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Kara Steinbrecher

University of Arkansas, Fayetteville

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LGBTQ+ Health Disparities: Healthcare Intervention

Kara Steinbrecher

Eleanor Mann School of Nursing

University of Arkansas

ABSTRACT

The lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community has carried the burden of countless health disparities throughout its history tied to discrimination, bias, prejudice, and stigma. LGBTQ+ individuals are disproportionately at higher risk for substance abuse, sexually transmitted diseases, cardiovascular disease, mental illness, suicide, and unequal access to healthcare, related to social stigma and bias that exists in healthcare itself. The purpose of this systematic literature review is to analyze existing health disparities among the LGBTQ+ population in the United States and the efficacy of various interventions of health care professionals to reduce them. Twenty-one articles from multiple online databases investigating existing LGBTQ+ health inequities and healthcare professional interventions were chosen according to keywords and inclusion criteria specific to the research question presented. Each of the selected articles were separated into two major themes: existing health care disparities of LGBTQ+ individuals and interventions taken by healthcare professionals. The second theme of healthcare intervention can be divided into three subcategories: addition of cultural competence education to training of healthcare staff, implementation of sexual orientation and gender identity data into electronic health records, and initiation of LGBTQ+-specific therapies. The prevalence and root of health inequalities impacting the LGBTQ+ community has proved to be multifaceted indicating the need for several approaches to intervention for reducing the incidence of these disparities and improving patient outcomes of the LGBTQ+ community.

INTRODUCTION

LGBTQ+ individuals account for 5-10% of the United States population (Pirschel, 2020), approximately 11 million adults (Caceres et al., 2020). The term LGBTQ+ is composed of a multitude of factors related to sexual orientation as well as gender identity and gender expression. Understanding the health of this population cannot occur without context of historical factors that have contributed to the inequalities LGBTQ+ individuals face today.

Advocacy of LGBTQ+ rights can be traced back to the Stonewall riots of 1969, often referred to as a “catalyst for LGBT movement for civil rights in the United States” (Human Rights News, 2009). Being openly gay during this time period was extremely dangerous considering several states had implemented laws against public homosexuality resulting in frequent raids of businesses, organizations, restaurants, and bars that were known to accommodate LGBTQ+ patrons. One of these raids occurred at Stonewall Inn in New York, a popular bar catered to the LGBTQ+ community in Greenwich Village. Patrons were harassed by police until a riot ensued, sparking the movement known today as “Pride.” Protests continued outside Stonewall Inn as the movement grew and gay rights activist groups developed in nearly every state (Human Rights News, 2009).

Forty years have passed since the Stonewall riots, and the US has made strides towards equality for the LGBTQ+ community including repeal of “Don’t Ask Don’t Tell” in 2010, legalization of same-sex marriage in 2015 (Public Broadcasting Service, n.d.), and implementation of the Equality Act in 2019 (Gonzales & Gavulic, 2020). Despite the progress the LGBTQ+ community has made in advocating for their civil rights, there is an undeniable disparity in LGBTQ+ health that still exists in present day. The LGBTQ+ population was officially defined as a health disparity by National Institutes of Health’s Gender Minority

Research Office in 2016 (Caceres et al., 2020). These ever-growing disparities with ties to historical discrimination, bias, and prejudice can be attributed to minority stress, “a term that encompasses stressful situations and experiences due to one’s race, ethnicity, sexual orientation, and/or gender identity” (Powell, 2021, para. 2). The Minority Stress Model originated from studies of LGBTQ+ individuals early in the 2000s (Powell, 2021). Types of minority stress include victimization, discrimination, heteronormative cultural norms, stereotyping and prejudice, and systematic bias (Powell, 2021). As a result of experiencing minority stress, individuals are placed more at risk for mental health disorders, substance abuse, lack of emotional support, high blood pressure, obesity, insomnia, heart disease, and poor coping mechanisms, adding to increasing disparities in this population (Powell, 2021).

A literature review addressing specific health disparities among the LGBTQ+ population will be beneficial in understanding their root causes, as well as what interventions by healthcare professionals will be efficient in promoting a decrease in unequal health outcomes. Results of this review may be applied to nursing practice in an effort to continue taking action to reduce health disparities among the LGBTQ+ community and serve LGBTQ+ patients as advocates for their health and civil rights. There are gaps in literature that must be addressed to indicate a need for research beyond this review, including several articles include studies with small sample sizes that could skew presentation and significance of data as well as a lack of general research regarding actions taken by healthcare professionals to improve health outcomes for the LGBTQ+ community. After accounting for articles discussing specific health disparities of the LGBTQ+ community, only half address intervention by healthcare. Significant research is required to further assess the impact of various healthcare interventions on reduction of LGBTQ+ health inequalities.

Research Question

Upon analyzing specific health disparities that exist among LGBTQ+ individuals, what healthcare interventions will ultimately improve patient outcomes and reduce these health disparities of LGBTQ+ individuals compared to standard care and nursing practice?

METHODS

In this review, twenty-one articles relating to this research question were analyzed. Three searches were conducted using three separate databases and specific keywords pertaining to LGBTQ+ health disparities and interventions of healthcare professionals. This review has also been conducted with consideration of PRISMA guidelines for clarification.

Search Strategy

Using the University of Arkansas online libraries, an electronic search was conducted on the databases CINAHL, Academic Complete, and MEDLINE/PubMed. The literature was limited to full text articles published from January 2015 through November 2021 written in English. The keywords 'LGBTQ+', 'health disparities', 'cultural competence,' and 'education' were used in the search of each database.

Inclusion/Exclusion Criteria

Articles were excluded from the review based on their relevance to the research being conducted. Articles that were not based in the United States, not written in English, or published before 2015 were excluded. Articles that did not specifically address LGBTQ+ health disparities or the role of healthcare in combating LGBTQ+ healthcare inequality were also excluded from review.

Data Extraction

Data was independently extracted from the articles based on relevance to research. Data chosen for inclusion in this review includes the setting of the study (i.e., city, state, or community), the sample size of the study, major variables studied, measurement, the purpose of the study, and key findings of each article. Figure 1 illustrates the method of selecting articles for review through eliminating duplicate articles, discarding articles with exclusion criteria, and assessing eligible articles based on relevance to research. A combined total of 262 results from each database were examined for review eligibility. After duplicate articles were removed from consideration upon cross-referencing database results, 176 results remained. Inclusion and exclusion criteria were applied to the remaining articles resulting in the discard of 145 more results. Of the thirty-one articles that were deemed eligible for review, only twenty-one were included in the final review due to relative lack of content relevant to the purpose of the review.

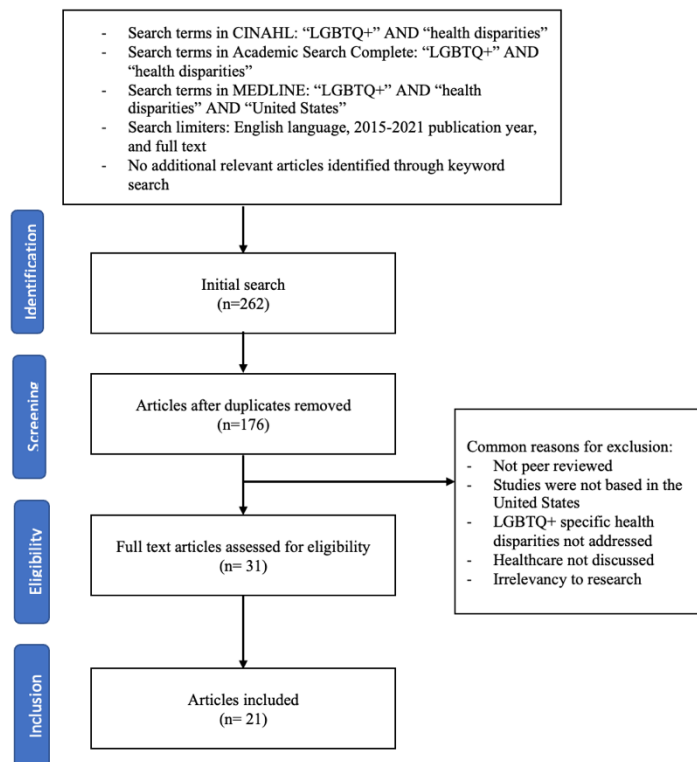


Figure 1. Flow chart of search strategy, data exclusion, and article selection via searches on CINAHL, Academic Search Complete, and MEDLINE/PubMed.

RESULTS

Of all the articles selected for review, two main themes emerged during their analysis. The first is the prevalence and root causes of health disparities among the LGBTQ+ community. The second is interventions healthcare professionals could be responsible for in order to reduce the health disparities discussed. These interventions can be divided into three subcategories: cultural competency education in training of healthcare staff, implementation of sexual orientation and gender identity (SOGI) data into electronic health records as routine practice, LGBTQ+ specific therapies and programs for sexual and gender minority patients. Of the articles discussing healthcare intervention, 36% discuss culturally competent care, 45% discuss implementation of SOGI data into EHR, and 19% discuss therapies and programs specific to LGBTQ+ health.

The articles addressing health disparities among the LGBTQ+ community focus primarily on their root cause. The articles show evidence of health disparities existing because of social factors causing minority stress such as household dysfunction (Baams, 2018), lack of education in sexual practices and sexual health information (Charest et al., 2016), limited healthcare access, bias and discrimination in healthcare (Pirschel, 2020) (Casey et al., 2019), discrimination in education, employment, etc. (Gonzales & Gavulic, 2020), bullying and sexual harassment (Hatchel et al., 2018), and even vulnerability related to the COVID-19 pandemic (Salerno et al., 2020).

Existing Health Disparities

An article important to include in this review written by Gonzales and Gavulic discusses the Equality Act of 2019. Only 15 states have implemented legal protection in compliance with this Act, leaving LGBTQ+ residents of the remaining 35 states vulnerable to discrimination in housing, education, and employment that further add to health disparities in this population

(Gonzales & Gavulic, 2020). In the recent COVID-19 pandemic, evidence shows the LGBTQ+ population was disproportionately affected (Salerno et al., 2020). According to the article by Salerno et al., 40% of LGBTQ+ individuals work in the service industry, the primary industry negatively impacted by the pandemic. Stay at home orders cost those in the service industry their jobs as well as health insurance benefits (Salerno et al., 2020). In addition, stay at orders had the potential to keep LGBTQ+ youth at home in unsafe households without access to school's mental health services (Salerno et al., 2019). These incidences further placed the LGBTQ+ individuals at risk for further minority stress leading to health disparities.

A survey completed among high schoolers in Minnesota assess the prevalence of household dysfunction and/or child abuse such as addiction, domestic violence, and sexual abuse. Results of the survey showed a disparity in these adverse childhood events among male and female LGBTQ+ adolescents compared to their heterosexual peers (Baams, 2018). A questionnaire assessing LGBTQ+ adults between the ages of 18-25 assessed their access to educational sources regarding sexual health and practices as well as incidences of sexual violence. The results of the study show that LGBTQ+ young adults are twice as likely as their heterosexual counterparts to have sex while intoxicated and have a higher rate of sexual violence. LGBTQ+ participants of this study also report a lack of reliable sources to provide adequate education about LGBTQ+ sexual health risks and behaviors, with most respondents obtaining their sexual health knowledge from unreliable sources such as pornography and social media (Charest et al., 2016). Another study addresses the prevalence of bullying and sexual harassment through surveying of 404 LGBTQ+ high school students across the US. Results showed a significant portion of respondents having experienced bullying and sexual harassment related to sexual orientation and gender identity, leading to increased feelings of isolation,

symptoms of mental illness, and decreased sense of belonging at school (Hatchel et al., 2018). In 2019, a study completed by Goodin et al. sought out to determine health disparities among LGBTQ+ youth related to alcohol use, mental illnesses, and support. 2,577 participants as young as twelve years old from high schools in Kentucky were surveyed about their history with alcohol use and symptoms of poor mental health as well as the presence of an adult emotional support system to rely on. Results of the study showed LGBTQ+-identifying students had reported increased alcohol use, increased symptoms of depression and anxiety, and decreased prevalence of a trusted adult to confide in (Goodin et al., 2019). These articles highlight health disparities among LGBTQ+ youth related to bullying, sexual assault, lack of education related to sexual health, and lack of support at home. The health disparities as a result of these social factors are increased alcohol abuse, increased mental illness, and increased suicidal ideation at very young ages. Other evidence shows that health inequalities experienced at these young ages have detrimental effects on LGBTQ+ individuals throughout adulthood (Hafeez et al., 2017).

Several other articles included in this review discuss LGBTQ+ health in adulthood such as poor cardiovascular health (Caceres et al., 2020), sexual transmitted diseases such as HIV (Shover et al., 2018), and cancer (Pirschel, 2020). The article by Caceres et. al explains evidence of LGBTQ+-identifying adults experiencing more cases of poor cardiovascular health, indicating the need for further research about what data exists about LGBTQ+ cardiovascular health and methods for improvement. LGBTQ+ stressors that lead to an increase in poor cardiovascular health includes general life stressors such as finances and work as well as institutional stress from lack of legal protection and social stigma, interpersonal stress from personal experience of discrimination and violence related to sexual orientation and gender identity, and intrapersonal stress from stigma, expectations and the coming-out process (Caceres et al., 2020). Physiological

risk factors for cardiovascular disease that affect LGBTQ+ individuals disproportionately include HIV, dyslipidemia, obesity, and tobacco use. LGBTQ+ individuals are credited with more use of tobacco, increased risk for obesity and diabetes, and HIV (Caceres et al., 2020). According to Shover et. al, transgender women, nonbinary individuals, gay men, and bisexual men are at an increased risk for acquiring HIV (Shover et al., 2018). Incidences of cancer are high among LGBTQ+ individuals due to higher self-reported occurrences of binge-drinking and tobacco use as well as negative experiences in healthcare that deter this population from receiving treatment (Pirschel, 2020).

Poor health outcomes highlighted in these articles attribute negative healthcare experiences. In a study conducted by Carpenter in 2021, twenty-two queer women and gender nonconforming adults were personally interviewed about their experiences with healthcare professionals during routine reproductive care. Respondents report relying heavily on online communities for information about LGBTQ+ sexual health, similar to results of the study performed by Charest et al. (Carpenter, 2021). One participant states, “It’s not like when you go to a fertility clinic, they have some sort of workshop where they explain all that to you” (Carpenter, 2021). Participants also reported feeling vulnerable to discrimination and stigma during care when disclosing their sexual orientation and gender identity. Another participant states, “I lie to most of my medical providers if I think that I need to get the type of medical care that I need. . . I will really play up my white, straight, middle-class persona. . . because it feels like I have to in order to get them to take me seriously... It is messed up that I’m not honest with my own doctors. . . . I just felt like it wasn’t an option if I wanted to get the care I wanted. Even though I was seeking reproductive health, I was downplaying the fact that I’m sexually active, and not disclosing that I was bi, not disclosing that I was poly, not disclosing that I had had an

abortion” (Carpenter, 2021). In another study of 273 LGBTQ+ cancer patients, similar sentiments were shared by participants through an anonymous online survey. Respondents report feeling the need to be their own advocates for their health, only disclosing sexual orientation and gender identity when feeling safe, and generally negative experiences upon disclosure of SOGI (Kamen et al., 2018). In a study of 3,453 LGBT-identifying adults, 18% reported avoidance of healthcare based on fear of negative experiences, and 16% reported discrimination during routine healthcare (Casey et al., 2019). The results of this study also include evidence of discrimination outside of healthcare. 57% of participants reporting threats or harassment related to sexual orientation or gender identity, 51% reported them or someone they knew experienced sexual assault or violence, 57% reported being called slurs, and 53% reported being victims of microaggression (Casey et al., 2019).

Healthcare Intervention

Culturally Competent Healthcare

A large percentage of articles in this review analyze health disparities among LGBTQ+ individuals with several discussing intervention by healthcare to reduce them. Implementation of culturally competent care education in training of healthcare professionals is a major theme among articles discussing intervention. A study completed in 2019 assessed the efficacy of modules presented to postgraduate medical students in 120 different residency programs in understanding LGBTQ+ health, terminology, and risks (Streed et al., 2019). Within the study, 1,018 tests were given to 833 postgraduate students to assess their knowledge before and after presentation of information from modules addressing LGBTQ+ health and culturally specific care. The ‘pretests’ showed a lack of knowledge regarding prevalence of STIs, substance abuse, and mental illness in this population. Scores of the ‘posttest’ following the module showed a

drastic increase in overall knowledge of LGBTQ+ health and culturally specific care. Year 1 students scored an average of 52.09% on the pretest and 80.20% average on the posttest, indicating the modules presented were effective in increasing knowledge of LGBTQ+ health and culturally appropriate care (Streed et al., 2019). A similar study was completed at University of Chicago Pritzker School of Medicine in 2020 when 83 first-year medical students were presented with a module about culturally competent care, intersectionality, and LGBTQ+ health (Bi et al., 2020). The module included five 10–15-minute testimonies of lived experiences of LGBTQ+ individuals, a two-hour “safe-space” training, a 30-minute lecture, and a 90-minute discussion followed by a 30-minute Q&A session. Once again, the scores from pretest and posttest showed drastic improvement, indicating success of the seminar in improving knowledge of LGBTQ+ health and culturally competent care (Bi et al., 2020). In 2015, 632 adults were surveyed as part of a study in analyzing attitudes, experiences, and health knowledge of LGBTQ+ individuals during routine care (Quinn et al., 2015). This anonymous online survey was composed of 60 questions asking about attitudes regarding healthcare, positive and negative experiences during care, and suggestions for improvement. 289 participants reported wanting healthcare professional’s knowledge of LGBTQ+ health and culturally appropriate care to be improved, 45.7% of respondents. Results of this study indicate a significant need for further research regarding hospital policy and need for implementation of training on LGBTQ+ appropriate care (Quinn et al., 2015). An article written in 2021 by Ruedas et al. discusses LGBTQ+ health disparities in Jacksonville, FL and St. Vincent Family Medicine Center’s formation of an advocate team to encourage didactic sessions, case-based learning, panels, and modules about LGBTQ+ health. The need for these interventions was reported being necessary at this institution due to overwhelming disparities in the health of LGBTQ+ patients including a higher risk for

UTIs related to avoidance of using public restrooms, tobacco use, alcohol use, homelessness, isolation, lack of access to social services, suicide, STDs, and mental illness (Ruedas et al., 2021). According to members of the advocate team, the goal of implementing training about culturally appropriate care is to make providers feel comfortable with and competent in caring for LGBTQ+ patients so they will feel supported and encouraged to seek out healthcare, ultimately reducing the significant of health inequalities in these patients (Ruedas et al., 2021).

Sexual Orientation and Gender Identity Documentation

Several articles in this review discuss the importance of implementing SOGI into electronic health records (EHR). An article written in 2019 by Grasso et al., analyzes research regarding standard documentation of SOGI into EHR to investigate its potential to improve health outcomes and improved patient experiences of LGBTQ+ individuals (Grasso et al., 2019). According to the article, 78-80% of healthcare providers reported thinking patients would be offended by assessing SOGI or thought patients would refuse to answer, while only 3-11% of LGBTQ+ patients reported offense or refusal to disclose. The article reports routine collection of SOGI data at registration of hospital clinics could be beneficial (Grasso et al., 2019). Another article written in 2019 by Maragh-Bass analyzes implementation of SOGI data into EHR. According to the article, guidelines from Centers for Medicare and Medicaid Services recommend incorporating SOGI data into EHR, yet approximately 75% of SO data and 65% of GI data is not included in EHR for patients across the US (Maragh-Bass, 2019). The article hypothesizes that providers will rely on stereotypes to assume a person's sexual minority status rather than standardizing the assessment of SOGI information to document into EHR. The article discusses there is a lack of training of providers that may lead to biases and offensive patient interactions such as misgendering patients and not providing comprehensive care. A quote from

the article states, “the puzzle is incomplete if it is based on one piece; therefore, SGM status must not be a shortcut for minimizing patients into risk factors rather than maximizing their unique and intersectional identities” (Maragh-Bass, 2019, para. 12). Knowing a patient’s sexual orientation and gender identity is a key piece to eliminating health disparities for LGBTQ+ patients by recognizing them as unique persons with diverse experiences and identities to provide the best possible care unique to them (Maragh-Bass, 2019). Shover et. al also discusses implementation of SOGI data into EHR as an effort to reduce the percentage of LGBTQ+ patients with HIV, viral hepatitis, and other STDs. The article states, “Collecting and reporting SOGI data are critical to achieving national health goals” (Shover et al., 2019). Caceres et. al also discusses that a lack of SOGI data serves as a barrier to research about LGBTQ+ health, indicating further evidence towards supporting the incorporation of SOGI data into EHR as a way of further determining the significance LGBTQ+ health disparities and taking measures to reduce them (Caceres et al., 2020). Conversely, a study by Rossman et. al in 2017 demonstrates adult LGBTQ+ patients with hesitancy to SOGI disclosure (Rossman et al., 2017). 206 LGBT-identifying participants living near Chicago were given an open-ended questionnaire to assess their reasoning for or against disclosing SOGI to healthcare professionals. 37% of participants reported not sharing their sexual orientation or gender identity to healthcare professionals for reasons including lack of inquiry by the provider and not seeing SOGI relevant to healthcare (Rossman et al., 2017).

LGBTQ+ Specific Care

Two articles addressed programs and therapies geared towards LGBTQ+ adults as a means to improve health disparities in this community. A study by Valentine et. al in 2021 analyzes the efficacy of veteran care coordinators (VCC) in caring for LGBTQ+ patients at VHA

facilities (Valentine et al., 2021). 79 VCCs were surveyed about the progress of the program in aiding LGBT-identifying veterans and providing LGBTQ+ affirming care. Results showed the biggest barriers to the program were a lack of resources, poor communication among VCCs and residents, and engagement (Valentine et al., 2021). Another study conducted in 2019 addresses the effectiveness of a therapy geared towards LGBTQ+ patients in New York City, NY and Miami, FL. 25,018 gay and bisexual men diagnosed with depression and anxiety were given a therapy entitled Effective Skills to Empower Effective Men (ESTEEM) which works to regulate emotions, reduce avoidance patterns, and improve motivation to adhere to health behaviors (Pachankis, 2019). The purpose of the study was to evaluate how beneficial ESTEEM therapy is in reducing health risks related to minority stress. In the pilot study, there was a 60% decrease in condomless sex in men using ESTEEM for six months (Pachankis, 2019).

The characteristics of these articles can be found summarized in Table 1.

Author	Year	Sample Size and Setting	Major Variables Studied	Measurement	Purpose of Study	Key Findings
Streed	2019	833 PGY1-3 students at 120 medical residency programs 1018 tests	Sexual and gender minority health: terminology, health disparities, substance abuse and mental health, and STDs	Pretest scores Module Posttest scores	Determine if giving modules about LGBTQ+ health, terminology, and risks would increase cultural competency	Drastic improvement from pretest scores PGY1 pretest: 52.09% PGY1 posttest: 80.20%
Pachankis	2019	25018-35 YO gay or bisexual men in NYC and Miami diagnosed with anxiety or depression	Effectiveness of ESTEEM program vs community mental health treatment and voluntary counseling; frequency of condomless sex, sex with use of drugs/alcohol, number of sexual partners, and PrEP use	Follow up appointments after initiation of intervention sessions (4 months, 8 months, 12 months)	Test how beneficial/efficient 10 session skill intervention would be in reducing health risks of gay men related to minority stress	60% reduction in condomless sex using ESTEEM for 6 months in pilot study
Baams	2018	282 schools in Minnesota 81,885 adolescents in grades 9-11	Reports of lifetime household dysfunction and child abuse in adolescents LGBTQ+, gender nonconforming, and heterosexual students	Survey questions and answers	Are LGBTQ+ and gender nonconforming students more likely to experience childhood trauma and abuse?	Only distinct and significant pattern detected in the survey answers → high level of household dysfunction and disparities in LGBTQ+ adolescents
Valentine	2021	79 LGBTQ+ veteran care coordinators Quality improvement project	Effectiveness of VCCs and VCC program Barriers to program effectiveness	Survey about the first year of the program being implemented at VHA facilities	Quality improvement project to determine barriers to providing LGBTQ+ affirming care, barriers to carrying out roles and responsibilities as a VCC, and get feedback about	Biggest barriers were lack of resources, communication problems, and problems with engagement

					program	
Charest	2016	386 adults between ages 18-25 Divided into higher education (306) and high school education (80) and heterosexual (215), and LGBTQ+ (171) groups	Sexual health information sources Sexual orientation and education level Reported confidence in knowledge of sexuality and sex behaviors	Demographic questionnaire, weighted topic measure about family sexual communication and sexual health practices self-efficacy scale	Determine where young adults obtain their sexual health information, sexual self-efficacy differences, and if there is a disparity between LGBTQ+ sexual health knowledge and self-efficacy compared to heterosexual individuals	Peers and educational websites and news outlets most reported source of sexual health information Heterosexual participants received more information from school courses than LGBTQ+ participants Heterosexual participants reported more confidence in sexual practices, safe sex, and SA than LGBTQ+ participants
Grasso	2019	NA	SO/GI data collection in EHR Potential of making patients uncomfortable by asking Improvement of patient care	“Champion” teams formed to start a timeline of how and when to implement questions to assess SO/GI information	Research about documentation of SO/GI in EHR -- will it help provide better care for LGBTQ+ patients?	Previous studies show that 78-80% of providers thought patients would be offended or refuse to answer SO/GI questions, only 3-11% of patients were Collecting data during registration at clinics/triage could be beneficial
Pirschel	2020	NA	Nurse responsibility to LGBTQ+ patients Health disparities like biases, risk factors for certain diseases (esp. cancer)	NA	Identify health disparities that exist among the LGBTQ+ community Identify what nurses can do to reduce health disparities.	Health disparities include limited healthcare access, bias, risk of diseases like cancer Nurses have a responsibility to ask about SO/GI to provide comfortable environment and better care to initially address disparities
Salerno	2020	NA	COVID 19 psychological effects on LGBTQ+ population	NA	Discuss vulnerabilities of LGBTQ+ population to be able to give appropriate interventions	40% of LGBTQ+ work in service industry → service employees laid off → loss of health insurance Stay at home orders may keep LGBTQ+ adolescents in possibly abusive households Stay at home = unable to attend school = unable to access school's mental health services
Maragh-Bass	2019	NA	Implementation of SO/GI information in EHR	NA	Implementation of SO/GI info in EHR not always done -- why?	Lack of training of providers may lead to biases → misgendering, not addressing risk factors, etc. SO/GI questions may only be asked based on stereotypes of what a sexual minority individual is thought to look like → need to standardize data collection “The puzzle is incomplete if it is based on one piece; therefore, SGM status must not be a shortcut for minimizing patients into risk factors rather than maximizing their unique and intersectional identities.”

Gonzales	2020	NA	SO/GI Equality Act of 2019	NA	Address the Equality Act of 2019's effect on LGBTQ+ discrimination and its impact on improving health disparities	Only 15 states have legal protections in compliance with Equality Act Discrimination in housing, education, employment, etc. add to health disparities as much as physical risk factors
Goodin	2019	2,577 survey participants ages 12+ and attending high school 282 "nonheterosexual" 202 LGBT 2244 heterosexual Kentucky	SO/GI Drinking habits Presence of a trusted adult to confide in Mental health status	Risk behavior survey assessing emotional status, suicidal ideation, alcohol use and frequency,	Determine the health disparities of LGBTQ+ youth compared to heterosexual youth related to alcohol use, mental health, and presence or absence of a support system	Non-heterosexual students more likely to report not having an adult to talk to and more likely to experience binge drinking "In addition to medical competence, non-heterosexual youth place high importance on health care providers' ability to be respectful, nonjudgmental, and able to make them 'feel comfortable.'"
Hatchel	2018	404 LGBTQ+ students across the US	Demographic data, frequency of bullying and sexual harassment, feelings of belonging at school, depressive symptoms perceived	Survey addressing violence and risky behavior in LGBTQ+ youth	Determine the prevalence of health disparities of LGBTQ+ youth related to sexual harassment and bullying in school	Bullying and sexual harassment contributed to increased feelings of detachment from belongingness at school and symptoms of mental illness Schools must adhere to Title IX protocol, implement GSAs, provide accommodating atmospheres
Shover	2018	19,993 patients of LA LGBT Center PLWH = 3176 Cisgender men = 17,115 Cisgender women = 1,949 Transgender women = 549 Transgender men = 178 Nonbinary individuals = 142	Health disparities among LGBTQ+ Incidence of HIV, STIs, and viral hepatitis Compare patients living with HIV vs patients not living with HIV Incorporation of SO/GI data in EHR	Analyze of EHRs of patients Nov 2016 - Oct 2017	What is the prevalence of HIV, STIs, and viral hepatitis in SGM? Can documentation of SO/GI in EHR help address disparities?	38% of PLWH tested positive for an STI, 29% of people without HIV tested positive for an STI Results varied greatly by GI SO/GI significantly associated with HIV HIV prevalence highest in transgender women and cisgender men "Collecting and reporting SOGI data are critical to achieving national health goals"
Bi	2020	83 first year medical students at University of Chicago Pritzker School of Medicine	Knowledge of intersectionality, SO/GI, race, ethnicity Cultural competence	Pre-module survey Five 10-15min video testimonies of lived experiences of LGBTQ+ with diverse health conditions, socioeconomic status, ethnicities, etc. 2 hour "safe space" training 30 min lecture	Determine if training on cultural competency, intersectionality increases knowledge and overall understanding of LGBTQ+ patient care	Drastic improvement in understanding from pre-module to post-module Several students had reported never hearing of the term intersectionality until introduction of the module All 83 participants were able to define intersectionality upon post-module survey

				90 min discussion 30 min Q&A Post-module survey		
Caceres	2020	NA	Cardiovascular health of LGBTQ+ individuals Risk factors among LGBTQ+ for CVD	NA	Determine LGBTQ+ risk for poor cardiovascular health	LGBTQ+ people defined as a health disparity in 2016 LGBTQ+ adults overall have worse cardiovascular health Only 4% of NIH-funded studies talk about CVH in the LGBTQ+ community Diagnosis of HIV causes increased risk for developing CVD SM women higher prevalence of obesity Transgender people higher prevalence of diabetes Lack of SOGI data in studies limits research about LGBTQ+ health = more evidence supporting SOGI data incorporation in EHRs Address gaps in literature: include LGBTQ+ health in school curriculum, increase research and data collection
Carpenter	2021	22 queer cisgender women and gender nonconforming individuals Ages 18-40 Currently planning pregnancy Had previously been pregnant in past 5 years	Negative healthcare experiences SOGI disclosure Sources of information regarding queer health	Individual personal interviews	Prevalence of negative healthcare experiences among SGM individuals seeking reproductive healthcare	Urgent need to address queerphobia and barriers to care for LGBTQ+ population Many reported comfort in queer providers or allies to LGBTQ+ community Many reported feeling vulnerable to stigma when disclosing SOGI info Many reported lack of information available to them, most relied on online communities for information
Casey	2019	3,453 LGBTQ+ identifying adults Ages 18+ 282 Caucasian 201 racial minorities 86 transgender adults	LGBTQ+ persons and LGBTQ+ family members or friends Harassment, microaggressions, slurs, sexual assault, discrimination in healthcare	Telephone survey 25 questions addressing personal experience with discrimination	Presence of discrimination among LGBTQ+ individuals	57% reported them or someone they knew being threatened or harassed 51% reported them or someone they knew experience SA or violence 57% reported slurs 53% reported microaggression 18% reported avoiding healthcare 16% reported discrimination during healthcare
Kamen	2018	273 LGBTQ+ cancer patients	LGBTQ+ patients Quality of care by nurses and providers Experiences during care	Online survey with open-ended questions to open discussion and personal experiences	Analyze data from LGBTQ+ cancer patients to determine disparities in quality of care	Main themes of responses include: participants were affected by providers' knowledge of LGBTQ+ health, participants based SOGI disclosure on feelings of safety, experiences differed based on various identities, care more effective when support system was involved, and participants felt they had to be their own advocates

Quinn	2015	632 participants from Tampa, FL 41% gay men 29% lesbian women 93% white 78% married or have a partner 88% have health insurance	Demographic data Barriers to care Disclosure of SOGI LGBTQ+ health knowledge Health insurance status Healthcare surrogate Avoidance of care	60 question online survey sent via email Voluntary Anonymous Responses from 11/1/2013 - 1/1/2014	Analyze the various attitudes, experiences, and health knowledge of LGBTQ+ individuals during care	289 participants reported wanting to improve HCP cultural competence 67% report always disclosing SOGI with less than 10% having negative experiences Majority reported wanting to feel comfortable sharing SOGI, more likely with posters, stickers, welcoming environment, etc. Need for further investigation of hospital policies and the need for training on culturally competent care for LGBTQ+
Rossmann	2017	206 participants Ages 18-27 74% living near Chicago	Race, ethnicity, gender identity, sexual identity, education Disclosure of SOGI Reasons for or against disclosure Themes related to disclosure	Open-ended questionnaire	Assess LGBTQ+ young adults' reasons for or against disclosing SOGI to HCPs	63% of participants disclosed 37% of participants did not disclose Biggest reason for nondisclosure was lack of inquiry by healthcare staff, next was participants not finding SOGI relevant to healthcare Biggest themes in disclosure: absence of any reaction, positive reaction, and perceived uncomfortableness from HCPs Continue to promote support for LGBTQ+ young adults to improve health outcomes
Ruedas	2021	NA	St. Vincent Family Medicine Center in Jacksonville, FL development of LGBTQ+ advocate team; implementation of LGBTQ+ health curriculum	NA	Identify health disparities among LGBTQ+ community Evaluate the need for education and training related to existing health disparities in FRMPs	Lesbian and bisexual women less likely to receive gynecological care and more likely to be overweight/obese Gay men more likely to acquire STIs including HIV Transgender individuals have higher prevalence of suicide, bullying, and STIs LGBTQ+ identifying individuals at more risk for UTIs, kidney infections, mental health issues, tobacco/alcohol use, suicide, and homelessness Need for didactic sessions, case-based learning, panels, and modules about LGBTQ+ health in FRMPs EHR data collection r/t SOGI needed St. Vincent advocate team actively working to implement education and training

Table 1. Data extraction table. 21 articles organized by chronological implementation of data in review. Author, publication year, setting and sample size of study (when applicable), variables studied, measurement of data of study (when applicable), purpose of the study or article, and key findings.

DISCUSSION

Summary of Findings

The authors of the articles reviewed discuss various health disparities of the LGBTQ+ community as well as interventions by healthcare that have potential to reduce them. The evidence in this literature review illustrates the multifaceted chain reaction that occurs as a result of minority stress leading to disproportionately poor health among the LGBTQ+ community with significant historical prejudice, discrimination, violence, and systematic bias at its core. LGBTQ+ individuals are more likely to experience sexual assault, discrimination in education, housing, and employment, bullying, and adverse events in the home that contribute to minority stress. For example, bullying and harassment related to LGBTQ+ status causes internalized stress that leads affected individuals to unhealthy coping mechanisms such as binge drinking, tobacco use, and unsafe sex practices. These coping mechanisms serve as a means for developing poor health outcomes that add to a growing disparity in health of the LGBTQ+ community. Increased tobacco use places individuals at higher risk for developing cancer and cardiovascular disease, and unsafe sex practices places individuals at higher risk for contracting sexually transmitted diseases such as HIV, viral hepatitis, chlamydia, etc. Another contribution to health disparities in this population is the lack of resources for LGBTQ+ individuals to educate themselves on safe sex practices, leading to more incidences of HIV and other STDs. The literature shows a correlation between lack of general and sexual health knowledge, poor health outcomes, and fear of experiencing further discrimination when seeking healthcare. Articles addressing LGBTQ+ patient experiences highlight the risk of patients refusing to seek out healthcare in fear of experiencing discrimination by healthcare professionals. LGBTQ+ patients are also hesitant to disclose sexual orientation and gender identity for these reasons, limiting the extent to which

care can be provided for these patients. Participants of studies in this review comment on lack of knowledge of LGBTQ+ care by providers, harassment, and refusal of treatment that add to unequal health outcomes in the LGBTQ+ community.

Several participants of studies within this review request the implementation of culturally competent education in training of healthcare providers. The articles showed success in increasing student knowledge of LGBTQ+ health and patient care, indicating a need for further implementation of modules, didactic exams, panels, discussions, and testimonies regarding LGBTQ+ health, experiences, and patient care to further ensure healthcare professional competence in caring for LGBTQ+ patients. This intervention may further reduce health disparities that exist in this population. Incorporation of SOGI into EHR was also a recurring theme in healthcare intervention. Standardized assessment of every patient's sexual orientation and gender identity is thought to be an intervention by healthcare that will allow providers to fully understand a patient's unique identity, health risks associated with sexual minority status, and obtain more data about LGBTQ+ health to be used in further research of LGBTQ+ health disparities. Each article addressing SOGI in EHR discusses the potential for improving health outcomes of LGBTQ+ patients. However, in other articles in this review, patients are not always comfortable with sharing SOGI information as a result of past negative experiences in healthcare, including discrimination, bias, and stereotyping. This indicates an even further need to improve the competency of healthcare professionals when caring for LGBTQ+, putting an end to active discrimination in healthcare and making patients feel safe disclosing their identities. Although few articles discussed specific therapies and programs for LGBTQ+ patients, there is a significant indication for reduction of poor health outcomes for LGBTQ+ individuals with continued use.

Systematic societal change is necessary before interventions presented may serve to reduce poor health outcomes for LGBTQ+ individuals. Evidence in this review suggests efficacy of these interventions, but with external societal factors at the heart of poor LGBTQ+ health, time and generational healing may prove to be the most significant aspect of change. Figure 2 illustrates the interconnections between health disparity causes according to evidence within review.

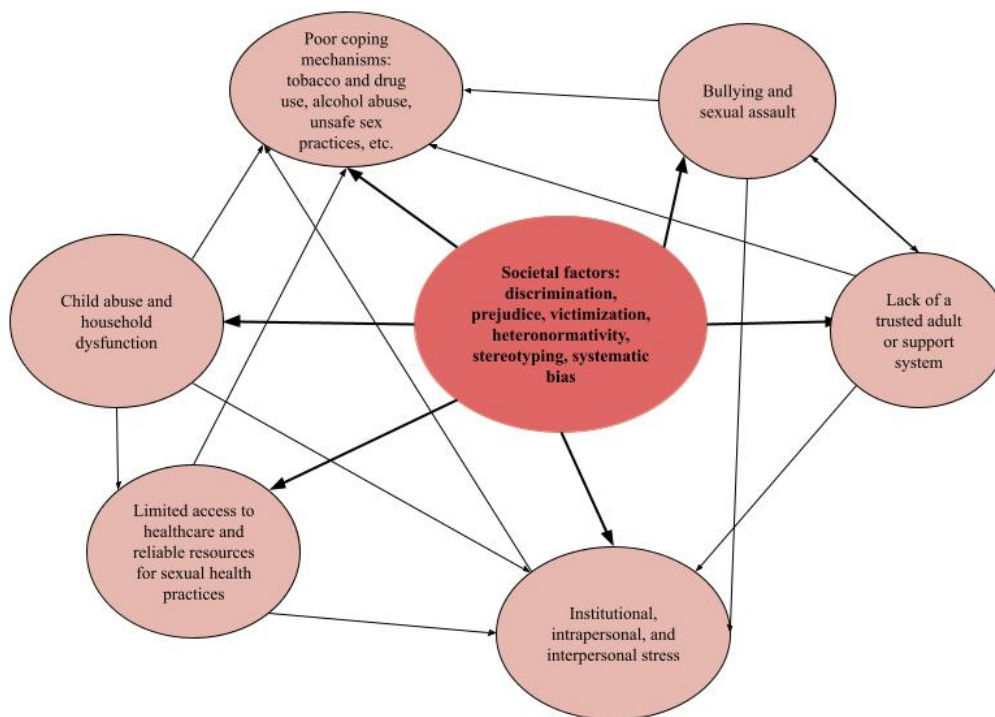


Figure 2. Web diagram illustrating connections between causes of prevalent health disparities among LGBTQ+ community.

Study Limitations

Limitations in the studies reviewed include small sample sizes, unclear methods of sample selection, and lack of research related to studies conducted. This review only contains 21 articles, although there are remaining articles relevant to this content that were not found through

this review's search methods. This indicates a need for more research to gather evidence to further support implementation of this content into practice. This review also covers a broad range of topics related to LGBTQ+ health and healthcare intervention. Further research dedicated to a specific disparity or specific intervention is necessary to fully understand and evaluate these results.

Gaps in Literature

Only two articles included discuss a program or therapy that could be used to reduce health disparities, indicating a need for more research regarding LGBTQ+ specific therapy, treatments, etc. that could reduce the incidence of poor health outcomes. More research about specific about LGBTQ+ patient health after standardized data collection of SOGI is necessary to determine its effectiveness in reducing health disparities in this population. Similarly, more research is needed among facilities with active implementation of cultural competency programs such as didactic modules to assess its long-term effectiveness of reducing LGBTQ+ health disparities.

Implications for Nursing Practice

This review provides several implications for the role of an RN. Evidence in this study shows that healthcare disparities among the LGBTQ+ have the potential to be reduced by measures taken in healthcare policy, but RNs also have the power to take control into their own hands. Cultural competence has been reported to improve patient comfort during care, thus creating a sense of security during care that will encourage routine medical appointments that aid in reducing unequal health problems. Cultural competence education in training of RNs is the focus of the articles in this review, however cultural competence can also be an independent character growth that may improve patient care on a much smaller scale. Pursuing continued education

about cultural competency and care of LGBTQ+ patients is available to those who seek it, not necessarily only provided in structured courses through hospital orientations, for example.

Nurses care for their patients physically, mentally, and emotionally with advocacy at its center. Advocacy in this case includes understanding the historical context of health disparities of the LGBTQ+ community and taking measures to implement policy changes such as incorporating SOGI data in EHRs, standardizing therapies specific to LGBTQ+ patients, and cultural competence education for healthcare staff, as evidenced by this review.

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