An S.O.S. from the LGBT: Identifying Healthcare Barriers Among the LGBT Community

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Abstract

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Methodology: The Access Barriers to Care Index (ACBI) was sent to participants via the Internet over the course of three weeks. The survey assessed the level of significance of various factors that may impact access to healthcare services.

Results: The most common barriers to healthcare included inconvenient scheduling times, long wait times, the inability to leave work or school, or not having the financial resources to pay for healthcare services. There were no statistically significant differences in the responses given by homosexual participants in comparison to heterosexual participants.

Conclusions: Logistic and financial causes were the most influential barriers in accessing healthcare. Additional qualitative data among the LGBT community would be recommended in order to obtain more in depth information regarding barriers to healthcare services.

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An. S.O.S. from the LGBT: Identifying Barriers to Healthcare Among the LGBT Community

By

Timothy J. Nervina, RN, BSN

Submitted in partial fulfillment of the requirements for the degree

Master’s in Advanced Practice Nursing

Supervised by

Wegmans School of Nursing

St. John Fisher College

April 2017
An S.O.S. from the LGBT: Identifying Barriers to Healthcare Among the LGBT Community

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St. John Fisher College Wegman’s School of Nursing
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Introduction

Healthcare access for the Lesbian, Gay, Bisexual, and Transgender (LGBT) communities often has been considered sub-optimal for a wide variety of reasons. However, recent changes in the U.S. healthcare system have taken strides to help improve care for this vulnerable community. The Affordable Care Act has worked to enhance healthcare access for the LGBT community by improving preventative and community services, prohibiting the discrimination of services based on gender identity, and allowing same-sex couples to enroll in the family insurance plans. The Healthy People 2020 campaign has also set an objective “to improve the health, safety and well-being of LGBT individuals.” This could not come at a better time as the
LGBT community is growing faster than ever before, and this presents additional healthcare challenges that must be addressed in order to eliminate disparities in healthcare.

According to the most recent census, approximately 9 million Americans identify as part of the LGBT community. While twice as many LGBT Americans report delaying medical care when compared to their heterosexual counterparts, LGBT individuals have reported an equal if not greater use of preventative care services such as annual flu shots and blood pressure screenings. This data suggests that members of the LGBT community are able to access medical services within their community, but are not able to establish rapport with a healthcare provider for long-term healthcare management. The evident gaps between the LGBT community and healthcare providers must be addressed, as research has shown that the LGBT community is at an increased risk for chronic diseases as well as mental health disorders, substance abuse, and lower socioeconomic status. While the gaps in healthcare have been identified, the causative factors contributing to the discrepancies in accessing healthcare remain unknown.

Members of the LGBT community are at an increased risk for various health issues, which further emphasizes the need to ensure the appropriate resources are readily available. Not only do these include medical conditions, such as HIV/AIDS, obesity, and Coronary Artery Disease (CAD), but these also include conditions that impact both mental health (such as depression and suicidal ideation) and socioeconomic health (such as substance abuse and intimate partner violence).

In addition to these healthcare disparities, research has also demonstrated how healthcare providers are in need of increased support and training when it comes to caring for members of the LGBT community. This training and support for healthcare providers is essential because it directly impacts not only the care received by patients, but providers need to feel comfortable in
caring for this population in order to allow patients to feel comfortable within the healthcare arena. Establishing rapport with healthcare staff is especially difficult for the LGBT community as past studies have indicated that patients are often perceptive of either the positive or negative behaviors demonstrated by their healthcare providers, and this directly impacts their decisions to utilize healthcare services. If these behaviors are interpreted as negative by patients this may influence the patients’ decisions to disclose their sexual orientation for fear of judgment or mistreatment by their provider. The purpose of this study aimed to identify the most common barriers experienced among the LGBT community in relation to accessing routine healthcare.

Methodology

Participants for this study were obtained through a combination of both snowball and targeted sampling. The survey was made available online and sent out to participants through an email link. The survey was also sent out through email to local LGBT groups, as well as through social media websites such as Facebook. Participants were also encouraged to forward the link to those that they felt were appropriate to complete the survey. A consent page was provided prior to taking the survey, and by taking the survey participants gave implied consent and agreed to the terms of the study that included a minimum age requirement of 18 years old.

The Access Barriers to Care Index was used in this study to assess current access to healthcare and perceptions of treatment through healthcare. This instrument has been tested with an internal reliability coefficient of 0.85. The scale uses a five-point Likert scale that asks participants to rate various barriers to healthcare from 1 (not at all difficult) to 5 (extremely difficult). Additionally, patients were asked to answer two questions in relation to their age and to identify their sexual orientation. Permission to use and modify the test was provided by the distributor, as the author was not available to contact. The survey was modified before beginning the study; this consisted of the re-phrasing or removal of non-applicable questions, as the
original survey was designed for women seeking prenatal care. The survey to be used for this study was submitted to a statistician for expert review following modification of the survey to ensure that the internal validity would be preserved; this however, was not tested prior to releasing the survey.

Over the course of three weeks, data was obtained anonymously to ensure the privacy of participants was maintained, and it was analyzed through Qualtrics following the data collection period. The open-ended questions were analyzed by the primary researcher for common themes and concepts.

Results

Upon completion of the data collection time period, a total of 123 individuals participated in the study. The most common age range of the sample group was between 22-25 years old (35.65%, n = 41), followed by 31-40 years old (20.87%, n = 24). In terms of sexual orientation, heterosexual females comprised the majority of the group (55.83%, n = 67), followed by homosexual men (25.0%, n = 30). Upon collapsing the variables, a total of 75 participants identified as heterosexual (62.5%), while 42 participants self-identified as homosexual, bisexual, or transgender (34.99%). Two participants (1.67%) self-identified as “other,” and one participant (0.83%) responded with “I do not wish to answer this question.” All categories were included in data analysis, with the exception of “I do not wish to answer this question.”

In order to obtain more accurate analyses of the data, sexual orientation variables were collapsed into either “heterosexual” or “homosexual” (the homosexual group also included those who identified as bisexual, transgender, or other); this was done because there were insufficient sample sizes among the various LGBT groups to run analyses independently (such as homosexual male, bisexual female, etc). The Likert scale used in the survey was also collapsed
in which “not at all discouraging” and “slightly discouraging” were combined; and “moderately discouraging,” “quite discouraging,” and “extremely discouraging” were combined to create two separate variables. After collapsing the aforementioned variables, independent t-tests were applied to evaluate for statistical significance in the responses between homosexual and heterosexual participants. Independent t-tests were conducted among each variable, and the Bonferroni correction was applied to control for the risk of detecting false-positive tests related to repeated analysis of the data ($\alpha = 0.005$). Once the appropriate adjustments were made, the responses from the heterosexual and homosexual groups showed no statistical significance when assessing for variables that included the areas examined.

Cross tabulations were generated in order to identify areas in which participants most frequently reported barriers to their healthcare. These cross tabulations were done using descriptive statistics among the variables prior to being collapsed (“heterosexual male,” “heterosexual female,” etc.) After reviewing the data collected, participants of all sexual orientations shared similar barriers in receiving healthcare services. The most common barriers are listed in table 1.

Table 1: Most commonly-reported barriers to healthcare access

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of respondents (n)</th>
<th>Percentage of total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The office does not provide weekend or evening hours”</td>
<td>55</td>
<td>45.46%</td>
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<tr>
<td>“The office cannot schedule timely appointments”</td>
<td>48</td>
<td>38.84%</td>
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<tr>
<td>“Long waiting times during visits”</td>
<td>46</td>
<td>38.02%</td>
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<tr>
<td>“I can’t leave work or school”</td>
<td>39</td>
<td>32.23%</td>
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<tr>
<td>“I don’t have enough money to access routine healthcare services”</td>
<td>29</td>
<td>23.97%</td>
</tr>
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</table>
While the Likert scale highlighted the logistics of accessing healthcare as the leading barriers for participants, the open-ended questions also described other challenges that impeded participants from seeking healthcare. Of the responses provided, the three most common themes were related to the scheduling of appointments, lack of healthcare insurance, and interactions with healthcare providers. Some of the concerns stated by participants in relation to healthcare providers included negative experiences with providers (“Lack of personalized care,” “The value of the service doesn’t come close to the cost,” “Feelings of discouragement from pursuing issues I feel are real,” and “I feel rushed when the provider comes into the exam room.”)

Discussion

The data gathered from this study suggests that both logistic barriers (finances, convenience of scheduling appointments, and prior obligations to work or family) and interactions with healthcare providers have hindered participants from seeking routine healthcare. Further analysis of the data may suggest root-cause analyses that may impact the individuals’ abilities to access healthcare. For instance having the ability to go to a healthcare provider may be contingent upon having healthcare insurance. This insurance may not be available or affordable for an individual to purchase through their employer, or unavailable entirely if the individual is unemployed. The form of employment also may influence other concerns that were reported through this survey, such as a lack of weekend or evening appointments. Another area that may be correlated would be the relationship between scheduling and experiences with healthcare providers. Many participants reported feeling rushed by their provider, or that their concerns were not relevant. This may be related to the long waits experienced at the healthcare office, as many times the providers are forced to see high volumes of patients in short periods of time. For this reason, it may be worth investigating the perceptions
of the patient’s experience on behalf of healthcare providers.

One barrier that should be recognized comes from the characteristics of the subject pool. While there was variability in the age range of the participants, the variation in sexual orientation was limited. The majority of respondents identified as heterosexual females, with fewer responses submitted from the LGBT community. In order to obtain essential information regarding healthcare disparities among the LGBT population, it would be recommended to obtain further data from this demographic for further analysis.

While there was no statistically significant data differentiating the barriers to healthcare between homosexual and heterosexual participants, there were areas of interest that would require further investigation for future research. First, it would be important to evaluate the current healthcare access of the participants and to what extent they utilize these services. It is unclear if the participants in this study currently used routine healthcare, and in order to best optimize future research, it would be most beneficial to reach out to those who do not currently have any form of healthcare access. Another suggestion for future research would be to use a more specific form of sampling that would generate a more balanced population consisting of individuals of all sexual orientations; this would allow for further analysis of quantitative data to depict barriers unique to the LGBT community. Additionally, further qualitative data should be pursued in order to obtain more detailed responses and experiences from those within the LGBT community. In doing so, healthcare may be able meet the needs of an already vulnerable population.
Resources


5. Human Rights Campaign


AN S.O.S. FROM THE LGBT: IDENTIFYING BARRIERS TO HEALTHCARE AMONG THE LGBT COMMUNITY

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THE LGBT COMMUNITY AS A VULNERABLE POPULATION

• Impact on health outcomes:
  ➢ Physical health
    ◦ Increased risk for obesity, coronary artery disease, asthma and other chronic diseases
  ➢ Mental health
    ◦ Increased risk for Depression, Suicidal ideation, Eating Disorders and other psychiatric disorders
  ➢ Social risk factors
    ◦ Increased risk for substance abuse, homelessness

Soderstrom & Robich, 2014

WHAT DON'T WE KNOW?

• What factors attribute to the barriers seen amongst access of care in LGBT populations?
  ➢ Insurance/Cost
  ➢ Fear of homophobia/heteronormativity amongst healthcare providers
  ➢ Internalized homophobia
  ➢ Perception of personal health
  ➢ Physical barriers to care

REVIEW OF LITERATURE

• Health Disparities Among Lesbian, Gay, and Bisexual Older Adults: Results from a Population-Based Study
• Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) Perceptions and Health Care Experiences
• Barriers to health care among adults identifying as sexual minorities: A U.S. national study
PROJECT PLAN

- Basic Demographics: Age and Sexual Orientation
  - Access to care for HIV:
    - 28 surveys that measure social, environmental and psychosocial barriers to care
    - 5-point Likert scale to assess degree of impact on accessing healthcare (relatively to extremely difficult)
    - Statements not applicable to GBT populations were edited or removed with the author's permission. The survey was then empirically reviewed to ensure the validity of the tool was maintained.
    - Permission for use and adjustment of survey obtained by author.
    - Internal consistency reliability coefficient = 0.85 (N=110)
- IRB approval received through C. John F. Fisher College; no other IRB approval required through other organizations.
- Consent was given prior to the participants beginning the survey
- Data was collected over the course of 3 weeks

METHODOLOGY

- How will you obtain your sample?
  - Targeted sampling
  - Survey will be disseminated via Internet (email, Facebook, etc.)

- What research methods are you using?
  - Quantitative Data (Likert Scale)
  - Qualitative Data (open-ended question)

- What do they mean by sample?
  - Social factors (impact of other people)
  - Environmental factors (transit, hours of operation, etc.)
  - Psychosocial factors (perception of healthcare system/personal relationships)

- What are your plans for analysis?
  - Qualitative: Independent T-tests

Distribution of age among participants
**DISCUSSION**

- The most common barriers in accessing healthcare came from logistical causes and experiences with healthcare providers.
- Are the factors mentioned within this survey related to one another?
- In this survey, there were no statistically significant differences in the responses provided by heterosexual versus homosexual participants.
- Additional research should be pursued that includes more qualitative data and has a stronger focus on the LGBT community.

**RESULTS**

- Total sample size: 123 participants
- Independent T-tests were conducted to determine if there was a significant difference in responses between the homosexual and heterosexual groups
- No significant difference was observed between the two groups
- Common themes identified by participants:
  - Scheduling of appointments
  - Lack of healthcare insurance
  - Interactions with healthcare providers
    - "Lack of personalized care"
    - "The value of the service doesn't come close to the cost"
    - "Feelings of discouragement from pursuing issues I feel are real"
    - "Feel rushed when the provider comes into the exam room."

**DISSEMINATION**

- This research is being done to meet the requirements to obtain a college degree. Therefore it is necessary that college faculty be involved in all aspects of the research but we will not have access to information linking specific individuals to participation. Dissemination in local, regional, national, or international conferences via paper or poster presentation may occur with all data being presented in aggregate form only and no individual identifiers. Final presentation of data will follow policies put forth by any collaborating institutions. All data will be stored in a locked file cabinet in a locked office or a password protected computer. Original data collection tools with individually identifiable data will be destroyed after 3 years.
DISSEMINATION & DISPOSITION OF DATA

- Target Audience: Healthcare Providers/Systems

- Potential Sources of Dissemination:
  > Medical institutions
  > Areas of medical/nursing education
  > Local LGBT-affiliated organizations (Rochester Gay Alliance)

- Implementation of program to enhance access to the LGBT community through Clinical Scholarship Project

REFERENCES


<table>
<thead>
<tr>
<th>Purpose</th>
<th>Year Data Collected</th>
<th>Number of Subjects</th>
<th>Subject Characteristics</th>
<th>Study Design</th>
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<th>Results</th>
<th>Implications</th>
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</table>
| To assess the existence of procedures and policies for identifying LGBT-competent physicians. | June 2012 - December 2012 | 138                | U.S. Medical Schools accredited by the Liaison Committee on Medical Education | - 15 minute telephone interviews  
- Dichotomous & Open-Ended Questions  
- Conducted via phone calls and email  
- Assessed availability of LGBT training awareness of available resources and suggestions to increase LGBT healthcare. | Phone Calls transcribed  
Fisher Exact Tests  
Logistic Regression  
Multivariate Regressions  
Statistical Analysis with Stata version 12.0 | 50% response rate  
56% Private Schools  
46% Public Schools  
< 9% had a procedure to identify LGBT physicians, with < 4% having a policy  
15% had a list of LGBT affiliations  
32% were aware of LGBT databases, but only 7% encouraged its use | There are few policies and trainings available for LGBT health  
While facilities are aware of databases, they are not frequently utilized due to hesitancy by healthcare providers. |

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</tr>
</thead>
<tbody>
<tr>
<td>To explore experiences in accessing primary healthcare of Australian adults who identify as LGBTQ</td>
<td>April 2010 – December 2011</td>
<td>99</td>
<td>18-60 years old Australian</td>
<td>Qualitative; Open-Ended Questions</td>
<td>Scripts reviewed by 3 researchers Coded for themes</td>
<td>Important Themes: Meaning of Identity (&quot;who I’m attracted to&quot;, &quot;Who I am&quot;) 26 had a regular practitioner 21 sought out LGBT-friendly practitioners 23 split healthcare services amongst providers, mostly d/t sexual health concerns Important to acknowledge family systems More training needs to be given to providers Visualization of symbols is important</td>
<td>Few disclose their sexual identity to their healthcare provider It is important to patients that providers are competent in LGBT-based care Patients are afraid of mistreatment due to their sexual orientation Recommendations: Environment is important to patients (visual signs of LGBT competency) Include family systems Increase training for staff</td>
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<tr>
<td>To explore and describe the experiences of homosexual patients utilizing primary healthcare services in Umlazi</td>
<td>September 2014 – November 2014</td>
<td>12</td>
<td>At least 18 years old, Self-identified as gay or lesbian, Have used primary healthcare within the past year</td>
<td>Qualitative; Exploratory, Descriptive Semi-structured Interviewed, Purposive Sampling Participants recruited at local clubs Interviews lasted 30-45 minutes and recorded with a digital recorder</td>
<td>Content Analysis Data saturation reached after interviewing 10 participants</td>
<td>Homosexual patients feel stigmatized by healthcare providers Patients are concerned they will feel judged by healthcare providers/judged by other patients 1 patient felt satisfied with their care, 11 felt dissatisfied Lack of heteronormativity/LGBT training Some healthcare providers attempted to convert patients/demonstrated homophobic behavior</td>
<td>Patients are perceptive of healthcare provider behaviors Additional LGBT training is needed for healthcare providers All staff members influence the patient’s healthcare experience (receptionists, other patients, etc.)</td>
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<tr>
<td>To identify patterns and behaviors of disclosure of LGBT adults to providers</td>
<td>2004-2005</td>
<td>396</td>
<td>18-59 years old 396 LGBT 39.3% bisexual men 32.6% bisexual women 10% gay men 12.9% lesbian</td>
<td>In Person Interviews Initial 3 hour interviews with 2 hour follow-up interviews 1 year later 4-point scale assessing minority stress, internalized homophobia, expectation of stigma, etc.</td>
<td>Logistic Analysis Regressions</td>
<td>79% Response Rate 94.3% that responded also responded to follow-up interview Participants more likely to come out to friends and family than providers or co-workers Bisexual men and women were significantly less likely to come out than gay men and lesbians Increased internalized homophobia leads to decreased disclosure rate Factors that decrease likeliness of women coming out: Women of color, born outside of the USA, lesbians with children, increased perception of homophobia Factors that decrease likeliness of men coming out: Younger age, recently out, increased nondisclosure amongst bisexual men or those out of the USA Disclosure of sexual orientation did not significantly change health outcomes, but did improve psychologic well-being</td>
<td>Patients internalized and perceived options impact decision to disclose sexual identity Those of other minority statuses are at especially increased risk of nondisclosure Disclosure of sexual identity significant increased psychologic well-being</td>
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<tbody>
<tr>
<td>Investigating differences between individuals in same-sex vs. different-sex couples on measures on healthcare access, use, and perceptions of provider care using nationally representative data.</td>
<td>1996-2007</td>
<td>137,372</td>
<td>696 individuals in same-sex relationships (0.5%)</td>
<td>Longitudinal surveys, clustered/stratified samples</td>
<td>Adjusted Wald Tests in Strata II P &lt; 0.10 Logistic Regression Models</td>
<td>Decreased public insurance amongst same-sex couples Decreased reports of mental health amongst same-sex couples Same sex couples report increased difficulty accessing providers and specialists Same sex women report decreased medical care when needed Same sex men report increased delay of services Better experiences reported with providers amongst different sex couples</td>
<td>Same sex couples have decreased access to routine providers LGBT members report decreased rapport with healthcare providers</td>
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<tr>
<td>1. Determine how providers and patients differ in perceptions of a culturally-sensitive environment</td>
<td>October 2008 – December 2008</td>
<td>7 focus groups</td>
<td>2 LGBT patients 2 transgender patients 3 Healthcare Providers</td>
<td>1.5 hour focus groups Semi-structured interviews Patients compensated with refreshments and $40.00 gift cards</td>
<td>Data was transcribed and analyzed via NVivo8 (qualitative data analysis software)</td>
<td>Important Elements: LGBT friendly environments Patient flow and interactions with staff Open communication, important to address sexuality early</td>
<td>Open communication with ensured privacy is key Increased training is required for all staff, not just providers Incorporate LGBT-friendly materials into environment</td>
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<td>2. Determine how providers and patients verbalize their concerns</td>
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<td>3. Identify education topics to tailor to the LGBT community.</td>
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</thead>
<tbody>
<tr>
<td>Analyze experiences of providers in working with LGBT populations</td>
<td>2015</td>
<td>24 physicians</td>
<td>Recruited via advertisements at local clinics, word of mouth and snowball sampling 5 straight men 1 gay man 2 LGBT women 16 heterosexual women</td>
<td>Qualitative Study; Semi-structured Phenomenologic/Ethnographic</td>
<td>Interviews audio recorded Transcribed verbatim Coded with ALTAS.ti qualitative data analysis software</td>
<td>19/24 physicians have had no LGBT-related training Some physicians learned homosexuality as a disease 5 physicians electively chose training Felt there was no change between straight and LGBT patients Felt sexual identity only relates to sexual practices &amp; transitioning “It matters, but it doesn’t matter”</td>
<td>Increased education required for healthcare providers</td>
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<tbody>
<tr>
<td>To assess the associations of LGBTQ and military experience with health indicators</td>
<td>2012</td>
<td>28,237 subjects</td>
<td>Military Veterans</td>
<td>48 institutions interviewed through web</td>
<td>Stratified analysis</td>
<td>2,316 (8.5%) LGBTQ</td>
<td>LGBTQ patients at increased risk for physical disease, psych conditions and other risk factors (i.e. smoking, IPV)</td>
</tr>
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<td></td>
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<td>51 subjects identified as LGBTQ</td>
<td>3 institutions interviewed through paper surveys</td>
<td>$x^2$, fisher exact test</td>
<td>Increased psych diagnoses and suicidal ideation over 12 months amongst LGBT</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>Studies assessed psych history, physical history and health risk indicators</td>
<td>Modified Poisson regression model</td>
<td>Increased HIV/Hepatitis amongst LGBT</td>
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<td>95% confidence level</td>
<td>Increased rates of HIV, cigarette use and discrimination</td>
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<td>Conducted with Strata version 13.1</td>
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<td>Cross contabulation to confirm people aren’t counted twice</td>
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Veterans are at especially increased risk for mental health conditions.
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<thead>
<tr>
<th>Purpose</th>
<th>Year Data Collected</th>
<th>Number of Subjects</th>
<th>Subject Characteristics</th>
<th>Study Design</th>
<th>Data Analysis Method</th>
<th>Results</th>
<th>Implications</th>
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<tbody>
<tr>
<td>How sexual orientation relates to health disparities among lesbian,</td>
<td>2003-2010</td>
<td>96,992</td>
<td>58,319 women 562 (1.03%)</td>
<td>Behavioral Risk Factor Surveillance System</td>
<td>t-tests</td>
<td>Mean response rate: 43-50%</td>
<td>LGBT increased risk for mental and medical health conditions</td>
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<td>gay and bisexual older adults.</td>
<td></td>
<td></td>
<td>Lesbian 291 (0.54%)</td>
<td></td>
<td>$x^2$, Fisher exact test</td>
<td>LGBT participants are more educated, younger and employed</td>
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<td>Bisexual 37,820 men 463 (1.28%)</td>
<td>Randomized phone surveys</td>
<td>Logistic regressions to control for SES, physical health and orientation</td>
<td>No significant changes in income</td>
<td>Increased risk for social behaviors</td>
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<td>Gay 215 (0.51%)</td>
<td>Stratified random sampling</td>
<td>Strata Version II</td>
<td>Lesbians/Bisexual Women have increased mental health disparities</td>
<td>Less likely to have medical insurance</td>
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<td>Bisexual 37,820 men 463 (1.28%)</td>
<td>Retrospective Likert Scale</td>
<td></td>
<td>Gay/Bisexual Men have increased physical and mental health comorbidities</td>
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<td></td>
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<td></td>
<td>Female age range: 50-94</td>
<td>Assessed age, SES, employment, race, living arrangement, children</td>
<td></td>
<td>LGBT participants increased risk for chronic diseases</td>
<td>More likely to have chronic diseases</td>
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<td>Male age range: 50-98</td>
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<td>LGBT less likely to have insurance</td>
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<td>LGBT more likely to have substance abuse issues (cigarettes, ETOH)</td>
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<td>To assess the general experiences of LGBT patients with providers.</td>
<td>November – December 2013</td>
<td>632</td>
<td>5 counties in Tampa counties 48.9% female 48.9% male 1.3% transgender 263 gay 158 lesbian 38 bisexual 110 straight</td>
<td>Web-based questionnaire Participants invited through email invitation 60-item based survey Open-ended questions</td>
<td>3 coders used grouped analysis for key terms Descriptive statistics</td>
<td>$\alpha = 0.05$</td>
<td>Bisexual individuals at significantly increased risk to disclose sexual orientation Patients suggest equal treatment, increased staff training, a more inclusive environment and forms using open-ended questions Encourage involvement of partners Increase universal language Encourage a more welcoming environment</td>
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<td>To assess to what extent lesbian, gay and bisexual adults age 18-64 experience access to care</td>
<td>2013</td>
<td>25,885</td>
<td>14,003 women 11,882 men 18-64 years old</td>
<td>Data obtained from the 2013 National Health Interview Survey Measures</td>
<td>Two-tailed significance tests P &lt; 0.05 Logistic Regression SAS-callable SUDAAN version 11.0</td>
<td>Response Rate: 61.2% 97.3% of respondents identified as straight Most had private insurance, not of low socioeconomic status, and had a good perception of self-health Those who identified as lesbian, gay or bisexual were significantly more likely to have trouble finding a healthcare provider Bisexual men and women had a significantly increased difficulty accessing healthcare due to non-financial reasons</td>
<td>Lesbian, gay and bisexual populations have difficulties accessing providers Bisexual men and women have an increased delay of care</td>
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<td>To examine how lesbian/bisexual women experience healthcare, where they access sexual health information and what suggestions they have to make healthcare more inclusive.</td>
<td>Jung-August 2013</td>
<td>22 women</td>
<td>Lesbians and bisexual women Located at 2 separate universities Average age: 23 13 black women, 5 mixed women, 4 white women 18 identified as lesbian, 4 identified as bisexual</td>
<td>Qualitative, semi-structured, in-person interviews Located on or near campus Interviewed auto-taped Interviews lasted between 15 minutes to an hour in length, average interview lasted 24 minutes.</td>
<td>Interviews transcribed verbatim Manually coded by researcher using open coding</td>
<td>Healthcare providers are educated on LGBTQ needs Women felt private healthcare provides better care Many women are hesitant to come out to healthcare providers, but state they would if medically necessary Increased socioeconomic status allows for more options for providers Many of those interviewed are concerned that providers are uneducated</td>
<td>Suggest more education for providers, more comprehensive sexual education Interactions with healthcare providers impact the patient’s decision to disclose sexual orientation</td>
</tr>
</tbody>
</table>
January 11, 2017

File No: 3647-121516-06

Timothy Nervina
St. John Fisher College

Dear Mr. Nervina:

Thank you for submitting your research proposal to the Institutional Review Board.

I am pleased to inform you that the Board has approved your Expedited Review project, "An S.O.S. from the LGBT: Identifying Common Barriers to Healthcare Amongst the LGBT Community".

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at irb@sifc.edu

Sincerely,

Eileen Lynd-Balta

Eileen Lynd-Balta, Ph.D.
Chair, Institutional Review Board

ELB: jdr