

Lesbian, Gay, Bisexual, and Transgender (LGBT) Healthcare in Rural Settings: An Integrative Review of the Literature

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LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) HEALTHCARE IN RURAL
SETTINGS: AN INTEGRATIVE REVIEW OF THE LITERATURE

by

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A thesis submitted in partial fulfillment of the requirements
for the Honors in the Major Program in Nursing
in the College of Nursing
and in The Burnett Honors College
at the University of Central Florida
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ABSTRACT

The lesbian, gay, bisexual, and transgender (LGBT) community is a unique population that has specific health issues and health care needs associated with lifestyle behaviors that increase risk for certain diseases. Health concerns include mental and behavioral health, issues associated with gender identity and relationships (i.e. intimate partner violence), sexually transmitted infections, and chronic illnesses. The research suggests poorer health outcomes for the LGBT population compared to heterosexual and/or cisgender counterparts. Most research conducted with LGBT populations occurred in more populated urban settings with very few studies focusing on this population in the rural context. Consequently, there is a paucity of information on the health care concerns of the rural LGBT population. Considering the information gap, this integrative review of 14 research articles focused on health-related issues of the LGBT population in rural regions. The findings revealed rural LGBT persons experience disparities in accessing health care and support services; coupled with health care providers who often were not culturally competent; and, sometimes, unfamiliar with evidence-based health care protocols when caring for the LGBT patient. Implications for nursing research, education, practice, and policy and study limitations are highlighted.

DEDICATIONS

I would like to thank everyone in my life who has pushed me to greatness and has motivated me to be the best version of myself possible. To Dawn and Mark, thank you for your support and encouragement as my loving surrogate mom and dad. To Pops, thank you for always pushing me to the point of extreme competition and for raising me to always strive for something greater.

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Table of Contents

Introduction	6
Purpose	8
Problem Statement	8
Background	9
Understanding the LGBT Population	9
The Minority Stress Model	10
The Fundamental Cause Theory	11
Significance	13
Methods	15
Findings	16
Disparities in Outcomes and Risk Behaviors	16
Physical Health	16
Mental Health	19
LGBT Utilization and Experiences with Health Care	20
Cultural Competency of Medical Providers	20
Barriers to Access	21
Discussion and Knowledge Gaps	23
Implications for Nursing	25
Education	25
Practice	25
Policy	27
Research	27
Conclusion	29
Figure 1: Methodology	31
Table 1: Summary of Reviewed Articles	32
References	39

Introduction

In the United States (US), among adults identifying as lesbian, gay, bisexual, or transgender (LGBT) comprises about 4.1% of the population; or about 10 million individuals (Gates, 2017). Precise demographic data for the LGBT population is limited associated with omission of sexual orientation questions on most state and federal health surveillance program surveys (Sell & Holliday, 2014). There is growing evidence suggesting individuals identifying as LGBT tend to experience notable disadvantages in respect to healthcare quality and outcomes compared to cisgender and/or heterosexual counterparts. Cisgender is defined a person whose gender identity correlates with the assigned gender at birth (Center for Disease Control [CDC], 2017). Since the percentage of individuals self-identifying as LGBT is relatively low, the phrase “sexual minorities” will be utilized in this review.

Individuals who self-identify as LGBT (i.e., sexual minorities) often face unique situations and stressors that can contribute to less than optimal outcomes on their overall health status (Woodell, 2016). In comparison to urban areas, rural environments generally have a smaller population distributed over a larger geographic region. Consequently, the essential rural population mass is lacking to support a particular service or industry, specifically services for LGBT persons. Studies focusing on LGBTs have predominately concentrated on urban samples which, in turn, cannot be generalized to comparable rural populations. This evidence deficit hinders understanding the particular health-related concerns and healthcare barriers confronting LGBT individuals in rural areas. Impaired access issues can impact the timeliness as well as quality of care for rural residents in general, and the LGBT population in particular (Woodell, 2016).

Healthy People 2020 (Department of Health and Human Services [DHHS] 2018) identifies access disparities associated with greater geographical distances between services and providers, fewer providers and specialists, in particular providers caring for patients having an alternative sexual orientation. Along with limited access to healthcare, rural LGBT persons often experience stigma, discrimination and culturally insensitive providers; thus, a factor in delaying or never seeking healthcare (Fisher, 2014). Social and geographic isolation is an often-reported concern for rural residents especially in more remote and medically underserved regions, and this may be of an even greater concern for someone having an alternative sexual preference/orientation (Whitehead et al., 2016). Healthcare provider's urban and rural alike generally require LGBT-sensitive education to properly serve minority populations. In particular, on average curricula in US and Canadian medical schools devote fewer than five hours to LGBT health care-related curriculum; some schools do not even address the topic (Obedin-Maliver et al., 2011). In rural areas, the number of individuals self-identifying as LGBT is quite low; thus, rural health care provider exposure to this population is very limited, and there may be no rural specialist focusing on this population. A provider's lack of knowledge about the particular needs of the LGBT population may result in cultural insensitive care and poorer health outcomes. Comparatively, urban-based providers are more likely to be exposed to and have greater educational opportunities to learn about the needs of LGBT persons (Obedin-Maliver et al., 2011). Healthy People 2020 (Office of Disease Prevention and Promotion, 2018) indicates residents in rural areas, regardless of sexual identity, have poorer health outcomes compared to urban residents. Given the information deficit, this integrative review will examine the research literature focusing on the rural LGBT healthcare concerns and outcomes.

Purpose

The purpose of this integrative literature review was to examine the health-related concerns and health outcomes among the LGBT population in rural geographical areas.

Problem Statement

Based on an examination of relevant research literature, what are the health-related concerns and health outcomes among the LGBT population in rural geographical areas?

Background

Understanding the LGBT Population

The LGBT community encompasses several diverse groups, including individuals who self-describe as lesbian, gay, bisexual, or transgender, often referred to as *sexual* and *gender minorities* (CDC, 2017). Within the scope of research studies, the classification of lesbians, gays, and bisexuals is typically made based on sexual orientation. *Transgender* refers to those whose gender identity or expression (i.e. masculine, feminine, or other) is separate and different from their assigned sex at birth (CDC, 2017). Compared to American culture, some American Indian and Asian communities recognize a transgender person as part of their mainstream society (Blosnich et al, 2010). Women oriented to other women are referred to as *lesbians*, men attracted to other men as *gay*, and individuals oriented to both men and women as *bisexual* (Mayer, Bradford, Makadon, Stall, Goldhammer, & Landers, 2008).

Gender identity refers to a person's internal understanding of gender, or the gender the individual identifies with (CDC, 2017). *Gender expression* refers to the outward presentation of an individual's sexuality (CDC, 2017). Gender identity and sexual orientation are distinct concepts and encompass different aspects of one's identity. Every human has a gender identity and a sexual orientation; however, one's gender identity does not necessarily determine sexual orientation. Although the transgender community is included in the LGBT population, these individuals may identify as, *heterosexual, homosexual, bisexual, asexual, other, or, none of the above*. The term, *cisgender* refers to a person whose gender identity corresponds with the assigned birth sex (i.e., male; female) (CDC, 2017). Another identifier is *gender non-binary* or *gender non-confirming* which refers to one's gender identity existing on a spectrum that can exist

outside of the *gender binary* and *cisnormativity*; in other words, the individual may display qualities of feminine, masculine, neither, or both in their gender expression. The term transgender can broadly apply to this subpopulation; however, the term *gender expansive* is sometimes used rather than gender binary. Essentially, sexual and gender identity/expression tend to be characterized by fluidity and change. For instance, there can be individuals who report homosexual behavior but self-identify as heterosexual; while others over time, vary their self-perception; thus, will self-identify as heterosexual, or bisexual, or homosexual.

Regardless of self-described gender identify/gender expression, health disparities exist in the LGBT population. Two models have been developed that can be useful to better understand disparities, specifically the *Minority Stress Model* and the *Fundamental Cause Model* (Meyer, 2015; Woodell, 2016). Both models are discussed in the next few paragraphs.

The Minority Stress Model

The *Minority Stress Model* proposes that sexual minorities experience unique stressors, including discrimination, victimization, and rejection which contributes to additional adverse mental and physical health outcomes compared to heterosexual counterparts (Meyer, 2015). Minority status exacerbates exposure to *distal stressors* (i.e. external events such as discrimination) and *proximal stressors* (i.e. internal byproduct of distal stressors, such as internalized homophobia) (Meyer, 2015). This model attributes environmental circumstances, particularly in rural settings that can contribute to stigma and prejudice - a lifelong stressor for many in the LGBT population. The model initially focused on sexual orientation, but more recently, has shown those who are transgender or gender nonconforming can be similarly impacted (Meyer, 2015). While LGBT persons tend to experience more discriminatory-based stress, the population as a whole generally is able to interact effectively in society and

demonstrate effective coping and resiliency. However, it is important to analyze minority stress as a contributing factor in understanding the manifestation of health disparities among the LGBT population.

The Fundamental Cause Theory

The *Fundamental Cause Theory* links the processes of stigma, discrimination and disparities with (limited) access to resources. Subsequently, these social and cultural factors are factors in health inequalities between heterosexuals and the LGBT community (Woodell, 2018). Over time, these factors are associated with health disparities (inequalities) which persist despite advancements in healthcare as evidenced by morbidity and mortality data. Among sexual minorities, “stigma” has been linked to poor health, social isolation, and poor, maladaptive coping mechanisms, such as substance abuse and interpersonal violence (Whitehead, 2016). In other words, some health disparities between heterosexual and LGBT populations could possibly be lessened if stigma was reduced toward the LGBT community.

The Fundamental Cause Theory and Minority Stress Model can help to frame factors contributing to health disparities among sexual minorities (Meyer, 2015; Woodell, 2016). Together, the two theories provide an explanation to better understand the rural context relative to LGBT health disparities in that particular setting, specifically, rural socio-cultural dynamics along with barriers to resources and providers.

Defining “Rural”

The 2010 Decennial Census Bureau reports about 60 million people, or 19% of the total population, reside in rural areas of the US. There are numerous definitions of rural, for example, some define *rural* as a town with fewer than 1000 people (Census Bureau, 2010). The Census

Bureau first defines an urban area; then, by default extrapolates rural. Specifically, an urbanized area (UA) is comprised of 50,000 or more people. An urban cluster (UC) has at least 2,500 and less than 50,000 people in the area (Census Bureau, 2010). Subsequently, a rural area encompasses all populations, housing, and territory not included within urban areas.

In rural areas, the population density is much lower spread across a larger geographical area compared to more-populated urban areas (Census Bureau, 2010). Consequently, in rural regions, a person's place of residence and businesses are located at greater distances from each other. Geographical distances along with transportation challenges in more austere rural environments contribute to a disparity in access to healthcare services, providers and other essential LGBT resources and community support. A rural individual who self describes as LGBT may also experience geographic and social isolation as well as stigma (Whitehead, 2016; Woodell, 2018). Anecdotally, some individuals report they feel they are the only LGBT person that they personally are aware of. Consequently, the express feeling alone, isolated and reluctant to disclose gender identify/orientation to peers, family, a physician and other health care providers.

Significance

Healthy People 2020 recommends further research is needed focusing on the rural LGBT population in order to document, understand, and address the environmental factors that contribute to their particular needs and health disparities (Office of Disease Prevention and Health Promotion, 2018). For example, lesbian, gay, and bisexual individuals have a higher prevalence of smoking, alcohol and/or illicit drug use, self-directed violence, and poor mental health compared to heterosexual counterparts (Rosenkrantz et al, 2017). The LGBT population also is at higher risk for chronic diseases specifically cardiovascular disease, certain cancers, respiratory diseases, asthma, headaches, and serious gastrointestinal problems (Farmer, Blosnich, Jabson, & Matthews, 2016). Using an online survey focusing on a population residing in a rural zip code (N = 1014), Whitehead, Shaver, & Stephenson (2016) reported that some LGBT individuals were more likely to engage in high-risk behaviors associated with their sexual identity and sexual experience. Specific lifestyle behaviors, associated with receptive anal intercourse among gay and bisexual men, places them at an increased risk for anal cancer, human immunodeficiency virus (HIV), and other sexually transmitted infections, while cardiovascular conditions and organ damage is more prevalent among the transgender population undergoing hormone therapy (Whitehead et al, 2016).

In a study using data from the 2010 Behavioral Risk Factor Surveillance System, Farmer et al. (2016) examined the risk factors for those self-identifying as LGBT (N=93,414) who meet criteria for rural residence in a nonmetropolitan statistical area. Risk factors that were identified for the rural LGBT community included decreased access to care, coupled with the reality that lesbian, gay, and bisexual persons were more likely to delay or avoid receiving medical care compared to heterosexual counterparts (Farmer et al., 2016).

LGBT adults also had lower screening rates for preventable or treatable diseases. For instance, lesbian and bisexual women are less likely than heterosexual women to have a Papanicolaou (Pap) test and mammograms (Whitehead et al., 2016). Furthermore, LGBT individuals, compared to heterosexual adults, are less likely to have a primary care physician, more likely to be uninsured, or unable to afford health services, even with implementation of the Affordable Care Act (Whitehead et al., 2016).

An Institute of Medicine (Institute of Medicine [IOM], 2011) report identified geographic location as one of four critical domains that can influence health status and access to care among LGBT individuals. Specifically, LGBT persons residing in a rural area or region having very low LGBT population, tend to feel less comfortable disclosing their sexual orientation or identity. Moreover, the rural LGBT population often have a decreased or nonexistent (community) support system, with limited access to culturally sensitive health care services and providers (IOM, 2011). In comparison, LGBTs residing in urban areas tend to experience less stigma, are more likely to find support services and have better access to specialized healthcare and providers who have experience in treating LGBT patients (Whitehead et al, 2016). For nurses to provide culturally competent and effective healthcare to the rural LGBT community, specific disparities and inequalities relative to healthcare access must be examined. Subsequently, reviewing the evidence about the rural LGBT population provides a strong rationale for undertaking this integrative review of the research literature focusing on the health concerns and health outcomes of this minority population.

Methods

For this thesis, research articles were identified, systematically analyzed and synthesized to gain a better understanding the rural LGBT population, their health concerns, inequalities and healthcare needs. Relevant literature for review was identified by searching CINAHL, Medline, Google Scholar, Pubmed, Psychinfo (EBSCOhost) and Academic Search Premier databases published in peer-reviewed journals between the years 2008 to 2018. Search terms included “rural,” health care or “healthcare,” and LGBT* or GLBT* or gay* or homosexual* or lesbian* or bisexual*. Inclusion criteria for the search results included: articles published in the English language; and, published during the aforementioned period. Exclusion criteria included articles published in a language other than English (See Appendix Figure 1; Methods Chart).

Each article was read, evaluated and critiqued by the author for relevance to the topic and its application to the LGBT community in rural healthcare settings. Subsequently, all of the articles were synthesized by the author to identify consistent and inconsistent findings as well as gaps in the research. An evidence table was developed to highlight findings for each article included in the review for this thesis. See Appendix Table 1.

The literature search yielded 27 results. After exclusion criteria was applied, 17 articles were eliminated. The remaining 10 articles, including four additional studies from references, were included in the literature review.

Findings

Disparities in Outcomes and Risk Behaviors

The analysis of the literature review revealed two common health-related themes among rural LGBT populations, specifically, physical health and mental health. Each of these areas is examined in greater detail in the next section of this paper.

Physical Health

Generally, individuals self-identifying as LGBT report more serious physical issues and limitations compared to heterosexuals. The study findings of Farmer et al. (2016) (N=93,414) focusing on the health disparities of LGBT persons in rural areas was further validated by Woodell (2018) and Rosenkrantz et al. (2017). Farmer's study concluded that sexual minorities report lower levels of self-rated health, with bisexual men and women reporting the highest risk for poor self-rated health (Farmer et al., 2016; Rosenkrantz, Black, Abreu, Aleshire, & Fallin-Bennett, 2017; Woodell, 2017).

As with the general population, lifestyle behaviors can have a major impact on the health status of LGBT persons. The LGBT population, rural and non-rural alike, are at increased risk for substance use and abuse associated with tobacco, alcohol, street and over-the-counter drugs (Blosnich et al, 2014; Rosenkrantz et al, 2017). Rural populations in general, and rural LGBT persons in particular, have a higher rate of current and former tobacco use and alcohol consumption compared to urban-based heterosexual and LGBT populations (Mayer et al., 2016; Rosenkrantz et al., 2017; Woodell, 2016). Recreational drug use, particularly stimulants among homosexual men, has been linked to an increased rate of high-risk unsafe sexual practices which contributes to HIV and other sexually transmitted infections (Mayer et al., 2016).

Studies have shown higher rates of heavy alcohol abuse with its associated problems among lesbians and bisexual women compared to women who identify as heterosexuals (Mayer et al., 2016). For example, sexual minority women report more frequent consumption of alcohol and are at increased risk of developing alcohol dependency (Woodell, 2016). Rosenkrantz et al. (year), utilizing a systematic review of literature (N=58), found the abuse and utilization of these substances also occurred at higher rates in the rural LGBT population compared to the urban LGBT population (Rosenkrantz et al., 2017). Along with increased prevalence of substance abuse, several studies report a higher prevalence of acute physical symptoms (i.e., headaches, sore throats, fever, colds) and chronic health conditions (i.e., diabetes, migraines, hypertension) (Rosenkrantz et al., 2017; Woodell, 2016). Furthermore, the LGBT population has a higher rate of asthma, osteoarthritis, and gastrointestinal incidents compared to heterosexual counterparts (Woodell, 2016).

Upon closer examination of these health conditions, there are noted gender differences. For example, the rural lesbian and bisexual population self-reported health status was worse (i.e., poorer) having a higher rate of chronic illnesses compared to heterosexuals (Farmer et al., 2015; Rosenkrantz et al., 2017). In a self-reported online survey of rural and urban lesbian-identifying women (N=895), Barefoot, Warren, and Smalley (2015) found that lesbian and bisexual women reported poorer physical health with an increased risk for becoming overweight and obese; and, they were less likely to participate in the recommended physical activity compared to heterosexual females (Barefoot et al., 2015; Woodell, 2016). Lesbian and bisexual identifying females also had a higher incidence and diagnosis of breast cancer, but, reported lower rates of receiving of Papanicolaou (PAP) screenings (Farmer et al., 2015; Barefoot et al., 2015; Rosenkrantz et al., 2017).

Sexual minority men experience specific health disparities that are distinct from lesbian and bisexual females and heterosexual males. More specifically, in a self-reported online survey (N=1,014), Whitehead et al. (2016) found, compared to heterosexual counterparts, gay men were at increased risk for cardiovascular disease. They also reported higher instances and frequency of fatigue and headaches; and were diagnosed with a higher number of acute and chronic health conditions (Farmer et al., 2015; Rosenkrantz et al., 2017; Whitehead et al., 2016). Furthermore, gay men were more likely to be diagnosed with cancer (prostate, lung, colon, skin, anal, testicular) and have lower survival rates than heterosexual males (Farmer et al., 2015; Rosenkrantz et al., 2017; Whitehead et al., 2016). Gay and bisexual men have a higher incidence of mental distress, smoking, and engage in activities that puts them at increased risk for HIV acquisition compared to heterosexual men, regardless of rural or urban status (Farmer et al., 2015). An interesting difference in physical health noted among gay and bisexual men is that they are less likely to be overweight or obese compared to lesbian and bisexual women (Rosenkrantz et al., 2017; Woodell, 2016).

Sexual risk taking is another variable that was examined in the reviewed studies. One measure of assessing high-risk sexual behavior is, “use of condoms during sexual exchanges.” In particular, a high rate of inconsistent utilization of condoms was reported among LGBT rural participants (Farmer et al., 2015; Fisher, Irwin, & Coleman, 2015; Rosenkrantz et al., 2017). Other risky behaviors identified among rural LGBT individuals included having multiple sex partners, anal sex, and sexual partnerships while under the influence of alcohol and/or drugs (Rosenkrantz et al., 2017).

Overall, both male and female rural sexual minorities have a greater prevalence of comorbidities ranging from three and four times higher compared to heterosexual counterparts

(Woodell, 2016). The studies that were analyzed for this review reinforced the fact that significant physical health disparities exist in the LGBT population in general; and sometimes, are exacerbated for those in rural areas associated with health care access disparities.

Mental Health

Another common theme that emerged in the reviewed research articles was related to the mental health status in the rural LGBT population. Compared to rural and urban heterosexual counterparts, the LGBT population was at increased risk for being diagnosed with generalized anxiety, mood disorders, post-traumatic stress disorders, depression, suicidal ideation and substance abuse disorders, including addiction to alcohol and illicit drugs (Farmer et al., 2015; Rosenkrantz et al., 2017; Whitehead et al., 2015; Woodell, 2016). Sexual minorities also reported higher levels of depressive symptoms, decreased self-esteem, and increased incidence of general distress compared to heterosexual counterparts (Whitehead et al., 2015).

Mental health outcomes are consistent with less than optimal physical health outcomes that may vary with sexual identity and gender. For example, while the LGBT population in general is at higher risk for anxiety, mood disorders, increased stigma, and depression, gay and bisexual men report an increased prevalence of psychological distress, panic attacks, and depression. Whereas lesbian and bisexual women report a higher incidence of generalized anxiety disorder compared to heterosexual counterparts (Woodell, 2016). Depression is a typical finding in the research focusing on the LGBT population. Compared to the urban LGBT population, there were increased rates of depression and depressive symptoms among rural LGBT adults (Fisher et al., 2014). Additionally, there were higher rates of previous suicide attempts among rural sexual minorities and transgender individuals (Rosenkrantz et al., 2017). Overall, the mental health status of the rural LGBT population poses serious concerns which can

exacerbate physical health problems. Unfortunately, mental and behavioral health care providers and support services to assess and manage these conditions tend to be far and few between, and often nonexistent in small rural communities, especially in remote and sparsely populated regions (Fisher et al, 2014).

LGBT Utilization and Experiences with Health Care

Cultural Competency of Medical Providers

The research suggests that rural LGBT individuals perceive inadequacies in the expertise and cultural competency among health providers in general (Obedin-Maliver et al, 2011). These findings could be attributed to the lack of integration of LGBT content in education curricula for health professional. For example, the median combined hours dedicated to LGBT content in undergraduate medical programs in Canada and the United States was five hours (Obedin-Maliver et al., 2011). Nursing educators are reported to have more positive attitudes toward the LGBT population among the urban sample (Sirota, 2013). However, nursing educators in rural settings were found to have more negative attitudes; and nurses reported “feeling uncomfortable” when treating lesbian or gay patients (Rosenkrantz et al., 2017; Sirota, 2013). For nurse educators in the urban sample, most believed it was important to teach nursing students about the LGBT population but personally felt unprepared to teach this content (Sirota, 2013).

Even when gay and bisexual men disclose their sexual identity and history to their primary care providers, the health services offered were not congruent with current evidence-based guidelines (Obedin-Maliver et al, 2011; Rosenkrantz et al., 2017). Likewise, lesbians and bisexual women upon disclosing pertinent sexual information, had similar experiences of not receiving appropriate treatment based on evidence-based recommendations from their health care

providers (Barefoot et al., 2015; Rosenkrantz et al., 2017). One particular concern related to healthcare providers (i.e., physicians, nurses) was having various levels of competence in treating a transgender patient, such as prescribing inappropriate hormones, providing or not providing access to surgery; and, making exceptions to or ignoring the *Standards of Care* for LGBT individuals (IOM, 2011). However, it is important to note there is a paucity of research on health professional education on LGBT content and LGBT cultural competence of providers in both rural and urban populations.

Barriers to Access

While the research is limited, what has been published suggests that LGBT individuals have different means and utilization patterns of health care services compared to heterosexual counterparts. The most frequently reported barrier to accessing health care resources by the rural LGBT community centered on health insurance issues, specifically being uninsured or underinsured (high co-pays, limited coverage, few preferred providers in a local areas/community, etc.), and discriminatory policy coverage (Barefoot et al., 2015; Farmer et al., 2015; Fisher et al., 2014; IOM, 2011; Rosenkrantz et al., 2017). Rural lesbian and bisexual women reported experiencing more health care cost barriers compared to heterosexual women. However, this finding also was consistent among non-rural (i.e., urban) lesbian and bisexual women (Barefoot et al., 2015).

Outside of the fiscal access barriers, the geographic barriers seriously limit health care access for the rural LGBT population. For example, rural LGBT individuals often must contend with transportation issues related to the weather, geographical factors, limited personal transportation coupled with the lack of public transportation to access a health care providers and services located at a great distance (Farmer et al., 2015). Another hindrance to access healthcare

for rural LGBT individuals is the lack of “LGBT-friendly environment” healthcare providers and services; and, facilities without LGBT-supportive policies which compromised access and quality of care for LGBT clients (Barefoot et al., 2015; Farmer et al, 2015; Rosenkrantz et al., 2017).

Within certain rural communities, the cultural dynamics contribute to the social stigma and discrimination associated with an alternative sexual orientation (Fisher et al, 2014; Whitehead et al, 2016). Consequently, for the rural LGBT residents, this reality contributes to increased stress, a lack of social support, decreased social engagement, and isolation (Barefoot et al., 2015; Farmer et al., 2015; Rosenkrantz et al., 2017; Whitehead et al., 2016). It is not unusual for the LGBT individual to not disclosing sexual orientation and/or gender identity to a health care provider or others in the rural communities (Barefoot et al., 2015; Farmer et al., 2015; Rosenkrantz et al.; Whitehead et al., 2016). The anticipated stigma is a universal perception for the LGBT person in utilizing health care services. However, rural LGBT populations experience some rather unique features compared to urban counterparts, such as a lack of providers, limited provider options, and commuting challenges (socio-economic, educational, inclement weather, distances, and lack of reliable transportation) to access appropriate and acceptable healthcare providers and services (Rosenkrantz et al., 2017).

Discussion and Knowledge Gaps

The literature review supports that the rural LGBT population experiences disparities in healthcare access and health-related outcomes. Geographic, environmental, economic and sociocultural barriers impact the rural LGBT community, such as anticipated stigma and various challenges in accessing healthcare. The literature synthesis found that LGBT individuals experience disparities in healthcare, but the mixed findings make it unclear whether rural LGBT participants experience similar disparities to the LGBT community in general. In other words, the findings comparing the urban and rural LGBT populations were conflicting. An overarching finding among studies is that rural LGBT people are particularly burdened by mental health issues, sexual risk-taking, and substance abuse, whereas, the outcomes of physical health were often less focused on the rural LGBT population.

A gap in the literature is the limited number of studies focusing on the rural LGBT population in general, and in particular, studies related to nursing care for the LGBT patient across the continuum of care. While several studies focused on LGBT content in health professional curricula, there were none that examined the actual opinions of nurses specifically caring for with the rural LGBT population (Obedin-Maliver et al., 2011). Additionally, no studies addressed appropriate communication on the part of health professional communication when working with sexual minorities, such as the utilization of LGBT inclusive terminology on intake assessments, health-related educational materials, and discharge planning along with culturally appropriate graphics and charts that are evident in healthcare facilities.

Another gap in the research is associated with more recent societal changes regarding the legislated civil rights of LGBT persons. This gap became evident when comparing LGBT-related research articles that were published in the mid to late 1990s compared to articles published in

this past decade. In the past five years, there also were more research articles focusing on LGBT individuals which has served to inform and educate the public; thus, increasing awareness and knowledge about the health care needs, concerns and civil rights of this population.

Another issue alluded to in the literature related to regional variations that reflected somewhat unique social and cultural factors that could contribute to differences in health concerns and health outcomes for LGBT persons. While some studies examined sexual minority health disparities comparing rural and urban populations (Barefoot et al., 2017; Fisher et al., 2011; Whitehead et al., 2015), these publications did not specifically define rural or mention the geographical region from which the sample was recruited. This information deficit further hinders presenting the rural perspective in respect to health care access and care seeking behaviors of LGBT individuals residing in sparsely populated areas. For this reason, future research should clearly define rural as it is used in the study; taking into consideration contextual and culture features which vary from one region to another.

Another serious gap in the literature relates to the issues and challenges confronting children and adolescents (under the age of 18) in rural settings, having an alternative sexual preference. While accessing this highly vulnerable LGBT population poses ethical and methodological challenges, information is needed to offer appropriate evidence-based health promoting services along with anticipatory guidance that potentially could prevent serious health problems. Another rural research challenge relates to the low numbers of individual with a particular condition (i.e., diagnosis, alternative sexual preference, HIV/AIDS). Consequently, the limited rural total population of a given condition, will restrict the sample size and could pose threats to assuring confidentiality and anonymity to study participants.

Implications for Nursing

Education

The disparities noted in this integrative literature review reinforces the necessity for increased nursing education about the LGBT population in general, and the rural issues and concern in particular. Even with the increased demand for patient-centered care and mandate for greater attention to the needs of sexual minorities, many nurses still lack the basic knowledge about LGBT patient care. This knowledge deficit is a contributing factor to the persistent negative attitude, stereotyping, and inequitable care and health disparities among sexual minorities. Although attitudes of nurses slowly are becoming more enlightened about LGBT individuals, nursing curricula still include minimal content on LGBT health topics. This deficit is attributable, in part, to nurse educators not being sufficiently informed to instruct about LGBT health topics. In turn, this contributes to nursing care and procedures being heterosexist in nature with the presumption that all clients are heterosexual and the social norm. Historically, nursing curricula have been slow to change, even though nursing should be responsive to social and political societal trends. Ultimately, this knowledge gap among nurses' impact patient care and health outcomes for the LGBT population in general, and those in the rural setting in particular.

Practice

Lack of knowledge among health care providers about the lifestyle and health care needs of the LGBT population contributes to persistent health disparities, discrimination, and stigma. Health care providers, nurses in particular, must become informed about the access disparities confronting LGBT patients who reside in rural areas. Anecdotal reports indicate that it is not unusual for rural LGBT residents to seek health care in an urban setting associated with the lack of culturally sensitive providers along with real, or perceived, stigma experienced in a close knit

small community. For those reasons, it is not unusual for the initial diagnosis of HIV to be made by an urban based health care provider. Sexual minorities (i.e., LGBT persons) often experience stigma and social isolation coupled with inadequate and culturally insensitive care from local rural-based healthcare providers. Integration of LGBT content in the curricula of health professional education, along with professional continuing education, is critical to inform professional clinical practice. Practice settings should also integrate linguistically inclusive language when completing physical assessments, on documentation forms and in educational materials. Vocabulary should be modified to include gender neutral terms when communicating with the LGBT patient. For example, this can be done by asking the patient to self-define biological sex, gender identity, and if appropriate, specifying transgender identity, sexual orientation, and preferred name or pronoun.

It is of utmost importance to create a culturally- attuned practice environment such as displaying posters and educational materials with LGBT-focused graphics, symbols, and terminology; health promotion information; availability of unisex restrooms; and, displays of symbols of inclusivity (e.g., pink triangle, rainbow flag, etc.). While environmental changes can go a long way to promote acceptance of LGBT patients, nurses should adapt their practice approaches as well. For example, when obtaining the patient's health history, the nurse should ask about one's "preferred" gender, name or pronoun. Subsequent questions can then focus on pertinent lifestyle risk behaviors and providing meaningful anticipatory guidance. Systematically including items on medical documents that address sexual orientation and gender identity could assist health care providers to better understand an individual's health care needs and preferences, reduce costs while providing quality care, as well as, enhancing patient satisfaction with the care received.

Policy

The IOM (2011), the Joint Commission, and Healthy People 2020 (Office of Disease Prevention and Health Promotion, 2018) all emphasize the need for collecting data on the health care needs and experiences of the LGBT population. More recent policies offered by the Centers for Medicare and Medicaid Services (CCMS) (2018) and the Office of National Coordinator of Health Information Technology (2015) mandate that electronic health record (EHR) systems allow users the option to record, change, and access structured data on sexual orientation and gender. The intent of these policies and regulations is to improve LGBT patients' health by offering appropriate healthcare services; and, ultimately, improve health outcomes and patient satisfaction with their experience. However, these regulations do not mandate that providers collect sexual orientation and gender identity data from every patient. An organization also should display its nondiscrimination policy to inform all individuals who access care in that facility. Efforts should be made to promote and advocate for public policy that is geared towards improving access to culturally- sensitive and high-quality care for LGBT individuals, particularly in rural areas. Furthermore, legislation must be implemented requiring inclusive terminology on medical documents focusing on sexual minority preferences.

Research

Based on the review of literature and the noted information gaps related to LGBT persons in rural settings, these are potential research topic areas. Given the lack of data regarding the noted health disparities, additional studies are needed to more precisely define the rural LGBT population, their health-related concerns, and health outcomes. Health specific evidence is needed despite low rural samples, specifically individuals who identify as LGBT. Efforts must be undertaken on the part of nursing professional organizations to include rural LGBTs in their

research agendas and advocating for research funding for studies with rural participants. Studies are critically needed focusing on rural youth (under the age of 18) who self-identify as having an alternative sexual orientation to determine their specific lifestyle risks and health-related concerns. Evidence-based practice guidelines also are needed to inform nurses on early treatment interventions to affect this rural population's health disparity; and, to provide cost-effective treatment approaches that improve health outcomes among the rural LGBT patient population. Finally, linguistically-appropriate surveys must be developed to effectively measure the rural LGBT patient's satisfaction with the health care they receive as mandated by legislation (i.e., Hospital Consumer Assessment of Health Care Providers and Systems [HCAHPS]) (CMMS, 2018).

Limitations

Several limitations are noted in this integrative review. The review was limited in scope to articles published between 2008 to 2018, conducted in the US, and written in the English language. Additionally, most of the studies that were reviewed presented the medical perspective rather than the nursing perspective. In turn, this focus limited the findings relevant to nurses and nursing practice. All the articles focused on adult populations; and, no studies focused on individuals under 18 years of age.

The findings from the reviewed studies are not generalizable for several reasons. The definitions used in the study differed for LGBT status, such that some studies were self-identifying for sexual orientation or relied on demographical data that did not include options for identifying as LGBT, and the term 'rural' had a various, imprecise or no definition. Also, imprecise or nonexistent, was health care provider education and health outcomes of the rural LGBT population. Most of the studies utilized self-reported surveys and had small convenience

samples, which typically focused on urban populations; and, there was little emphasis on transgender populations. Another limitation was the sample consisted predominately of “white” urban participants; and, not adequately representing racial and ethnic diversity within the rural population. Additionally, the studies did not take into consideration the unique social, economic and cultural features of a rural region which differs from one region to another. Finally, a power analysis was not included in the studies analyzed to predetermine the appropriate sample size for the various studies.

Despite these limitations, the information that was gleaned in this integrative review is relevant and can enhance awareness of the healthcare needs of the rural LGBT population. Generalizability of studies that occur within the urban context should not be extended to counterparts in a rural context given the inequities in health care access. Although there are challenges in recruiting adequate sample sizes for research, more work is needed to overcome this barrier to appropriately represent the healthcare needs and outcomes for this population.

Conclusion

Nurses, as a member of the health care team, must strive for equity of access and quality of care for all patients in the US to eliminate health disparities among the rural LGBT population. Impaired access to healthcare is a common reality in many rural settings, which may pose even greater challenges for sexual minorities associated with social and geographic isolation coupled with real or perceived stigma. Regardless of sexual orientation, rural residents have an increased risk of negative health outcomes associated with access barriers to health care and the social dynamics that take place in small close-knit communities. This integrative review

reinforced the need for additional evidence to better understand and care for rural LGBT individuals, an underserved minority population.

Figure 1: Methodology

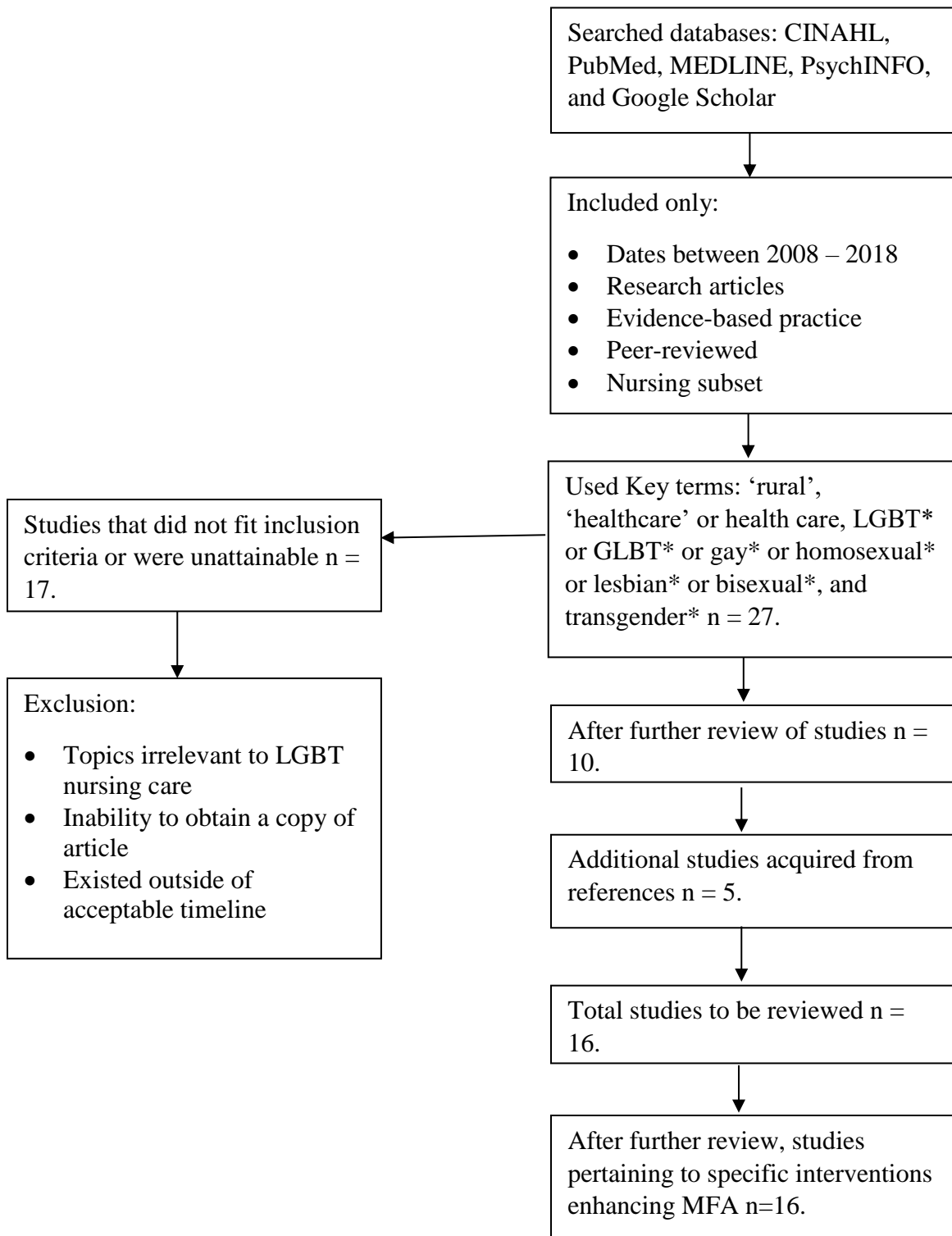


Table 1: Summary of Reviewed Articles

Authors / Date	Title	Population	Location	Method	Topics / Main Findings	Limitations
Whitehead, Shaver, & Stephenson (2016)	Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations	946 LGBT individuals, including transgender & non-binary participants (all rural)	US National Sample	Recruitment primarily via Facebook ads targeted towards age 18+ w/ LGBT-related interests who reported residence in rural area codes; Quantitative online survey	1. Higher scores on stigma scales were associated with lower utilization of health care services for transgender & non-binary participants 2. Higher levels of disclosure of sexual identity and orientation were associated w/ greater utilization of health services for cisgender men	1. Recruitment bias of relatively young sample 2. Lacked expected racial & ethnic diversity in target rural population 3. Did not collect data on gender identity expression or how others perceive respondents' gender
Sirota (2013)	Attitudes Among Nurse Educators Toward Homosexuality	1,282 nurse educators (153 rural)	US National Sample	Recruitment via contacts for nurse educators employed full- or part-time in Commission on Collegiate Nursing Education-accredited colleges of nursing; Quantitative online survey	1. Most respondents believed it was important to teach nursing students about homosexuality, but they considered themselves unprepared to teach this content 2. Outcomes based on Attitudes Toward Lesbians and Gay Men Scale (ATLG = high scores = more	1. Excluded faculty in associate degree programs and diploma schools of nursing, which limits generalizability of study 2. Regional differences not explored

					negative attitudes) resulted in increase in ATLG	
Farmer, Blois, Labson, and Matthews (2015)	Gay Acres: Sexual Orientation Differences in Health Indicators Among Rural and Nonrural Individuals	139,534 LGB & heterosexual persons; 615 lesbians, 654 gay, 683 bisexual; (18% = 25,106 rural)	10 states: Alaska, Arizona, California, Maine, Massachusetts, Montana, New Mexico, North Dakota, Washington, Wisconsin	Quantitative: data analysis from individual state Behavioral Risk Factor Surveillance Surveys (BRFSS) data with contains sexual orientation in the 2010 survey	<p>1. There were fewer differences on key health indicators between rural LGB persons and rural heterosexual counterparts than among non-rural LGB participants and their non-rural heterosexual counterparts</p> <p>2. Poorer health for LGB persons; however, gay and bisexual men had a lower prevalence of being overweight/obese than heterosexual men in both rural and non-rural settings</p> <p>3. Bisexual men and women had more negative health indicators than gay men and lesbian women, regardless of rural or non-rural status.</p> <p>4. Findings run counter to the notion that LGB persons in rural areas have poorer health</p>	<p>1. Use of only sexual orientation self-identification (not sexual behavior or attraction)</p> <p>2. Only 10 states; missing states from the US South, where rural areas may be qualitatively different</p> <p>3. LGB subgroups still too small to reliably detect significant within-group differences</p> <p>4. Possible confounding by state-level policies</p>

					outcomes than non-rural counterparts.	
Fisher, Irwin, and Coleman (2014)	LGBT Health in the Midlands: A Rural / Urban Comparison of Basic Health Indicators	Survey 770 LGBT individuals; (10.5%, n = 75 rural)	Nebraska	Quantitative: online survey w/ recruitment via community-based participatory research (CBPR) approach	<p>1. High smoking and drinking overall for LGBT population</p> <p>2. Rural / urban differences: less health insurance, less social engagement, less outness, less self-acceptance for rural respondents</p>	<p>1. Convenience sampling</p> <p>2. Multiple comparisons, with some of the borderline significances being through chance</p> <p>3. All measures were self-report</p>
Barefoot, Warren and Smalley (add year)	Women's Healthcare: Experiences and Behaviors of Rural and Urban Lesbians	895 lesbian-identifying cisgender women (31.1% rural)	National survey	Quantitative: online survey through email communication to LGBT-focused organizations and online advertisements	<p>1. Low percentage of rural lesbians reported that they had a Women's Health Care Provider (WHCP) that they see on a regular basis for preventative care.</p> <p>2. Fewer rural lesbians indicated that their current WHCP had discussed/recommended human papilloma virus vaccination in comparison to urban lesbians.</p> <p>3. No significant difference in experiences of care with WHCPs emerged between urban</p>	<p>1. Convenience sampling</p> <p>2. Majority of respondents were Caucasian / European-American (almost 70%), limiting the generalizability to lesbians who are racial/ethnic minorities</p> <p>3. All measures were self-report</p>

					and rural respondents. 4. Low percentage of rural and non-rural lesbians reported having STI/HIV screening, PAP, or HPV vaccine.	
Kenneth Mayer, Harvey Makadon, Ron Stall, Hilary Goldhammer, Stewart Landers (2008)	Sexual and Gender Minority Health: What We Know and What Needs to be Done	Review article	United States	Conceptual paper: comprehensive review of existing literature regarding the barriers and disparities for sexual minorities	<p>1. Unique health indicators for sexual and gender minorities include obesity/overweight, tobacco and substance use, risky sexual behavior, mental health, violence, and access to care.</p> <p>2. Barriers to optimal health care for this population included reluctance by LGBT patients to disclose orientation, insufficient number of culturally-competent providers, and structural barriers, such as health insurance or limited medical decision-making rights for LGBT people.</p>	<p>1. Author did not provide a methodology</p> <p>2. Most studies were small-scale, qualitative, and highly regionally bound</p>
Meyer	Resilience in the Study of Minority	Review article	United States	Conceptual paper: comprehensive review of	1. Enhancing resilience as an intervention for LGBT	1. Author did not provide methodology

	Stress and Health of Sexual and Gender Minorities			existing literature regarding the aspect of resilience in the minority stress model	population to promote greater health outcomes 2. Community resilience is related to social identity as a sexual minority within the LGBT community and is reliant on the resources available in that respective region. LGBT persons can be limited by the structure of their community.	
Obedin-Maliver, Goldsmith, Stewart, White, Tran, Brennan, Wells, Fetterman, Garcia, Lunn (2011)	Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education	176 medical schools	United States	Quantitative: online survey sent to 176 medical schools through email	1. Nine schools reported dedicating zero hours to LGBT-related content. 2. The institutions' LGBT content was rated as "fair" at 58 schools. 3. Median reported time dedicated to teaching LGBT content in the entire curriculum was five hours.	1. Variations existed between institutions regarding preclinical and clinical hours, ranging from zero to 32 hours. 2. Did not assess the content experienced in graduate or diploma programs.
Woodell (2016)	Understanding Sexual Minority Health Disparities in Rural Areas	Review article	United States	Conceptual paper: comprehensive review of existing literature regarding the disparities that exist for sexual	1. The negative health outcomes that existed for the LGBT population regardless of region were exacerbated for those in rural	1. Utilizing LGB under one category may inflate or mask the reality of the disparity.

				<p>minorities in rural areas</p>	<p>areas largely due to stigma.</p> <p>2. Social support should be included as a measure in the minority stress model and fundamental cause theory.</p> <p>3. Sexual minorities face structural barriers to health care, such as lack of access as well as discrimination.</p>	<p>2. Non-preventable disparities were not discussed because they cannot be reduced or eliminated through use of resources for any group.</p> <p>3. Author did not provide a methodology.</p> <p>4. Most studies were small-scale, qualitative, and highly regionally bound.</p>
<p>Rosenkrantz, Black, Abreu, Aleshire, Fallin-Bennett (2017)</p>	<p>Health and Health Care of Rural Sexual and Gender Minorities : A Systematic Review</p>	<p>Systematic review of 58 articles</p>	<p>United States</p>	<p>Systematic review: analysis of 58 articles that looked at three primary themes: disparities in health outcomes, healthcare experiences, and sociocultural factors of rurality and health.</p>	<p>1. Rural LGBT persons had a higher prevalence of current and former tobacco use, high-risk drinking, and use of other illicit substances.</p> <p>2. Rural and urban LGBT had inconsistent use of condoms and had increased incidence of using the internet to find sexual partners, receptive anal sex, and sexual activity while under the influence.</p> <p>3. Rural lesbians and bisexuals</p>	<p>1. Pertinent studies may have been missed as they were not published in research database and/or not labeled by indexing system.</p> <p>2. Heterogeneity of included studies limits ability to make generalizable conclusions.</p> <p>3. Reviewed studies varied widely in their definition of LGBT status and rurality</p>

					<p>had worse health outcomes compared to heterosexual counterparts.</p> <p>4. Stigma in healthcare settings was not only anticipated by patients, but experienced directly as evidenced by 12 articles.</p> <p>5. Rural LGBT people perceived inadequacies of their primary care providers' cultural competency.</p> <p>6. Barriers to access existed for rural LGBT populations, such as lack of health insurance and discrimination in insurance policies.</p>	<p>4. Many surveys employed small convenience sampling or qualitative methods</p>
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