cancer incidence and increase in late stage diagnosis.

Top 10 Cancers in US 2014

- Cancer is the 2nd leading cause of death in the US, exceeded only by heart disease.
- 1:4 deaths in the US are due to cancer, ~600,000 in 2014 in US
- ~1 million LGBT cancer survivors in the US currently

Per 100,000 persons
<table>
<thead>
<tr>
<th></th>
<th>All Races</th>
<th>White</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Female Breast (123.9)</td>
<td>Female Breast (124.8)</td>
<td>Prostate (154.1)</td>
<td>Female Breast (90.0)</td>
<td>Female Breast (73.7)</td>
<td>Female Breast (91.8)</td>
</tr>
<tr>
<td>2</td>
<td>Prostate (95.5)</td>
<td>Prostate (86.9)</td>
<td>Female Breast (122.4)</td>
<td>Prostate (45.5)</td>
<td>Prostate (49.5)</td>
<td>Prostate (79.9)</td>
</tr>
<tr>
<td>3</td>
<td>Lung /Bronchus (58.3)</td>
<td>Lung / Bronchus (59.1)</td>
<td>Lung / Bronchus (59.9)</td>
<td>Lung / Bronchus (32.8)</td>
<td>Lung / Bronchus (42.2)</td>
<td>Colon/Rectum (33.7)</td>
</tr>
<tr>
<td>4</td>
<td>Colon/Rectum (38.4)</td>
<td>Colon/Rectum (37.5)</td>
<td>Colon/Rectum (44.1)</td>
<td>Colon/Rectum (29.6)</td>
<td>Colon/Rectum (29.5)</td>
<td>Lung/Bronchus (29.7)</td>
</tr>
<tr>
<td>6</td>
<td>Melanomas Skin 21.4</td>
<td>Melanomas Skin 24.1</td>
<td>Kidney/ Renal Pelvis (17.8)</td>
<td>Thyroid (14.9)</td>
<td>Kidney/ Renal Pelvis (14.7)</td>
<td>Non-Hodgkin Lymphoma (16.8)</td>
</tr>
<tr>
<td>7</td>
<td>Urinary Bladder 19.8</td>
<td>Urinary Bladder 21.1</td>
<td>Pancreas (15.6)</td>
<td>Non-Hodgkin Lymphoma (12.8)</td>
<td>Liver/ Bile Duct (11.1)</td>
<td>Kidney/ Renal Pelvis (15.9)</td>
</tr>
<tr>
<td>8</td>
<td>Non-Hodgkin Lymphoma (18.5)</td>
<td>Non-Hodgkin Lymphoma (19.0)</td>
<td>Non-Hodgkin Lymphoma (13.9)</td>
<td>Liver/ Bile Duct (12.4)</td>
<td>Non-Hodgkin Lymphoma (9.9)</td>
<td>Liver Bile Duct (13.4)</td>
</tr>
<tr>
<td>9</td>
<td>Kidney/ Renal Pelvis (16.2)</td>
<td>Kidney and Renal Pelvis (16.4)</td>
<td>Myeloma Skin (12.3)</td>
<td>Stomach (10.1)</td>
<td>Urinary Bladder (8.4)</td>
<td>Thyroid (13.4)</td>
</tr>
<tr>
<td>10</td>
<td>Thyroid (14.5)</td>
<td>Thyroid (15.0)</td>
<td>Urinary Bladder (11.4)</td>
<td>Ovary (9.0)</td>
<td>Pancreas (8.3)</td>
<td>Pancreas (10.8)</td>
</tr>
</tbody>
</table>

Cancer Incidence Rates
Rates of Cancer Based on Site
within Race-and Ethnic-Specific Categories (US 2014)
Top 10 Cancers
LA vs US 2014
Per 100,00 persons

All Cancers are Local
LGBT HealthLink:
http://www.lgbthealthlink.org/
Est. New Cancer Cases 2018

\begin{itemize}
\item Prostate: Males - 164,690, Females - 266,120
\item Lung & bronchus: Males - 121,680, Females - 112,350
\item Colon & rectum: Males - 75,610, Females - 64,640
\item Urinary bladder: Males - 62,380, Females - 63,230
\item Melanoma of the skin: Males - 55,150, Females - 40,900
\item Kidney & renal pelvis: Males - 42,680, Females - 36,120
\item Non-Hodgkin lymphoma: Males - 41,730, Females - 32,950
\item Oral cavity & pharynx: Males - 37,160, Females - 26,240
\item Leukemia: Males - 35,030, Females - 25,270
\item Liver & intrahepatic bile duct: Males - 30,610, Females - 22,660
\item All sites: Males - 856,370, Females - 878,980
\end{itemize}
Est Cancer Associated Deaths, 2018

Males
- Lung & bronchus: 26%
- Prostate: 9%
- Colon & rectum: 8%
- Pancreas: 7%
- Liver & intrahepatic bile duct: 6%
- Leukemia: 4%
- Esophagus: 4%
- Urinary bladder: 4%
- Non-Hodgkin lymphoma: 4%
- Kidney & renal pelvis: 3%
- All Sites: 100%

Females
- Lung & bronchus: 25%
- Breast: 14%
- Colon & rectum: 8%
- Pancreas: 7%
- Ovary: 5%
- Uterine corpus: 4%
- Leukemia: 4%
- Liver & intrahepatic bile duct: 3%
- Non-Hodgkin lymphoma: 3%
- Brain & other nervous: 3%
- All Sites: 100%

323630 males, 286101 females
Risk Factors for Cancer

• Cancer pathology is NOT completely explained by exposure to “carcinogens” or “inherited susceptibility”

• “Risk factors” effect cancer development/survivorship but may not be carcinogen (mutable or immutable)

• Reducing risk factors is associated with avoiding certain behaviors and increase screening
  – Decisions regarding lifestyle and health care choices
  – Additional screening/ genetic testing and/or counseling

• Absolute Risk (as part of a group, 2% of group/ 1 in 8) vs Relative risk ( compared to another group, 5 x the risk, 200% increase in risk)
Risk Factors for Cancer

Different Risk for Different Malignance/Leukemia

• General risk factors for cancer include:
  – Older age
  – Prior Cancer/genetic predisposition
  – ANY Tobacco use
  – “Excessive” alcohol use
  – Pathogens (viral HPV HCV
  – Carcinogens: chemicals, radiation (UV)
  – Chronic Inflammation/Immunosuppression
  – Diet: High in fat, sugar or processed food diets
  – Chronic persistent hormone imbalance
Cause of Lung Cancer

- Tobacco use accounts for 90% of lung cancers
  - Tobacco smoker: 25 X higher risk of lung cancer
  - 2nd Hand Smoke Exposure: 5 x higher risk of lung cancer
  - Smoke > 40 cigs/day : 1 in 7 will die of lung cancer

Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, 2018
Other Contributors to Lung Cancer

• Asbestos: “Asbestos workers”
  – Exposed: 5x greater risk of developing lung cancer
  – Exposed & tobacco use: 50-90x greater risk than non-smoking peers
• Radon gas exposure: 12% of lung cancer deaths
  – Concurrent tobacco use increases risk of lung cancer
• Air pollution and genetics are each associated with ~1-2% of lung cancers
Negative Effects of Tobacco

• Tobacco is the leading cause of premature, preventable death in the US and most parts of the world
  – 25% of all smokers will die before age 50
  – US: average age of death smoker 64 average age of death non smoker: 72

• Mortality rates smokers 3 x higher
  – 36%: cancer, 39%: CVD 24%: chronic lung dx

• Tobacco use is the leading cause of death in Person Living with HIV (PLWH) (if diagnosed CD4 > 350)
Negative Effects of Tobacco

• Regardless of exposure type tobacco has a systemic effects with increase risk/severity of heart disease, stroke, aortic aneurysm, arthritis COPD, erectile dysfunction, ectopic pregnancy, low weight infants/congenital defects, TB, pneumonia, diabetes, osteoporosis, macular degeneration, cataracts, asthma severity, chronic inflammation impaired immune function.

• Documented negative effects on fetal/adolescent brain development resulting in adverse neurological consequences.
The longer one smokes, the greater risk of harm including earlier death.

Health Consequences of Tobacco Use
Negative Effects of Tobacco

• Developments in Tobacco processing has increased its pathological potential (how it is inhaled/processed)
  – Ventilated filters to “decrease tar” increased levels of inhaled tobacco-specific nitrosamines
  – Despite decrease in overall use: rates of lung cancer or COPD in smokers has increased compared to non smokers
  – Severity of lung cancer has increased with a decline in squamous cell but increase in adenocarcinomas.
## Premature Deaths Caused by Tobacco/Exposure to 2nd Hand Tobacco Smoke 1965–2014

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking-related cancers</td>
<td>6,587,000</td>
</tr>
<tr>
<td>Cardiovascular/metabolic diseases</td>
<td>7,787,000</td>
</tr>
<tr>
<td>Pulmonary diseases</td>
<td>3,804,000</td>
</tr>
<tr>
<td>Conditions related to pregnancy and birth</td>
<td>108,000</td>
</tr>
<tr>
<td>Residential fires</td>
<td>86,000</td>
</tr>
<tr>
<td>Lung cancers due to 2nd hand smoke</td>
<td>263,000</td>
</tr>
<tr>
<td>Coronary heart disease by 2nd hand smoke</td>
<td>2,194,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20,830,000</strong></td>
</tr>
</tbody>
</table>
Tobacco and Cancer

• Tobacco: leading cause of cancer/cancer death
  – Despite method of ingesting: smoking, oral, 2nd hand

• Tobacco accounts for 90 % of all lung/80% of all other cancers
  – The chemicals in tobacco used to process the leaves are carcinogens that damage DNA
  – Processing of tobacco is largest contributor of carcinogenic effect: Nitrosamines/polycyclic aromatic hydrocarbons

• Each year of cessation decreases risk of cancer
  – 15 years post cessation results in same risk as non smoker
Tobacco and Cancer

• Cancers caused by tobacco
  – Via smoking: lung, larynx (voice box), mouth, esophagus, throat, bladder, kidney, liver, stomach, pancreas, colon and rectum, and cervix, as well as acute myeloid leukemia.
  – Via general ingestion (smokeless/ chewing tobacco) all the above plus higher risk of mouth, esophagus, and pancreas cancers.

• There is no safe level of tobacco use

• After a diagnosis of cancer, if tobacco is stopped there is a significant reduction in risk of death
Risk of Cancer in LGBT Community

• LGBT health disparities occur due to a various social/economic factors/behaviors
  – Most associated stress of living as a minority
• These disparities result in higher risk of some cancers
• Disparity in LGBT Cancer Survivorship is also significantly different in areas of sexuality, social relationships, and medical care
Increase Risk of Cancer in LGBTQ Community

- “Minority Stress Theory” Increased stress in LGBTQ individual due to systemic discrimination and marginalization may result in unhealthy coping behaviors that increase risk of developing cancer
  - increase tobacco and alcohol use
  - Increase risk to second hand smoke
- Low rates of health insurance in LGBTQ due lower rates of “marriage”
- Fear of discrimination by HCS results in lack of disclose decreasing over all quality of relationship with provider
- Fear negative experience decrease HC use limiting “routine” care: less screening/ later diagnosis

Increase Risk of Cancer in LGBT Community

• Higher rates of cancer in Gay and Bisexual women
  – Associated with decrease rates of giving birth
    • bisexual women were 2x twice as likely to have never given birth increasing risk for ovarian and endometrial cancers
    • bisexual women were 2x more likely to have a teenage pregnancy which also has health implications
  – Decrease rate of screening mammogram or pap test

• Gay men were 1.9 x more likely to report a lifetime history of cancer diagnosis than heterosexual men.

Rate of Tobacco use in LGBTQ Community

- Adults identifying as LGB: 23.9%
- Adults identifying as Straight: 16.6%
Massachusetts: 38.8% Straight, 30.9% LGBT, 20.6% Bisexual, 22.0% Lesbian/Gay

New Mexico: 39.1% Straight, 27.2% LGBT, 22.0% Bisexual, 22.0% Lesbian/Gay

Washington: 38.7% Straight, 29.5% LGBT, 19.2% Bisexual, 16.6% Lesbian/Gay

Screening for Smoking Associated Cancer

• Standard Cancer screening
• Yearly low-dose CT scan
  – Greatest screening benefit in current or former smokers/ages 55-74, and >30 pack-year smoking history.
  – Assure understanding of benefits, limitations, and risks of screening
The 5 A's to Treat Tobacco Use / Dependence
Via Intermediate (<10 minutes) of Intensive (> 10 minutes) counseling sessions

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask about tobacco use</td>
<td>Identify and document tobacco use status of EVERY patient at EVERY visit.</td>
</tr>
<tr>
<td>Advise to quit</td>
<td>In a clear, strong and personalized manner urge every tobacco user to quit.</td>
</tr>
<tr>
<td>Assess Willingness</td>
<td>Patients willingness to make a quit attempt/ challenges to or remaining abstinent.</td>
</tr>
<tr>
<td>Assist</td>
<td>If willing to quit offer intervention</td>
</tr>
<tr>
<td></td>
<td>• Medication AND counseling/ behavioral intervention</td>
</tr>
<tr>
<td></td>
<td>For unwilling to quit at this time,</td>
</tr>
<tr>
<td></td>
<td>• Provide motivational interventions designed to increase future quit attempts.</td>
</tr>
<tr>
<td></td>
<td>For recent quitter: provide relapse prevention</td>
</tr>
<tr>
<td>Arrange</td>
<td>For Follow up, support services, consoling access.</td>
</tr>
</tbody>
</table>
### The 3 A's to Treat Tobacco Use / Dependence

<table>
<thead>
<tr>
<th>Step</th>
<th>Action 3 minutes of Brief intervention</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask.</strong></td>
<td>While collecting VS or other basic intake data clinic staff can <strong>ASK</strong> the patient about tobacco use, document any tobacco use in chart or EMR at <strong>EVERY VISIT</strong></td>
<td>1 minute HPC</td>
</tr>
<tr>
<td><strong>Advise</strong></td>
<td>BRIEFLY but CLEARLY <strong>ADVISE</strong> the patient to quit Deliver in a non judgmental tone and personalize the reason for the individual patient base on health concerns or life circumstances</td>
<td>1 minute TCP</td>
</tr>
<tr>
<td><strong>Assist</strong></td>
<td>Refer to QUITLINE or other community counseling support line/ resources. Assess appropriateness of pharmaceuticals and assist in accessing ( RX and instructions)</td>
<td>1 minute with referral sheet HCP May be longer with RX TPC</td>
</tr>
</tbody>
</table>
Increase Efficacy of Smoking Cessation with Pharmaceutical Interventions

<table>
<thead>
<tr>
<th>Intervention versus comparison</th>
<th>% increase abstinence (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single NRT vs placebo</td>
<td>6 (6–7)\textsubscript{d}</td>
</tr>
<tr>
<td>Dual form/combination NRT vs placebo</td>
<td>11\textsubscript{e}</td>
</tr>
<tr>
<td>Cytisine vs placebo</td>
<td>6 (4–9)\textsubscript{f}</td>
</tr>
<tr>
<td>Bupropion vs placebo</td>
<td>7 (6–9)\textsubscript{f}</td>
</tr>
<tr>
<td>Nortriptyline vs placebo</td>
<td>10 (6–15)\textsubscript{f}</td>
</tr>
<tr>
<td>Varenicline vs placebo</td>
<td>15 (13–17)\textsubscript{f}</td>
</tr>
</tbody>
</table>
Tobacco Cessation Programs for LGBTQ Community

• Assure LBGTQ “friendly” facilitator who is also appropriately trained to lead support group
• Provide services via a welcoming/accessible venue that is well known/respected in the LGBTQ community.
• Assure comprehensive program addressing multiple issues of the LBGTQ community
Tobacco Cessation Programs for LGBTQ Community

• Use education materials that are designed for LBGTQ community
• Assure the safety and confidentiality for LGBT participants in cessation services.
• LGBT HealthLink

http://www.lgbthealthlink.org/
Providers have Highest impact On Success of Tobacco Cessation

- Smokefree.gov: Create My Quit Plan
- Consider using a smartphone apps / text message programs
- NCI Smoking Quitline 877–44U–QUIT (7848)
- Where To Get Help When You Decide To Quit Smoking:
  - LGBT HealthLink: http://www.lgbthealthlink.org/
Means to Decrease Cancer Risk in LBGTQ Community

• Stop Tobacco use and avoid secondhand smoke. Providers should assure
  – Brief Intervention with the 3 A’s
  – Offer/ prescribe nicotine cessation pharmaceutics
  – refer for support
  – continue to closely monitor.
• Address weight: Provide resources/training to obtain/ keep healthy weight.
• Address alcohol “over” use
• Resource - LGBT HealthLink: http://www.lgbthealthlink.org/
Means to Decrease Cancer Risk in LBGTQ Community

• Address physically active: Provide resources/training to assure/increase physical activity
  – to improve heart condition decreases inflammation, decrease stress.
  – Avoid sedentary behaviors: excessive sitting, lying down, screen-based entertainment.

• Assure appropriate screenings
  – benefits/limitations of cancer screenings and access to appropriate testing/screening per individual risk factors
  – Promote early detection: smaller, asymptomatic and limited spread improve outcomes

http://www.lgbthealthlink.org
LGBT HealthLink: http://www.lgbthealthlink.org/.
Cancer Survivor: 
Tony’s Experiences

Tony Burns, Peer Mentor and Advocate

LGBTQ Community Cancer Research Advisory Board Member,
George Washington University Cancer Center
Cancer Survivor: 
Michael’s Experiences

Michael Louis Robinson, MSW, LCSW
The BACH GROUP & BACH Therapeutic Counseling Services
This interactive tool and additional cancer resources are available from our MyLGBTHealthLink.org member site. Join today – it’s free!
JOIN THE MOVEMENT TO ACHIEVE LGBT HEALTH EQUITY!

www.mylgbthealthlink.org

HealthLink members have access to:

- Weekly LGBT Health News Roundup
- Scholarships to help support and promote leadership in LGBT health
- Members-only online networking groups
- Exclusive webinars and resources available for download
- Co-branding opportunities
Special Considerations - Cancer Concerns For and Of Sexual Gender Minority
May 15, 2018 | 2pm ET

Moderator: Earl Nupsius Benjamin, DrHSc, Community Advisory Council Member

Presenters:
Dr. Keisa Fallin-Bennett, M.D., University of Kentucky
Dr. Christine Brennan, Ph.D., FNP Louisiana State University
Tony Burns, Cancer Survivor
Michael L. Robinson, MSW, LCSW
Tuesday, May 15, 2018
12pm ET: SOGI Data: Promotion and Data Inclusion at State and Local Government Agencies
2pm ET: Special Considerations - Cancer Concerns for and of Sexual Gender Minority
4pm ET: Social Service Navigation: Leveraging Your Referral Network into a Well-funded Case Management and Navigation Program

Wednesday, May 16, 2018
12pm ET: Cervical Cancer Screening for Sexual and Gender Minority
2pm ET: Funding Your Programs through Practice-based Research Partnerships
4pm ET: Best and Promising Practices for LGBTQ Inclusion and Cultural Competence at State and Local Health Departments

Thursday, May 17, 2018
12pm ET: Effective Programs for Reaching and Engaging Underserved and Hard to Reach Populations
2pm ET: Birth of the LGBT Tobacco Control Movement: A Movement to Save Health and Lives
4pm ET: Beyond the Quitline