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Exploring Barriers to Primary Care in the LGBT Community

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Dr. Julianne Ossege, Advisor

Final DNP Project Report

Exploring Barriers to Primary Care in the LGBT Community

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College of Nursing

Fall 2017

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Table of Contents

List of Tables

Introduction to Exploring Barrier's to Primary Care in the LGBT Community

Desiree Price

University of Kentucky

Exploring Barriers to Primary Care in the LGBT Community

Introduction

In the United States, adverse health outcomes effect the Lesbian, Gay, Bisexual and Transgender (LGBT) community at exponential rates compared to their straight counterparts (Institute of Medicine [IOM], 2011; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Research provided by The Williams Institute shows that of the U.S. population, 9 million persons, approximately 3.5% of adults, self-identify as LGB and 0.3%, approximately 700,000, identify as transgender (Gates, 2011).

In contrast to those who self-identify as LGBT, a national survey of 18 to 44-year old's, reports 8.8% have had experiences of same sex behavior and 11% have same sex attraction (Chandra, 2011), although they do not self-identify as LGBT. In addition, the 2010 United States Census identified more than 600,000 households throughout the country headed by same-sex couples (Abigail, 2011). As this lifestyle is becoming more socially acceptable, healthcare accessibility is fundamental to minimizing health disparities in the LGBT population. A component of accessible healthcare includes the prospect of disclosing ones' sexual orientation (SO) and/or gender identity (GI) to health care providers in order to open up a dialog of trust and acceptance so disclosure will not be a barrier to receiving recommended health screenings and preventative care. Although public acceptance is evolving, the reality of the LGBT community is that they continue to suffer discrimination, violence, and stigma which jeopardizes access to needed health services ((Mayer et al., 2008; Meyer, 2003; Coker et al., 2010; IOM, 2011; Obedin-Maliver et al., 2011; Smith & Matthews, 2007; Strong & Folse, 2015).

Heteronormative assumptions and discrimination, perceived or actual, among sexual minorities in healthcare settings are primary factors which promote negative communication

patterns, impedance of health seeking behaviors and/or disclosure of SO/GI among the LGBT population. Other factors contributing to disparities in this population stem from structural and legal factors, and a lack of culturally competent health care (IOM, 2011).

When there is structural realignment to an environment of competence, acceptance, equality and inclusion, there can be an improvement in the disparities among this community. Healthy People 2020 (2016) proposes LGBT health as a significant aim, with frontline healthcare professionals being expected to deliver safe and culturally competent care to this population (Sirota, 2013; Lim, Johnson, & Eliason, 2015).

Exploring Barrier's to Primary Care in the LGBT Community

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University of Kentucky

Background

An increase in access is a major priority and responsibility of all health care practitioners ("Healthy People 2020," 2014). Gaps in the knowledge and attitude of health care providers towards LGBT persons affect access and quality of patient care. Implementation of culturally competent training can enhance clinical competency in LGBT health care providers, so a responsive environment can be developed and health disparities can be reduced among this population. A reduction of social and structural inequities of stigma and prejudice among health care providers can help reduce medical risks of this diverse and special population (Centers for Disease Control and Prevention [CDC], 2014).

Health-related disparities exist in the LGBT population, and result in significant numbers of risk factors associated with poor health outcomes. These contributing risk factors include discrimination and harassment, victimization, depression, anxiety and psychological disorders and family rejection (Ard, 2016). Studies show that alcohol abuse is higher in lesbian women, while illicit drug use and cardiovascular issues are prevalent in bisexual men (Healthy People 2020). The LGBT population has also been known to have greater psychological distress and mental health disorders (Law, Mathai, Veinot, Mylopoulos & Webster, 2015). Although there are limited data on adult LGBT suicide attempts and completed suicides, it is known that for gay and bisexual men, the rate of suicide attempt is four times higher than the general population, and transgender persons are at an even greater risk, being 40% more likely to attempt suicide than the heterosexual population (King, Semlyen, Tai, et al., 2008; Maza & Krehely, 2010). Primary care providers can be beneficial in identifying mental health issues and helping to assuage the detrimental outcomes associated with these risks. However, if the provider is not

culturally competent in providing care, or the patients are not seeking this help, providers cannot administer the appropriate interventions to deter these outcomes.

Nurses' knowledge of LGBT health is limited, with studies showing 82% lack the proper knowledge to provide culturally competent care (Rondahl, 2009). According to Obedin-Maliver, et al. (2011), in an article referenced in the *Journal of American Medical Association* (JAMA), physicians receive approximately five hours of formal training during their education and continue to remain unaware of preventative health needs of the LGBT community. Research has found that lack of education leads to providers being uncomfortable addressing sexual orientation and the practices of the LGBT population (Kates & Ranji, 2014; Smith, 2007).

Sexual orientation and gender identifying data can be instrumental in reducing health disparities, disease transmission, and health care costs, while increasing longevity in the LGBT population. These data help to promote appropriate screening for sexually transmitted disease, cancer screens, mammography, colonoscopy, pap smears and prostate screens. One study suggest nondisclosure rates to healthcare providers, were significantly higher among bisexual men (39.3%) and bisexual women (32.6%) compared with gay men (10%) and lesbians (12.9%; Durso, & Meyer, 2013).

Consequences of elevated risk behaviors such as hormone therapy in transgender persons or risky sexual behaviors, coupled with a lack of primary care, contributes to an increase in cardiac disease, organ damage, anal cancer, HIV and sexually transmitted infections, suicide, and tobacco and substance use disorders (IOM, 2011). Due to decreased rates of access and completion of preventative breast, prostate and cervical cancer screens, LGBT patients are at greater risks of long term health problems (Floyd, Geraci and Pierce, 2016).

According to Nguyen & Yehia, 2015, "Patient disclosure of sexual orientation to their providers has the potential to improve health outcomes and to ensure that opportunities for risk-appropriate preventive care are not missed (p.1)." When there is a lack of primary care and preventative screening, there may be subsequent late stage diagnoses. In order to improve health disparities that plague this unique community, this practice inquiry project will identify, from the patients' perspective, the factors contributing to underutilization of primary care services and investigate why there is a lack of SO/GI disclosure.

Study Purpose

This project initiative is based on the need to improve health care seeking behaviors in the LGBT community by providing a responsive and quality primary care environment and mainstreaming this population as health citizens (Davey, 2012). Addressing the prejudices and stigmas associated with providers and clients that hinder health seeking behaviors, can lead to activities to promote a responsive primary care environment. When determinants to responsive care are identified and implemented, there can be increased trust, which in turn increases disclosure of sexual and health status. When identifiable data are obtained and documented appropriately, this pertinent information can be instrumental in improving patient health outcomes, decreasing disparities and reducing healthcare costs associated with gaps in understanding this patient population's healthcare needs (IOM, 2011).

The objective of this study was:

To identify the LGBT patient's perspective of what factors could contribute to a more responsive primary care environment.

Study Design and Setting

The study was a non-experimental, descriptive study utilizing an anonymous, internet based electronic survey. A survey/questionnaire tool, developed for the study, contained multiple choice and short answer questions. Additional space was provided for comments as well. The survey was open to participants for 4 weeks.

Study Sample

The study sample was comprised of members of the greater Louisville LGBT community who participated in the online communities of the University of Louisville (U of L) LGBT Center listserv and the Fairness Campaigns Facebook page. The U of L LGBT Center listserv consist of approximately 2900 participants and the Fairness Campaign's Facebook page consists of approximately 3000 participants. Between the two groups, 81 participants in total responded to the survey. The sample was inclusive of adults, aged 18 and older, who were lesbian, gay, bisexual, cisgender, transgender and gender neutral, and were able to read in English. There was no racial exclusion. Exclusion criteria was non-English speaking, heterosexuals, who were less than 18 years of age.

Study Procedure

Permission was obtained to conduct this study from the University of Kentucky's Institutional Review Board (IRB) and the Norton Healthcare Office of Research Administration (NHORA). The sample was a convenience sample of those from the University of Louisville Lesbian, Gay, Bisexual, Transgender (LGBT) Center's listserv and the Fairness Campaign's Facebook page, who volunteered to participate in the anonymous online survey. The PI, via a

volunteer member, disseminated an electronic cover letter/informed consent to the U of L LGBT Center listserv, and to the Fairness Campaigns Facebook page.

Participants voluntarily consented to participate in the survey by proceeding to the survey link contained at the end of the informed consent. There was no request for a signed informed consent in order to protect the identity of the participants. Data was collected through Qualtrics Surveys and was anonymous. Survey responses were automatically uploaded into Qualtrics. No names or identifying information was included in the data collected by the PI. There was no interaction between the participants and the PI. Demographic information was obtained, but no individual identifiers were associated with the data collected.

Data Analysis

Descriptive statistics were used to summarize study variables using the Statistical Package for the Social Sciences (SPSS) software.

Results

A total of 81 participants responded to the online survey, ranging in age from 18 years old and above. The majority of those who responded were in the age range of 25-39 years old. The majority of the participants were Caucasian (95%) and identified as female gender (63%). Given that the survey was partially disseminated to a university based listserv, it is not surprising that twenty-nine percent were college graduates and 50% of the respondents were highly educated, completing graduate level studies. The surveyed respondents were well insured, with 57% having employer provided insurance, 11.8% privately insured and just under 10 percent (9.2%) were covered by parents plans. Six percent were covered by Medicaid and those who were on Medicare and uninsured were equal at 2.6 %. Table 1.

Seventy six percent of those who responded see a regular primary care provider (PCP), as opposed to 17% who did not. LGBT patients acknowledged voluntarily disclosing their SO/GI 37.5% of the time, but were only asked about their identity 17.2% of the time. Eighty-one percent stated they were never asked about their SO/GI by their provider. When the respondents were asked to identify factors that affect disclosure, the number one response (15%) was displaying non-judgmental and non-heterosexist attitudes toward LGBT patients. This was followed by feelings of confidentiality (14.5%), feelings of safety in the healthcare setting (14%), knowledge of staff (12.4%) and non-biased, inclusive language (10.2%). See table 2.

This study data is inconsistent with discrimination found in a 2009 study by *Lambda Legal*, as more than two-thirds (70%) of the participants in this study deny experiencing such behavior. When asked what the most important quality in a primary care provider is, a great portion of the narrative response inferred a need for providers to show more empathy, compassion and inclusiveness to improve the patient-provider experience. See table 3.

Heart disease risks are increased in the lesbian population due to physical inactivity and obesity. Less than twenty percent of participants were compliant with blood pressure (18%) and cholesterol screens (12.5%). Although 38.7% of the survey respondents were over 40 years old, the recommended age to begin mammograms, less than 10 percent (6.6%) of those who responded receive regular mammography screening for breast cancer. Less than one-fifth (15.8%) of lesbian participants received recommended mammograms and 47% received cervical cancer screens. This study revealed results consistent with studies showing that lesbians abstain from receiving recommended female screening such as mammograms and Pap smears at a greater rate compared to heterosexual women, who have a 65% and 69% compliance rate,

respectively, which places lesbians at increased risks for delayed diagnosis and treatment of illness (CDC, 2016).

According to the CDC (2016), gay men and MSM are at increased risk for different types of cancer, including HPV related cancers. Study results found that less than 1% of the participants in this study who were eligible for prostate screening had completed this. Likewise, only 7 percent of the participants in this study reported they been screened for Hepatitis C. The percentage of participants in this study who received the recommended screens for Hepatitis A, Hepatitis B, gonorrhea and chlamydia (12%, 17%, 7% and 7%) respectively. Among the LGBT community, transgender women are at increased risk for diagnosis of HIV, with 15% being diagnosed between 2009 and 2014. (Herbst, 2008; CDC, 2016). In 2015 the CDC determined 55% of new HIV diagnosis was made among gay and bisexual men. This study revealed that 6.4% of respondents self-identified as transgender and 16% identified as gay or bisexual collectively, but only 13.2% of total respondents reported receiving recommended HIV screening. See table 3. Among males, 53% were tested, while 31% of females were tested. A look at the Fisher's exact p-value showed no significant association between gender identity and HIV testing (p=.32). For transman, transwomen, gender queer and intersex, none were screened. See figure 1.

Transgender individuals suffer a higher prevalence of victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or LGB individuals (Healthy People 2020). This survey revealed that one-third or 34% of participants admitted to depression and anxiety, which does not compare to the national rate of depression (62%). One fifth (20%) of those who responded had suicidal ideation, while 5.7% have had a suicide attempt.

Multiple studies indicate physical assault or abuse among the transgender population as great as 60%. More than half (56%) of lesbians and gay persons have reported experiencing domestic violence and bisexual adults suffered at a rate of 47%. This is a difference of 29% and 38% compared to heterosexual adults (SAMHSA, 2012). In this study, much lower rates of domestic violence, physical abuse and bullying were reported (10%, 11.4%, and 18%) respectively. Of those who were surveyed, more than half (62%) use alcohol regularly, 15.6% use illegal substances, and 17.8% use tobacco products. See table 4.

Limitations.

Limitations to this study include that it was a cross sectional study that was self-reported by the participants, and may not be generalized to LGBT population at large. One respondent stated that there were technical difficulties accessing several questions when the survey was initially posted, which may have affected obtaining complete data. Another limitation was length of time the survey was posted. It was initially to be posted for a full four weeks (30 days), but there was a delay of six days by the groups who were posting the survey on behalf of the author.

Discussion

Stigma and Discrimination

LGBT patients have been reluctant to disclose their sexual orientation or gender identification to providers as a result of deleterious experiences, perceived prejudice, stigma and suboptimal care. When the LGBT population is not disclosing SO/GI and providers are not inquiring, the treatment is not administered according to guidelines. It is a fundamental right for all individuals to access basic preventative care, and be treated for illness or injury in an

environment of inclusion and safety (Daulaire, 2014). Health disparities suffered by this community can be reduced if this patient population feels they are receiving safe, patient centric care from a provider who is LGBT knowledgeable, inclusive and affirming.

According to Lambda Legal's 2009 survey, *When Healthcare isn't Caring: Survey of Discrimination Against LGBT People and People with HIV*, fifty-six percent of LGB persons who responded to their survey, recalled experiencing perceived or actual refusal of care; limited touch, excessive use of personal protective equipment (PPE), being the victim of physical abuse or rough handling, abusive language; and/or being blamed for negative health outcomes related to lifestyle and their health status. Seventy percent of the transgender population and 63% of those afflicted with HIV, report experiencing one or more of these forms of discriminatory behavior.

Health Screenings and Recommendations

Each subgroup of the LGBT community has their own distinct health issues. In an effort to foster a more responsive environment for the LGBT patient, it is crucial to understand the multitude of health problems that affect this diverse population. To provide care for this population and decrease the noted disparities, it is important for providers to administer culturally competent care to every patient, no matter their age, race, health status, sexual orientation, gender or socio-economic status. Respectful and sensitive care involves encompassing the LGBT patients' self-identity and how they prefer to be addressed (AAMC, 2016). Culturally competent care is defined as acknowledging the importance of social and cultural influences on patients' health beliefs and behaviors, disease prevalence and incidence, inherent challenges that intertwine and contribute to that culture, and constructing interventions

that ensure implementation of equitable and quality health care to this diverse population (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003).

Lesbian and bisexual women pose an increased risk for developing heart disease, breast and ovarian cancer (American Cancer Society, 2017). The increased use of alcohol and tobacco, pose a health threat to all three previously mentioned illnesses and yet, drinking/alcohol abuse among the lesbian and bisexual subgroups is about 22.6% (VanKim & Padilla, 2010), and they have significantly high tobacco use rates of all the LGBT subgroups, ranging from 30-39% (American Lung Association, 2010). Bisexual women are at increased risk of acquiring Human Papillomavirus (HPV), one of the most common sexually transmitted infection's (STIs), spread by vaginal or anal sex. According to the CDC (2016), 17,600 women are diagnosed with HPV annually. Once transmitted, this chronic infection, can be without symptomology and makes a pathway to lead to reproductive cancers.

The participants in this study were well educated, predominantly Caucasian, lesbian with male or female partners. They had lower than average rates of domestic violence, and rates of depression and suicide ideation/attempts were on par with the national statistics. Their reports of common and essential health screenings were very low. Clearly there is room for improvement in providing care to the LGBTQ population in this area.

Implications

Mandating provider education and cultural competency of diverse groups could reduce the stressors that LGBT patients face, however, recent studies indicate only 5 hours of LGBT focused education is given to medical students (Obedin-Maliver et al., 2011), while approximately 82% of nurses' lack formal education in competent care of LGBT patients

(Rondahl, 2009). The Association of American Medical Colleges (AAMC, 2014) have released recommendations for provider specific training to perform proficient care for LGBT patients.

There is limited data regarding the LGBT community due to discrepancies in electronic health record (EHR) documentation systems, provider apprehension with HIPAA (Health Insurance Portability and Accountability Act) laws, providers' comfort and competency levels, and ability to address SO/GI (CDC, 2016). Implementing open-ended questionnaires relative to SO/GI and marital status on intake forms may promote improved disclosure. The Healthcare Equality Index (HEI), the national LGBT benchmarking tool, evaluates healthcare facilities' policies and practices related to the equity and inclusion of their LGBT patients, visitors and employees, and has specific recommendations to promote inclusive care among this population. As of 2011, the Joint Commission, who certifies health care organizations for Medicare reimbursement, requires each to have an LGBT non-discrimination statement to continue accreditation. Ensuring that providers have a non-discriminatory policy for potential patients and patient visitors, which are inclusive of sexual orientation and gender identity are relatively simple transitions. This policy should be readily accessible and endorsed by the entire care team and staff. The information should be accessible via internet, intranet, and waiting areas and should be disseminated to employees at regular intervals.

Providers who are LGBT friendly can encourage positive relationships by advertising acceptance in their offices and by displaying literature and posters which sponsor same sex and transgendered persons. This act is comprehensive of providing affirmative and inclusive intake forms. Providers must not assume sexual identity, sexual partner identity or patient preference, and just simply ask these questions. In the instance that the transgender patient feels discomfort from unsolicited stares or perceived judgment in the waiting area, maybe having a separate

waiting area available, would allow that comfort level for the patient. Offering multidisciplinary referral to affirming specialists can also make for cohesive, patient centered care. These small steps could lead to word of mouth recommendations that this practice is one that can be trusted and is accepting, and are imperative to providing optimal care to LGBT patients.

The organization in which this study was done is making extensive inroads in becoming a preferred provider and competent caregiver for the LGBT community. In addition to the implementation of accepted pronouns in electronic documentation, which will allow for better discernment of patient identity, they are following the recommendations to educate and provide cultural competency training to enhance patient centered care.

The Human Rights Campaign (HRC) Foundation, in its endeavor to assist in provider education in LGBT patient centered care, has worked with several organizations to establish greater than 60 online training options for providers and staff to optimize knowledge with continuing education. In 2013, the Office of Minority Health of the U.S. Department of Health & Human Services, in conjunction with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) developed a tool fused to advance health equity and eliminate disparities and provide quality improvement amongst sexual minorities. With the use of these tools, we can work toward a healthy environment by thinking more patient centered and gaining a better understanding of the needs of this community.

Conclusion to Final DNP Project Report

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Conclusion

One principal goal of the U.S Department of Health and Human Services' Healthy People 2020 (2012a), is to abolish health disparities, promote health equity and improve health of all, including the LGBT population. Healthcare providers have the responsibility and means to recognize clinical differences among different groups, launch a pathway for open communication and provide care in a secure, trusting environment. In a national survey by the U.S. Census Bureau, LGBT persons between the ages of 18 and 64, had a higher prevalence of binge drinking alcohol than heterosexual adults (Ward, Dahlhamer, Galinsky, Joestl, 2014). According to a 2015 National Survey on Drug Use and Health, the LGB population was more than twice as likely (39%) to use illicit drugs than the general population (Medley, Lipari, Bose, Cribb, Kroutil, McHenry, 2016). When there is no forum for open communication, providers miss opportunities to screen for domestic violence, substance abuse/overuse and psychological disorders, deterring or missing opportunities to intervene where needed. Studies show that LGBT adults who have suffered from stigma and discrimination have increased stress levels compared to non-LGBT persons who have suffered discrimination (Anderson, 2016). To improve outcomes for this marginalized population, reducing barriers to obtaining competent care can be the difference in combating these disparities.

Unfavorable outcomes of this population include barriers facilitated by culturally incompetent care (Betancourt, Green, & Carillo, 2002). Competent care enhances provider-patient relationships and can ultimately improve rates of disclosure, which can positively impact the many disparities affecting this community. A vanguard leader in LGBT healthcare, the Fenway Institute, along with other policy making forums, endorse provider cognizance, comprehensive environments and customized care for the LGBT patient (Ard & Makadon,

2012). In addition to the aforementioned endeavors, there is a call for intense promotion of provider education and cultural competency training (IOM, 2011; GLMA, 2006; Healthy People 2020, 2016; Joint Commission, 2011). These may help to ameliorate this problem by enhancing provider introspect, reducing bias towards LGBT patients, and assist in identifying approaches to diminish the physical and mental discomfort LGBT persons may experience in healthcare settings. Culturally competent care of the LGBT patient should be an essential part of provider and support staff onboarding, as this population is becoming more prevalent.

Table 1. Demographic characteristics of survey respondents (N = 81)

	(%)
Age	
Under 18	2.5
18-24	11.3
25-39	47.5
40-59	27.5
+60	11.3
Education	
Some high school	1.3
High school graduate	5.3
Some college	14.5
College graduate	28.9
Graduate school	50.0
Ethnicity	
White	94.9
Black or African American	2.6
Other	2.6
Employment status	
Employed for wages	72.4
Self-employed	5.3
Unemployed	3.9
Homemaker	2.6
Student	9.2
Military	2.6
Retired	2.6
Insurance status	
Private	11.8
From employer	57.1
Covered by parents	9.2
Medicaid	6.6
Medicare	2.6
Uninsured	2.6

Table 2. Sexual identifiers

	(%)
Sexual orientation	
Gay	14.3
Lesbian	27.1
Bi-sexual	24.3
Straight	22.9
MSM	1.4
Asexual	1.4
Other	8.6
Gender identification	
Male	24.2
Female	62.9
Trans man	3.2
Trans woman	3.2
Gender queer	4.8
Intersex	1.6
Gender pronouns used	
He/Him/His	25.9
She/Her/Hers	50.6
They/Them/Theirs	3.7
Other	
Attracted to	
Men	35.6
Women	34.4
Queer people	13.3
Trans people	11.1
Other	5.6
Sexual partner's	
Males	42.7
Females	44.0
Trans	8.0
Other	5.3
Sexually Active	
Yes	65.6
No	34.4

Table 3.

	(%)
Do you have a primary care provider?	
Yes	76.3
No	17.1
Sometimes	5.3
Unsure	1.3
Have you ever felt discriminated against in a healthcare setting?	
Yes	29.7
No	70.3
Does your provider ask about sexual identity?	
Yes	17.2
No	81.3
Sometimes	1.6
Disclosure to provider	
Yes	37.5
No	15.6
Sometimes	4.7
Not been asked	42.2
Factors influencing disclosure	
Feelings of safety	14.0
Non-judgmental and non-heterosexist/genderists attitudes of staff	15.0
Non-judgmental and non-heterosexist/genderist attitudes of other patients	2.7
Advertising of a service in LGBTQ publications and communities	4.3
Use of non-biased, inclusive language	10.2
Feelings of confidentiality	14.5
Staff who are knowledgeable of LGBTQ	12.4
Availability of specialized treatment of counseling services	3.8
Anti-discrimination policies	9.1
LGBTQ positive materials in the waiting areas	4.8
Other	9.1
Have you received recommended vaccinations?	
Influenza	26.8
Tetanus	25.2
HPV	11.4
Shingles	7.3
Hepatitis A	12.2
Hepatitis B	17.1
Have you received recommended health screenings?	
Annual blood pressure check	18.4
HIV test	13.2
Gonorrhea	6.6
Chlamydia	7.2
Pap smear (Cervical cancer screen)	15.8
Cholesterol check	12.5

Hepatitis C blood test	7.2
Mammogram (Breast cancer screen)	6.6
Colonoscopy	7.2
Prostate cancer screen	0.7
Dexa scan (Osteoporosis screen)	4.6

Table 4. Psycho-Socio-Environmental factors

	(%)
Substance use	
Cigarettes	17.8
Alcohol	62.2
Illegal substances	15.6
Other controlled substances	4.4
Experienced the following	
Physical abuse	11.4
Domestic abuse	10.6
Bullying/harassment	17.9
Depression/anxiety	34.2
Suicidal ideation	20.3
Attempted suicide	5.7

Figure 1.

			Have you received the recommended health screenings or tests: (Choose all that apply HIV test		
			0	HIV test	Total
What is your gender identity? Please choose only one answer.	Male	Count	7	8	15
		% within What is your gender identity? Please choose only one answer.	46.7%	53.3%	100.0%
		% within Have you received the recommended health screenings or tests: (Choose all that apply HIV test	16.7%	40.0%	24.2%
	Female	Count	27	12	39
		% within What is your gender identity? Please choose only one answer.	69.2%	30.8%	100.0%
		% within Have you received the recommended health screenings or tests: (Choose all that apply HIV test	64.3%	60.0%	62.9%
	Trans man	Count	2	0	2
		% within What is your gender identity? Please choose only one answer.	100.0%	0.0%	100.0%
		% within Have you received the recommended health screenings or tests: (Choose all that apply HIV test	4.8%	0.0%	3.2%
	Trans woman	Count	2	0	2
		% within What is your gender identity? Please choose only one answer.	100.0%	0.0%	100.0%
		% within Have you received the recommended health screenings or tests: (Choose all that apply HIV test	4.8%	0.0%	3.2%
	Gender queer	Count	3	0	3
		% within What is your gender identity? Please choose only one answer.	100.0%	0.0%	100.0%
		% within Have you received the recommended health screenings or tests: (Choose all that apply HIV test	7.1%	0.0%	4.8%
	Intersex	Count	1	0	1

	% within What is your gender identity? Please choose only one answer.	100.0%	0.0%	100.0%
	% within Have you received the recommended health screenings or tests: (Choose all that apply HIV test	2.4%	0.0%	1.6%
Total	Count	42	20	62
	% within What is your gender identity? Please choose only one answer.	67.7%	32.3%	100.0%
	% within Have you received the recommended health screenings or tests: (Choose all that apply HIV test	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	6.898[a]	5	.228	.225		
Likelihood Ratio	9.099	5	.105	.156		
Fisher's Exact Test	5.490			.325		
Linear-by-Linear Association	5.736[b]	1	.017	.016	.005	.004
N of Valid Cases	62					

a. 9 cells (75.0%) have expected count less than 5. The minimum expected count is .32.
b. The standardized statistic is -2.395.

Appendix A.

What constitutes safe, comfortable care environment?

Empathy and Compassion; Understanding that we all come from various backgrounds and ways of life. We must respect one another before we can care for each other in a medical setting.
Having LGBTQ language on forms, trained staff on diversity and inclusion, LGBTQ pamphlets or language on website that says that they serve diverse populations including LGBTQ
Presentation of LGBTQ as an option and/or keeping questions open ended enough where those identities can be included.
Tolerance
Competency of staff and physicians
The comfort of the doctor and staff with issues related to LGBTQ
Symbols like the pride flag and reading material that lets patients know the providers in the office understand/have competency in LGBTQ care
Having references to the non-discrimination or EEOC policy to include sexual orientation and gender identity/expression
Display of safe zone or something similar in waiting area
Trust and respect
Inclusive attitudes and obvious displays of multiple types of families and patients
Inclusive forms, accepting staff
No judgmental attitude and willingness to learn
Language, documents, forms & information for patients that is non-discriminatory, and staff who are accepting of various lifestyles, rather than just assuming a default mainstream 'normal'.
Non-bias
having the setting/provider inquire/be sensitive to LGBTQ issues.
Someone knowledgeable and friendly who is non-judgmental
LGBTQ Health ads and magazines in waiting room, open dialogue about gender and sexual orientation, adequate and updated training for physicians on LGBTQ physical and mental health and anti-oppression training
Safe
Expressing that they are inclusive without having to be prompted
Ability of provider to perform job

	Kind knowledgeable staff
	Competency
	Open communication
	Non-judgmental staff, compassionate staff
	Non-judgmental, inclusive care
	Acceptance
	The welcoming attitudes of staff and providers
	Knowledgeable understanding staff
	Plenty of spaces that one can isolate themselves at if necessary.
	Open and friendly staff.
	Having a staff that is knowledgeable about differences in care and behavior for LGBTQ+
	Confidential, compassionate, gender neutral pronoun usage, staff trained in this area (maybe they lack knowledge on the LGBTQ community)
	Inclusive language, signage
	All patients treated with respect
	Acceptance
	Displayed information
	Be treated without judgement
	An LGBTQ-friendly staff

Appendix B.

What is the most important quality in a primary care provide?
Inclusiveness; a healthcare provider needs to be knowledgeable about the extreme diverse backgrounds of their patients. Failure to recognize this diversity creates a barrier between provider and patient and makes delivering patient-centered care impossible.
empathy and openness
Compassion
patient-driven care that does not force normative roles on patients
a good, experienced physician with an ability to make a personal connection with me
respect from provider and those who provide their support in the office
Non-judgmental
Trust and skill
medical expertise
Willingness to listen
Expertise
Openness to discussion
Knowledgeable & approachable
Listening
being up to date on the science.
Competency and Bedside manner
Being an empathetic and generally understanding person
Adequate and up to date scientific knowledge and the ability to be an active listener!
Available
Trans-friendly and trans-knowledgeable
Knowledge
Evidence based patient centered care
Knowledge
Non-judgmental
Compassion

Professional excellence
Compassion
A doctor who makes you feel comfortable to discuss very personal issues regarding health and wellness.
The ability to actually hear what the patient is saying
Patience
Cost
Clinical excellence.
Positive attitude towards LGBTQ+
Compassion
Knowledgeable
competence.
Knowledgeable
Listens
Availability
Thoroughness

Appendix C.

Comments or concerns that would help in providing improved care to the LGBTQ population...

Healthcare providers of all fields should be trained in developing appropriate approaches to treating individuals who identify as LGBTQ.

For me, when asking about if sexually active and I say yes, and then asking if I use birth control and I say no, comes with a response of shun until I say that I'm a lesbian. Not having to disclose this in such an uncomfortable way would be amazing.

Better training in Medical school and not bringing personal, religious beliefs into their practice

Physicians need to receive better training

Providers should advertise to everyone that they are inclusive

Doctors need education about LGBTQ people. I don't think most are hostile, but just ignorant.

Reduction in heteronormative questioning or assumptions would be wonderful

None at this time, I wish I did have input, but I can't think of anything, I just wish everyone had access to medical care where they could feel compassion and safe

Give doctors and their staff more training about these issues and maybe have them attend a LGBTQ+ panel to ask questions and get informed

Find out how many workers do not understand LGBTQ life style; perhaps more training needs to be offered so they can improve the care of those patients.

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