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## Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) Perceptions and Health Care Experiences

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### Abstract

**Background:** The goal study of this was to explore attitudes, health knowledge, and experiences with healthcare setting and providers among gay, lesbian, bisexual, transgender, queer/questioning (GLBTQ) individuals and to identify areas for improvement.

**Methods:** Members of Equality Florida™ residing in the five counties of the Tampa Bay region were recruited through email invitation to complete a 60-item questionnaire assessing demographics, attitudes, and experiences with healthcare providers (HCPs). Additional open-ended questions focused on experiences with HCPs and suggestions for ways to improve HCPs' cultural competency.

**Results:** 632 respondents completed the survey of which 41% were gay men and 29% were lesbian. The majority of participants was White, non-Hispanic (93%), married/partnered (78%), and had health insurance (88%). The majority (67%) reported they always or often disclosed their sexual orientation/identity to an HCP and few had negative reactions in the healthcare setting (<10%). Healthcare settings with equality signs and gender-neutral language were perceived as safer. Participants' responses suggested need for policy changes and improved cultural competence among HCPs.

**Conclusion:** Results show high rates of sexual orientation disclosure, greater acceptance from providers of GLBTQ status, and the need for examination of hospital policies and improved cultural competency.

### Keywords

GLBTQ; healthcare policy; disclosure; disparities; cultural competency

## Introduction

The gay, lesbian, bisexual, transgender, queer/questioning (GLBTQ) community represents a growing and underserved population in the United States. GLBTQ include people of all races and ethnicities, all ages, all socioeconomic statuses, and from all regions of the United States (Centers for Disease Control and Prevention 2014). Previous surveys have estimated that approximately 3.4% of the adult U.S. population (a random telephone interview sample of 121,290 adults, aged 18 and older, living in all 50 U.S. states and the District of Columbia) identify as GLBTQ (Gates 2011; Gates and Newport 2012). Compared to non-GLBTQ heterosexuals, previous studies have reported that GLBTQ tend to have attained less education, have lower incomes, and are less satisfied with their standard of living (Gates and Newport 2012). Additionally, health and utilization of healthcare services among GLBTQ individuals are still adversely affected by marginalization (Bjorkman and Malterud 2009), and approximately 30% of GLBTQ adults do not seek out healthcare services or lack a regular healthcare provider (Winter 2012). GLBTQ adults are also more likely to avoid or delay seeking healthcare compared to heterosexuals, resulting in delayed proper treatments and poorer health outcomes (Shields et al. 2012). Previous studies have reported highly prevalent risk factors and behaviors in the GLBTQ community including illegal drug use, alcohol use, smoking, obesity, and high prevalence of HIV/STDS, as well as mental health issues including depression, anxiety, eating disorders, and suicide (Cochran, Sullivan, and Mays 2003; Fredriksen-Goldsen et al. 2013; Grella et al. 2009; Mollon 2012; Treatment 2001). These risk factors, combined with perceived access barriers to healthcare, create a need for targeted and tailored health services for this community.

Despite the critical need for healthcare in the GLBTQ community, structural (e.g., cost, reduced access to health insurance, binary male/female medical record identification system) barriers to healthcare information and treatment significantly contribute to the avoidance or delay of seeking healthcare (Krehely 2009; Roberts and Fantz 2014). While the Affordable Care Act has introduced a ban on pre-existing condition exclusions, improved coverage for screening and preventative care, and a filter option for same-sex partner coverage, GLBTQ individuals continue to experience many barriers to healthcare access (The White House 2013). Because of legal discrimination, financial barriers, and the unique healthcare needs of this population, GLBTQ individuals are less likely to have health insurance coverage for themselves and their partners than their heterosexual counterparts (Fredriksen-Goldsen et al. 2013; Krehely 2009; Roberts and Fantz 2014). Consequently, GLBTQ are less likely to afford the costs associated with testing and screening for certain illnesses and are more likely to access emergency services and delay treatment until the condition becomes extremely difficult to treat or cure (Krehely 2009). Furthermore, unique healthcare setting related barriers to this population include fear of disclosing sexual orientation or gender, due to perceived discrimination, lack of healthcare professional knowledge and/or negative views of GLBTQ persons, and lack of sufficient access to culturally-sensitive healthcare resources and referrals (Krehely 2009). Some individuals choose not to disclose their sexual orientation or gender identity to healthcare providers as a logical decision, given the frequency of GLBTQ experience of negative attitudes, through both overt and covert forms of discrimination (Krehely 2009; Roberts and Fantz 2014). Many GLBTQ individuals report

intense anxiety related to sexual orientation disclosure in healthcare settings, fearing that such disclosure will make them vulnerable to mistreatment and denial of care (Mollon 2012; Roberts and Fantz 2014; Stanton 2013). Moreover, lack of healthcare provider knowledge of GLBTQ individuals' needs and the lack of GLBTQ resources and supportive environments result in less frequent healthcare seeking behaviors (Krehely 2009; Roberts and Fantz 2014). Given the risk status of this community, removal of these barriers are imperative to improve the well-being of GLBTQ individuals.

Presently, there are limited data about the specific barriers in seeking healthcare in the GLBTQ population. This research is part of a larger study that will collect state and national data on the GLBTQ population; however, in the present study we created a web-based questionnaire to survey a GLBTQ community in the Tampa Bay area about general experiences with healthcare providers and facilities, recent experiences related to hospitalization, and to provide opportunity for comments on areas needed improvement. The web-based questionnaire was derived from other published studies and validated instruments, with the addition of open-ended items that provided an opportunity for qualitative analysis in order to guide future research.

## Methods

### Study Population

Members of Equality Florida™, including GLBTQ individuals and straight allies, residing in the five counties of the Tampa Bay region were recruited through an email invitation. Equality Florida™ is a non-profit advocacy group and the largest civil rights organization dedicated to securing full equality for Florida's GLBTQ community. Participants were part of the Equality Florida™ email listserv and resided in the geographic catchment area of the H. Lee Moffitt Cancer Center & Research Institute in Tampa, FL, which includes the counties of Hillsborough, Pinellas, Pasco, Polk and Manatee. A total of 632 participants completed the survey and of those, 242 replied to a separate email address to enter a gift card drawing. The investigators of this study did not have access to these email addresses which were monitored by a research assistant.

Participation was voluntary and anonymous. Participants received an e-mail invitation from Equality Florida™. The invitation included a link to the online survey. The email was sent out three times between November and December of 2013. Each email blast was delivered using the Dillman Method (Dillman 1978) which included three waves. The survey was available on-line from November 1<sup>st</sup> 2013 through January 1<sup>st</sup> 2014. Respondents were eligible to enter a drawing to receive a \$100 <https://Amazon.com> gift card by providing an e-mail address to a separate website (not on the survey). A total of 35 gifts cards were distributed via a drawing of 5 cards weekly between November 8<sup>th</sup> and January 6<sup>th</sup>.

### Web-Based Survey

A 60-item web-based survey was developed based on the *Rainbow Health Initiative* and "The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding" report from the Institute of Medicine (2011; RainbowHealthInitiative

2013). Survey items were categorized by: demographics, knowledge, attitudes, and behaviors. The survey included branching that contained questions unique for the GLBTQ community members and for straight allies, as well as skip patterns to minimize respondent burden. In the opening set of items, there was an item for gender identity (male, female, transgender MTF, transgender FTM, other, prefer not to answer) and an item for sexual orientation (lesbian; gay; transgender MTF; transgender FTM; queer; questioning; straight; prefer not to answer).

Demographic data were collected including age, ethnicity, race, relationship status, education level, employment status, and annual household income. Healthcare-related items assessed insurance status and healthcare surrogacy (“do you have a healthcare surrogate?: yes, or something similar; no; prefer not to answer”). Knowledge of GLBTQ national health statistics was evaluated by providing choices for respondents to mark the most appropriate. Statements included respondents’ awareness that members of the GLBTQ community are diagnosed with later stage cancers due to delay of treatment and/or lack of routine screening, exposure to cancer or any other serious medical condition other than cancer, the amount of current research directed towards the GLBTQ community.

Attitudes were evaluated using questions regarding respondents’ perceptions of: the ability to disclose sexual orientation with healthcare providers, fear of the reaction of healthcare professionals towards GLTBQ status, reaction towards presence of GLBTQ equality sign in a healthcare setting, the impact of the word choices on health intake forms in relation to their views of the healthcare setting, cultural competency levels of healthcare providers regarding the GLBTQ community, and suggestions for needed changes or improvements they would like to see in the healthcare setting in terms of GLBTQ cultural competence (open-ended). Behaviors were evaluated with questions that asked about the respondent’s disclosure of sexuality with healthcare professionals, involvement of allies in the care of GLBTQ patient, and whether or not they had a healthcare surrogate.

### **Statistical Analyses**

For quantitative measures, descriptive statistics were used to present the survey responses for gay men, lesbian women, bisexual men and women, and straight men and women (see below for details). Group differences were explored using an appropriate parametric or non-parametric test statistic with  $\alpha = .05$ . The initial comparison included all four groups. Statistically significant differences were further explored with a series of paired comparisons (e.g., gay men vs. lesbian women).

### **Qualitative Analyses**

Qualitative responses from the open-ended questions were reviewed by three coders, hand-coded, and grouped for key themes based on the a priori content of the questions. Emergent themes were identified when participants reported similar thoughts about a topic that was not expressly asked about in the survey. Content analysis was used to sort and thematically organize the open response comments. An inter-coder reliability rate of .95 was achieved in one round of coding.

## Results

### Sexual Orientation and Gender Identity

Table 1 presents self-reported sexual orientation by gender identity among the 632 participants completing the survey. The most frequent sexual orientation was gay (41.9%), followed by lesbian (30.1%), straight (18%), bisexual (6.2%), queer (2.4%), and questioning (0.5%). There was one male-to-female transgender respondent (0.2%) and no female-to-male transgender respondents (0%). Less than one percent marked 'prefer not to answer.'

In terms of gender identity, there were equal percentages of females (48.9%) and males (48.9%), and a few male-to-female (0.5%) and female-to-male transgender respondents (1.3%). Because of too few transgender sexual orientation and gender identity respondents, these categories were not included in subsequent analyses. Data for four sexual orientation groups were analyzed: gay men ( $n = 263$ ), lesbian women ( $n = 158$ ), bisexual men and women ( $n = 38$ ), and straight men and women ( $n = 110$ ).

### Demographic Information, General Health, and Healthcare by Sexual Orientation

Table 2 presents demographics and health-related information by sexual orientation group. Group comparisons revealed significant differences for several variables. For age group ( $\chi^2(3) = 27.2$ ), bisexual men/women tended to be younger than the other groups ( $z$ 's  $< -3.06$ ) and lesbian women tended to be younger than gay men and straight men/women ( $z$ 's  $< -2.19$ ). For race ( $\chi^2(6) = 20.3$ ), bisexual men/women were less likely to be White than the other groups ( $\chi^2(2)$ 's  $> 10.3$ ). For relationship status ( $\chi^2(3) = 14.5$ ), lesbian women were more likely to be married/partnered than gay men or bisexual men/women ( $\chi^2(1)$ 's  $> 5.4$ ).

For employment status ( $\chi^2(9) = 24.4$ ), the distribution of employment categories differed for all groups except lesbian women and bisexual men/women ( $\chi^2(3)$ 's  $> 9.3$ ). For annual household income ( $\chi^2(3) = 15.2$ ), gay men and lesbian women reported higher income than did bisexual men/women and straight men/women ( $z$ 's  $> 2.39$ ). For health insurance ( $\chi^2(3) = 13.4$ ), and gay men were more likely to report having insurance than all other groups ( $\chi^2(1) > 3.99$ ) and lesbian women were likely to report having insurance than bisexual men/women ( $\chi^2(1) = 4.05$ ). For having been diagnosed with a serious medical illness ( $\chi^2(3) = 31.3$ ), gay men were more likely to report this situation than lesbian women or straight men/women ( $\chi^2(1) > 18.7$ ). The difference between gay men and bisexual men/women was marginally significant ( $\chi^2(1) = 3.39$ ).

### Experience with Healthcare Providers by Sexual Orientation

Table 3 presents results for items concerning behaviors and feelings in relation to healthcare providers. These items were not administered to straight allies. There were significant differences among the three groups for disclosure and fear of negative reaction ( $\chi^2(2)$ 's  $> 6.8$ ). Bisexual men/women were less likely to disclose sexual orientation than were gay men ( $z = -2.53$ ), who were less likely to disclose than were lesbian women ( $z = -1.98$ ). Gay men were less likely to report fearing a negative reaction from a healthcare provider than were lesbian women ( $z = 2.16$ ). The difference between gay men and bisexual men/women was

marginally significant ( $z = 1.95$ ). There were no differences among the three groups in reported experience of a negative reaction from a healthcare provider.

### Equality Sign and Inclusive Language Terms by Sexual Orientation

Table 4 presents participants' perceptions of the use of the Human Rights Campaign logo (Human Rights Campaign 2014) and behaviors related to inclusive language terms. When asked about their feelings towards the presence of the Human Rights Campaign equality sign in healthcare settings, the majority of all groups felt more trust toward the setting. However, about one-in-four respondents reported 'have never seen the HRC Equality sign'. The only significant difference was observed for the 'Do not notice' response ( $\chi^2(3) = 8.5$ ) where lesbian women marked this option less than often than did bisexual men/women and straight men/women ( $\chi^2(1)'s > 4.5$ ).

The majority of gay men, lesbian women, and bisexual men/women reported looking for 'significant other or domestic partner' on medical intake forms. There were significant group differences ( $\chi^2(2) = 24.1$ ) with lesbian women were more likely to mark yes than gay men and bisexual men and women ( $\chi^2(1)'s > 16.3$ ). Furthermore, about 70% of respondents in all three groups stated that the setting was then viewed as more inclusive, although about 18% stated that this language has not been seen on an intake form.

Similarly, the majority of respondents in all three groups reported looking for gender neutral language when referring to spouse/partner with significant group differences ( $\chi^2(2) = 17.9$ ). Lesbian women were more likely to mark yes than gay men and bisexual men/women ( $\chi^2(1)'s > 7.9$ ). About 60% in all three groups stated that the setting was then viewed as more inclusive, although about 18% stated that this language has not been seen on an intake form.

### Cultural Competence

Nearly half of the participants ( $N = 289$ ) provided open-ended comments on ways to improve GLBTQ cultural competence in a healthcare facility. Participants indicated a need for respect, equal treatment, and overall inclusiveness. A participant summed up the thoughts of many through this suggestion: "*The golden rule. Treat others as you want to be treated.*" Participants also suggested a need for staff training to improve knowledge and sensitivity: "*Sensitivity would encourage nervous patients to be more honest*" and "*Improved non-discrimination training for all levels of staffing, including service staff.*" Participants wanted more partner involvement and visitation rights, in the healthcare setting: "*Accept my word or that of my partner... that my partner is allowed to see me ANYTIME. Straight people DO NOT need documentation, why should we?*" and "*Healthcare providers should be more inclusive of spouse/significant other in discussing patient's condition.*" Participants indicated need for improvement of health intake forms: "*Universal inclusive language on forms and staff training so they are not surprised and act surprised*" and "*I would like hospitals to ask for both gender and sexual orientation on intake forms.*" Participants also suggested a welcoming environment with visible GLBTQ stickers and signs: "*Maybe have some sort of recognition or acknowledgement of GLBTQ people, even a HRC [Human Rights Campaign] equality sticker that only "we" know about*" and "*I really*



*like the idea of safe zone/LGBT friendly signage ... assuming it's done in a way that feels legitimate.*" Finally, multiple lesbian respondents noted the requirement of a pregnancy test by medical institutions, particularly after they had disclosed their sexual orientation was "a slap in the face" or was taken as an indication the health care provider "was not listening to me" or "collecting information but not tailoring my care to my needs."

## Discussion

Using a web-based questionnaire, this analysis assessed GLBTQ attitudes, knowledge and experiences of general healthcare by sexual orientation. The results indicated that more participants reported having healthcare insurance, greater incidences of disclosure, greater acceptance from providers of GLBTQ status, and more positive and less negative experiences with healthcare providers than previous studies (Bjorkman and Malterud 2009; Boehmer, Miao, and Ozonoff 2011; Durso and Meyer 2013; Eliason and Schope 2001). Our results suggest the GLBTQ community is becoming more recognized and accepted in the healthcare system. Furthermore, disclosure is widely regarded as having a positive impact on GLBTQ individuals' health. In previous studies, many lesbian women chose to disclose their sexual orientation in an effort to build open and trusting relationships with health providers (Austin 2013). Other studies have suggested that disclosure results in greater satisfaction with healthcare providers as well as more routine receipt of preventive screenings (Austin 2013) and that non-disclosure is associated with poorer psychological well-being (Durso and Meyer 2013). Thus, studies disseminating the positive aspects of disclosure and highlighting limited numbers of negative experiences may encourage members of the GLBTQ community to share this personal information with a health care provider.

Under the umbrella term of GLBTQ, each group has unique and specific healthcare needs associated with self-identified gender and sexual orientation. For example, lesbian and bisexual women have specific needs in areas of sexual and cervical health, reproductive health and parenting, mental health, substance use, and aging (McNair 2003). However, they are less likely to seek healthcare providers and more likely to delay seeking routine care such as pap tests, breast exams, cervical cancer screening and mammograms (Fredriksen-Goldsen et al. 2013). Gay men also use health services less frequently than their heterosexual counterparts (Fish and Anthony 2005; Heck, Sell, and Gorin 2006). Specifically, gay men are less likely to inquire about or receive a prostate screen compared to heterosexual men (Fredriksen-Goldsen et al. 2013). The need for preventive and mental health in these populations has been documented but less is known about barriers to access of these services. Future studies in our research group will focus on these key issues.

Due in part to the additional risk factors associated with this community, GLBTQ populations also face an increased risk of some cancers, which may go unrecognized by the individual and by the physician (Johnson et al. 2004; Lee 2000; Mayer et al. 2008). Additionally, lesbian women are more likely to report having cervical and uterine cancer and gay men are twice as likely to receive a late stage cancer diagnosis compared to heterosexual males (Boehmer et al. 2011). Moreover, GLBTQ cancer survivors are more likely to report fair or poor health compared to heterosexual cancer survivors (Boehmer et al. 2011). The needs and desires of GLBTQ patients with terminal cancer are not fundamentally different

from any other individuals' needs. However, for GLBTQ cancer patients, the usual challenges of diagnosis and treatment are further complicated by the need to disclose sexual orientation, which may be difficult based on previous negative healthcare experiences (Katz 2011). While our study found less negative healthcare experiences than reported by other authors, our results still highlight the need for policy changes, like cultural competence and welcoming signage, which will continue to improve the healthcare experience for the GLBTQ population.

Social stigma and insensitivity of GLBTQ issues are stressors with profound mental health consequences, resulting in low self-esteem, suicidal ideation, depression, anxiety, substance abuse, tobacco use, and feelings of powerlessness and despair (Johnson, Mimiaga, and Bradford 2008). Consequently, providing a safe and welcoming environment in healthcare facilities is imperative to increasing screening and treatment seeking behaviors in the GLBTQ and other minority populations (Brach C and Fraser I 2000; Hutchinson MK, Thompson AC, and Cederbaum JA 2006). A statistically significant number of participants reported they felt more trust and safer to disclose information when there were visible equality signs and symbols throughout the hospital. Furthermore, they looked for gender neutral language and symbols on forms to increase this sense of security and influence their view of the institution and setting as inclusive. The appropriate usage of language and symbols are essential for this population whose past history of stigmatization and discrimination have made these individuals feel unsafe and oppressed (Sardar 2008).

Because of the barriers the GLBTQ community faces in seeking healthcare, it was essential to learn how to facilitate care and improve their experiences within healthcare settings and with healthcare providers. Participants' comments on ways to improve GLBTQ cultural competence at any healthcare facility indicated a great need for additional staff training to improve GLBTQ knowledge, a sense of overall inclusiveness from healthcare staff, cultural sensitive healthcare forms, and a welcoming healthcare environment. These findings are in line with common opinions and needs from this community (Lee 2000; Mayer et al. 2008; Roberts and Fantz 2014).

Risk factors such as smoking, excessive drinking and, risky sexual behaviors may place GLBTQ individuals at higher risk for developing certain cancers. Participants reported higher incidences of cancer diagnoses than previous studies on lesbian, bisexual males and females, and gay individuals (Boehmer et al. 2011). Increased incidence of cancer diagnoses in this population indicate an essential need to prevent future cancers through routine screens and increased accessibility to cancer care facilities and treatment. For GLBTQ individuals with terminal cancer, legal restrictions and societal attitudes can negatively affect their dying experiences. Lesbians and gay men face many challenges, including issues of disclosure in the healthcare setting, discrimination, misconceptions, legal and financial barriers and the disenfranchised grief of surviving same-sex partners (Smolinski and Colón 2006). If these challenges are not resolved through legal and social means, the healthcare disparities evident in the GLBTQ community will continue to worsen.



## Limitations

This study has several limitations. We did not use a random sampling strategy to collect these data. There were very few bi-gender and transgender individuals in the sample. Also, data were collected in one geographic area in Florida and participants' demographic information and views may not represent those of other areas of the US. We partnered with Equality Florida, a statewide advocacy group for GLBTQ persons and their allies because they have the largest population of supporters in the Tampa Bay region. While our study population is highly representative of the known GLBTQ population of the counties of Florida where the study was conducted, GLBTQ individuals who are not members of Equality Florida or who do not identify with this community did not have access to the survey and are therefore not represented.

## Conclusions

Healthcare providers have a vital role in promoting awareness of GLBTQ health issues and inequalities through education, research, and health policy (McNair 2003). Healthcare providers' attitudes are vital to the care of GLBTQ individuals, as they can affect their ability to provide appropriate care to this community. GLBTQ individuals' experience of healthcare disparities can be eliminated if clinicians elicit information about sexual orientation and gender identity and provide a nonjudgmental and empathetic environment (Makadon 2012). Medical institutions, physicians, nurse educators, practitioners, and policy-makers all have critical roles to play in the accessibility of healthcare and cancer care for GLBTQ individuals. Future studies, that include larger number of individuals across broader geographic areas, are needed to understand the healthcare needs and barriers of GLBTQ individuals.

As a result of this study, our healthcare institution is changing medical intake forms to include additional gender identity options and sexual orientation. Additionally, we will review clinical guidelines and hospital policies to explore a provision of explanation for why pregnancy tests are required of all females or discontinue requiring these tests for women who report their sexual orientation as lesbian and do not consider pregnancy a possibility. Other important policy issues include hospital visitation and end-of-life decision making. Hospital visitation policies may not recognize same-sex partners and these partners may be unable to enforce directives regarding health and hospice care. We also recommend improvements to confidentiality of disclosure, particularly for transgender individuals.

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**TABLE 1.**

Frequency Distribution of Self-Reported Sexual Orientation and Gender Identity

Sexual Orientation	Gender Identity					Total (%)
	Female	Male	Trans- gender: F-to-M	Trans- gender: M-to-F	Other	
Gay	2	263	0	0	0	265 (41.9)
Lesbian	185	1	1	3	0	190 (30.1)
Straight	74	36	1	3	0	114 (18.0)
Bisexual	31	7	0	1	0	39 (6.2)
Queer	11	1	1	0	2	15 (2.4)
Prefer not to answer	3	1	0	0	1	5 (0.8)
Questioning	3	0	0	0	0	3 (0.5)
Transgender: M-to-F	0	0	0	1	0	1 (0.2)
Transgender: F-to-M	0	0	0	0	0	0 (0.0)
<b>Total (%)</b>	309 (48.9)	309 (48.9)	3 (0.5)	8 (1.3)	3 (0.5)	632

**TABLE 2.**  
Demographics and General Healthcare by Sexual Orientation

	Sexual Orientation <sup>1</sup>			
	Gay (N = 263)	Lesbian (N = 185)	Bisexual (N = 38)	Straight (N = 110)
<b>Male</b> <sup>2</sup>	100.0	0.0	18.4	32.7
<b>Age Group</b>				
18 – 29 years	4.9	12.4	29.0	13.6
30 – 42 years	14.1	22.2	26.3	17.3
43 – 55 years	42.2	31.4	29.0	18.2
56 – 64 years	21.7	21.6	15.8	25.5
65 or more years	17.1	12.4	0.0	25.5
<b>Race</b>				
White	94.7	91.9	75.0	93.5
Black or African American	1.9	4.4	8.3	3.7
Other	3.4	3.8	16.7	2.8
<b>Hispanic ethnicity</b>	4.6	5.9	10.5	5.4
<b>Married/Partnered</b>	62.0	78.4	60.5	68.2
<b>Education</b>				
HS diploma/GED or less	7.3	6.5	5.4	7.3
Some College	16.8	15.7	27.0	24.6
Graduated College	38.6	35.1	37.8	32.7
Postgraduate Degree	37.4	42.7	29.7	35.5
<b>Employment Status</b>				
Full-time	53.9	62.0	55.3	46.4
Part-time	9.2	7.1	13.2	10.0
Retired	23.5	13.0	2.6	26.4
Other	13.5	17.9	29.0	17.3
<b>Median Household Income Category</b> <sup>3</sup>	\$70–79K	\$60–69K	\$40–49K	\$50–59K
<b>General Health and Healthcare</b>				
Insured	90.5	84.2	70.3	82.6
Have a healthcare surrogate	63.2	63.2	48.7	53.7
Surrogate is spouse or partner	74.6	82.8	66.7	70.7
Have received cancer diagnosis	17.7	14.7	10.5	14.6
Have received serious illness diagnosis	42.0	22.3	26.3	17.4

<sup>1</sup>Gay sexual orientation was restricted to males; lesbian sexual orientation was restricted to females; bisexual and straight sexual orientations were restricted to males and females.

<sup>2</sup>All values presented in table are percentages (%), except for household income.

<sup>3</sup>9.7% of participants marked 'Prefer not to answer.' N's for the four Sexual Orientation groups were 21, 14, 4, & 19. For all other items providing this response option, less than 1.2% marked this option for a variable. Furthermore, no one participant marked this response to more than 2 items. 'Prefer not to answer' was treated as missing data for all group comparisons.

**Table 3.**

## Experience with healthcare providers

	Sexual Orientation <sup>1,2</sup>		
	Gay (N = 263)	Lesbian (N = 185)	Bisexual (N = 38)
<b>Disclosed sexual orientation<sup>3</sup></b>			
All providers	64.9	73.6	47.2
Some providers	29.0	22.5	30.6
None	6.2	3.9	22.2
<b>Have experienced negative reaction<sup>3</sup></b>			
Yes	11.9	10.5	14.7
Possibly	11.2	12.7	8.8
No	76.9	76.8	76.5
<b>Fear negative reaction</b>			
Always	3.8	4.3	2.6
Often	6.1	9.2	7.9
Sometimes	32.1	37.3	44.7
Rarely	22.5	22.7	29.0
Never	35.5	26.5	15.8



**TABLE 4.****HRC Symbol and Inclusive Language Terms by Sexual Orientation**

	<b>Sexual Orientation<sup>1,2</sup></b>			
	<b>Gay (N = 263)</b>	<b>Lesbian (N = 185)</b>	<b>Bisexual (N = 38)</b>	<b>Straight<sup>3</sup> (N = 110)</b>
<b>When you see HRC ‘Equality’ sign or other universal signs of acceptance<sup>4</sup></b>				
Feel more trust toward the setting	63.9	57.8	68.4	59.1
Feel it is safer to disclose	47.5	49.7	63.2	N/A
Does not make a difference	7.2	5.4	2.6	6.4
Am suspicious of the setting	1.5	0.5	0.0	2.7
Do not notice	5.3	2.7	13.2	8.2
Have never seen the HRC ‘Equality’ sign	24.0	27.6	28.9	32.7
<b>Do you look for the option of “significant other or domestic partner” on health intake forms?</b>				
Yes	70.5	86.9	55.6	N/A
No	25.2	9.8	38.9	N/A
Don’t know/Not sure	4.3	3.3	5.6	N/A
<b>Seeing this option for marital status, how does it impact your perception of setting?</b>				
View institution/setting as inclusive	69.1	73.5	73.0	N/A
Has no impact	14.5	6.5	2.7	N/A
Other	0.4	1.6	2.7	N/A
Have never seen this option	16.0	18.4	21.6	N/A
<b>Do you look for gender neutral language for partner on health intake forms?</b>				
Yes	59.0	77.2	54.3	N/A
No	35.9	20.7	40.0	N/A
Don’t know/Not sure	5.1	2.2	5.7	N/A
<b>Seeing gender neutral language, how does it impact your perception of setting?</b>				
View institution/setting as inclusive	56.7	64.9	56.8	N/A
Has no impact	21.7	15.1	18.9	N/A
Other	1.5	1.1	8.1	N/A
Have never seen this option	20.1	18.9	16.2	N/A

<sup>1</sup> Gay sexual orientation was restricted to males; lesbian sexual orientation was restricted to females; bisexual and straight sexual orientations were restricted to males and females.

<sup>2</sup> All values presented in table are percentages (%). Those marking N/A (e.g., have not completed a medical form) or prefer not to answer were coded as missing.

<sup>3</sup> N/A represents those items/responses for straight respondents that were not applicable (i.e., not asked or not given the response option).

<sup>4</sup> Participants were permitted to check each of the six response options. Group comparisons were completed for each response option.