ORGANIZATIONAL AND ECOLOGICAL EFFORTS TO ADDRESS GENDER AND SEXUAL MINORITY HEALTH DISPARITIES AND INCLUSIVITY WITHIN THE HEALTHCARE AND MENTAL HEALTHCARE DELIVERY SYSTEM

A Dissertation by

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DEDICATION

I want to dedicate this to those who believed in me. From the mentors and friends, I had during my undergraduate career, to the mentors and friends I had throughout my work in community health and AmeriCorps and through the mentors and friends that I have now at Wichita State University and George Washington University. All the people I have met throughout my journey has contributed and impacted the person I am today. And for that, I am forever grateful. I want to dedicate this to my cohort, who has seen me in my bad and good days. Thank you for being there for me when I needed you the most. Furthermore, I dedicate this to my loud and funny family; my brothers and sisters, to my parents and step parents. I want to also dedicate this to my spouse who have been with me throughout my graduate career and have been my number one cheerleader. And of course, to our fur babies, especially Garnet, who would spend late nights waiting for me to go to bed (which sometimes never happen).

Lastly and especially, I want to dedicate this dissertation to the people who made this country care about our existence, the people involved in the Stonewall Riots, especially the trans women of color who lead this movement. To Marsha P. Johnson. To Sylvia Rivera. Without their voices, without their sacrifices, this dissertation would not be possible.

“History isn’t something you look back at and say it was inevitable……it happens because people make decisions that are sometimes very impulsive and of the moment, but those moments are cumulative realities…”

-Marsha (Pay It No Mind) Johnson
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ABSTRACT

According to the Health Equity Index (Human Rights, 2016), only three hospitals in Kansas were determined as leaders for health care equality. All three facilities are located closer to Kansas City and therefore inaccessible for many gender and sexual minorities residing in Wichita, KS. The recent index has motivated the LGBT Health Coalition to ensure that other facilities are determined as healthcare equality leaders; however, it’s been difficult to create broader positive changes that ensure safe spaces for LGBT patients. In a collaborative effort with the Wichita LGBT Health Coalition, Human Rights Campaign, George Washington University, and Wichita State University, interviews were conducted with medical students and physician assistants \( n=8 \) and medical administrators \( n=9 \) to identify what barriers exist for healthcare facilities to become health equality leaders. In addition, interviews were conducted with sexual minority women and gender minorities \( n=13 \) to gain insight into their experiences in healthcare within Wichita. The study used an inerative analysis; the research team has alternated between finding emerging themes of the data similarly to grounded theory (Glaser & Strauss, 1967), but in addition, using the etic of existing theories (Srivastava & Hopwood, 2009). In this case, the minority stress model (Meyer, 1995), the ecological model (Eliason, & Fogel, 2015) and the cultural competence model (Betancourt, Green, & Carrillo, 2002). Findings include lack of healthcare access that caters to gender and sexual minorities, how the community disseminates resources and advice related to health, and a lack of LGBT related support for medical administrators and health professional students. Although there have been strong efforts in creating a safety net for gender and sexual minorities, there is still mistrust especially towards faith-based healthcare services. Medical administrators expressed the need for improving services for this population but has not found support or data to justify investing in inclusive-related policies and practices. Recommendations for policies and initiatives for the City of Wichita will also be discussed.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>1.1</td>
<td>Glossary of Terms</td>
</tr>
<tr>
<td>2.</td>
<td>LITERATURE REVIEW</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Sexual Minority Women Health</td>
</tr>
<tr>
<td>2.1.2</td>
<td>Gender Minority Health</td>
</tr>
<tr>
<td>2.1</td>
<td>Minority Stress Model</td>
</tr>
<tr>
<td>2.2</td>
<td>An Ecological Perspective on Resiliency and Unique Queer Communities</td>
</tr>
<tr>
<td>2.3</td>
<td>Inclusivity Within the Healthcare Delivery System</td>
</tr>
<tr>
<td>2.3.1</td>
<td>Research Studies</td>
</tr>
<tr>
<td>2.3.2</td>
<td>Gender and Sexuality Minority Education and Training</td>
</tr>
<tr>
<td>2.3.3</td>
<td>Discrimination in the Healthcare Workplace</td>
</tr>
<tr>
<td>2.3.4</td>
<td>Creating Change within Healthcare Organizations</td>
</tr>
<tr>
<td>2.3.5</td>
<td>The Organizational Level</td>
</tr>
<tr>
<td>2.3.6</td>
<td>The Structural Level</td>
</tr>
<tr>
<td>2.3.7</td>
<td>The Clinical Level</td>
</tr>
<tr>
<td>2.3.8</td>
<td>Health Administrators</td>
</tr>
<tr>
<td>2.4</td>
<td>Academic Medical Institutions</td>
</tr>
<tr>
<td>2.4.1</td>
<td>Medical Students</td>
</tr>
<tr>
<td>2.4.2</td>
<td>Physician Assistant Students</td>
</tr>
<tr>
<td>2.5</td>
<td>The Present Study</td>
</tr>
<tr>
<td>2.5.1</td>
<td>Background and Context</td>
</tr>
<tr>
<td>2.5.2</td>
<td>Health Equality Index</td>
</tr>
<tr>
<td>2.5.3</td>
<td>Summary</td>
</tr>
<tr>
<td>2.6</td>
<td>Research Questions</td>
</tr>
<tr>
<td>3.</td>
<td>METHODOLOGY</td>
</tr>
<tr>
<td>3.1</td>
<td>Research Design</td>
</tr>
<tr>
<td>3.2</td>
<td>Background</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS (continued)

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1</td>
<td>Participants and Settings</td>
</tr>
<tr>
<td>3.3</td>
<td>Procedure</td>
</tr>
<tr>
<td>3.3.1</td>
<td>Interviews</td>
</tr>
<tr>
<td>3.3.2</td>
<td>The Research Team</td>
</tr>
<tr>
<td>3.3.3</td>
<td>Plan of Analysis</td>
</tr>
<tr>
<td>4.</td>
<td>RESULTS</td>
</tr>
<tr>
<td>4.1</td>
<td>Gender Minorities and Sexual Minority Women</td>
</tr>
<tr>
<td>4.1.1</td>
<td>Other Demographics</td>
</tr>
<tr>
<td>4.1.2</td>
<td>Healthcare Services Demographic Experiences</td>
</tr>
<tr>
<td>4.1.3</td>
<td>The Minority Stress from an Ecological Perspective</td>
</tr>
<tr>
<td>4.1.4</td>
<td>Ecological and Minority Stress Model Open Codes and Themes- Gender and Sexual Minorities</td>
</tr>
<tr>
<td>4.1.5</td>
<td>Ecological and Minority Stress: Secondary Coding</td>
</tr>
<tr>
<td>4.2</td>
<td>Health Professional Students</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Themes found in Open Coding</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Secondary Coding for Health Professional Student Sample</td>
</tr>
<tr>
<td>4.3</td>
<td>Medical Administrators</td>
</tr>
<tr>
<td>4.3.1</td>
<td>Open Coding: Medical Administrators</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Secondary Coding for Medical Administrators</td>
</tr>
<tr>
<td>4.4</td>
<td>The Cultural Competency Model</td>
</tr>
<tr>
<td>4.4.1</td>
<td>The Vignettes and Cultural Competency Model</td>
</tr>
<tr>
<td>4.4.2</td>
<td>Overall Factors of Organizational, Structural, and Clinical Cultural Competency</td>
</tr>
<tr>
<td>5.</td>
<td>DISCUSSION</td>
</tr>
<tr>
<td>5.1</td>
<td>Research Question 1</td>
</tr>
<tr>
<td>5.2</td>
<td>Research Question 2</td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS (continued)

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3 Research Question 3</td>
<td>156</td>
</tr>
<tr>
<td>5.4 Limitations</td>
<td>158</td>
</tr>
<tr>
<td>5.5 Recommendations and Future Study</td>
<td>158</td>
</tr>
<tr>
<td>5.5.1 Addressing the Lack of Education among Professional Students and Implications for Other Healthcare Professional Students</td>
<td>159</td>
</tr>
<tr>
<td>5.6 Conclusion</td>
<td>160</td>
</tr>
</tbody>
</table>

REFERENCES 161

APPENDICES 183

| A Interview Materials | 184 |
| B HEI Criteria and Vignettes | 205 |
| C Notes and Open Coding | 208 |
| D Definition of Themes for All Three Populations | 222 |
Chapter 1

Introduction

When the Supreme Court decided on marriage equality as a constitutional right in June of 2015, it made positive strides towards human rights for gender and sexual minorities and it is only a matter of time before social norms will shift towards same sex relationships (Fetner, 2016). Unfortunately, there is a lot of work to be done in integrating inclusivity within the current healthcare system. In fact, according to the research literature, there are documented evidence of health disparities among sexual and gender minorities (Bostwick, Boyd, Hughes, & McCabe, 2010; King et al., 2008b; McCabe, Hughes, Bostwick, West, & Boyd, 2009; Meyer, 2003). Research has indicated that gender and sexual minorities experience worse physical health compared to their heterosexual and cisgender counterparts (Lick, Durso, & Johnson, 2013). According to the Centers for Disease, Control and Prevention’s (CDC) Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey (2014), Lesbian, Gay and Bisexual (LGB) individuals are more likely than heterosexual individuals to rate their health as poor; LGB individuals have reported more chronic conditions, more asthma diagnoses, headaches, allergies, osteoarthritis, gastrointestinal problems and have higher prevalence and earlier onset of disabilities compared to the heterosexual population.

Furthermore, the literature shows that disparities are significantly related to the negative stress related psychological events perpetuated by systematic stigma and discrimination (Meyer, 2003; Burton et al., 2013; Bostwick et al., 2014). For the past few years, the research literature delved into why mental health disparities are higher for sexual minorities (Burton et al., 2013; Bostwick et al., 2014). Some of these findings indicate that
the alarming increase of disparities may be due to the discrimination many sexual minorities face daily (Hatzenbuehler, Keyes, & Hasin, 2009; Mays & Cochran, 2001; Meyer, 2003). The research also suggests that most mental health care providers have a misconception that mental health disorders are related to their patients’ sexual minority status (Bockting et al., 2004), even when there is evidence that shows that being a sexual minority does not have any effects on mental health (Haraldsen & Dahl, 2000).

The marginalization of gender and sexual minorities has led to delays in seeking healthcare services in a timely matter (Bjorkman & Malterud, 2009). A substantial rate (30%) of the population underutilizes healthcare service or lacks having a primary care physician (Winter, 2012) which often leads to delays and treatment in healthcare service, thus compounding potential poor health outcomes (Mayer, Bradford, Makadon, Stall, Goldhammer, & Landers, 2008).

Gender and sexual minorities often do not disclose their orientation or gender identity because of past overt and covert discrimination incidences with healthcare facilities (Krehely, 2009; Roberts & Fantz, 2014). A significant portion of the community felt they cannot disclose issues of gender and sexuality due to the lack of understanding from medical providers and staff members (including negative views against gender and sexual minorities), lack of cultural competency with the healthcare setting and the lack of culturally sensitive resources, referrals, and materials (Krehely, 2009). Even when they do disclose, gender and sexual minority patients have reported feeling high levels of anxiety, stemming from the fear of refusal of healthcare services and/or being mistreated (Mollon, 2012; Roberts & Fantz, 2014; Stanton, 2013).

Because there is a dearth in the literature on lesbian, bisexual women, transgender and non-binary populations, the focus of this study will solely be on these populations. For the
purpose of this dissertation and in collaboration with the Human Rights Campaign, Wichita
LGBT Health Coalition, Wichita State University and George Washington University, the aims
of this study are to understand the experiences of sexual minority women and gender minorities
within healthcare settings. The study aims to understand the experiences of healthcare
professionals and students and identify the barriers to inclusivity in their care. It is my hope that
the findings will not only contribute to the research literature but also become an educational
resource for healthcare professionals and non-profit organizations within the Kansas and Wichita
community.

Glossary of Terms

This paper includes terminology that are commonly used among the gender and sexual
minority community and in the research literature. The following glossary of terms is
provided for the reader’s convenience.

LGBT, LGBTQ, LGBTQA, TBLG: These acronyms refer to Lesbian, Gay, Bisexual,
Transgender, Queer or Questioning, and Asexual or Ally. Although all of the different identities
within “LGBT” are often lumped together (and share sexism as a common root of oppression),
there are specific needs and concerns related to each individual identity.

Bisexual: A person who is attracted to both people of their own gender and another gender. Also
called “bi”.

Cisgender: Types of gender identity where an individual's experience of their own gender
matches the sex they were assigned at birth.

Cultural Competence: Providing services that meets the social, cultural, and linguistic needs of
their patients (Betancourt, Green & Carillo, 2002).

Cultural Humility: “a lifelong commitment to self-evaluation and self-critique, to redressing the
power imbalances in the patient-physician dynamic, and to developing mutually beneficial and
non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals
and defined populations” (Tervalon & Murray-Garcia, 1998)

Gay: A person who is attracted primarily to members of the same sex. Although it can be used
for any sex (e.g. gay man, gay woman, gay person), “lesbian” is sometimes the preferred term
for women who are attracted to women.

Gender identity: The sense of “being” male, female, genderqueer, agender, etc. For some
people, gender identity is in accord with physical anatomy. For transgender people, gender
identity may differ from physical anatomy or expected social roles. It is important to note that
gender identity, biological sex, and sexual orientation are separate and that you cannot assume
how someone identifies in one category based on how they identify in another category.

Genderqueer: A term which refers to individuals or groups who “queer” or problematize the
hegemonic notions of sex, gender and desire in a given society. Genderqueer people possess
identities which fall outside of the widely accepted sexual binary (i.e. "men" and "women"). Genderqueer may also refer to people who identify as both transgendered AND queer, i.e. individuals who challenge both gender and sexuality regimes and see gender identity and sexual orientation as overlapping and interconnected.

**Gender Non-conforming:** A term for individuals whose gender expression is different from societal expectations related to gender.

**Health Equality Index:** an initiative started by the Human Rights Campaign in 2007 to establish recommended policies and practices that address the healthcare needs and health disparities of gender and sexual minorities. Once a healthcare setting implements such policies and practices, they are considered “Leaders in Health Equality” and listed in the publication annually.

**Heteronormative:** a societal assumption that someone is heterosexual

**Cisnormative:** a societal assumption that someone is cisgender

**Heterosexual:** A person who is only attracted to members of the opposite sex. Also called “straight.”

**Homophobia:** A range of negative attitudes and feelings toward homosexuality or people who are identified or perceived as being lesbian, gay, bisexual or transgender (LGBT). It can be expressed as antipathy, contempt, prejudice, aversion, or hatred, may be based on irrational fear, and is sometimes related to religious beliefs.

**Homosexual:** A clinical term for people who are attracted to members of the same sex. Some people find this term offensive.

**Latinx:** Latin Americans whose gender identities fluctuate along different points of the spectrum, from non-binary to gender non-conforming, genderqueer and genderfluid

**Lesbian:** A woman who is primarily attracted to other women.

**Queer:** 1) An umbrella term sometimes used by LGBTQA people to refer to the entire LGBT community. 2) An alternative that some people use to "queer" the idea of the labels and categories such as lesbian, gay, bisexual, etc. Similar to the concept of genderqueer. It is important to note that the word queer is an in-group term, and a word that can be considered offensive to some people, depending on their generation, geographic location, and relationship with the word.

**Pansexual:** A person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions, not just people who fit into the standard gender binary (i.e. men and women).

**Sexual orientation:** The type of sexual, romantic, and/or physical attraction someone feels toward others. Often labeled based on the gender identity/expression of the person and who they are attracted to. Common labels: lesbian, gay, bisexual, pansexual, etc.

**Transgender:** This term has many definitions. It is frequently used as an umbrella term to refer to all people who do not identify with their assigned gender at birth or the binary gender system. This includes transsexuals, cross-dressers, genderqueer, drag kings, drag queens, two-spirit people, and others. Some transgender people feel they exist not within one of the two standard gender categories, but rather somewhere between, beyond, or outside of those two genders.
Chapter Two

Literature Review

Healthy People 2020 has indicated that health disparities have a significant relationship with marginalization, social stigma and denial of many human rights including denial of healthcare services. Structurally, the health care setting does not provide inclusivity for gender and sexual minority patients which has a significant relationship with delays and underutilization of health services (Krehely, 2009; Roberts & Fantz, 2014). Gender and sexual minority patients have reported they choose not to give out their orientation or gender due to the number of negative attitudes perceived through either overt or covert discrimination from staff and medical providers (Krehely, 2009; Roberts & Fantz, 2014).

In fact, because of the discrimination and stigma within the healthcare system against gender and sexual minorities, many patients fear discussing their orientation or gender with their medical providers. Discrimination is defined as a process where stigmatized groups are devalued through the exercise of social, cultural, economic, and political power (Link & Phelan, 2006). Stigma is often tied to the reproduction of social difference, which reinforces the status quo (Parker & Aggleton, 2003). Therefore, structural, and institutional discrimination are often perpetuated by the intentional or unintentional policies and practices that limits or create barriers for marginalized people (Corrigan, Markowitz, & Watson, 2004). In this chapter, we will explore the unique experiences within the lesbian and bisexual women community and the transgender and non-binary community. Furthermore, the research literature will highlight a variety of systemic issues found among healthcare settings including educational healthcare settings (i.e. medical and physician assistant schools).
Lesbian and bisexual women report poorer overall physical health and higher rates of asthma and urinary tract infections, and heightened risk for and diagnosis of some cancers, higher rates of cardiovascular disease diagnosis and Hepatitis B and C than heterosexual women (CDC, 2013). There have been several reviews done on lesbian and bisexual women’ health disparities, although there have been several limitations, there are many indicators supporting evidence of higher health disparities compared to heterosexual women (Simoni, Smith, Oost, Lehavot, & Fredriksen-Goldsen, 2017). These findings are supported based on a meta-analysis and another systemic review, lesbian and bisexual women have significantly higher rates of body mass index (BMI) compared to heterosexual women which may put them at a higher risk for diabetes, cardiovascular disease, and other chronic disease (Boehmer, Bowen, & Bauer, 2007; Boehmer et al., 2011; Eliason, Ingraham, Fogel, McElroy, Lorvick, Mauery, & Haynes, 2015; Farmer, Jabson, Bucholz, & Bowen, 2013; Jun et al., 2012; Simoni, Smith, Oost, Lehavot, & Fredriksen-Goldsen, 2017). Fredriksen-Goldsen et al., (2013) found lesbian and bisexual women over the age of 50 are reporting significantly higher rates of cardiovascular disease compare to heterosexual women (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). Compare to heterosexual women, lesbian and bisexual women have a higher prevalence of substance use (Cochran, Ackerman, Mays, & Ross, 2004; Farmer et al., 2013; Hughes, Johnson, & Matthews, 2008; Lee, Griffin, & Melvin, 2009; Marshal et al., 2012; Parsons, Kelly, & Wells, 2006). There has also been an indication of significantly higher rates of self-reported anxiety and mood disorders among lesbian and bisexual women compare to their heterosexual counterparts (Burgess, Lee, Tran, & Van Ryn, 2008; King et al., 2008b).
Along with the health disparities, lesbian and bisexual women often underutilize preventative tests including pap smears and sexually transmitted infection testing compare to their heterosexual counterparts (Agenor, Krieger, Austin, Haneuse, & Gottlieb, 2014; Charlton et al., 2011; Fish, 2009; Tracy, Lydecker, & Ireland, 2010; Diamant, Schuster, & Lever, 2000). This could be a result of discrimination against lesbian and bisexual women often displayed in many healthcare settings, including medical providers and professionals who are not knowledgeable on lesbian and bisexual health and do not address the needs of their lesbian and bisexual patients (Clift & Kirby, 2012; Hutchinson, Thompson, & Cederbaum, 2006; Matthews, Brandenburg, Johnson, & Hughes, 2004). In addition to health disparities, there are systemic issues that have a negative impact on lesbian and bisexual women’s access to healthcare such as not including inclusivity in healthcare policies or in healthcare facilities’ intake forms (Eliason, Dibble, DeJoseph, & Chinn, 2009).

**Gender Minority Health**

According to the recent 2015 Report of the U.S Transgender Survey (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016), 22% of the transgender and non-binary community reported their health as “fair” or “poor” compared with 18% of the national general population. About 1.4% of the respondents reported that they had a diagnosis of the human immunodeficiency virus (HIV) which is a significantly higher rate compared to the general population at 0.3%. Furthermore, transgender women are more than twice as likely to have a HIV diagnosis. HIV rates among transgender people of color is even higher; the CDC (2013) reports that for every four transgender people of color, one is diagnosed with HIV. And in fact, according to the US Transgender Survey (James et al., 2016), one in five black transgender
women have a HIV diagnosis while Native American and Latina transgender women are three times more likely to be diagnosed.

Gender and sexual minorities are 1.5 to 2 times more likely to be diagnosed with anxiety or mood disorders (Bostwick et al., 2010). Untreated mental health illnesses could potentially be detrimental or even fatal to one’s health. An estimated 37% to 50% of gay and lesbian populations have experienced suicidal ideation (McBee-Strayer & Rogers, 2002; McDaniel, Purcell, & D’Augelli, 2001; Ploderl & Fartacek, 2005; Rotheram-Borus, Hunter, & Rosario, 1994). However, for transgender and non-binary individuals, about 39% reported currently experiencing serious psychological symptoms, which is eight times more than the general population (James et al., 2016). Furthermore, about 40% of the respondents have attempted suicide in the past compared to 4.6% of the general population. Eighty-two percent of the respondents reported suicide ideation in their lifetime and 71% reported having a history of attempted suicides with 46% reported attempting three or more times (James et al., 2016). Transgender and non-binary individuals are three times more likely to be chemically dependent of illicit drugs; compared to 10% of the general population, 29% of the sample population reported using illicit drugs, and/or non-medical prescription drugs in the past month (James et al., 2016).

The concerning high rates of psychological distress can be attributed to the overt marginalization that transgender and non-binary individuals face daily (Meyer, 2003). For example, 51% of the respondents reported losing their employment, 59% reported being physically attacked and 60% reported being sexually assaulted in the past year due to their gender identity. Furthermore, respondents who experienced job loss, physical and/or sexual
violence were more likely to experience serious psychological distress compared to the rest of the sample population (James et al., 2016).

Not only does discrimination impact the transgender and non-binary community outside of the healthcare system, discrimination commonly happens within healthcare. For example, although 72% of the sample population shared their gender identity with their mental or social care provider, 18% reported their mental and social care provider tried to stop them from being transgender which represents 13% of the sample population (James et al., 2016). It also increased their likelihood of experiencing serious psychological distress, suicide ideation, homelessness and doing sex work (James et al., 2016).

In many cases members of this populations chose not to disclose their gender identity to any of their medical providers. One third of the respondents also reported having a negative experience. Negative experiences include having to teach their provider about their gender identity to receive appropriate care, being asked unnecessary questions about their gender identity, refusing transition-related healthcare, having a health provider use abusive language, refusing non transition-related healthcare due to their gender identity, having a health care provider be physically abusive, physically attacked by someone during their visit and sexually assaulted during their visit (James et al., 2016). Discrimination is its own barrier when it comes to transgender and non-binary healthcare. About 23% of the sample population have reported that although they needed healthcare services, they did not seek it due to fear of being discriminated against; reported the same for seeking mental healthcare (James et al., 2016).

While significant barriers to healthcare exist for transgender and non-binary individuals, many have limited access to healthcare due to cost and availability of providers. Location and the need for transgender and non-binary friendly medical providers is also another barrier.
Respondents are three times likely to travel 50 miles or more to receive routine transgender-related healthcare (James et al., 2016).

**Minority Stress Model**

The Minority Stress Model (Meyer, 1995) suggests that discrimination and stigma has a negative psychological and physical impact on minorities including lesbian and bisexual women (Brooks, 1981) and transgender and non-binary individuals (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013). Minority Stress is a process where dominant values conflict with minority values negatively impacting the social ecology of minority communities (Meyer, 2003). Minority stress can lead to underlying stressors that minorities experience: discrimination, expectations of rejection, concealing identity, and internalized oppression. Minority stress that is perpetuated by present events of discrimination are known as distal minority stressors; internalized oppression, expectations of rejection and concealing one’s own minority identity are known as proximal minority stressors (Meyer, 2003).

The model was originally created to explore alternative interpretations of high mental health distress among gay cisgender male populations (Meyer, 1995). Since the original creation, the research literature has found that many different minority communities have also experienced minority stress (Alamilla, Kim, & Lam, 2010; Wei, Ku, & Liao, 2011; Wei, Ku, Russell, Mallinckrodt, & Liao, 2008). Sexual and gender minorities are exposed to distress due to their minority status that is often stigmatized and discriminated by society (Meyer, 2003). The model also explains how minority stress can not only lead to distress but also could explain the high health disparities among gender and sexual minorities (Frost, Lehavot, & Meyer, 2015; Huebner & Davis, 2007; Lehavot et al., 2009; Pantalone et al., 2010); the literature supports evidence of discrimination and stigma as barriers to healthcare for sexual and gender minorities (Conron,
For lesbian and bisexual women, the research literature suggests the minority stress model may explain why there is a discrepancy in BMI rates compared to their heterosexual counterpart (Mason & Lewis, 2015). The proximal stressors lesbian and bisexual women experience are likely to lead to social isolation and unhealthy coping mechanisms, and in this case, binge eating (Mason & Lewis, 2015).

For transgender and non-binary individuals, minority stress is more pervasive. For example, one of the stressors is to conceal their own identity which can increase hypervigilance and therefore becomes a significant stressor (Bockting et al., 2013). “Passing” is a term that the transgender and non-binary community and others associate with as passing in the gender they are expressing. Passing becomes a social stressor as it is an investment to fit the gender they are either hiding or authentically being. The stressor is often associated with the fear of being outed, expectations of discrimination (especially being assaulted due to their gender identity), and internalized oppression. All of which are direct associations to prior distal minority stress-related experiences (Meyer, 1995; 2003). A full description of the minority stress model is in figure one.
Figure 1. The Minority Stress Model (Meyer, 1995; 2003)

The minority stress model has also been used to look at how minority stress could influence gender and sexual minorities’ decision to disclose their sexual orientation or gender identity to their healthcare providers (Durso & Meyer, 2013; Frost, Lehavot, & Meyer, 2015; Meyer, 1995, 2003). One study found that non-disclosure to medical providers and clinicians significantly predicts negative changes in psychological wellbeing, even after a year later (Durso & Meyer, 2013). The Joint Commission (2011) and The Fenway Institute (2012), recognize that medical providers facilitating in patients’ disclosure of gender identity and sexual orientation is considered an important asset of cultural humility-related healthcare. Yet, less than 20% of providers provide sexual health information pertaining to sexual minority’s orientation (Labig & Paterson, 2006). Although patients want to disclose their orientation (Stein & Bonuck, 2001), most do not (Berstein et al., 2008; Boehamer & Case, 2004; Eliason & Schope, 2001; Petroll & Mosack, 2011; Stein & Bonuck, 2001).
There are several explanations as to why patients do not disclose their sexual orientation or gender identity. Nondisclosure may stem from fears that they will be mistreated, patients’ perceptions that it is irrelevant to healthcare, and/or privacy concerns (Barbara, Quandt & Anderson, 2001; Boehmer & Case, 2004; St. Pierre, 2012; Stein & Bonuck, 2001). Among lesbians, disclosure is related to health status, relationship status and internalized homophobia (St. Pierre, 2012) and bisexual women and lesbian women of color disclose significantly less than their white lesbian women counterparts (Durso & Meyer, 2013). In addition, patients have reported distress when the provider presumed that they are heterosexual and believe that disclosing does relate to increased honesty (Barbara, Quandt, & Anderson, 2001) and improved care (Stein & Bonuck, 2001).

**An Ecological Perspective on Resiliency and Unique Queer Communities.**

The research literature on resiliency against health disparities among gender and sexual minority populations is severely lacking (Kwon, 2013). Resiliency, defined as the ability to survive and thrive in the face of adversity, also means adapting positively towards minority stress and avoiding the negative impacts on health. Coping is a process of which a minority makes an effort to respond to stress. However, the difference between coping and resiliency is that coping doesn’t always necessary lead to positive and healthier outcomes like resiliency does. Therefore, resiliency is identified as a component of the minority stress model as an adaptive functioning factor against the specific stressor (Masten, 2007; Meyer, 2015). It is imperative to note that the focus of this dissertation will not just solely be on individual resiliency as it can lead to problematic assumptions including the issue that gender and sexual minority health disparities can just be solved through individual resiliency. Only being concerned about individual
resiliency could shift our biases towards victim blaming instead of problem solving (Meyer, 2015). In fact, Dr. Ilan Meyer (2015) warns against this perspective stating the following:

"I say that a focus on individual resilience is hazardous because, from a public health policy perspective, it can remove or reduce social responsibility to protect disadvantaged populations as it creates expectation of individual resiliency."

Therefore, another focal point of the minority stress model is minority coping which is often referred to as community resiliency (Meyer, 2003). Community resiliency is defined as the process in which “communities further the capacities of individuals to develop and sustain well-being” (Hall & Zautra, 2010). The research literature indicates that access to a community with similar minority factors can lead to access to resources, role models and social support which may reframe one’s social values and norms and capacity to redefine one’s life goals and successes (Croker & Major, 1989; Riggle, Whitman, Olson, Rostosky, & Strong, 2008; Riggle, Rostosky, McCants, & Pascale-Hague, 2011; Rostosky, Riggle, Pascale-Hague, & McCants, 2010). This was exemplified in a study where House and Ball (an underground queer subculture where people “walk” to compete and win trophies) community members were surveyed on access to healthcare (Cahill et al., 2017). The results indicated how this strong community communicate with each other to share healthcare advice, resources, and recommendations for healthcare services. The results also suggest that a sense of community and belongingness reduces barriers to healthcare and increases the likelihood of gender and sexual minorities disclosing their identities to their medical providers.

To activate such resources, one must be involved with the community and garner a sense of belongingness. Meyer (2015) noted it could be difficult when there are queer communities that are often biphobic, transphobic, racist, classist and sexist. Furthermore, he explains it is often a mistake to assume all gender and sexual minorities belong to one monolithic, white, and
middle class dominated “LGBT” community. More than often, multiple communities of many intersectional identities often find resilience on their own terms (Bowleg, Huang, Brooks, Black & Burkholder, 2003; Moore, 2010). As an alternative, gender and sexual minorities may even actively seek a community and a sense of belongingness through the internet (Chong, Zhang, Mak, & Pang, 2015). Which found to have functioned significantly similar to physical communities like providing information on resources and gender and sexual minority friendly centers (Wong, 2015).

It may also be a mistake to make assumptions about what community that a gender or sexual minority could belong to and benefit from. There has been evidence to suggest that gender and sexual minorities with supportive families report positive mental health outcomes and high self-esteem (Zimmerman et al., 2015). It is not just having higher rates of self-esteem, we must also recognize macro-social determinants like income, mental health, pre-existing social networks and access to education and healthcare. Thus, community resiliency is more about individuals reclaiming specific and most valued aspects of their identities (Wong, 2015). In a review on gender and sexual minority community resiliency, Wong (2015) explains the individual difference of community resiliency as the following:

“What we have here is more than competing ‘identities’ but also difference in socio-cultural boundaries-macro-social determinate that shape and/or regulate what is ‘permissible’ or ‘desirable’ identity to have and how that identity should be expressed”.

Nonetheless, it is essential to assess at resiliency at multiple levels of the ecological model. In fact, Meyer (2015), specifically notes not to ignore individual resilience and view community resilience as an opposite. Instead, he suggests viewing resiliency from an individual to a community level as interdependent. The ecological model is often suggested in the research literature as a model to assess the interdependence of each social system (Kelley, 1979). Fusing
the ecological model with the Minority Stress Model and incorporating the understanding of resiliency may reduce the possibility of victim-blaming. Furthermore, Eliason and Fogel (2015), quoted to say the following:

“Unless we address all levels of the ecological model, interventions that focus on individual behavior can easily slide into victim-blaming tools, be too simplistic to address the impact of minority stress on health and wellbeing and thus be unsuccessful.”

Paralleling what Meyer (2015) has stated before, interventions that promote resiliency and reduce minority stress must be addressed at all levels of the ecological model. Therefore, our research questions will stem from the understanding of resiliency and minority stress through the perspective of the ecological framework.

Bronfenbrenner (1979) first introduced the Ecological Model of Human Development as a conceptual model which then became a theoretical model by the 1980s (Bronfenbrenner, 1999). The ecological model is a theoretical framework that determines the interrelationships of environmental and social factors that significantly impact an individual, their decision making and behaviors (Bronfenbrenner, 1979). The ecological model framework has been used to address health disparities that are related to discrimination, stigma, and violence (Krieger, 2002, 2012).

Eliason and Fogel (2015), published a literature review article exploring the possibility that the Ecological Model can be infused with the Minority Stress Model to understand high obesity rates among lesbian and bisexual women. The authors found a few indicators on the individual, interpersonal, community, institutional and societal levels that may impact sexual minority women’s weight management based on the research literature. Some examples include: At the individual level, where they found limited research literature suggesting that the most common eating disorder among sexual minority women is binge eating disorder (Coker, Austin,
& Schuster, 2010; Feldman & Meyer, 2007). At the relationship level, same-sex relationships may have a significant influence of each other due to the lack of family support and societal support (Kurdek, 2004). In addition, living with a romantic partner was significant associated with higher BMI scores (Yancey, Cochran, Corliss, & Mays, 2003). At the community level, Hostetler (2012) defined the gender and sexual minority community as having a common historical background and experience of discrimination, stigma, and political movements. There is limited research that indicates that there is a lack of a community among sexual minority women. Instead, there are more loosely connected subgroups based on other factors (Brown-Sracino, 2011). The research literature also suggests that the lesbian community is often exclusive towards bisexual women, especially bisexual women of color (Thompson, 2012; Weiss, 2011). At the institutional level, the issue of stigma within health-related organization as indicated before, may increase the likelihood of sexual minority women withholding their sexual orientation from their medical provider. In addition, providers tend to create barriers to access of care due to lack of knowledge and heterosexism. And finally, at the societal level, the authors argue that policies, stigma and heterosexism can negatively impact the health of sexual minority women (Eliason & Fogel, 2015). See figure 2 for a diagram of the model.
Inclusivity Within the Healthcare Delivery System

Despite advances in research and policy changes, a lack of unawareness and stigma continues to perpetuate within the healthcare system (Bonvicini, 2017). In fact, there still is a significant amount of evidence indicating gender and sexual minorities have negative experiences with healthcare providers, including stigma-related discrimination and unsatisfactory delivery of services (Chapman et al., 2012). For example, in a national online survey conducted with gender and sexual minority physicians, 65% reported hearing derogatory comments from healthcare professionals about their gender and sexual minority patients and 34% reported witnessing a patient being discriminated against for their gender or sexual minority identity (Eliason, Dibble, & DeJoseph, 2010). Another study indicated that providers including medical physicians, nurses and mental health providers reported pervasive implicit and explicit preferences for heterosexuality (Sabin, Riskind, & Nosek, 2015). In fact, one other study
indicated that 23% of providers surveyed at a northeastern medical institute reported that homosexuality is always or almost always morally wrong (Kitts, 2010).

Research Studies

More importantly, when medical providers do not address sexual orientation or gender identity, they lose the opportunity to provide proper health education on wellness and disease prevention (Johnson, & Nemeth, 2014) which increases the risk of these health disparities. For example, one qualitative study interviewed 12 medical providers and 55 transgender individuals about stigma, discrimination, and medical encounters. The study found medical providers often have a severe lack of training and understanding in transgender healthcare, this often produced uncertainty and ambivalence when first treating transgender patient. Researchers also found transgender individuals would anticipate that medical providers do not know what they are doing and often must educate their medical providers about hormone regimens and gender identity. Because of the uncertainty and ambivalence, it disrupts the patient-provider relationship as medical providers use stigma and discrimination to establish authority within the provider-patient relationship (Poteat, German, & Kerrigan, 2013). Yet, what the study is lacking is understanding of how comprehensive policies on cultural humility within an organization may impact medical providers. There was no analysis done on the organization’s climate, policies and mission statement and how it may reflect on the healthcare services. The focus of this study seems to solely emphasize the individual (i.e. the medical provider) and not the root of the problem (i.e. organizational culture). It would have been vital to ask what circumstances of the healthcare setting could possibly assist these medical providers to address the needs of their gender minority patients.
Medical experts and educators have emphasized the ethical need for the medical profession to reduce health disparities through social justice, cultural humility, and humanism (AAMC, 2014). Often times, the multicultural medical research literature coins the term “cultural competence” as providing services that meet the social, cultural, and linguistic needs of their patients (Betancourt, Green & Carillo, 2002). However, cultural competence tends to make the assumption there is an end point to being fully competent in cultural and social aspects of health (Tervalon & Murray-Garcia, 1998). In fact, cultural humility is often suggested as an alternative to cultural competence as a feasible goal within multicultural medical education. Cultural Humility is described as a “a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations” (Tervalon & Murray-Garcia, 1998). Therefore, the terminology, culture humility will be used in this project.

Health professionals who do not believe patients’ sexuality isn’t important to healthcare or within healthcare settings do not emphasize cultural humility towards the gender and sexual minorities can significantly and negatively impact a patient’s quality of care (Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007; Hinchliff, Gott, & Galena, 2005; Eliason & Schope, 2001). In fact, one study found that health professionals would tolerate gender and sexual minority patients rather than respecting them. Whereas about 70% of the sample reported having low self-efficacy when treating gender and sexual minority patients (Burch, 2008).

*Gender and Sexuality Minority Health Education and Training*

Although, the literature is still unclear about what is the most effective way to address these issues and educate health professionals about gender and sexual minority health, the
research literature does indicate that trainings that promote cultural humility do benefit and improve patient outcomes, changes in attitudes, an increase in knowledge, and improved outcomes related to accessibility and utilization (Truong, Paradies, & Priest, 2014). Obedin-Maliver and colleagues (2011) found that the minimum that a healthcare provider must know to fully understand their gender or sexual minority patients are the following: 1) techniques in sexual history taking, 2) definitions related to gender and sexual minorities, 3) an understanding of the differences between sex, 4) gender and sexual orientation, 5) diversity of sexual orientation, 6) gender identity and gender expression within society, 7) sexual developmental disorders and intersex conditions, 8) barriers to healthcare, 9) behavioral health and chemical dependency disparities, 10) adolescent gender and sexual minority medicine, 11) relationship and domestic violence, 12) chronic disease risks, 13) transitioning, 14) sexual reaffirming surgery and hormone therapies, psychological and social impacts of coming out and, 15) parenting. Moreover, there have been several ways experts have come with to optimize cultural humility from computer-based education including patient simulations, to working with volunteers who are gender and sexual minorities (Baraitser, Elliot, & Bigrigg, 1998; Browning, Meyer, Truog, & Solomon, 2007; Haist et al., 2004; Jayasuriya & Dennick, 2011).

Despite the numerous educational and training materials resources that medical providers and clinicians can access and learn about healthcare and health disparities for gender and sexual minority patients (US Department of Health and Human Services, 2016; National LGBT Health Education Center; 2016; HRC, 2017; Patient Care Services, 2016; GLMA, 2016), in a survey conducted about US academic practices (Khalili, Leung, & Diamant, 2015), only 16% reported having comprehensive training about gender and sexual minorities and 52% reported having no training whatsoever. Moreover, only about 15% of the practices had a list available of all the
physicians who participated in such trainings. In fact, the lack of gender and sexual minority health training has been observed in almost every level of healthcare and mental healthcare including clinical psychology, dentistry, and nursing (Corliss, Shankle, & Moyer, 2007; McNair, 2003; Amato & Morton, 2002; Tesar, & Rovi, 1998; Shindel, Ando, Nelson, Breyer, Lue, & Smith, 2010; Anhalt, Morris, Scotti, & Cohen, 2003; Anderson, Patterson, Temple, & Inglehart, 2009; Eliason, Dibble, & DeJoseph, 2010).

**Discrimination in the Healthcare Workplace**

Additional to the discrimination that gender and sexual minority patients face, gender and sexual minorities who are also gender or sexual minorities also face similar challenges in the workplace. The limited evidence suggests that coming out in a workplace has been associated with improved work performance and satisfaction (Day & Shoenrade, 1997). Yet, unfortunately, the fear of disclosing identity is related to how patients and employees may react to their identity. For example, a national survey showed that 30% of a random sample of Americans would change providers if they found out they are gender or sexual minorities; 35% reported they would even change the practice affiliation (Lee et al., 2008). In addition, within another study, 10% of gender and sexual minority medical providers have been denied referrals from there heterosexual colleagues due to discrimination. 27% have witnessed discrimination against a gender or sexual minority colleague (Eliason, Dibble, and Robertson, 2011).

Discrimination and a hostile environment within a healthcare workplace could impede a gender or sexual minority healthcare professional’s work performance. One study interviewed 16 healthcare professionals, confidentially, who were sexual minorities. The data suggested that healthcare providers who concealed their identities while providing care created anxieties and distractions (Riordan, 2004). What is lacking in this study is determining how policies may
influence gender and sexual minority providers. It would be interesting to see how non-discrimination employment policies may address the barriers of provider quality care. The study should have also looked at the organizational climate of their work settings as well as their everyday interactions.

Creating Change within Healthcare Organizations

Mansh, Garcia, and Lunn (2015), argue that the medical field can overcome the negative culture against sexual and gender minorities through the following practice: 1) updating research for the medical workforce, 2) creating new policies that will promote supportive training and practice culture, and 3) develop recruitment practices with the goal of increasing diversity within the workforce. In fact, there have been several efforts made to encourage healthcare organizations to participate in diversity and inclusion efforts to better serve gender and sexual minorities. For example, both the Joint Commission (2011), the non-profit that accredits healthcare organizations as a requirement for the receipt of Medicaid and Medicare reimbursements, and the Institute of Medicine (2011) published guidelines for healthcare services to better serve their gender and sexual minority populations. However, what made the most strides in the healthcare of gender and sexual minorities and inclusivity is a benchmarking tool that is annually published by the Human Rights Campaign (HRC; 2017), The Health Equality Index (HEI).

The HEI is a publication that lists American healthcare facilities and organizations that meets certain policy and efforts required to be recognized as a “health equality leader”. The HEI was first published in 2007 and provided 10 recommendations including four established elements of gender and sexual minority patient-centered care: a non-discrimination policy for gender and sexual minority patients, gender and sexual minority inclusive visitation policy, a
non-discrimination policy to protect gender and sexual minority employees, and staff training on
gender and sexual minority patient-centered training. In, 2016, most healthcare facilities were
motivated to adopt the first three elements of patient-centered care. Furthermore, 85% of
facilities that are currently participating have adopted patient-centered training for their staff and
providers. In fact, the HEI has recorded more than 43,000 hours of trainings provided to staff.
Since its inception, the HEI is in their 10th edition and 590 healthcare facilities have participated
in the 2017 HEI survey to become a health equality leader. Furthermore, the HRC organization
actively researched more than 900 non-participating hospitals and their key policies.
Unfortunately, they found that only 61% had policies that included both gender identity and
sexual orientation and only 53% were found to have an inclusive employment non-
discrimination policy for gender and sexual minorities. This year, 590 facilities participated and
303 were considered leaders where for the first time, participants were scored based on how
many policies and practices are implemented based on the four different criteria; the four
foundational elements of patient-centered care, patient services and support, employee benefits
and policies and lastly, patient and community engagement.

One case study noted that the Veterans Affairs (VA) Boston Healthcare System made
gender and sexual minority patient-centered healthcare a focal point when the organization first
participated in the HEI survey in 2012 (Ruben et al., 2017). The leadership with the VA Boston
Healthcare System recognized the need especially since health care providers in the VA system
rarely asked about sexual orientation or gender identity nor understand the risks of mental health
issues for gender and sexual minorities (Sherman, Kauth, Shipherd, & Street, 2014). To address
the issue, a strategic plan was developed based on the cultural competence framework
(Betancourt, Green, & Carrillo, 2002). The framework outlines three levels where cultural
competency should be addressed; these levels are the following: organizational, structural, and clinical.

The Organizational Level

The organizational level is defined as the leadership and workforce of the delivery system that is diverse, supportive, and inclusive to all patients. This is addressed through organizations, foundations, and governmental entities to create initiatives geared to the mission of diversity (Ruben et al., 2017). There has yet to be an organizational change model focused on integrating gender and sexual minority inclusiveness for healthcare organization (Eckstrand, Lunn, & Yehia, 2017). Generally, organizational change model focuses on the following elements: engaged leadership (Hoss, Bobrowski, McDonagh, & Paris, 2011; Betancourt, Green, & Carrillo, 2002; King et al., 2008a; Wooten, Anderson, Pinkerton, Noll, Lori, & Ransom, 2006; Smedley, 2004), dedicated resources (Hoss, Bobrowski, McDonagh, & Paris, 2011; Chin et al., 2012; Washington et al., 2008; Smedley, 2004), continuous training and development (Hoss, Bobrowski, McDonagh, & Paris, 2011; Lee & Woods, 2012; Betancourt, Green, & Carrillo, 2002; Brach, & Fraser, 2000; Wooten, Anderson, Pinkerton, Noll, Lori, & Ransom, 2006), open and interdisciplinary communication between organizational and community stakeholders (King et al., 2008a; Washington et al., 2008), and ongoing management or quality improvement (Hoss, Bobrowski, McDonagh, & Paris, 2011; Lee & Woods, 2012; Washington et al., 2008; Smedley, 2004).

Eckstrand, Lunn, and Yehia (2017) developed and published an organizational change model to address gender and sexual minority health disparities. This framework differentiates elements, which are needed to create change, and processes which are the catalyst to implement the change. The framework identifies six elements for success; 1) Organizational champions
which are visionary and multidisciplinary leaders who have skills in facilitating and implementing change; 2) Organizational priority which is when organizations must prioritize gender and sexual minority diversity and inclusion within their goals and mission; 3) Depth of mission which is when the organization’s goals and mission is embedded within every institutional division; 4) Commitment to continuous learning which consists of the capacity to monitor performance through an evidence-based direction to achieve learning goals consistently; 5) Commitment to diversity and inclusion which consists of diversity and inclusion embedded in policies, performance metrics and trainings; and 6) Organizational resources which refers to having an available human advocate, financial, technological, and other resources needed to achieve the organization’s mission and goals.

In addition to the elements, the framework also consists of six processes, including: 1) Change management which includes defining, communicating, implementing and evaluating the change; 2) Information exchange which is on how effective the information is being disseminated between leaders, stakeholders and organizational members; 3) Action research which includes ongoing data collection and analysis in relation to sexual orientation and gender identity; 4) Relationship building which consists of establishing alliances with important stakeholders with the goal of amplifying diversity and inclusion; 5) Values in action which consist of making sure that diversity and inclusion is built into all aspects of the institution’s functionality; and lastly, 6) Leveraging resources which consist of effectively utilizing prominent resources to adhere to the institution’s goals and mission.

The VA Boston case study exemplified change within the organizational level similarly to Eckstrand, Lunn, and Yehia (2017)’s model. With VA Boston (Ruben et al., 2017), a collaborative and grassroots group of clinicians and researchers were developed. This allowed
the group to discuss ways to create safe spaces for gender and sexual minority patients and create policies for transgender patients’ access to care. VA Boston became the first VA with a transgender healthcare policy. The collaboration evolved and established themselves as the Psychology Diversity and Inclusion Committee with a mission of providing discussions about clinical cases that involved gender and sexual minority veterans and diversity topics. The committee was supported by the leadership from the institution and in collaboration with a hospital-wide diversity committee to develop a memorandum in 2012 addressing appropriative, ethical, and safe care management for gender and sexual minority veterans. The committee conducted self-studies within the institution and implemented educational events related to gender and sexual minority health. This initiative ensured care, respect and confidentiality for gender and sexual minority veterans through grassroots efforts.

*The Structural Level*

The structural level is defined as cultural competence to remove barriers to healthcare, and making care accessible for all (Ruben et al., 2017). One of the structural barriers often talked about is how intake forms are collected and documented in patients’ health records (Cahill et al, 2014). The transfer of patient health information from paper to Electronic Health Records (EHR) was accelerated across the nation due to the American and Reinvestment Act of 2009 and The Patient Protection and Affordable Care Act in 2010 in hopes of creating a structural change to improve health outcomes, reduce costs and address health disparities (US Department of Health and Human Services, 2013). This goal reflected the needs of gender and sexuality minority community. Furthermore, the Institute of Medicine published a report to recommend adding sexual orientation and gender identity indicators as an objective for the EHR Incentive Program which was ran by the Office of the National Coordinator for Health Information Technology.
(ONC) and the Centers for Medicare and Medicaid (CMS; National Institutes of Health, 2011). In fact, collecting gender and sexual minority data within clinical settings also parallels the efforts made by the U.S. Department of Health and Human Services to collect health data for gender and sexual minorities which was authorized under Section 4302 of the ACA (US Department of Health and Human Services, 2013) and efforts made by The Joint Commission which also encouraged data collection for gender and sexual minorities within healthcare organizations (The Joint Commission, 2011).

There are various of ways in which intake forms are commonly cis-heteronormative that prohibits gender and sexual minority patients from disclosing their identities (Miller & Weingarten, 2005). For example, when asking for a legal name, it is recommended to also include the name the patient goes by. Furthermore, instead of mother/father, it is recommended to change it to parents/guardians and husband/wife to spouse/domestic partner (Miller & Weingarten, 2005). In addition, it is best to add an area to describe legal sex and a checkbox for intersex with an area to allow the patient to describe their intersex history. One study looked at how patients perceive intake forms that included sexual orientation and gender identity (Cahill et al., 2014). About 301 patients from four community health centers participated in a survey about their sexual orientation, gender identity, and their perceptions about the sexual orientation and gender identity questions. The community health centers were from diverse areas; a rural setting in South Carolina; Baltimore and Columbia, Maryland; Chicago, Illinois; and Boston, Massachusetts. At least 3 out of 4 respondents agreed that asking about sexual orientation and gender identity on intake forms is important and could understand the questions clearly.

Another way for healthcare organizations to address barriers to care is by establishing a relationship with the gender and sexual minority community as it has community predicted
likelihood of gender and sexual minorities disclosing to medical providers (Durso & Meyer, 2013). VA Boston set the standard of establishing such relationship (Ruben et al., 2017). The organization had empowered their gender and sexual minority patients and staff by getting involved in community events like the LGBT Pride Parade in Boston. In addition, the organization disseminated information about gender and sexual minority related events like Transgender Day of Remembrance and National Coming Out Day through posters, computer screensavers, and tabling events where experts could answer questions from patients, staff, and providers.

*The Clinical Level*

The clinical level is defined as the providers’ and staff’s knowledge on sociocultural factors and health disparities. Barriers include providers and staff unintentionally using bias and stereotypes that impedes quality of healthcare (Ruben et al., 2017). One qualitative interview-based study looked at cultural competence among health and social service providers, executive managers, and program coordinators to meet the needs of older gender and sexual minority adults in Denver, Colorado. Interview questions were developed based on a previous community needs assessment and the coding analysis focused on whether the data indicated high competence, seeking improvement and not aware. Only about four organizations were rated as high competence, however twelve were indicated as seeking improvement while eight organizations were not aware. Many providers indicated that they were unaware about their patients’ sexual orientation or gender identity and were unlikely to understand health disparities related to marginalization. Lastly, most providers reported needing more assistance to better serve older gender and sexual minority populations (Portz et al., 2014).
Healthcare organizations can incentivize trainings through continuing medical education. Continuing medical education (CME) are essential accreditations for clinicians and medical providers to improve cultural humility, interactions with patients, and quality of healthcare services (Bonvicini, 2017; AACME, 2017). To accomplish this, it may be beneficial for the medical providers and clinicians to raise self-awareness of their biases, assumption, and values they may intrinsically or extrinsically hold during their interactions with patients (McGarry, Clarke, Landau, & Cyr, 2008). According to the Accreditation Council on Continuing Medical Education (ACCME), medical organizations that make CMEs a requirement are often in the forefront of addressing health disparities and promoting cultural humility in medical practice (ACCME, 2017). It is vital to train non-clinical staff as every interaction that a patient has with every staff member is a contributing factor to optimizing healthcare outcomes. Patient satisfaction can lead to the likelihood that gender and sexual minorities will disclose their gender identity and sexual orientation including pronouns and their authentic names (Abel et al., 2017). These welcoming practices have shown to alleviate any fear gender and sexual minorities may feel when interacting with healthcare staff members and healthcare providers (McKnight, 2015).

For VA Boston’s initiatives within the clinical level (Ruben et al., 2017), the organization hosted a colloquium about senior gender and sexual minority adults and intersectional health. The committee also hosted several discussions and trainings with providers and staff. In addition, the organization purchased multimedia resources on gender and sexual minority health and disseminated them to staff and clinicians. The organization also established a support group ran by patients for transgender and gender-questioning patients. Some of the outcomes of these initiatives include having a significant impact on the national level of VA healthcare policy, developing an Interdisciplinary Transgender Treatment Team which consist of psychology,
social work, speech pathology, primary care and endocrinology, the organization was also able to implement a gender and sexual minority health fellowship and lastly, the organization could share their work and expertise at national conferences with other VA organizations.

*Health Administrators*

Over the years, traditional business models (like Nike and eBay) have focused on diversity education and training models about gender and sexual minorities for their heterosexual and cisgender employees (Murphy, 2015). These models are based on McNaught’s corporation consultation work on diversity (McNaught, 1994; 1998; 2010). Yet, the healthcare sector is “severely” lagging compared to these traditional corporate organizations (Murphy, 2015). It is difficult to apply these models as healthcare administrations tend to work within intricate and complex healthcare settings such as multiple levels to the organization’s model and multiple roles (Murphy, 2015). To identify the needs of employees, board members and consumers in terms of diversity and inclusivity is a complicated process due to social norms, attitudes, and organizational climate (Ruben et al., 2017). As previously mentioned, one case study exemplified organizational change through grassroots initiatives by motivated employees and stakeholders within the organization itself (Ruben et al., 2017).

According to the literature, cultural humility within the public administration realm is defined as a “respect for, and understanding of diverse and cultural groups, their histories, traditions, beliefs and value systems in the delivery services” (Bailey, 2005). The public administration field recognizes cultural humility as strengthening the government-citizen relationship which would lead to addressing disparities among racial ethnic groups (Carrizales, 2010; Schacter & Liu, 2005). Yet, there has been a gap in the literature in identifying the barriers to adapting healthcare policies to increase cultural humility and improve services for
gender and sexual minorities.

One study addressed the literature gap by interviewing mental health administrators about “helpful” or “unhelpful” policies to improve quality of healthcare services for gender and sexual minority patients (Israel, Walther, Gortcheva, & Perry, 2011). About nine mental health administrators participated in a semi-structured interview. The administrators were defined as professionals who had managerial and fiscal duties that went beyond clinical supervision. Due to how policies and practices are often influenced by the mission or culture of the organization, a holistic case study analytic approach was used. Then, the researchers reviewed the records and established themes using such approach (Patton, 2002).

The results indicated five salient factors; 1) Service delivery for transgender clients: administrators reported that there were a few policies and practices that do not help transgender clients. They explained that there was a lack of resources for clear policies and there was a lack of staff training. “Unhelpful” practices that were identified were reports of staff members feeling uncomfortable providing services such as unwillingness to help clients change and mistaking the patient’s pronouns. Another issue emerged as mental health providers often described transgender clients as “disheveled” or “bizarrely dressed” because the clients’ attire did not match their sex assigned at birth; 2) Coordination inside and outside of the agency: what administrators found the most “helpful” was finding collaborations with outside organizations to address the needs of gender and sexual minority clients. In addition, coordination among agencies (including one example where organizations and agencies collaborated to provide support groups for lesbian women) was “helpful”. Multidisciplinary treatment teams that integrate the client’s partner has also been “helpful” for gender and sexual minority clients. However, there were indications where practices weren’t “helpful”. For example, the lack of
communication and collaboration has been described to be “unhelpful” to gender and sexual minority clients. In one case, a therapist was unable to contact a lesbian client who then felt unwelcomed in the facility. Or when a transgender student was inappropriately referred out by an academic setting because of gender identity instead of the severity of mental health illness as it seemed to translate as an invalidation of the client’s own gender identity. The challenge seems to be coming from the lack of communication and collaboration amongst agencies, organizations and communities; 3) connections to other gender and sexual minorities: a theme that was considered the most “helpful” was when agencies were able to connect with gender and sexual minorities at each level, from collaborating with organizations and groups to including the client’s spouse in the treatment plan. Support groups and collaboration with other organizations to plan gender and sexual minority related events tend to reduce isolation for many gender and sexual minority clients; 4) An openly gay staff: administrators who worked with an openly gay staff found it important and “helpful” for gender and sexual minority clients. Administrators who worked with a staff that had a lack of diversity reported the opposite, and believed that it was “unhelpful” for gender and sexual minority clients. Many administrators reported remediating policies to garner an openly gay staff and have shown to improve services for gender and sexual minority clients; 5) power and position of gender and sexual minority affirming staff: in addition to an openly gay staff, administrators found that it was “helpful” for clients to interact with staff that is affirming of their minority status. And quite the opposite when staff are not affirming towards gender and sexual minority status.

The results of the study described possible needs for gender and sexual minority clients which had expanded the literature research on administrators. However, one aspect of the study that was lacking is addressing the barriers towards implementing policies that are inclusive
towards gender and sexual minorities. In addition, the study allowed the administrators to identify such “helpful” policies and practices but they were not presented with expert recommendations such as the HEI nor did they ask gender and sexual minority patients themselves whether they deemed such policies or practices as helpful or not.

**Academic Medical Institutions**

Besides promoting cultural humility and gender and sexual minority inclusivity within the healthcare system, academic medical institutions have also been severely lacking in training future healthcare professionals on minority health which is problematic because students may not be prepared to provide care for gender and sexual minorities (Bonvicini, 2017). In fact, one survey examined at students within the United States and Canada where students who felt that they were lacking education in sexuality, had sexual issues or were lacking sexual experience, were very likely to report that they felt unprepared to ask about a patient’s sexuality (Shindel et al., 2010). Even within schools of Public Health there seems to be a lack of gender and sexual minority health education, in a study involving 35 public health schools only 17.6% of faculty were involved in non-HIV related gender and sexual minority health research and only 10.8% planned to offer a course on non-HIV related gender and sexual minority health in the following three years (Corliss, Shankle, & Moyer, 2007). Wallick and colleagues (1992), evaluated medical undergraduate programs and found the national average of hours dedicated to homosexuality education was 3 hours and 26 minutes spanning across four years. Six years later, Tesar (1998) reported a decreasing average of 2.5 hours and about 50% of medical undergraduate programs with no education about the topic whatsoever.

Students often may carry negative assumptions about gender and sexual minorities because of group membership. For example, one study investigated attitudes of health profession
students (medical, nursing, dentistry, and counseling; n= 475). Findings suggested higher reports of religiosity and the lack of understanding different religious perspectives of sexuality predicted lower positive attitudes toward gender and sexual minorities (Wilson et al., 2014). Yet, the research literature has indicated several factors that predict comfortability and increased skills of treating gender and sexual minority patients; this includes number of hours dedicated to sexuality, students’ religious background and experience interacting with a gender and sexual minority patient or individual (McKelvey, Webb, Baldassar, Robinson, & Riley, 1999; Sanchez et al., 2006). While there are so many health professional careers, the focus of this dissertation will specifically assess medical students’ and physical assistant students’ perspective, attitudes, and experiences.

This dissertation will focus on two academic programs in healthcare practice, medical doctoral programs and physician assistant programs. The rationale for including medical students is based on reliance the public has for medical doctors. According to a survey conducted by the American Academy of Family Physicians (2012), 72% of Americans reported they trust medical doctors the most for reliable information about their health and having the most medical experience compared to other medical professions. According to the Bureau of Labor Statistics (2015), there is about 708,300 medical doctors in the United States and the job outlook will increase 14% from 2014 to 2024 which is significantly higher than the average of all occupations which is 7%.

The rationale for including physician assistant students stems from the gap seen in the research literature on physician assistant curriculum and gender and sexual minority inclusivity (Compton & Whitehead, 2015). According to the Bureau of Labor Statistics (2015) the job outlook or the number of jobs for physician assistants will increase by 30% from 2014 to 2024.
which is twice as fast as medical doctors. This may be the result of the demand for medical providers and how cost-efficient physician assistants are in a healthcare setting, especially since they are able to provide similar care as compared to medical doctors (Bureau of Labor Statistics, 2015). Physician assistants also give out medical advice to patients in health clinics similarly to medical providers. Furthermore, these two populations were chosen because both programs are available in Wichita, Kansas; Whereas, nurse practitioner programs are further away.

Medical Students

In 2014, the Association of American Medical Colleges (AAMC) produced a detailed publication that provide guidelines for medical schools on how to teach, train, evaluate, and support the learning environment to improve healthcare for gender and sexual minorities. Yet, future medical graduates lack cultural and structural humility training (i.e. socioeconomic class, institution, healthcare systems, neighborhoods, transportation, influence of health, patient-provider relationships) that are essential to care for diverse populations (Metzl, & Hansen, 2014). In fact, a study looked interviewed deans from 150 medical schools in the US and Canada asking if students have time allotted to gender and sexual minority health in their curriculums, one third of medical schools allotted no time for gender and sexual minority health and of those that did, spent on average less than 5 hours in total (Obedin-Maliver et al., 2011). Another study assessed how well medical students are prepared to work with gender and sexual minority patients. Only 49% asked about the patients’ partners and 18% asked about their children. Asking about family and sexual history increased when they have more exposure to gender and sexual minorities (Sanchez et al., 2006).

Lack of education and cultural humility also seems to be a common trend by the time students start their residency. In one study, researchers interviewed chiefs for internal medicine,
pediatrics, general surgery, and obstetrics/gynecology to explore any potential gaps in readiness for newly trained physicians within residency training programs. Chiefs noted several deficiencies. Including concerns about physicians’ abilities to think systemically about their patients’ health. This included cost-efficient care, knowledge of preventative care and community health and, skills in improving quality of care (Crosson, Leu, Roemer, & Ross, 2011). The Accreditation Council on Graduate Medical Education emergency medicine (EM) residency do not include LGBT resident education (Perina et al., 2012). In fact, one study consisted of a survey sent to accredited residency programs in EM across the nation to see if any of these programs ever present gender and sexual minority health information. About 124 programs responded out of 160 programs. The researchers found that 26% of EM programs ever presented any information on gender and sexual minority health. Programs averaged about 45 minutes of gender and sexual minority health education. 16% of the programs did not support the necessity of gender and sexual minority health education (Moll et al., 2014).

There has also been limited data indicating medical school creates an environment where gender and sexual minority medical students are harassed due to their identity. In fact, in 2013, the AAMC conducted a graduate survey of a sample size of 13,072 students and found that 2.3% reported that they were subjected to offensive insults related to sexual orientation (AAMC, 2013). The AAMC (2013) also piloted an anonymous questionnaire, the Medical Student Life Survey (MSLS) to look at the wellbeing of medical students. About 3,466 second year students responded to the questionnaire. About 5.9% of the sample reported being a sexual minority. The survey also indicated that’s LGB medical students experience higher stress levels, isolation, and financial restraints compared to their heterosexual counterparts. Furthermore, they were more likely to lack a support system and encounter a negative emotional climate during training
(Grbic, & Sondheimer, 2014). Furthermore, sexual and gender minority medical students have reported that disclosing their identity has led to discrimination in admissions, evaluations, and residency matching; it is rare for students to be out in undergraduate and graduate applications (Merchant, Jongco III, & Woodward, 2005).

Although the AAMC (2014), recognizes that there is a need for more education about gender and sexuality minority socio-political health and health disparities, there continues to be barriers like a lack of effective education and training, a lack of trained and expert faculty, limitation of time, faculty attitudes towards gender and sexual minorities, the lack of sexual and gender minority health and health disparities mentioned on national exams and the lack of role models to discuss the difference between sexual orientation, attraction and gender identity (Tamas, Miller, Martin, & Greenberg, 2010). Research also has indicated that medical students were more likely feel confident in their ability to serve gender and sexual minority patients if they practiced asking about sexual orientation and sexual history with gender and sexual minorities (Sanchez et al., 2006). This also reflects residency programs when gender and sexual minority trainings are provided. In one study conducted on medical residents’ readiness to provide care to gender and sexual minority patients have shown to increase among 96% of the participants after a three-hour training (McGarry, Clarke, Landau, & Cyr, 2008).

**Physician Assistant Students**

Since 1960s, education for physician assistant profession (PA) continues to be a strong asset to the healthcare system (Compton & Whitehead, 2015). Current programs are approximately 27 months long in which a student completes more than 100 credit hours into a master’s degree (Compton & Whitehead, 2015). After a year of classroom education, PA programs tend to start a year of residency and participate in a series of supervised rotations. They
are often in Emergency Medicine, Pediatrics, Women’s Health, inpatient Internal Medicine, Psychiatry, Surgery, and Ambulatory (Primary) Care, (ARC-PA, 2010). Through this year, the students are given evaluations of their care, knowledge, and performance for each rotation. After completing the rotations, students can add extracurricular clinical rotations. They also must complete a capstone project before they take the national certifying exam to get their license (Compton & Whitehead, 2015).

Throughout the two years of training and studying, physician assistant students only real experience working with gender and sexual minorities are the patients they meet during medical rotations, without any training in understanding sexual orientation nor gender identity. This may increase the likelihood that these students will mistakenly use a heterosexual/cisgender model instead of addressing the needs more pertinent to gender and sexual minorities (Compton & Whitehead, 2015). This inadequate preparation leads to increased risks of lowering the quality of healthcare services for the patient. Without a strong relationship between the provider and their patient, it can lead to inaccessibility to healthcare for many gender and sexual minorities (Compton & Whitehead, 2015).

Furthermore, there is a lack of gender and sexual minority education and research literature for physician assistant students (Compton & Whitehead, 2015). There are no specific publications on the interactions physician assistant students have with gender and sexual minority patients, and the only articles that mention gender and sexual minority health remotely, are in subsections of general cultural competency articles. Two experts integrated gender and sexual minority health education for Physician Assistant students. They developed grounding education by training willing faculty members to provide grounding education for the students. The students were then placed in to small discussion groups to discuss cases and vignettes. Then
the students broke into smaller groups to practice sexual history taking or practiced scripts to follow when providing care to patients from the LGBT community. The curriculum was evaluated with pre-and post-tests on knowledge (Compton, & Whitehead, 2015). Although the experts published their work about the curriculum, they had not reported the results or analysis on any potential changes in knowledge.

**The Present Study**

According to the HRC’s State Equality Index (Warbelo & Diaz, 2016), Kansas introduced five bills that were considered “bad policies” against gender sexual minorities when there were only two “good policies” that protect gender and sexual minorities. The health of gender and sexual minorities in Kansas is negatively affected by statewide policies, such as the recent reversal of the anti-discrimination statute that included sexual orientation and gender identity as protected classes (Warbelo & Diaz, 2016; James et al., 2016). This allows for systemic discriminatory practices to occur, and ultimately, makes the case of including sexual orientation and gender identity during health intake processes a lower priority.

The state also currently permits health insurance exclusions for transgender individuals and does not include transgender services for governmental employees (Warbelo & Diaz, 2016; James et al., 2016). Another barrier within the state of the Kansas, is the lack of data. In Kansas, the latest dataset for sexual minorities is the Census 2010 where the only population that was captured were same-sex couples (Gates & Cooke, 2012). According to the Williams Institute (Gates & Cooke, 2012), the Census 2010 had a record of 4,009 same-sex couples in the state of Kansas. For Sedgwick County, the Census 2010 recorded about 907 same-sex couples. In addition, U.S Transgender (James et al., 2016) also collected data for transgender individuals living in the state of Kansas; 197 transgender individuals residing in the state of Kansas, took the
survey. Out of that 197, about 36% of the sample reported living in poverty and 15% reported being fired from their jobs due to their gender expression or gender identity. Furthermore, about 33% of those who saw a medical provider had at least one negative experience due to their gender identity including refusal of treatment, verbal harassment or physical or sexual assault or having to teach their medical provider about gender identity. In addition, 29% of the sample reported delays in healthcare services because of the fear of being mistreated due to their gender identity; And 11% of the sample reported that a mental health professional such as a psychologist, counselor or religious leader have attempted to convince them to stop being transgender.

Needless to say, lack of data makes it difficult for organizations who serve gender and sexual minorities to receive any funding from foundations and grants. Additionally, this barrier prohibits the possibility to explain to policymakers whenever a policy is detrimental to the community. Therefore, there is a necessity to expand data collection for gender and sexual minorities residing in the state of Kansas.

**Background and Context**

The Center of Wichita, Inc., (The Center) is a nonprofit organization whose mission is “To prevent prejudice and discrimination for the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community through partnerships, programming, and education.” The Center accomplishes its mission by hosting a safe meeting space for several mission-driven LGBTQI advocacy groups in Wichita, as well as multiple LGBTQI youth groups. In addition, an expansive library of population-specific resources from around the country are maintained at The Center’s headquarters and made available to community members. One of their most active groups that help The Center to achieve its mission include the Wichita LGBT Health Coalition; a
network of healthcare, academic, and public health professionals looking to enhance all areas of lesbian, gay, bisexual, and transgender health. One of their proudest project is the Provider Directory website.

The Wichita LGBT-Friendly Provider Directory is a local listing of healthcare providers who deliver competent services and understand the unique health concerns of the lesbian, gay, bisexual, and transgender community. The Center has provided a foundation for a driven group of healthcare, academic, and advocate professionals to establish the Wichita LGBT Health Coalition in 2010. The health advocates in the Coalition determined that an online resource would be beneficial in today’s fast-paced society and would allow interested parties to easily search for a provider in their proximity. To ensure providers are LGBTQI friendly and culturally sensitive to the community’s needs, the Coalition requires specific information from each applicant and a signed consent form before the provider is listed in the directory. For providers who are supportive but not necessarily well-informed about LGBT concerns, the Health Coalition has provided brief cultural competency trainings as part of other ongoing efforts.

Health Equality Index

As previously mentioned, the Health Equality Index (Human Rights Campaign, 2017; HEI) is an annual publication developed by the Human Rights Campaign in 2007. Every year, the publication presents recommendations for policies and practices for healthcare gender and sexual minority inclusivity. In addition, the HEI lists healthcare organizations that have implemented such policies and practices. Unfortunately, according to the HEI in 2017, only three hospitals in Kansas were determined as leaders for healthcare equality. All three facilities are located at the north area of Kansas, closer to Kansas City. These hospitals are two and a half hours away from the city of Wichita. This recent index has motivated the LGBT Center of
Wichita and the LGBT Health Coalition to ensure that other healthcare facilities are determined as healthcare equality leaders; however, it has been difficult to create broader positive changes that ensure safe spaces for gender and sexual minority patients in Wichita. One suggestion was exploring potential barriers to gender and sexual minority-inclusive care with providers, healthcare administration, and LGBT patients, using qualitative methods.

Summary

According to Healthy People 2020, health disparities have a significant relationship with marginalization, social stigma and denial of many human rights including denial of healthcare services. Gender and sexual minority patients have reported that they choose to not give out their orientation or gender due to the number of negative attitudes perceived through either overt or covert discrimination from staff and medical providers which has shown to increase barriers to quality care (Krehely, 2009; Roberts & Fantz, 2014). In relation to the minority stress model and the research literature, health disparities within the gender and sexual minority communities are significantly associated with minority stress. Minority stress is the psychological stress that is perpetuated by past experiences of discrimination and the expectation of future discrimination. The minority stress model (Meyer, 1995) will be fused with an ecological framework (Eliason, & Fogel, 2015) to assess and identify the resiliency, needs and barriers for gender minorities and sexual minority women. The rationale for this is to avoid bias and assumptions that often lead to victim blaming (Meyer, 2015).

Structurally, the health care setting does not provide inclusivity for gender and sexual minority patients which has a significant relationship with delays and underutilization of health services (Krehely, 2009; Roberts & Fantz, 2014). Although the research literature has significantly expanded on gender and sexual minority health research, there is still evidence that
indicate negative experiences within almost every level of the healthcare delivery system (Bonvicini, 2017).

Although, the literature is still unclear about what is the most effective way to address issues of inclusivity and discrimination for gender and sexual minorities, the research literature does indicate that promoting cultural humility does benefit and improve patient outcomes, changes in attitudes, an increase in knowledge, and improved outcomes related to accessibility and utilization (Truong, Paradies, & Priest, 2014). The cultural competence model framework is often used to promote cultural humility within an organization. The framework outlines three levels where cultural competency should be addressed; these levels are the following: organizational, structural, and clinical. In addition, the Human Rights Campaign also developed recommended policies and practices for healthcare services within the United States. Therefore, the cultural competency model and HRC’s recommendations will be utilized to understand the perspectives of medical students, PA students and healthcare administrators.

Research Questions

The three central research questions for the present study are presented:

1. **What are the structural barriers to adopting HRC’s recommended policies with the healthcare setting?**

   Considering how only three facilities were consider as health equality leaders in the state of Kansas, we want to explore what specific barriers impacts a healthcare organization’s decision to adopt policies that promote inclusivity with their services. The study plans to gain insight from administrators who work in healthcare organizations in efforts to understand why it may be difficult for services to be inclusive.
2. **What are the experiences of gender minorities and sexual minority women within a healthcare setting in the city of Wichita?**

   This study aims to examine the views and perceptions from gender minorities and sexual minority women in the city of Wichita. Since the study is essentially about the lives of gender and sexual minorities, we felt it was important to capture their experiences within a healthcare setting.

3. **What are the experiences of medical and physician assistant residency students in terms of gender and sexual minority health training?**

   In addition to understanding the barriers within the healthcare setting, we also want to know if students are prepared to provide healthcare services to gender and sexual minorities. The decision to include physician assistant students was contributed to how similar the professions (physician assistant and medical doctor) are (Compton & Whitehead, 2015).
Chapter 3

METHODOLOGY

Research Design

This study will adopt a triangulation approach to explore the quality of healthcare for gender minorities and sexual minority women (Yin, 2009). The study will consist of three phases of data collection: 1) interviews with gender minorities and sexual minority women, 2) interviews with medical and PA resident students and 3) interviews with healthcare organizations’ administrators. Using three sample populations, this study will explore the underlying interactions and policy impacts between healthcare facilities and gender minority and sexual minority women populations. For a model of the research design, see figure 3.

Figure 3. Triangulation of the Data Collection (Yin, 2009)
Background

During the last few meetings, the LGBT Health Coalition have discussed conducting interviews with healthcare residential students, healthcare administration and patients. In a collaborative effort with the Wichita LGBT Health Coalition, Human Rights Campaign, George Washington University, and Wichita State University, this dissertation will be an exploratory and qualitative research project. The aim of this project is to develop a report that would benefit other healthcare facilities in Kansas, the Human Rights Campaign, and Wichita LGBT Health Coalition.

Participants and Settings

Participants will be recruited through word of mouth, through Wichita State University’s Physician Assistant Program, University of Kansas’ medical school and social media. In addition, recruitment will be announced during Wichita’s LGBT Health Coalition meetings and e-mail listings as many medical and healthcare stakeholders often participate in the coalition. The information will be used to create workshops that can assist healthcare facilities to participate in the Health Equality Index. In addition, the hope is to gain two more leaders for health equality in the state of Kansas. Lastly, the project will also be presented at George Washington University as a capstone project for the LGBT Health Policy & Practice Graduate Certification Program.

See figure 4 for the timeline of the project.

**Project's Timeline**

![Figure 4. Current Study Timeline](image-url)
Procedure

Interviews

Interviews were conducted with 30 participants and three sample populations (gender minorities and sexual minority women, and healthcare executive administrators). The aim is to identify what barriers exist for healthcare facilities in the Wichita area to become health equality leaders. The administrators and students were recruited through the relationships established with health professionals in the Wichita LGBT Health Coalition, relationships within the university, and by gender and sexual minority participants who mentioned healthcare facilities where they had positive interactions. Information was sent out through e-mails, word of mouth, social media, and through snowball sampling. Recruitment for gender minorities and sexual minority women consisted of social media announcements on the Wichita LGBT Health Coalition Facebook page, through word of mouth, school announcements (shocker blasts) and through snowball sampling. There has been a growing interest among the Wichita LGBT Health to participate in the Health Equality Index as well. The interview guide and materials can be found in Appendix A.

The semi-structured interview guide and open-ended questions were created by the researchers with feedback from healthcare professionals, healthcare undergraduate students, gender and sexual minorities and other colleagues. In addition, the interview guide and questions were also developed based on the research literature. Each participant will be provided with ten vignettes that were developed based on the HRC’s Health Equality Index’s criteria (2017), which includes vignettes of hypothetical healthcare facilities that meet (or doesn’t meet) the policy recommendations. The criteria provided by the Human Rights Campaign and the vignettes can be found in Appendix B.
If the participants agreed to participate, they were asked to sign a consent form indicating that they are aware of the benefits and risks of the study and their rights. The sessions were recorded using a digital recorder and transcribed by undergraduate students and research lab team members. Each participant filled out a short demographic survey before starting the interview. Interviews stopped when the saturation has been reached and interviewees add nothing to the data (Rubin & Rubin, 1995). Given the number of interviews, there will be enough data collected without the necessity for a larger sample, especially if the participants take an extensive time to share their insights (Morse, 2000).

The gender minorities, sexual minority women and healthcare professional students were compensated with a 20-dollar gift card for taking the time to share their experiences as an incentive. A lead researcher conducted the interview while the interviews were transcribed by undergraduate students and the research team.

The Research Team

The research team consisted of 6 individuals in which the primary investigator held several meetings with to discuss the Human Rights Campaign’s HEI initiative regarding Wichita, Kansas. The primary investigator asked for simple demographics of each team member to fully describe the different perspectives that were involved in the process of developing themes and coding.

One team member is a graduate student who is pursuing a degree in Community Psychology at Wichita State University. He described himself as a white, straight and cisgender male who is 30 years old. He is an atheist and a liberal democrat. Another team member described herself as an Afro-Latina, queer/bisexual and cisgender woman who is 23 years old.
She explained that she is a Jehovah’s Witness and is currently an undergraduate student studying Psychology and Women’s studies at Wichita State University.

The third team member described himself as a black, heterosexual, and cisgender male and a 24-year old undergraduate student who is studying graphic design at Wichita State University. He is also a Jehovah’s Witness. The fourth team member described herself as a poly-bisexual, white, and cisgender woman who is a 25-year-old undergraduate student studying Psychology at Wichita State University. She is an agnostic and a spiritualist who considers herself a Democratic Socialist.

The fifth team member described herself as a bisexual, white, and cisgender woman who is a 25-year-old graduate student from the Sociology department at Wichita State University. She is an atheist and politically aligns as a Communist. Lastly, the sixth member of the team described herself as a heterosexual, white Hispanic and cisgender woman who is a 20-year-old undergraduate student, studying Biology and Psychology at Wichita State University. She said she is a Christian and is politically aligned with liberal ideals. Although, the team aligns more progressive, it seems that in terms of religion, sexuality, and racially, this team is fairly diverse.

Plan of Analysis

This dissertation used an inerative analysis; meaning that the research team will alternate between finding emerging themes of the data similarly to grounded theory (Glaser & Strauss, 1967), but in addition, using the etic of existing theories (Srivastava & Hopwood, 2009). In this case, we will use the minority stress model (Meyer, 1995) and the ecological model (Eliason, & Fogel, 2015) for the interviews with gender minorities and sexual minority women and the cultural competence model (Betancourt, Green, & Carrillo, 2002) for interviews with administrators, minorities, and students.
After the interview data is transcribed, the coding of the data will consist of a two-step process. During the data immersion phrase or in phase 1, undergraduates and research team members will open code independently each interview. Then, the team met together to discuss the open coding (see Appendix C for notes on open coding). Within these discussions, it was expected that emerging themes will come up from such dialogue. Using grounded theory (Glaser & Strauss, 1967), the team will discuss emerging themes, refining these themes and resolving any discrepancies. If a specific code does not meet an agreement within five minutes, it will be dropped from the analysis. Then a constant comparative method (Charmaz, 2006) will be used to lump codes into broader themes with the guide of the existing theories and then create the codebook for each population.

For the interviews with gender minorities and sexual minority women, the broader themes will be examined through the lens of the minority stress model (Meyer, 1995), the ecological model (Eliason & Fogel, 2015), and the cultural competence model (Betancourt, Green, & Carrillo, 2002). As for the interviews with healthcare professional students and medical administrators, the broader themes will be examined through the cultural competence model (Betancourt, Green, & Carrillo, 2002). After creating the codebook, there was second round of coding to determine a focused analysis of the data. Latsly, a coding chart was generated with the results of the final coding. Data will be uploaded to an Excel program. See figure 5 for process model of the analysis. See figure 5 for a diagram on the process of analysis.
Figure 5. Process of Analysis
Chapter 4

RESULTS

A total of thirty interviews were done in a span of two months with gender minorities and sexual minority women (n=13), health professional students (n=8), and medical administrators (n=9). Due to the large saturation of data, especially among the gender and sexual minority sample, the results will be organized first by discussing the characteristics of each sample population. First, we will share the results of the characteristics found in the gender minority and sexual minority women sample and how the minority stress model (Meyer, 1995) and ecological model (Eliason & Fogel, 2015) have been applied to the themes in relation to the functionality of this community in the Wichita area. Second, I will share the characteristics and barriers found within the health professional students sample and, lastly, the medical administrators sample.

Afterwards, I will share the results of the themes across all three sample populations in regards to vignettes which were based on the Human Rights Campaign’s HEI criteria which were then organized by the factors found in the cultural competence model (organizational, structural and clinical; Betancourt, Green, & Carrillo, 2002). The results will be organized to describe how the three factorial levels and ten vinegettes impact the three samples and their collective reactions to each of the criterias found in the HEI. The purpose is to provide results that captures gender and sexual minority health in the Wichita area.

Gender Minorities and Sexual Minority Women

Thirteen participants were recruited to participate in the interviews pertaining gender minorities and sexual minority women’s health. Although, there was an attempt to avoid saturation, due to this eclectic and diverse sample, individuals shared similar experiences but from
several different perspectives due to who they were and how they handled their understanding of their minority identity and minority stress. The gender minority and sexual minority community is not a monolith and encompasses several very unique experiences. It's important to note that sexual orientation and gender identity are not mutually inclusive, for example, regardless of gender identity it is difficult to make an assumption of what their sexual orientation might be.

In addition, it is difficult to guess how many identified as a sexual minority woman because of the nuances of gender identity, so these numbers are an approximation based on how the participants answered; and therefore those who reported a female (whether it is trans or cis) identity and all of those who reported a lesbian identity. Fifty-four percent (54%) of the participants reported having a sexual minority woman identity (n=7). About 46% of the sample reported being bisexual (n=6), half of the bisexual participants identified as cisgender women (50%; n=3), only one bisexual individual had a transgender woman identity as well (17%; n=1) and lastly, two bisexual participants reported being genderqueer (33%; n=2). One of the gender queer individuals reported bisexuality but also questioning and pansexuality. Only three participants reported a lesbian identity (23%; n=3). One lesbian reported having a cisgender woman identity (33%; n=1), one reported having a transgender woman identity (33%; n=1) and, one lesbian individual who identified as genderqueer (33%; n=1).

In addition to sexuality, about 69% reported having a gender minority identity (n=9). One participant reported having an identity of a transwoman and as someone who is genderqueer (11%; n=1) and another participant reported “other” and reported having a non-binary identity (11%; n=1). Both have reported a pansexual identity and one have also reported questioning and bisexuality. About four of the participants reported being transmen (31%; n=4); one reported having an asexual identity (25%; n=1), one reported having a gay male identity (25%; n=1), one
reported having a heterosexual identity (25%; n=1) and one reported having a pansexual identity (25%; n=1). There are two participants who reported a transgender woman identity (15%; n=2). One has already been reported to have also had a genderqueer, bisexual, pansexual, and questioning identities (50%; n=1) and the other transwoman identifies as a lesbian woman (50%; n=1). Crosstabs table on all of the gender identity, sexual orientation and sex assigned at birth is located on table 1.

Table 1
Sexual Orientation and Gender Identity

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Cisgender Female</th>
<th>Transgender Male</th>
<th>Gender Identity</th>
<th>Transgender Female</th>
<th>Genderqueer</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
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<td>1</td>
<td>0</td>
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<td></td>
</tr>
<tr>
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<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Bisexual</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Asexual</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
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<td>1</td>
<td>4</td>
<td></td>
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<td>2</td>
<td>3</td>
<td>1</td>
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</tr>
</tbody>
</table>

n=13

Other demographics

Over half of the sample identified as white or European American (54%; n=7), about four reported biracial or multiracial identities (31%; n=4), and two reported having a Latinx identity (15%; n=2). In terms of marital and relationship status, what as unique with this sample is that
some reported a relationship status but also responded with “other”. One who reported single and another participant who reported being married also mentioned that they were in “poly” relationships, meaning they have several relationships or have an open relationship. Another unique characteristic of this sample population is that over half reported that they did not practice religion (62%; n=8). For more information on the demographics please see table 2.

Table 2

_Demographics of Sexual and Gender Minority participants (n=13)_

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian/Asian</td>
<td>9%</td>
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</tr>
<tr>
<td>American/White/European American</td>
<td>23%</td>
<td>3</td>
</tr>
<tr>
<td>Native American/ White/ European American (Biracial)</td>
<td>16%</td>
<td>2</td>
</tr>
<tr>
<td>Latinx</td>
<td>54%</td>
<td>7</td>
</tr>
<tr>
<td>White/ European American</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
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<td></td>
</tr>
<tr>
<td>Married</td>
<td>38%</td>
<td>5</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>24%</td>
<td>3</td>
</tr>
<tr>
<td>Single</td>
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<td>5</td>
</tr>
<tr>
<td>Is a Veteran/Active Military</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15%</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>85%</td>
<td>11</td>
</tr>
<tr>
<td>Household income</td>
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<td></td>
</tr>
<tr>
<td>Less than $10,000</td>
<td>31%</td>
<td>4</td>
</tr>
<tr>
<td>$10,001-$20,000</td>
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<td>$20,001-$30,000</td>
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</tr>
<tr>
<td>$40,001 and above</td>
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<td>3</td>
</tr>
<tr>
<td>Religion</td>
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</tr>
<tr>
<td>Christian</td>
<td>15%</td>
<td>2</td>
</tr>
<tr>
<td>No Religion</td>
<td>62%</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>23%</td>
<td>3</td>
</tr>
</tbody>
</table>

_Healthcare Services Demographic Experiences_

In addition to demographics, participants were also asked about their perceptions of their health and mental health outcomes and when was the last time they received healthcare services. Participants were asked about their overall physical health. About 59% reported their health to be
very good (n=7) and about 31% reported their health as fair (n=4). Please see figure six for a
graph of the responses.

Figure 6. Physical Health Reported

Participants were also asked about their overall mental health. About 54% of the
participants reported that they consider their mental health, fair (n=7). Whereas about 31%
reported they have good mental health (n=4). Please see figure 7 for a full graph of this question.
Participants were asked when was the last time they saw a primary care doctor. About 84% of participants reported visiting their primary care providers within the past year (n=11). In addition, about 16% of participants reported visiting 3-5 years ago (n=2). Please see figure 8 for a full graph on primary care visitation.
Participants were asked when was the last time they were tested for sexual transmitted infections (STIs). About 63% of the participants reported getting tested for STIs (n=7). In addition, 25% of the participants reported never receiving any STIs testing (n=3). Please see figure 9 for a full graph of STIs testing.
Participants were asked when was the last time they received preventative services like pap smears, prostrate exams or breast examinations. About 54% of the participants reported receiving preventative services within the past year (n=7). About 23% of participants reported never receiving preventative services (n=3). Please see figure 10 for a full graph of receiving preventative healthcare.
Lastly, participants were asked when was the last time they visited the emergency room. About 39% of participants reported visiting the emergency room within the past year (n=5). About 23% of the participants reported never visiting the emergency room (n=3). Please see figure 11 for a full graph of receiving emergency room services.
In addition to asking about healthcare services experiences, participants were given a table where they were asked to check mark whether they expected discrimination, experience discriminated and/or never experienced discrimination on several levels from their individual self, to the community, organizations and all the way through federal politics and pop culture/media.

When asked about their experiences with discrimination, about 92% reported experiencing internalized discrimination (n=12), 85% reported experiencing discrimination from federal politics (n=11) and 85% experienced discrimination from their own families (n=11).
When asked about where they expect to be discriminated against, about 77% reported they expect it from religious organizations (n=10), 77% reported they expect it from healthcare organizations and services (n=10), and 70% reported that expect it from pop culture or the broad media (n=9). When asked about where they have never experienced discrimination. About 62% reported that they never experienced discrimination within social services (n=8), 62% reported never experiencing discrimination within their neighborhoods (n=8), and lastly 54% reported never experiencing discrimination from mental health services (n=7). Please see table 3 to see the full results on this table.

Table 3: Ecological View of Minority Stress

<table>
<thead>
<tr>
<th>#</th>
<th>Question</th>
<th>Experienced discrimination before</th>
<th>Expect being discriminated</th>
<th>Never been discriminated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yourself</td>
<td>60.00%</td>
<td>35.00%</td>
<td>5.00%</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Family</td>
<td>55.00%</td>
<td>40.00%</td>
<td>5.00%</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Friends</td>
<td>46.67%</td>
<td>20.00%</td>
<td>33.33%</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Peers</td>
<td>52.94%</td>
<td>35.29%</td>
<td>11.76%</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Public Schools</td>
<td>33.33%</td>
<td>33.33%</td>
<td>33.33%</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Universities</td>
<td>29.41%</td>
<td>41.18%</td>
<td>29.41%</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>Religious Organizations</td>
<td>47.62%</td>
<td>47.62%</td>
<td>4.76%</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Other non-profit organizations</td>
<td>18.75%</td>
<td>43.75%</td>
<td>37.50%</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>Healthcare Services</td>
<td>45.00%</td>
<td>50.00%</td>
<td>5.00%</td>
<td>1</td>
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<tr>
<td>10</td>
<td>Mental Health Services</td>
<td>25.00%</td>
<td>31.25%</td>
<td>43.75%</td>
<td>7</td>
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<tr>
<td>11</td>
<td>Social Services</td>
<td>12.50%</td>
<td>37.50%</td>
<td>50.00%</td>
<td>8</td>
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<tr>
<td>12</td>
<td>Neighborhood</td>
<td>7.14%</td>
<td>35.71%</td>
<td>57.14%</td>
<td>8</td>
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<tr>
<td>13</td>
<td>Businesses</td>
<td>20.00%</td>
<td>46.67%</td>
<td>33.33%</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>Workplace</td>
<td>35.29%</td>
<td>35.29%</td>
<td>29.41%</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 3. (continued)

<table>
<thead>
<tr>
<th>#</th>
<th>Question</th>
<th>Experienced discrimination before</th>
<th>Expect being discriminated</th>
<th>Never been discriminated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Local Politics</td>
<td>45.00%</td>
<td>9</td>
<td>45.00%</td>
<td>9</td>
</tr>
<tr>
<td>16</td>
<td>State Politics</td>
<td>52.63%</td>
<td>10</td>
<td>42.11%</td>
<td>8</td>
</tr>
<tr>
<td>17</td>
<td>Federal Politics</td>
<td>57.89%</td>
<td>11</td>
<td>36.84%</td>
<td>7</td>
</tr>
<tr>
<td>18</td>
<td>Pop Culture and the Media</td>
<td>50.00%</td>
<td>11</td>
<td>40.91%</td>
<td>9</td>
</tr>
</tbody>
</table>

Ecological and Minority Stress Model Open Codes and Themes - Gender and Sexual Minorities

Themes were found within the 13 transcribed interviews which were developed by several engaging conversations with the research team. If team members disagreed after five minutes, the theme was dropped. The conversations were organized in written notes based on the questions from the interviews (see Appendix C for notes and coding). These open dialogued themes will be discussed in such order: Discrimination, Community, Social Support, and Experiences in Healthcare.

**Discrimination.** Almost all of the participants have experienced discrimination in the Wichita area. Some have experienced overt discrimination while others have experienced microaggressions or a subtle form of discrimination. Regardless of how subtle or overt, every participant described their reaction to it as negative or would justify what was happening with the individual who was perpetuating the discrimination. For example of such justification is found in the following quote:

Participant 9

“I'm going in and I'm sitting there and getting my order, my pizza. I'm sitting there, and I hear somebody in the back say, um, ‘can you take this pizza up there? I don't want to that thing up there’ and I walk, and I sit and I'm not like a shy person. So, I stood up and kind of glared at him and then the other person gave me my pizza and as much as I have a thick skin, it bothered me so
much to hear that and it was probably some… punk high school kid who didn't know what he was talking about or understand things and I was like, you're not worth my time… But it was, that was like a first one of the first times I had felt like blatantly like, wow, that was really obvious discrimination… If made a big deal about it because I could have, I could have said something to a manager, I could have written a letter. I didn't want to make a big deal out of it. And it's like, you know what, I work with that population who are high school kids, I get it, they are ignorant, and I have to move on with my life. it is what it is. It is.”

One of the key topics during the dialogues with the research team is that gender and sexual minorities would actively justify what was happening when they are being discriminated against. In addition, many participants spoke about concealing their identity to avoid discrimination. Participant 9 for example, has only had this experience of overt discrimination within the Wichita community. Throughout the interview, they mentioned how they often conceal their identity to the outside world. Although participant 9’s gender identity is non-binary and goes by the pronouns them, theirs, and they, within the drag performing community (they are a non-binary drag performer), outside of that community and especially in their work environment they inauthentically use their deadname, use his, him, and he pronouns, and presents themselves as a cisgender man.

Avoiding expected instances of discrimination by concealing gender or sexual minority identities, as previously mentioned before, is an issue that is often pervasive within healthcare services. It leads to misunderstanding in the working relationship between the medical provider and their patient and may become a potential barrier to necessary preventative healthcare services (Meyer, 1995). Even more so, it seems that not only do gender and sexual minority conceal their identities in healthcare, they actively do so with most people who may not understand their minority identity and the outside world. Concealment has also been an associating factor in perpetuating minority stress that could contribute to poor health and mental health outcomes (Meyer, 1995).
Throughout the open coding and discussions, team members observed troubling situations where a participant shared their identity and then was actively discriminated against or had their experiences invalidated due to the stigmatization of their identity. It seemed that outside persons who may have had little to no experience interacting with gender and sexual minorities or may hold biases against them, would often view gender and sexual minorities as too sensitive or exaggerating their life experiences. One example of such comes in the following quote:

Participant 10

“.....So, I went to [the] new restaurant and I put in an application. Had a meeting with her, explained to her that I'm in a transition and uh, I go by [NAME] and I am working on getting my legal name changed blah blah blah. I told her I would like to be treated as any other woman at the restaurant. I would like to use my name and my proper pronouns. Um, she hired me and the day I went into work, every single person in there knew that I was trans. She had outing me. And then the first time I got sexually assaulted was when I was working there. I had to close the restaurant at the time...and I am the last one out and I have to lock the door. They made us park our cars across the street because they didn't want us to use the customers' spaces at the parking lot. And I was on my way to my car. and um someone attacked me and raped me...I told my boss and I said, I can't close anymore, not without somebody else. And she said, ‘I can't, I can't pay a cook to stay here just so you can walk to your car’. I said, ‘but on Tuesdays you have the cooks stay here for when the waitresses have to run late because they do a full change-out on the restaurant, all sorts of pepper shakers and all of this stuff.’ I said, ‘what's the difference?’ and she said ‘they're women’. And I told her, I said, I can't do it. And she said well that's insubordination, and I'm going to have to let you go. So I got fired for being a trans woman so yeah.... that's discrimination.”

In this specific incident, the participant discloses to her employer that she is transitioning, and she wants to go by her authentic name and pronouns. This is an example of when gender and sexual minorities share their minority identity to people who may not have the awareness/understanding or may hold negative attitudes towards the community. The outcomes often end negatively. This employer for example, refused to recognize the participant as the
woman she said she is. Even after being sexually assaulted, her minority status made it difficult to receive any protections from the employer and was eventually fired.

Concealment has also been a pervasive topic when conversing with sexual minority women, and more particular, bisexual women who are married and participants who are in polyamorous relationships. Examples can be found with two participants in the following quotes:

Participant 5

“I’m a bisexual woman in a heterosexual marriage, so I have a male partner. Um, so I don't necessarily advertise it a whole lot. It's not as [discrimination] commonly occurring here…It's challenging in a sense that being bisexual, but in a heterosexual marriage, I can hide it if I want to. I don't have to advertise it. It's not like I'm out with any female partners currently. Um, so it's challenging in a sense that I obviously can't just tell everybody who I am or what I, you know, how identify. Um, so I guess it'd be challenging in a sense that you can't be your true self as you want to be.”

Participant 7

“I kinda feel like, ya know, so yeah. Especially being polyamorous, people that know about my relationships, they don't understand, ya know, and they'll ask me questions. I'm like, are you curious or being voyeuristic? You know what I mean? That's the only type thing that makes me step back from those type groups because there is not like a polyamorous community in Wichita.”

Both participants have reflected on feeling hesitant to even share their identities within gender and sexual minority communities. In interviews with bisexual participants, many have brought up the concept of “bi-erasure” meaning that individuals would assume they are heterosexual and therefore erase their bisexual or queer identities. This is more prevalent in bisexual participants who are married to heterosexual individuals. Many of the bisexual women interviewed spoke about how they would live through a world where the people around them would just assume that they are heterosexual due to their marriages with heterosexual men, even if they continue to engage in sexual relationships with other women. Which may increase misinformation with this
population about who should be tested and who may not need to be tested. This is exemplified by participant 3 in the following quote:

Participant 3

“There's this assumption that you don't need to be screened for like an STI if you're a female. And having sexual encounters with females like, like, oh yeah, you're not going to catch STDs, and you're not going to get pregnant, which is really antiquated thinking. And it's like, yeah. And there are other. Because I do have male and female sexual partners, like, you know, sexual partners. I have, I could be with other partners too. So I mean to me, if you're sexually active you should take charge of your reproductive health and you know, get yourself tested is as part of being responsible as a sexual adult.”

Another invalidation of identity relates to participants’ polyamory identities. There is a stigma related to open relationships and marriages including the assumption that it is a form of infidelity. Participant 7 especially spoke about their struggles with sharing this aspect of their identity. They described how people would react negatively towards their open marriage or begin to objectify and fetishize their sexual identity. Whether it is sexualizing or negatively reacting to their sexuality and their relationships, they expressed concealing that aspect to avoid being rejected, invalidated and discriminated against. Regardless, concealing polyamory and bisexual identities is especially problematic when bisexual and polyamorous participants spoke about concealing their identities from their medical provider, including hiding how many sexual partners of different genders they had in the past.

This knowledge is essential for medical providers so that they would be able to provide proper sexual health education. The research team discussed how it is often difficult to share minority identities because it may make life situations worse. According to the minority stress model (Meyer, 1995), previous experiences of invalidation and discrimination may influence
one’s expectation for future rejection and therefore are more likely to conceal their one identities for the sake of safety and protecting oneself.

**Community.** Several interesting topics came up including the type of resources gender and sexual minorities will share with each other. It seems that recommendations for healthcare were not just based on how inclusive organizations can broadly be, although there was mentioned of about three or four “fringe” or smaller healthcare organizations and agencies who were known for their inclusivity in the Wichita area. As for the rest of the healthcare services in Wichita, many gender and sexual minorities have identified inclusivity in care based on specific providers that were known to cater to gender and sexual minorities.

Furthermore, team members observed that there seemed to be a pattern in how sexual and gender minorities disseminates healthcare advice and access to LGBT-friendly healthcare services. Some of the participants mentioned actively seeking resources whether it is exploring Wichita’s healthcare services (even when it is not to seek healthcare services themselves) or creating/developing healthcare-related resources so that they contribute to improving the quality of life for the gender and sexual minority community. In addition, the participants who actively sought resources for their community were often also leading grassroots efforts in organizing a community of gender minorities, sexual minorities and allies to increase visibility in the Wichita area, provide support, to increase civic engagement, and disseminate resources that have made living in Wichita as a gender and sexual minority easier. The following are two quotes from two participants who are founders of two prominent transgender support groups and organizations in the Wichita area:
Participant 10

"I am the one giving advice umm because I have a list of all the therapists and all the health care providers, um, even legal services that are trans friendly and um, stuff like that. That's one of the things that we have kind of been working on is a resource guide where you can go or...even restaurants... you can go and be treated like a person and stuff like that. So yeah, that's really important to us. Um, I'm usually the one telling people if you want to be treated like a human being and not like somebody different, this is where to go."

Participant 6

“[That’s] kind of what I, what I'm building [GENDER MINORITY SUPPORT GROUP] around is once a week we pose a question if you're looking [to] post questions anytime throughout the week, but on Sunday I asked like, who's your dentists? Who are you comfortable that, you know, will call you the right name when you go to get your hair cut? Anything that literally and um, people will be fairly open with, hey, don't go to this one place because they will run you out if they can't figure out if you're a man or a woman. If you're too androgynous they will kick you out. And that happens. Like, you know, some dentists are really awful. I happened to find one that umm right now my name isn't legally changed. I found one that will actually call me by my name that I prefer my name and um, so, so yeah, things like that in the online forum seems pretty good for pulling that kind of information and then we also meet twice a month and we'll talk about it then too. So we have advice flowing constantly, I would say to kind of figure out who's safe and who's not safe.”

The research team wanted to come up with a term for such a key role in the community and came up with the term, “Gate Keeper”. Gate keepers are generally individuals who are active in the community and are often found in leadership roles of grassroots initiatives. They are the “protectors” of the community with an active goal of keeping their marginalized communities safe and out of harm’s way as much as possible. Participant 10 has described herself as a “mother” to community members she engages with, while participant 6 have described moments where he invited other transgender men to his house so that he can help them with gender affirming hormone injections. In addition to providing to their communities, they also interact with the outside broader community to increase visibility. Participant 10, for example, said that she and her organization has worked with healthcare facilities and provided free training.
for their employees. They have not only shared information and awareness with small healthcare facilities, they also have provided trainings to the biggest hospital in the Wichita area. Although there is a lot of room for improvement for this city, it seems that the foundation for healthcare inclusivity does exist because of the passion and dedicated efforts by resilient minority advocates.

There is another key role that the team members had named “sharers”. These individuals are the community members who receive LGBT health-related resources but also has shared those resources with other members. They don’t actively seek out resources to bring back to the community but has still actively disseminated information to others which is an essential component. These two roles provide the functionality in this community’s resiliency. Some of these members spend their time developing, seeking and disseminating resources that they find useful for their community, while the others passed those resources along so that resources can be reached out by all members of the gender and sexual community.

The sense of community did not only come from grassroots initiatives, many participants have expressed a sense of community, and more particularly a sense of a gender and sexual minority community within institutional settings as well. For example, several participants expressed belongliness in a community within university settings. Even beyond graduating from the university, many still go and connect with this institution. In fact, although participant 10 has never studied in the local state university, she has established a strong relationship with the diversity and inclusion office. Her role as a gate keeper meant that she also interacts with the university so that gender and sexual minority students may also receive the same resources. In addition, some of the participants were students in the same local state university. For many participants who are active students, the campus has become a place that allows these participants the opportunity to foster their identities, authentically. Especially since this university
resides in a state like Kansas where students have gathered from several rural areas outside the city limits. These themes can be found in the following quotes:

Participant 2

“I am from Emporia, Kansas. Which is like, much smaller than Wichita. It’s a small overall feel. So, I guess that is what I am comparing it to. Wichita has been a little better. I feel like I can be a little more authentic here. I was like, dating like LGBT dating is more open here and obviously more options and more outlets to connect with people on the spectrum...But I think that’s probably...like my perception ...is severely changed by the fact that I am from rural Kansas...I feel like at [UNIVERSITY NAME] I have been able to meet and connect with a lot of people who are on the spectrum especially bi-women. So that’s really cool to like connect with people and share experiences and make friends within the community. So, like that's been incredible. Specifically, on campus within student organizations and stuff. A bigger opportunity to connect with people on the spectrum... So as someone who has somewhat recently been more public and out it's like so important for me. Um, to find people who sort of like normalize these feelings that I have had forever. It's honestly like, what's kept me alive. It means a lot to me that I have a space where I can exist and feel comfortable and supported. So being a part of a community is really, really critical to me. Especially right now at these times of newness and like coming out. Since I don't have support of my immediate family and parents so being a part of the community is really important.”

Participant 11

“There is this organization on campus called [STUDENT ORGANIZATION] and um, I've met amazing people through spectrum and a lot of them are my now friends and um, that's been a really good help to me and I would say that's probably ...probably... the best... everyone respects one another and it's a judgment free zone and we all talk about our experiences and it's like a whole safe zone. So, what said it in that room isn't, isn't allowed. You're not allowed to tell someone else about it.”

Participant 2 described how important her community at the university setting has been in expressing her sexual minority identity, authetically. The local state university allows a space for her to express her identity without worrying about the backlash especially from family members. Participant 11 also expressed the value in being a student within the university setting as a sexual minority. One aspect within the university setting that both participants mentioned is a student organization that is established as a gender and sexual minority community. These students meet
weekly to seek a safe space where they can be themselves without experiencing discrimination or being outed. The team referred “safe spaces” as a confidential space where minorities can express what they are feeling and share their vulnerability without anyone passing any judgement.

Overall, the local state university has been seen as haven for several participants especially when they mentioned the student organization and the office of diversity and inclusion. In addition, at an institutional level, these participants were able to seek health related resources that addressed the needs of gender and sexual minorities. For example, one of the participants spoke about how the student organization would always provide condoms and other sex positive resources every week and would collaborate with the office of diversity and inclusion and student health services to host several sex health related events that are gender and sexual minority friendly. So not only did students interact with other outside community members to share resources, they were also receiving support and resources at an institutional level.

As previously mentioned before, gender and sexual minorities are not a monolith and not all of the participants actively sought out a specific LGBT-based community to identify with. One participant in particular explained that the gender and sexual minority community in Wichita does not meet their needs as a gender minority. This is exemplified in this quote:

Participant 7

“Uh, I feel like the LGBTQ community is really small here and I don't know. Cause like, that could mean a lot of things. Like I wish it had more active community here….I'm involved in a lot of the natural community. Like people out there with chickens and make their own shit… So, that's a pretty open-minded group… So you kinda have to… I just kinda made it my goal to find safe people and always surround myself with them. It's not worth the fuckery with other people, ya know?”
This participant in particular felt a lacking sense of community with gender and sexual minorities in the area and has actively sought out their own community that is not rooted in the shared experiences of a minority but are open-minded and have positive attitudes towards gender and sexual minorities. Some of the participants found community in their work places while others found community in shared interests like playing the ukelele. Some found community that is attached to other identities participants may have. For example, later in the interview, participant 7 who is a parent, found community in others who are also parents through the relationships their children have with each other.

In terms of seeking healthcare advice and resources, these particular participants had other alternative ways to get proper healthcare because the communities they were part of are not equipped to provide such resources and advice. Many have turned to the internet to seek friendly providers while others have lived in Wichita since they were children and had established strong relationships with their medical provider who were luckily open minded to their transition. Two of the following quotes exemplify these situations:

Participant 4

“Personally for me I haven’t had a whole lot of problems um I’ve been very fortunate with that umm like my primary care physician was a bit tricky just cause she’s known me since I was in the womb, so getting the pronouns changed with them in her office was a bit tricky umm…but yeah so that’s really been the only issue with that. My surgeon and her team were all super nice, super uh supportive of all that -pronouns- all that stuff was good um and the two therapists I’ve seen in town were also really helpful with the shit and all that so overall like medically speaking everything’s been like really good here”

Participant 13

“There's a lot of networking that goes into that [seeking inclusive healthcare services]. I mean, you can do a little bit on Google, but again, like the surgeon that I went to doesn't have anything on Google. There's like whispers and rumors on Google where somebody says this doctor does it, but you can't find proof of it anywhere. But on the other hand, there's [FRINGE HEALTHCARE
Participant 4’s primary care provider, although had a hard time changing his pronouns and his name, for the most part was accepting of their patient’s minority identity. Because of this, participant 4 was able to seek appropriate services for their transition and healthcare needs. And whereas participant 13 may not have been so lucky but has found ways via the internet to seek his own services and needs. The research team discussed how they would refer these individuals in terms of seeking healthcare resources are their own and the term, “Self-researchers” was coined. Although they do not have access or feel connected with the gender and sexual minority community due to concealing their identities or percieving a lack of gender and sexual minority representation, they have found alternative ways to connect to resources that will address their healthcare needs.

Although some of the participants who do not necessarily interact with any gender and sexual minority communities within Wichita, many do actively seek gender and sexual minority specific communities in online spaces. Many of these online spaces provide a forum where gender and sexual minorities would share advice and their life experiences. This specific quote details one online community in particular.

Participant 12

“I am kind of part of a group on Facebook for transmen only, so you have to be accepted into the group and uh, they started this thing where they wanted to pair trans men who had been on hormones longer with those who are just starting out or pre-T. And that's been really nice because I've been able to guide, you know, I've been on hormones for almost four years, so I've been able to guide these younger guys who are starting out because they're scared, and they don't know where to go. So. So it's, it's really nice and it's an international group. So yeah, it's from all members... uh, it's basically just a group where guys can ask questions, they can, you know, ask advice. They can give advice, posts, pictures.
They have a lot of positivity threads where they asked for pictures, he posted that you feel masculine and things like that. And what's cool is not that we want to exclude it, for example, if you know for example MTFs, but this is specifically targeted for trans men.”

Participant 12, found that was best to engage in a community online more so than engaging with the community in Wichita. Especially since he knows of the transgender organization that participant 10 is a part of, he still mentions that he has never participated in any of their events. As shown in the following quote:

Participant 12

“I will say [GRASSROOTS ORGANIZATION], I've never actually gone to anything but…and [PARTICIPANT 10] have always made me feel very welcome. So I, I like, I feel like I could drop in and be a part of that. That's pretty cool.”

From these interviews, there has been speculation of several participants who have experienced and expressed different forms of isolation. The research team discussed potential explanations as to why some of the participants have preferred isolation over engaging with the gender and sexual minority community. Although in many of these cases it stems down to the personality of the participants, especially those who are more introverted, many of the team members found evidence related to concealment of identity and the expectation of getting rejected or discriminated against. This quote exemplifies that specific situation when participant 1 was asked about her connection with the community she is a part of.

Participant 1

“For the most part, yes, I would like to think so. Though, my brain likes to tell me otherwise...I get these really invasive, repetitive thoughts that, like, nobody wants me around, that I’m just a useless dumpster fire, and it colors so much of my life. It’s really frustrating because I know that I have people who care about me and I know there are people out there who, you know, want to see me happy and healthy. But at the same time, I have a hard time actually feeling that connection because my brain is constantly telling me that, like, I live in a world
that hates me and wants me dead. And a lot of internalized societal messages about trans people or disabled people, so, yeah.”

**Social Support.** Participants were also asked about their social support and if it is any different from their sense of community. The responses varied among each participant. Most of the participants who were the most active in gender and sexual minority circles within Wichita had also developed a tight knit support system within the community, especially with those that shared similar experiences in minority status and stress. In addition, many who have experienced discrimination from family members due to their minority identity expressed having found family within these social circles. Other participants had also mentioned relying on their romantic relationships for support and sought a sense of family with their spouses’ family if they were more accepting of minority identities than their biological family members. Some of the participants still had close relationships with their biological family members, especially when they were gender or sexual minorities as well or if they were accepting of the community. While others relied on the internet to connect with old friends, family members who lived further away or even their geographically closer friend circles when they want to communicate with them immediately.

Social support circles do not necessarily share resources especially when their tight knit support does not share the same experiences of minority status. The participants who engage more often in the gender and sexual minority community may engage more into sharing advice pertaining to their health and are more likely to have their support system present while receiving healthcare services. For example, one participant shared that they often took a cisgender female friend to appointments just in case he gets deadnamed by a nurse or front desk person so that he won’t get looks from others in the waiting room because they would just assume they were calling his female friend’s name instead.
**Healthcare experiences.** As previously mentioned, the participants were more likely to seek out specific friendly providers instead of broadly seeking out friendly organizations. In addition, many explained that they would have to go through the healthcare system by trial and error to seek services that approve of gender and sexual minorities. For example, one participant explained that he would call facilities to see if they were accepting first before he would ever step foot into a clinic. Furthermore, some of the participants explained that many friendly healthcare providers were “closeted allies”. Meaning that although they are open and willing to provide healthcare for gender and sexual minorities, they do not necessarily advertise it in fear of backlash. This is exemplified in the following quote:

Participant 13

“My surgeon has like, she does several top surgeries a year, but her main clientele are old farmers with skin cancer, so she does not advertise that she does gender affirming work in any way, shape or form in her office. She doesn't have brochures laying out, she doesn't have it on our website, but she does do it, but it's just because of the mass quantity over clientele or the biggest proportion of her clientele being older and conservative for her own safety and for her patients’. I think she doesn't talk about it.”

In addition, there seemed to be a type of healthcare services they felt the safest with and the type of healthcare services they felt the least safe with. The types of places they mentioned that were perceived as the friendliest were mostly what one participant called it as “fringe” type places. These were non-profit facilities and agencies, many of them of which only provide a specific service like providing support and advocacy in cases of sexual assault or provide free STI testing with the mission of reducing STIs rates in the city of Wichita. There also have been about 2 or 3 healthcare services that were mentioned repeatedly. They were either a women’s healthcare facility that provided family planning and sexual health services and federally qualified healthcare services.
The following quotes exemplify these services:

Participant 3
"Whether it's...places where... there's an event and the community is organized, they're always tabling local healthcare providers like the [FRINGE HEALTHCARE SERVICES] and [SEXUAL ASSAULT ADVOCACY AGENCY] which [are] very, very, very important resources in the community, especially for sexual and gender minorities...Like I, I go to [FRINGE HEALTHCARE SERVICES] because I received medical care through Indian health services and they are the local provider for that. And so, like additionally, like there are some things that are specifically targeting to the two-spirit community, the urban two-spirit community and like, you know, the intersectionality of that identity of being LGBTQAI of being urban indigenous like that, that the, the risk matrix or like suicidal ideation like is much, much higher than in other groups even. Um, and so like there is, they've identified that and there's this, it's like a best practice in Indian health services and so there is this specific need for them to address that to specifically target the individuals who, um, have those intersecting identities so that they could give the specialized treatment that they need for their medical.”

Participant 6
“You know about...Um, um, what's it called, [WOMEN'S HEALTHCARE CENTER]? That's where I got hormones. They are one of the few people that actually prescribe HRT and [FAMILY PLANNING HEALTH CENTER] just started.”

Although these services exist in Wichita, there are limitations to them. For example, many of the healthcare services, more specifically the family planning/ women’s healthcare services are often stigmatized due to the anti-abortion rhetoric in this city. Therefore, some of these facilities often face pro-life protestors almost daily which increases many of these participants’ expectations for rejection and concerns for safety. The following quotes are presented with participants sharing such concerns.

Participant 6
“Just as an example, like they do trans care and they do, you know, women's care and all that kinda stuff as well. But I have to drive past a literal fake graveyard of dead baby graves. They've set up and whenever they see a lone guy in a car, they literally hold up a cross and yell at me every time I pull into the parking lot...and you know if there was a center that was just gender and sexual
stuff. I think, um, I think we'd see similar things. I think there would be pushback.”

Participant 13

“If people in larger Kansas were aware of [GENDER AND SEXUAL MINORITY INCLUSIVITY IN HEALTHCARE], they would be, they would have trouble, boycotted, discriminated against, picketed. It'd be like what people do outside [WOMEN’S HEALTHCARE CENTER] every day.”

Another type of healthcare services that participants brought up several times were facilities provided by a local medical university. There are a few providers in the medical university that have been in forefront of LGBT healthcare inclusivity within the city of Wichita. Many of these providers have started their impact on the community by at first providing sexual health and HIV healthcare services and over time have expanded to include gender affirming healthcare. In addition, there has been positive comments about the local veterans’ healthcare center. One participant who is a veteran mentioned that she has had many positive experiences from receiving services from the veterans’ healthcare center where there is an office that specifically catered to gender and sexual minority veterans.

Although there have been several mentions of welcoming healthcare services, many of these facilities have limitations in the capacity of healthcare. For example, currently, there are no hospital system that are state, or government run. Most of the hospitals and largest networks of healthcare services in the city of Wichita are often faith-based and/or corporate entities. This has become a barrier in this city because many of the participants had several negative experiences with religious entities that have invalidated their identities in the past. In addition, according to these participants, there is a perception that Kansas is a conservative state that is influenced by individuals with the highest socioeconomic status, many of which profiteers from private healthcare services. This exemplified by the following two quotes,
Participant 3

“There's a lot of special interests with a lot of money in this community and they are very, very, very much anchored to, you know, conservative politics and the conservative social views and that is a problem with being in administration for any kind of organization is you have to kind of sing for your supper and if you want to do anything with your policies, with your practices that is too far outside of what is normative for your community, for your political culture then there's the backlash as well. It's going to get cut. So, then there are people who are policy makers and administrators that are like, well, here, here's this dilemma that I'm faced with is they're going to cut our funding, which means I'm going to have to put all these people out of a job... And so, like there's this cost benefit analysis...”

Participant 9

“I think a lot of pushback [comes] from more conservative voices who just disregard identities of sexual minorities in anyway because as, as a wonderfully liberal progressive as our city is there is a lot bigger more conservative money that funds a lot of our healthcare. And there's a lot of our healthcare. I would say another barrier is our healthcare is very religiously funded, we have a lot of religious based institutions that do discriminate doctrinally or otherwise against sexual and gender minorities. So, I would say that probably one of the bigger obstacles is going to a hospital and getting not good service because you're trans... I would say those are the barriers.”

All participants had perceptions that most healthcare services in Wichita were not welcoming to gender and sexual minorities. Furthermore, they believed that there is a relationship between the current political climate and the lack of inclusive healthcare services. They expressed that state politics has had an impact in their access to inclusive healthcare services, but they also believed that federal politics could do more to protect them from being discriminated against within the healthcare system. In addition, almost all the participants expressed that the current president, Donald Trump has also influenced their access to inclusive healthcare services and have negatively impacted their quality of life. Here are some examples in which participants brought up the current president:
Participant 10
“[Barriers to inclusive healthcare services] Maybe the barriers of hateful Trump, a dictator in society. I think that's our biggest barrier right now, what's going on and our country, and the right-wing policies often are a barrier.”

Participant 6
“I had people (gender minorities) calling me in the middle of the night and try to commit suicide and all this stuff because he (Trump) had been elected”

Participant 4
"[When asked about pressures in not providing inclusive healthcare service] yeah definitely especially with you know Trump and all that um just overall the atmosphere in America has changed...

Another presenting issue that came up in three interviews were also discussed. There seemed to be a troubling trend with medical providers and health insurance that denied surgeries pertaining to sex organs for gender minorities because of the assumption that these participants wanted this service due to their gender identity and not for other healthcare reasons. The following three quotes will present cases of where the healthcare system failed them (or almost failed them) because of these assumptions:

Participant 12
“Insurance plays a huge part of. I was almost denied. I was denied my hysterectomy because they thought it was for transitioning purposes. My doctor had to go above and beyond and, and set all kinds of records files, all of my x rays, all my sonos, all of my scans showing that it was medically necessary before they did, before they will approve. It was just a bunch of hoops… for no reason.”

Participant 6
“It took me a year to find a surgeon who would do one for me. And that wasn't even for my transition. I had really severe endometriosis and I was hemorrhaging pretty constantly. Again, it was really bad, and I couldn't help but think that if I was a cis woman, I would've had that surgery in a blink of an eye just because I was trans and it looks like I was pushing it from my transition. Um, yeah, it was some of the worst pain I've ever experienced. And that's kind of saying something. But yeah, I, you know, I went through two doctors and three
surgeons and I finally found one who was like, I've never had a trans patient before, but I don't have a problem doing it on you...So he did. And um, I was left there at the hospital overnight because hysterectomy is a pretty big surgery...the nurse, uh, literally put me in a room and locked the door, took away my call button, I was not given food or water and was left to bleed out for like eight or nine hours. Like I almost died.”

Participant 1

“I was trying to get an orchiectomy from the [HEALTHCARE SERVICES]. That is removal of the testicles... Basically I got turned down through legit channels three times for an orchiectomy and I finally ended up just doing it myself. When I called 911 to be taken to the hospital to have myself patched up, like, the cops wanted to keep me on scene even though I had, you know, a gaping wound that was tied off by a truncate...to see if they can look for threats. And I’m just like oh my gosh there are no threats, I did this to myself, please just take me to the hospital... I guess they thought that I was on drugs because I wasn’t in any apparent pain but that’s because I had used an ice pack... finally I get to the hospital, the trauma surgeon tells me I’m crazy and I’m like yeah, I know, but that’s not the point. The point is you need to fix me up because I was either going to die in five years from a heart attack because of my meds or I was going to, you know, bleed out right then and there. So obviously I didn’t bleed out and I am not dying from my meds anymore... I just got denied three times and I kept getting BS responses and balls are gone. I lived. Fuck yeah.”

All three participants were denied healthcare services because of the assumption that it was related to their gender identity. Two of the participants are transmen who also had endometriosis which was reducing their quality of life. Participant 1 is a transwoman who was concerned that her medications were having a fatal interaction with her body producing testosterone. All three had to “jump through hoops” to get the health care they needed regardless of how it was being done. Participant 12 was the luckiest in terms of healthcare because he had a doctor that was advocating for him.

For participant 6 and 1, they had to make riskier choices. Participant 1 believed she had no choice and was later denied hormone replacement therapy because medical providers believed she was a risk to herself. Participant 6 had no choice but to go with a doctor who neglected him afterwards and he was almost left to die if it weren’t for a family friend who was advocating for
him. After the surgery, participant 6 went through three septic episodes before his former
primary care provider did not take his symptoms seriously. And when getting sick got worse,
participant 6’s boyfriend had to convince him to go to the emergency room. After being
neglected, denied, and not taken seriously, participant 6 did not want to endure another
discriminating healthcare-related visit.

However, on a positive note, the hospital that he was taken to were sympathetic,
respected his identity, and connected him to better primary healthcare that were open to his
identity. When asked about filing for a medical malpractice lawsuit, participant 6 explained that
he went and spoke with several lawyers who said he wouldn’t be able to win because Kansas
allows discrimination against gender and sexual minorities in response to religious freedom.
Later in the interview, participant 6 said it was common for medical professionals to assume that
their gender minority patients were exaggerating their healthcare needs and would often be
treated with neglect.

Ecological and Minority Stress: Secondary Coding

After the discussions, and notes were gathered, the primary investigator broaden the
themes into categories found in the the Minority Stress and Ecological theoretical frameworks
(Meyer, 1995; Eliason & Fogel, 2015). See Appendix D for all of the broad categories and their
definitions. After the codebook was developed, the research team coded each time the participant
spoke. Inter-rate reliability was done with 25% of the gender minority and sexual minority
women sample and therefore three transcripts were coded twice and found to have a moderate
level of inter-rater agreement of .73, .68 and .62. The secondary coding will be presented within
the Minority Stress Model and Ecological Model framework.
**Minority Stress Model.** The open coding was organized and broaden into some of the factors found in the Minority Stress Model (Meyer, 1995). The factors include Distal Minority Stress, Proximal Minority Stress, and Coping and Social Support. See figure 10 to see the following factors.

![Minority Stress Model](image)

**Figure 10. Minority Stress Model**

Within the distal minority stress, coders coded for Discrimination, Invalidation of Identity and Stigmatization of Identity. There was 76 instances in which participants brought up discrimination, there was 84 instances where participants mentioned the invalidation of identity and there was 51 instances in which stigmatization of identity was mentioned. These three factors were analyzed to find themes that were mentioned in the same instances. The highest mentions are listed in table 4.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discrimination</td>
<td>76</td>
</tr>
<tr>
<td>Invalidation of Identity</td>
<td>16</td>
</tr>
<tr>
<td>Stigmatization of Identity</td>
<td>10</td>
</tr>
<tr>
<td>Work Place Setting</td>
<td>13</td>
</tr>
</tbody>
</table>
Table 4 (continued)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional Setting</td>
<td></td>
</tr>
<tr>
<td>Federal Politics</td>
<td>7</td>
</tr>
<tr>
<td>Negative Attitudes Against the LGBT Community</td>
<td>15</td>
</tr>
<tr>
<td>Invalidation of Identity</td>
<td>84</td>
</tr>
<tr>
<td>Stigmatization of Identity</td>
<td>11</td>
</tr>
<tr>
<td>Concealment of Identity</td>
<td>8</td>
</tr>
<tr>
<td>Expectation of Rejection</td>
<td>7</td>
</tr>
<tr>
<td>Romantic Relationship</td>
<td>10</td>
</tr>
<tr>
<td>University Setting</td>
<td>8</td>
</tr>
<tr>
<td>State ID/ Insurance Does Not Match Identity</td>
<td>6</td>
</tr>
<tr>
<td>Positive Attitudes Against the LGBT Community</td>
<td>10</td>
</tr>
<tr>
<td>Negative Attitudes Against the LGBT Community</td>
<td>9</td>
</tr>
<tr>
<td>Minority Identity</td>
<td></td>
</tr>
<tr>
<td>Work Place Setting</td>
<td></td>
</tr>
<tr>
<td>Negative Attitudes Against the LGBT Community</td>
<td></td>
</tr>
</tbody>
</table>

Within the proximal minority stress factor, coders coded for Concealment of Identity, Expectation of Rejection, and Internalized Phobia. There was 66 instances of concealment of identity, 46 instances of Expectation of Rejection, and there was 26 instances where internalized phobia was mentioned. These three factors were analyzed to find themes that were mentioned in the same instances. The highest mentions are listed in table 5.

Table 5. Minority Stress (Proximal)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concealment of Identity</td>
<td>66</td>
</tr>
<tr>
<td>Expectation of Rejection</td>
<td>10</td>
</tr>
<tr>
<td>Internalized Phobias</td>
<td>9</td>
</tr>
<tr>
<td>Family</td>
<td>6</td>
</tr>
<tr>
<td>Romantic Relationship</td>
<td>6</td>
</tr>
<tr>
<td>Work Place Setting</td>
<td>7</td>
</tr>
<tr>
<td>Negative Attitudes Against the LGBT Community</td>
<td>8</td>
</tr>
<tr>
<td>Expectation of Rejection</td>
<td>46</td>
</tr>
<tr>
<td>Healthcare Utilization</td>
<td>5</td>
</tr>
<tr>
<td>Lack of Healthcare Utilization</td>
<td>5</td>
</tr>
<tr>
<td>Negative Attitudes Against the LGBT Community</td>
<td>5</td>
</tr>
<tr>
<td>Internalized Phobias</td>
<td>26</td>
</tr>
</tbody>
</table>
Table 5 (continued)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>4</td>
</tr>
<tr>
<td>Invalidation of Identity</td>
<td>4</td>
</tr>
<tr>
<td>LGBT Community</td>
<td>4</td>
</tr>
</tbody>
</table>

Within the factor, coping and social support, coders coded for low and high connectiveness in community and for safe space. Participants mentioned being highly connected with a community 18 times, feeling a low connection with a community 12 times and there was 90 instances where safe space was mentioned. These three factors were analyzed to find themes that were mentioned in the same instances. The highest mentions are listed in table 6.

Table 6. Coping and Social Support

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Connection</td>
<td></td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>18</td>
</tr>
<tr>
<td>The Non-LGBT Community</td>
<td>8</td>
</tr>
<tr>
<td>Low Connection</td>
<td></td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>12</td>
</tr>
<tr>
<td>Safe Space</td>
<td></td>
</tr>
<tr>
<td>Healthcare Utilization</td>
<td>6</td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>26</td>
</tr>
<tr>
<td>The Non-LGBT Community</td>
<td>18</td>
</tr>
<tr>
<td>Work Place Setting</td>
<td>12</td>
</tr>
<tr>
<td>Online Community</td>
<td>10</td>
</tr>
<tr>
<td>University Setting</td>
<td>26</td>
</tr>
<tr>
<td>Positive Attitudes Against the LGBT Community</td>
<td>8</td>
</tr>
</tbody>
</table>

Invalidation, Stigmatization and Discrimination were then computed together to create an overall factor of Minority Stress (distal); there was 211 instances of Minority Stress (distal). From those instances, 26 of those instances mentioned negative attitudes towards the LGBT community and 15 mentioned concealment of identity. See figure 11, to see the top themes mentioned in relation to Minority Stress (distal).
Concealment of identity, internalized phobias, and expectation of rejection were computed to create an overall factor of Minority Stress (proximal). Overall, there was 138 instances in which Minority Stress (proximal). Within those instances the two highest themes mentioned was Invalidation of Identity (18 times) and Negative Attitudes towards the LGBT community (13 times). See figure 12, to see the top themes mentioned in relation to Minority Stress (proximal).
High connectiveness to the community and safe space was also computed to develop an overarching factor for Support and Coping. Low connectiveness was not included in the computing because it does not accurately describe support. Overall, there has been 108 instances in which Coping, and Support was mentioned. Out of those instances, the top two themes that were mentioned the most was the LGBT Community and University Settings. See figure 13 to see the top themes mentioned within the instances that Coping and Support was mentioned.
Figure 13. Themes Mentioned in Coping and Support

**The Ecological Model.** The open coding was organized and broadened into some of the factors found within the Ecological Framework (Eliason & Fogel, 2015). The open coding was categorized within each of the following levels: Individual, Relationships, Community, Institutions, Government and Society and Culture. See figure 14 for a ecological model of Wichita. Themes were analyzed if they had been mentioned 20 or more times. Therefore, the themes that were analyzed are the following; Individual level: Health Utilization; Relationships: Family and Romantic Relationships; Community: LGBT, Non-LGBT, and Gate Keeper; Institutions: Fringe Healthcare Services, Corporate Healthcare Services, and University Settings; Government: Federal and State; Society and Culture: Religion, Positive Attitudes toward
LGBT, Negative Attitudes toward LGBT, and Lack of LGBT Representation. See figure 15 for all the themes.
Figure 14. Ecological Perspective of Wichita LGBT Community

Figure 15. Instances of Ecological Themes Mentioned
At the individual level, health utilization and minority identity were analyzed. There was 42 instances where utilizing healthcare services was mentioned and there was 34 instances in which minority identity was mentioned. These two factors were analyzed to find themes that were mentioned in the same instances. The highest mentions are listed in table 7.

Table 7. Individual Level

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Utilization</td>
<td></td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>7</td>
</tr>
<tr>
<td>Safe Space</td>
<td>6</td>
</tr>
<tr>
<td>University Setting</td>
<td>6</td>
</tr>
<tr>
<td>Sharing Information about Inclusive Healthcare Services</td>
<td>7</td>
</tr>
<tr>
<td>Minority Identity</td>
<td></td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>9</td>
</tr>
<tr>
<td>Stigmatization of Identity</td>
<td>6</td>
</tr>
</tbody>
</table>

At the relationship level, family and romantic relationships were analyzed. There was 46 instances where family was mentioned and there was 39 instances where participants mentioned romantic relationships. These two factors were analyzed to find themes that were mentioned in the same instances. The highest mentions are listed in table 8.

Table 8. Relationship Level

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>6</td>
</tr>
<tr>
<td>Concealment of Identity</td>
<td>6</td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>9</td>
</tr>
<tr>
<td>Religion</td>
<td>6</td>
</tr>
<tr>
<td>Negative Attitudes Towards the LGBT Community</td>
<td>11</td>
</tr>
<tr>
<td>Romantic Relationship</td>
<td></td>
</tr>
<tr>
<td>Invalidation of Indentity</td>
<td>10</td>
</tr>
<tr>
<td>Concealment of Identity</td>
<td>6</td>
</tr>
<tr>
<td>Safe Space</td>
<td>7</td>
</tr>
<tr>
<td>Work Place Setting</td>
<td>12</td>
</tr>
<tr>
<td>Family</td>
<td>9</td>
</tr>
</tbody>
</table>
At the community level, online communities, grassroots communities, institutional communities, workplace, the LGBT community and the Non-LGBT community were analyzed. There was 30 instances in which online communities were mentioned, 21 instances in which grassroots-related communities were mentioned, 51 instances in which institutional based communities were mentioned, 51 instances that mentioned the work place setting, 93 instances that mentioned the LGBT community, and 47 instances that mentioned the non-LGBT community. These factors were analyzed to find themes that were mentioned in the same instances. The highest mentions are listed in table 9.

Table 9. The Community Level

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Online Community</strong></td>
<td></td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>30</td>
</tr>
<tr>
<td>Sharing Health-related Advice</td>
<td>6</td>
</tr>
<tr>
<td><strong>Grassroots Community</strong></td>
<td></td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>9</td>
</tr>
<tr>
<td>The Non-LGBT Community</td>
<td>6</td>
</tr>
<tr>
<td><strong>Institutional Community</strong></td>
<td></td>
</tr>
<tr>
<td>Positive Attitudes Towards LGBT Community</td>
<td>8</td>
</tr>
<tr>
<td>Negative Attitudes Toward LGBT Community</td>
<td>6</td>
</tr>
<tr>
<td>University Setting</td>
<td>22</td>
</tr>
<tr>
<td>Fringe Healthcare Services</td>
<td>7</td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>8</td>
</tr>
<tr>
<td>Discrimination</td>
<td>10</td>
</tr>
<tr>
<td><strong>Work Place Setting</strong></td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>13</td>
</tr>
<tr>
<td>Stigmatization of Identity</td>
<td>7</td>
</tr>
<tr>
<td>Concealment of Identity</td>
<td>7</td>
</tr>
<tr>
<td>Low Connection to Community</td>
<td>12</td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>10</td>
</tr>
<tr>
<td>University Setting</td>
<td>23</td>
</tr>
<tr>
<td>Positive Attitudes Towards LGBT Community</td>
<td>8</td>
</tr>
<tr>
<td><strong>The LGBT Community</strong></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>9</td>
</tr>
<tr>
<td>Sharing Health-related Advice</td>
<td>12</td>
</tr>
<tr>
<td>Sharing Information about Inclusive Health Services</td>
<td>8</td>
</tr>
<tr>
<td>University Settings</td>
<td>22</td>
</tr>
<tr>
<td>Religion</td>
<td>7</td>
</tr>
</tbody>
</table>
Table 9 (continued)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Attitudes Towards the LGBT Community</td>
<td>6</td>
</tr>
<tr>
<td>The Non-LGBT Community</td>
<td>47</td>
</tr>
<tr>
<td>University Settings</td>
<td>11</td>
</tr>
<tr>
<td>Positive Attitudes Towards the LGBT Community</td>
<td>6</td>
</tr>
</tbody>
</table>

At the institution level, fringe healthcare services, corporate healthcare services, and the university setting were analyzed. There was 79 instances in which fringe healthcare services were mentioned, 44 instances in which corporate healthcare services were mentioned, and, 157 instances where the university setting was mentioned. These factors were analyzed to find themes that were mentioned in the same instances. The highest mentions are listed in table 10.

Table 10. The Institutional Level

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Fringe&quot; Healthcare Services</td>
<td>79</td>
</tr>
<tr>
<td>Institutional Settings/ Communities</td>
<td></td>
</tr>
<tr>
<td>Corporate Healthcare Services</td>
<td>23</td>
</tr>
<tr>
<td>University Settings</td>
<td>26</td>
</tr>
<tr>
<td>Positive Attitudes Towards the LGBT Community</td>
<td>10</td>
</tr>
<tr>
<td>Corporate Healthcare Services</td>
<td>44</td>
</tr>
<tr>
<td>University Setting</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>8</td>
</tr>
<tr>
<td>Negative Attitudes Towards the LGBT Community</td>
<td>6</td>
</tr>
<tr>
<td>Positive Attitudes Towards the LGBT Community</td>
<td>6</td>
</tr>
<tr>
<td>University Settings</td>
<td>157</td>
</tr>
<tr>
<td>Positive Attitudes Towards LGBT Community</td>
<td></td>
</tr>
<tr>
<td>Negative Attitudes Toward LGBT Community</td>
<td></td>
</tr>
<tr>
<td>Invalidation of Identity</td>
<td></td>
</tr>
<tr>
<td>High Connection with Community</td>
<td></td>
</tr>
<tr>
<td>The Non-LGBT Community</td>
<td></td>
</tr>
<tr>
<td>Work Place Setting</td>
<td></td>
</tr>
<tr>
<td>Sharing Information about the Access to Inclusive Services</td>
<td></td>
</tr>
<tr>
<td>Sharing Health-related Advice</td>
<td></td>
</tr>
<tr>
<td>The LGBT Community</td>
<td></td>
</tr>
</tbody>
</table>
At the government level, state politics and federal politics were analyzed. There was 50 instances in which state politics were mentioned. There was also 26 instances in which federal politics were mentioned. These factors were analyzed to find themes that were mentioned in the same instances. The highest mentions are listed in table 11.

Table 11. The Government Level

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Politics</td>
<td>50</td>
</tr>
<tr>
<td>Federal Politics</td>
<td>11</td>
</tr>
<tr>
<td>Negative Attitudes Toward LGBT Community</td>
<td>15</td>
</tr>
<tr>
<td>Conservativism</td>
<td>8</td>
</tr>
<tr>
<td>Religion</td>
<td>6</td>
</tr>
<tr>
<td>Federal Politics</td>
<td>26</td>
</tr>
<tr>
<td>Discrimination</td>
<td>7</td>
</tr>
<tr>
<td>Negative Attitudes Towards LGBT Community</td>
<td>9</td>
</tr>
</tbody>
</table>

At the culture and society level, conservativism, religion, negative attitudes towards the LGBT community, and positive attitudes towards the LGBT community were analyzed. There was 38 instances in which conservativism was mentioned, 54 instances where religion was mentioned, 134 instances in which negative attitudes towards the LGBT community were mentioned, and 66 instances in which positive attitudes towards the LGBT community were mentioned. These factors were analyzed to find themes that were mentioned in the same instances. The highest mentions are listed in table 12.

Table 12. The Societal and Cultural Level

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservativism</td>
<td>38</td>
</tr>
<tr>
<td>State Politics</td>
<td>8</td>
</tr>
<tr>
<td>Negative Attitudes Toward LGBT Community</td>
<td>8</td>
</tr>
<tr>
<td>Religion</td>
<td>54</td>
</tr>
<tr>
<td>Lack of Healthcare Utilization</td>
<td>6</td>
</tr>
<tr>
<td>Negative Attitudes Toward LGBT Community</td>
<td>22</td>
</tr>
<tr>
<td>Family</td>
<td>6</td>
</tr>
<tr>
<td>Corporate Healthcare Services</td>
<td>8</td>
</tr>
<tr>
<td>State Politics</td>
<td>6</td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>7</td>
</tr>
</tbody>
</table>
Table 12 (continued)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discrimination</strong></td>
<td></td>
</tr>
<tr>
<td>Negative Attitudes Toward LGBT Community</td>
<td>134</td>
</tr>
<tr>
<td>Discrimination</td>
<td>15</td>
</tr>
<tr>
<td>Stigmatization of Identity</td>
<td>9</td>
</tr>
<tr>
<td>Concealment of Identity</td>
<td>8</td>
</tr>
<tr>
<td>Refusal to Invest in Institutional Resources</td>
<td>6</td>
</tr>
<tr>
<td>State Politics</td>
<td>15</td>
</tr>
<tr>
<td>Federal Politics</td>
<td>9</td>
</tr>
<tr>
<td>Conservativism</td>
<td>8</td>
</tr>
<tr>
<td>Religion</td>
<td>22</td>
</tr>
<tr>
<td>Family</td>
<td>11</td>
</tr>
<tr>
<td>Corporate Healthcare Services</td>
<td>6</td>
</tr>
<tr>
<td>Institutional Community Settings</td>
<td>6</td>
</tr>
<tr>
<td>The LGBT Community</td>
<td>6</td>
</tr>
<tr>
<td>University Setting</td>
<td>8</td>
</tr>
<tr>
<td>Lack of Institutional Resources</td>
<td>10</td>
</tr>
<tr>
<td>Positive Attitudes Toward LGBT Community</td>
<td>66</td>
</tr>
<tr>
<td>Invalidation of Identity</td>
<td>10</td>
</tr>
<tr>
<td>Discrimination</td>
<td>6</td>
</tr>
<tr>
<td>Safe Space</td>
<td>8</td>
</tr>
<tr>
<td>University Settings</td>
<td>12</td>
</tr>
<tr>
<td>Optimism</td>
<td>7</td>
</tr>
<tr>
<td>Corporate Healthcare Services</td>
<td>6</td>
</tr>
<tr>
<td>The Non-LGBT Community</td>
<td>6</td>
</tr>
<tr>
<td>Work Place Setting</td>
<td>8</td>
</tr>
<tr>
<td>Fringe Healthcare Services</td>
<td>10</td>
</tr>
</tbody>
</table>

**Ecological Perspective Of Minority Stress.** The ecological factors of the Individual Level (Minority Identity, Risk Behaviors, Health Utilizations, and Isolation), the Relationship Level (Family and Romantic Relationships), the Community Level (LGBT, non-LGBT, Gate Keeper, Sharer, Self-Researcher, Grassroots, Institutional, Online, and Work Place), the Institutional Level (Fringe, Corporate, and University), the Government Level (State Politics, Federal Politics and Trump), and Society and Culture Level (Religion, Generation, LGBT Attitudes, LGBT Representation, Conservatism, and Progressivism), were then computed.
together into each of its own level to see the overall affects on Minority Stress (distal), Minority Stress (Proximal), and Support and Coping. A model was then generated of the fusion of the two theoretical perspectives. See figure 16 to see the full model.

Figure 16. Ecological Perspective of Minority Stress

Within the 124 instances of the individual level, minority stress (distal) was mentioned 25% (31) of the time, the community level was mentioned 34% (42) of the time, and the Society and Culture level was mentioned 34% (42) of the time. Within the 85 instances of the relationship level, minority stress (distal) was mentioned 34% (29) of the time, the society and culture level was mentioned 40% (34) of the time, and community level was mentioned 25% (80) of the time. Within the 280 instances of the institutional level, coping and stress was mentioned 12% (34) of the time, and the society and culture level was mentioned 21% (60) of the time. Within the 86 instances of the government level, minority stress (distal) was mentioned
17% (15) of the times, and the society and culture level was mentioned 47% (4) of the time. Lastly, within the society and culture level, minority stress (distal) was mentioned 17% (60) of the time.

**Health Professional Students**

There was a total of 8 interviews with health professional students. Four of them were physician assistant (PA) students from a local state university and the other four were medical students from a local state medical school. This sample is unique in a sense that the majority of students have had clinical experience from several cities in the state of Kansas. Some of them had no experience working in clinical settings within the city of Wichita. One medical student, for example, specifically worked in rural settings that were further west of Kansas. However the majority of the students did have some clinical experiences in Wichita, KS.

In terms of demographics, the majority of the students are white/ European American (78%; n=7). In addition, all of the students reported that they are heterosexual (n=8), and Christian (n=8). See table 13 for the demographics of the students.

**Table 13**

*Demographics of Health Professional Students (n=8)*

<table>
<thead>
<tr>
<th>Race</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Asian</td>
<td>9%</td>
<td>1</td>
</tr>
<tr>
<td>American/White/European American</td>
<td>78%</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>38%</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
<td>1</td>
</tr>
<tr>
<td>Single</td>
<td>50%</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is a Veteran/Active Military</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12%</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>88%</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household income</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,000</td>
<td>63%</td>
<td>5</td>
</tr>
<tr>
<td>$30,001-$40,000</td>
<td>12%</td>
<td>1</td>
</tr>
<tr>
<td>No Answer</td>
<td>25%</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 13 (continued)

<table>
<thead>
<tr>
<th>Religion</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>100%</td>
<td>8</td>
</tr>
<tr>
<td>Gender Identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cisgender Male</td>
<td>12%</td>
<td>1</td>
</tr>
<tr>
<td>Cisgender Female</td>
<td>88%</td>
<td>7</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>100%</td>
<td>8</td>
</tr>
</tbody>
</table>

Although there wasn’t a lot of diversity within this sample, there was a diversity of clinical experience. For example, in the demographic questionnaire, the students were asked about the clinical settings they have worked in. Overall, all 8 students reported work in combination of 19 different settings. The students commonly reported working in inpatient clinics (32%; n=6) and lone outpatient clinics (32%; n=6). See table 14 for the rest of the settings students worked in.

Table 14. Settings students had worked in

<table>
<thead>
<tr>
<th>Settings</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>31.58%</td>
<td>6</td>
</tr>
<tr>
<td>Outpatient</td>
<td>31.58%</td>
<td>6</td>
</tr>
<tr>
<td>Outpatient (multiple locations)</td>
<td>26.32%</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>10.53%</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>19</td>
</tr>
</tbody>
</table>

In addition to settings, the students has had a variety of experiences working in clinical settings owned by different entities. The majority of the students worked in religious owned clinical settings (16%; n=5) and non-profit clinical settings (16%; n=5). Overall, all the students worked in 32 different owned clinical settings. See table 15 for a full table of ownership of those clinical settings.
The students were openly coded by the research team although there was only a few findings among the characteristics of the students. The majority of the students reported not having any clinical experiences working with gender and sexual minority patients. The most prevalent issue that came up several times in the interviews is that the majority of the students did not have a full understanding of the healthcare services’ organizational climate. Meaning, they were not aware of the policies, procedures or the culture of the organization. When asked about any existing organizational orientations, the students responded that some healthcare organizations do provide it while others don’t. Regardless, many of them reported that they

<table>
<thead>
<tr>
<th>Table 15. Experiences in the Type of Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Religiously Affiliated</td>
</tr>
<tr>
<td>Other non-for-profits</td>
</tr>
<tr>
<td>Investor-Partnership</td>
</tr>
<tr>
<td>Investor- Individual</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>City-County</td>
</tr>
<tr>
<td>County</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>Hospital district or Authority</td>
</tr>
<tr>
<td>Federal VA</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Themes found in Open Coding

The students were openly coded by the research team although there was only a few findings among the characteristics of the students. The majority of the students reported not having any clinical experiences working with gender and sexual minority patients. The most prevalent issue that came up several times in the interviews is that the majority of the students did not have a full understanding of the healthcare services’ organizational climate. Meaning, they were not aware of the policies, procedures or the culture of the organization. When asked about any existing organizational orientations, the students responded that some healthcare organizations do provide it while others don’t. Regardless, many of them reported that they
often forget what is in these orientations or they are just give a large book on all the policies in which they do not have time to read. It is evident in the following quotes:

Participant Student 1
“To be honest, I would need to know what they provide to me. We're just not that far into it and I don't have a job and so like, I'm only at these locations for like six weeks so we don't have any in-depth knowledge on any of that [policies].”

Participant Student 2
To be honest with you, I've never really read the policies, so I can't say whether it has or not. I mean I wish, I wish I could tell you, I just have never read the policies so I'm, I'm just not sure… [when asked if they were given a manual] … they do, but I mean who reads through a 300-page manual? I'm sorry, I don't have time a read through it.

Within the context of the PA students, they are given 6 assignments of clinical rotations within the entire state of Kansas, and more specifically in rural settings. The PA students especially reported that they often are not aware of how inclusive a clinic can be, and furthermore may just make assumptions that the clinics are not open, culturally, toward gender and sexual minorities because of the location of the clinic. There seems to be a miscommunication between the healthcare facilities and the health professional students who participate in clinical rotations in their facilities due to the lack of time and resources. Therefore one of the codes that was established in the beginning of the dialogue with team members is the unawareness these students have about the organizational climate in clinical settings in which the students have worked in.

Another common occurrence found in the interviews was the denial of potential bias in healthcare services. Several of the students said that they believe that if they just treated the
patient with respect, it wouldn’t matter how aware they are about gender and sexual minority health. There is some consistencies within reporting a lack of policies that could potential protect gender and sexual minority patients versus simply stating that as long as they treat each patient, their biases wouldn’t impact the quality of care they are providing. This is seen in the following quotes.

Participant 2

“Um, no, not that I've come across [inclusive policies]. I mean I, I've had several [gender and sexual minorities]. and -- there was no barrier. I treated them just like I would I treat anyone else.”

Participant 3

“I mean, for most of my rotations, I've had minimal experiences with it [providing services to gender and sexual minority patients]. I would say that when it has come up, I feel like the people I've worked with haven't treated the patient any differently than they would treat anybody else…I guess my only question is like -- I don't see it as -- I guess I don't separate it out. So, like, to me, it's like I don't sit there and separate someone who is transgender from somebody who's not. Like I don't, it doesn't -- it doesn't really play into my decision making role or how I'm going to treat them.”

In addition, the research team observed a lack of understanding among the participants in terms of gender and sexual minorities and their needs. One example that stood out to the team was in the beginning of the interview with participant 4. When the interviewer asked the participant about gender and sexual minorities, the participant stopped the interview because they did not know the terms for gender minority and sexual minority. The team came up with the code for “lack of awareness” because of examples like this case. In addition, there would be times where students would make assumptions about what exactly gender and sexual minorities need in terms of healthcare. This is exemplified in the following quote when the interviewer asked if understanding gender and sexual minority is important or not important to their medical career.
Participant Student 7

“It really depends on my field. because certain fields I mean, you can connect with your patients better, if you're more aware of that, but in terms of like their healthcare, what you deal with has nothing to do with that [sexuality and gender identity], but there's also certain fields that are very very relevant. So, a lot of the patients that we see at [clinic name], you know, have sexually transmitted diseases and therefore something that we need to incorporate with asking like, like what is the sex of your partner? How many partners you have to ask all these extra questions because it matter. But for other people, you know, for a different field, they may not.”

This student assumed that the only reason why a medical provider would need to know about their patient’s sexuality and gender identity is to provide sexual health services. However, the research team discussed how this is not reflected in why the gender and sexual minority sample population was saying. Especially many gender minorities are put in a position where they have to educate their providers about their medication regiment. This student in particular exemplified a clinical student that may not have a full understanding on the importance understanding gender and sexual minority health, regardless of the clinical field the student might work in the future.

Another example of lack of understanding that the research team have found is when the participant makes statements that gender and sexual minorities may find discriminatory. An example of this is found in the following quote after being asked if it was possible to implement policies that prohibits harassment in binary bathroom stalls.

Participant Student 6

“I don’t think patients want them…[because] Wichita has a lot of older retired people. I don't think that the older ladies want young men using the same bathrooms as them.”

This quote is an example of a student who misgendered gender minorities, hypothetically. And although earlier in the interview, this student said that they had “too much” training about
gender and sexual minorities, this student is found invalidating gender minorities. Another issue that came up in these interviews is that idea that inclusivity for gender and sexual minorities means treating this population as an “exceptional minority”. This relates back to if there is no bias in healthcare services because they treat minorities like any other patient.

Students were also asked about how confident they were in asking patients about their sexual orientation and gender identity. There was mixed response which depended on the student’s experience working with gender and sexual minorities. Here is one quote that exemplifies their experiences in asking about identity.

Participant Student 5

“A lot of the students, even though we're trained to be open and have an open mind, a lot of students will not ask about sexual orientation, how many partners have you had, are you currently having sexual relations? Stuff like that. It's a topic that a lot of students are too uncomfortable to talk about. Which needs to be addressed because the US prevention task force recommends that you screen everybody above the age of 13 - 65 for STDs and HIV. Are we asking from 13 to 65? No. It says everybody, it doesn't say if you have a risk or anything, it says everybody.”

As this student explains, although there is some training in terms of feeling confident in asking about sexuality and gender identity, students feel uncomfortable bringing up these questions to their patients. The students were also asked about what type of education and how many hours do they receive concerning gender and sexual minority health. The following quote is about a student who is almost done with their program but has yet have not been exposed to education about gender and sexual minority health.

Participant Student 3

“No, I haven't [had any LGBT training]. But I wish I had. I feel like even for my own benefit that would be helpful just because I again don't feel like I know enough about it to be educated.”
Another issue that was brought up by a few participants is the push back they experienced from fellow classmates who may hold negative attitudes towards gender and sexual minorities. The following two quotes describe two incidents where students were pushing back against health education because it did not fit with their belief system.

Participant Student 8

“I feel like there would definitely be some people that would push back a bit, I guess. I've had people in my class that came from Western Kansas who are very conservative and, you know, we had a lecture about abortion and they were just like freaking out about it. Like, "This is dumb! I'm never going to do this in my life. I don't believe in this." And I mean like I personally don't believe in that either, but for me it's a matter of like -- it's a matter again of finding the right resources for the patient. Like, ‘No, I'm not going to do it because it's against my views, but I'm not going to tell them that they can't do it and I'm obligated as their physician to find someone for them that can.’”

Participant Student 5

[When asked about gender and sexual minority education in the program] “It was a little more than an hour because we made it longer because we were interested in that. But it was very sad to see that it used to be a required lecture, you had to get through it, but so many people from previous classes before raised a lot of issues of having to go to that lecture because it wasn't with their viewpoint, so they had to make it an optional course.”

It seems that there have been efforts by these healthcare programs to be inclusive in their clinical training, but it is often met with backlash by some of the students who may not feel that it is appropriate or may not fit with their point of view. Another interesting aspect of these interviews is that unlikely places that students do find enriching education on gender and sexual minority health. One avenue is presented in the following quote when the interviewer asked the participant how many hours of education they received that pertained to gender and sexual minority health.
Participant Student 7

“Strictly in class, probably only 2-3 hours, but if you go down and volunteer in [clinic], you're around a lot of those physicians who are very progressive, then you get more. If I say I probably have like 10 hours worth, but most of it is just experience and not actual class time.

This student mentioned clinic that medical students have the opportunity to volunteer to. The clinic is free for patients who can’t afford medical services or don’t have any insurance. Because of this unique experience, the student has the opportunity to learn by interacting face to face with patients from many different backgrounds. Earlier in the interview the patient described this clinic with the following quote:

Participant Student 7

“It’s so very, very inclusive culture. I mean a lot of the students that volunteer there. I mean it's a free clinic so I see a lot of people that are from minorities, like not just socially but also racial and circumstantial situations. And so we just try to be inclusive as possible for all of those patients because they don't usually see that.”

Another avenue for education that students praised for were events where they got to hear gender and sexual minorities talk about their experiences in planned panels provided by their healthcare program. A few students explained how that experience opened their minds when they interacted with gender and sexual minorities. It was particularly rewarding for those who had never met a gender or sexual minority. The follow quote is by a student who specializes in rural health and had little experience interacting with gender minorities before.

Participant Student 8

“There's a lot of misinformation, I guess, about that. And just confusion and people don't really understand. So I feel like if there were more opportunities like that for people to share their stories because we actually, for medical school, we were required to attend the transgender patient panel. That was really cool to listen to their stories because a lot of them are afraid to tell their stories because they don't know what people think. And I feel like kind of in general people are
more trusting of healthcare providers because you know, like it’s a time when you are vulnerable and exposed to healthcare providers….When they were talking to, you know, a panel of medical students, they could be themselves and tell their story because that's what they were there for. And that was really cool.”

Lastly, another form of education came from mentorship with other medical providers. Although there have been several mentions of how different current students are compared to older medical providers, there has been several medical providers who have been their own champions in terms of gender and sexual minority health. The students benefit the most when they watch medical providers provide services that are inclusive. Students have mentioned that there has been a generation shift in how they think compare to older medical providers from especially family health clinics. They described being more open compare to medical providers who have had a career for years. Yet, students have also expressed how helpful it was to shadow providers who do understand gender and sexual minority health. This is exemplified in the following quote with a student who has worked with a prominent medical provider in Wichita who is known to provide inclusive care.

Participant Student 5

“So she has an open clinic. What she does is she is very good with her patients and is very good with her staff, she has a kind of routine in asking like, what is your gender preference? What do you have? Who do you want to be your person that we contact? She's very methodical so when one does come up where people have a difference of gender preferences or anything, she is like OK, this is what was happening, and then we just kind of go from there. The way she does it in her clinic, she asks everybody about their gender roles and who they want to be considered, like their pronouns and all that stuff. And they ask everybody so it's not like something someone is excluded from...”
Secondary Coding for the Health Professional Student Sample

After the opening coding was done, the themes were the organized into broader categories and into the cultural competence model (Betancourt, Green, & Carrillo, 2002). For this section of the results, only the characteristics will be reported. See Appendix D for Themes and Definitions. After the codebook was developed, the research team coded each time the participant spoke. Inter-rate reliability was done with 25% of the the healthcare professional student sample and therefore two transcripts were coded twice and found to have a moderate level of inter-rater agreement of .63 and a lower level of .42.

The top five instances mentioned are the following: Lack of Awareness and Education on LGBT Health, Negative Attitudes toward the LGBT Community, Small Healthcare Services, Conservativism, and Religion. There was 54 instances where the lack of awareness and education on LGBT health was mentioned. Negative Attitudes toward the LGBT community was mentioned 44 times. Small healthcare services were mentioned 34 times. Conservativism was mentioned 27 times. Lastly, religion was mentioned 27 times. See table 16 for a table of all of the themes related to students’ characteristics.

Table 16. Student Characteristics and Themes

<table>
<thead>
<tr>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of LGBT Awareness and Education</td>
</tr>
<tr>
<td>Negative LGBT Attitudes</td>
</tr>
<tr>
<td>Small Healthcare Services</td>
</tr>
<tr>
<td>Conservativism</td>
</tr>
<tr>
<td>Religious</td>
</tr>
<tr>
<td>Location</td>
</tr>
<tr>
<td>University Settings</td>
</tr>
<tr>
<td>Denial of bias in Services</td>
</tr>
<tr>
<td>Generational Culture</td>
</tr>
<tr>
<td>Corporate Healthcare services</td>
</tr>
<tr>
<td>Institutional refusal of Investment</td>
</tr>
<tr>
<td>Issue</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lack of Data</td>
</tr>
<tr>
<td>Unaware of Organizational Climate</td>
</tr>
<tr>
<td>Lack of Institutional Resources</td>
</tr>
<tr>
<td>State Politics</td>
</tr>
<tr>
<td>Confidence in Treating LGBT</td>
</tr>
<tr>
<td>Lack of LGBT Medical education</td>
</tr>
<tr>
<td>Insurance Coverage</td>
</tr>
<tr>
<td>Uncomfortable Asking About Identity</td>
</tr>
<tr>
<td>Access to LGBT Medical Education</td>
</tr>
<tr>
<td>No Confidence in Treating LGBT</td>
</tr>
<tr>
<td>Comfortable Asking about Identity</td>
</tr>
<tr>
<td>Invalidation of Identity</td>
</tr>
<tr>
<td>Positive LGBT Attitudes</td>
</tr>
<tr>
<td>Federal Politics</td>
</tr>
<tr>
<td>Progressivism</td>
</tr>
<tr>
<td>No Exceptional Minority</td>
</tr>
</tbody>
</table>

**Medical Administrators**

There was total of nine interviews with medical/healthcare administrators within the Wichita area. The majority worked for healthcare centers however, there were three administrators who worked for agencies and provided specific and specialized services. In addition, many of the participants were asked for an interview because their organization was brought up as inclusive in interviews with the gender and sexual minority sample population. In terms of demographics, all of the participants were cisgender, and only one reported to be a sexual minority. In addition, the majority of the participants were white (78%; n=7). See table 17 for the demographics of all of the participants.
Table 17. Demographics of Medical Administrators (n=9)

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/Black American</td>
<td>9%</td>
<td>2</td>
</tr>
<tr>
<td>White/ European American</td>
<td>78%</td>
<td>7</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>11%</td>
<td>1</td>
</tr>
<tr>
<td>Single</td>
<td>89%</td>
<td>8</td>
</tr>
<tr>
<td>Household income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$30,001-$40,000</td>
<td>12%</td>
<td>1</td>
</tr>
<tr>
<td>$40,000 or More</td>
<td>88%</td>
<td>7</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>56%</td>
<td>5</td>
</tr>
<tr>
<td>No Religion</td>
<td>22%</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>22%</td>
<td>2</td>
</tr>
<tr>
<td>Gender Identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cisgender Male</td>
<td>33%</td>
<td>3</td>
</tr>
<tr>
<td>Cisgender Female</td>
<td>67%</td>
<td>6</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>89%</td>
<td>8</td>
</tr>
<tr>
<td>Gay</td>
<td>11%</td>
<td>1</td>
</tr>
</tbody>
</table>

As previously mentioned before, the organizations that each administrators represented were fairly diverse. About 6 of the administrators represented healthcare organizations that provided a variety of healthcare services. Whereas, three of the administrators represented health-related agencies that provided restrictive and specialized services related to health. One of these agencies was a home health agency where they provided health and home care needs to an elderly population. The second agency had a focus on providing free STI testing to the Wichita community. Their mission is to reduce the rates of HIV within the city. The last agency has a focus on providing support for those who are survivors of sexual assault and to connect survivors to the proper channels in getting the best healthcare and advocacy. All three of these agencies had a unique perspective because they either specifically cater to gender and sexual minorities or
had a personal reason to ensure that gender and sexual minorities are treated with respect. See figure 17 to see the types of settings represented by each administrator.

In addition, two of the facilities are faith-based meaning they are run by religious organizations. Two other facilities are federally qualified healthcare services meaning they receiving their funding from federal channels. Overall, with the exception of the home health agency, these organizations provide free healthcare and support services regardless of healthcare insurance or income. One of the healthcare facilities is housed within a local state university. See table 18 for the types of ownership.
Table 18 Types of Ownership

<table>
<thead>
<tr>
<th>Ownership Type</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religiously Affiliated</td>
<td>20.00%</td>
<td>2</td>
</tr>
<tr>
<td>Other non-for-profits</td>
<td>50.00%</td>
<td>5</td>
</tr>
<tr>
<td>Investor Corporation</td>
<td>10.00%</td>
<td>1</td>
</tr>
<tr>
<td>Hospital district or Authority</td>
<td>10.00%</td>
<td>1</td>
</tr>
<tr>
<td>State University</td>
<td>10.00%</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

Open Coding: Medical Administrators

Because of the unique perspectives from several of different settings and types of health and support care, the team discussed several unique barriers and resiliency elements within the healthcare system. Before mentioning the issues that were brought up the most pertaining to healthcare administrators, its essential mention the parallels between this sample population and the students, and gender and sexual minority sample populations. For example, as previously mentioned, students have expressed not really having a full understanding of the organizational climate of each clinical facility that they have worked in. One administrator, interestingly enough, also brought up that issue in the following quote.

Participant Administrator 6

“I was talking yesterday in another meeting about like just our residency program and what we know we're doing with the[medical] residents and we really haven't...that's just been operating the way it operates forever and we probably need to be revisiting it and making sure that we're providing some training and some kind of cultural, you know, information like this is who we are, this is who we serve, this is how we serve them and you know, making sure that that's meeting our standards, we don't want a residency program and I'm not saying it doesn't, but it would be a huge disconnect if we had, if we were, you know, had students in who weren't able to support the mission the way we want to support it.”
The administrator expressed concern during the interview on whether the medical students who have done clinical rotations in their health facilities understood the values of the facilities. More specifically, since this administrator has made it a mission for the organization to be more inclusive towards gender and sexual minorities, they explained that there would be a disconnect if the students were not educated enough to follow through on the organization’s mission to inclusive care. Another parallel found was in an interview with a health administrator who was also medical doctor that provided care in the same facility. This administrator explained how medical providers make referrals for patients that need gender and sexual minority catered healthcare services. The description is provided in the following quote.

Participant Administrator 9

“In the [healthcare system] there are people who have beliefs that you think seems a little outdated. That sounds a little uninformed and there's not always a really good check and balance for that other than OK, I'm not going to send my patient there because I know they might get advice that I don't personally agree with or I don't think is in their best health interest. There's not necessarily a place where an outside entity intervenes and sort of call someone out on that behavior, you know, even just because often the way we would find that out is sending a patient to a physician who, where the patient has a bad experience. Whether it's something like recommending some, a controversial treatment for their gender identity or sexual health and sexual preferences kind of thing, or whether it's just in how they get treated. Like, oh, I found out that you happened to be, um, a transgender individual, so now you get treated very differently in my office than before, the way we usually find that out is the patient comes back to us and says, I'm never going there again. And then you're like, oh yeah, we'll won't be sending anyone else there. But there's no way to really find that out until someone has a bad experience, which seems um kind of sad, right? Because someone has to go and have a bad experience in order for us to know unless it's just sort of the among the medical community. It's sort of, we have sort of non-discrimination standards to follow like anyone else, but in terms of like many organizations, I think they're pretty, they're pretty boiler plate there's kind of a ‘So what?’ that happens. And I think that's an area that physicians just tell each other, hey, I have a patient that needs this, go here not there, .... We sort of know some of it is an expertise, right? So, if someone tells me that they're going to transition, I know the people in town that do that really well...they don't need me. They need someone who does this all day, every day. It has lots of support mechanisms in place.”
What is interesting about this quote is that it describes the same mechanisms in finding inclusive healthcare services that is like how the gender and sexual minority community find inclusive healthcare services. This administrator is part of a large corporate network of a variety of healthcare services and clinical settings; they also happen to be a medical provider in a clinic that they are in charge of within the same medical network. Just like minorities, medical providers do not rely on their own healthcare organization’s or other organization’s no tolerance for discrimination standards to ensure that their patients will receive the quality of care that they need. In addition, they rely on the poor experiences of their patients to figure out if some providers are not inclusive enough. In a sense, this provider is describing gate keeping by proxy, except they are still relying on gender and sexual minorities to figure out if a specific provider is inclusive enough.

The most prominent issue that came up in several of the interviews, similar to what was seen with students, is the perceived notion that inclusive-related policies are almost not a necessity if the healthcare facilities treat all of their patients equally. Similar to students, many of the administrators were not aware of the potential bias that could perpetuate if the right policies are not in place. Therefore one of the themes the team had discussed was this denial of bias existing within healthcare services. This is exemplified in the following quotes:

Participant Administrator 1

“I think it really probably depends on how you’re set up… I probably say it’s a combination of value system and who’s kinda leading the charge. We are pretty easy going, like I said, meet you where you are type of clinic. So, it really doesn’t matter, and everybody deserves healthcare. So that’s pretty much our bottom line, so our thing is probably more on…respect…that type of thing. We’re kinda here to rock with you, so to speak, so everything else is obsolete.”
Participant Administrator 3

“This one's almost as hard to answer as the last one because since we, since we don't ask the sexual preference of our patients, we don't - it's just fascinating. We don't encounter this. Yeah, it fascinating - our goal is to reduce all barriers to healthcare to provide health quality services. So, we would never deny a patient care under any circumstances because of their sexual preference.”

It’s essential to note that every administrator that was interviewed, did strongly believe in providing quality care for gender and sexual minority patients. A lot of these administrators did not think to or believe they needed written policies to protect gender and sexual minority patients or employees not because they have negative attitudes against the gender and sexual minority, but because they believe that inclusivity is already fostered within the organizational climate. Many of these organization have been historically known to be inclusive towards gender and sexual minorities, is just recent that they are in the process of implementing such policies within their organization. The following quotes are just some of the examples the team has seen throughout most of the interviews.

Participant Administrator 2

“We do have a philosophy and probably an expectation that we, um, our gender and sexual - that we don't have discrimination against gender or sexual minorities, but nothing in writing.”

Participant Administrator 6

“Um, I think that this is probably our organization in practice, but not necessarily, um, cemented in formal policies and systems. That is something we're working on doing.”

Participant Administrator 8

“We are, I mean obviously we were full on nondiscrimination as a, as an organization we, we don't, I wouldn't say we have, I don't think we, we have written policies on them. We're just, we're one of those where we're just non-discriminatory all around an ally to all. Um, we, uh, from, from our services to
our policy is not really our services. Pretty much show that we, we don't have the discrimination, we don't have the, oh it's, it's, it's very based on who wants it and when it's not on who you are.”

There seems to be several barriers that may have impacted the decisions and assumptions that the administrators may have in terms of gender and sexual minority healthcare. For example, participant 3, throughout the interview had mentioned the concern about asking patients for their gender identity and/or sexual orientation not due to negative attitudes but due to concerns of the not providing the right care for gender and sexual minorities. They believed that in asking, that it may increase the risk of outing a patient or increase the risk of discrimination. Participant 3 also shared concerns with other administrators in terms of following the Health Insurance Portability and Accountability Act (HIPAA)’s guidelines. There seems to be concerns about violating confidentiality. The research team had discussed this could be indication that some administrators may not be aware of the necessity in asking those indicators in terms of providing care that caters to the patient’s needs.

In addition, administrators are also more interested in not risking harm to a patient if a mistake was made. Similar to what participants from the sexual and gender minority sample have said, administrators were concerned about implementing employee and patient representation practices in fear that it would out a specific employee or even being perceived as giving specific privileges to one minority group over the other. Many felt that this could be seen as ingenuine or even trying too hard to cater to minorities. This was also a theme that came up with the healthcare professional student sample, the idea of treating one minority more exceptional than the other. This is exemplified in the following quotes:

Participant Administrator 1

[ when asking about LGBT outreach] “But I haven’t to been no black power events either, so it’s just — We’re just trying here to close the gap, and with
what limited resources we have. We have to be very intentional and particular where we are. Doesn’t say that we don’t support XY or Z, it’s just this is the mission, anything outside of this we have to pick and choose what resources we have.”

Participant Administrator 3

“I don't think we ask these questions of any of our employees is they're hired or even after they're hired. Um, I don't know that I could speak to having an LGBTQ holiday at the facility other than celebrating we, we celebrate everyone here as an individual and as a person. So that would be similar to having a straight white man day or um, yeah, I just, I don't know that we could have a specific holiday dedicated to what we, we treat as not a minority because everyone is welcomed.”

Another concern that was brought up in the interviews is the culture that is nested within Wichita, and Kansas as whole. For example, there were many administrators that believed that federal and state politics does play in role on how administrators run their clinics. Several administrators have explained that their organizations often rely on state politics and policies for support and funding. Therefore, many must follow the guidelines and policies, especially non-discrimination related policies. The following quote exemplify this specific situation.

Participant Administrator 5:

“[When asked about inclusive health benefits for employees, it was brought up that state politics has a deciding role in deciding employee health benefits] Absolutely. [it’s the] State legislation, state legislature, but we both know that it's not going to happen right now…. [when asked about inclusive intake forms] we do a very, very brief intake form…is not very inclusive regarding gender identity. And I can also tell you the reason for that. We keep that information only because we reported to funders and we only have the option of reporting male or female. Yeah. So, we, we don't keep anything else. … [the structural barrier comes from?] from the federal government.”

Participant Administrator 4

“When you look at the standard, most companies will put their standard EOE language in their brochure or in their employee practices, they'll put in, um, the standard, a non-discrimination clause and that does not include sexual orientations or things like that. And I have insisted that that was added. So, when we do hand out information and we do discuss our non-discrimination policy, it is clearly indicated that sexual orientation is a part of our concept of you will not
be discriminated. In fact, we recently hired a transgender employee and the staff…the interviewee came into my office and… they disclosed to me. They wanted to know, how we, how we take a stance in supporting that? And I said we supported a hundred percent like we would anything else if this individual has legitimate concern, I will personally take care of it. I think we've tried to show when you live in a conservative state where the laws don't necessarily support it. We've tried to show in our own policies that we're going to support a person.”

Administrators spoke about how the state government has negatively impacted their decisions pertaining to provide inclusive healthcare services. Some of the administrators believed part of the problem is the cultural outlook most community members within Wichita uphold, and more specifically, the conservative and religious outlook that may not only influence state politics but also the majority of the healthcare system in the city of Wichita. In addition, some of the administrators explained that healthcare services that have religious support and funding are often restricted in what type of care these services could provide.

For example, one administrator that was in charge of a religiously run healthcare facility mentioned that providers were prohibited from prescribing birth control because it goes against the views held by the leadership. However, both of the administrators who represented religiously-run healthcare services did expressed interest in becoming more inclusive toward gender and sexual minorities. As one administrator said, many of these faith-based healthcare organizations have had a positive impact in Wichita, especially since Kansas does not have enough resources to support more government run healthcare facilities, however because there is no restriction or regulations, these facilities are more likely to have a negative impact on marginalized communities when there are no resources, education, support, or even awareness.
Additionally, administrators raised concerns over the lack of resources, the lack of support, and especially the lack of data. Most of the administrators explained that it is difficult to invest in additional inclusive practices that the Human Right Campaign has recommended within the healthcare facilities because there is no data to justify it. This was expressed by administrator who has been motivated to make the healthcare center they represent, an equality leader, it is exemplified in the following quote:

Participant Administrator 6

“One of the barriers my manager raised is just number of patients, for our patient centered medical home we have to have a certain number of patients in case management scenario and I don't know what that number is off the top of my head, but we when looking at our population of identified patients. We don't have that number that meets that requirement for case management. So, I mean we're still going to look at ways to move forward, but it's just a small population for us. And so, when it's kind of a very small population, it can be hard to get good data, get good information, make good decisions... [when asked about whether an increase in data within the city of Wichita would be helpful] ... I think that would be very helpful in terms of helping us to understand the opportunity as opposed to just coming at it from our current environment.”

Participant Administrator 4

“Yes, I do. Um, one of them would simply be, it's an out of sight, out of mind kind of circumstance [in terms of leadership within healthcare]. If people's perception is, is that, oh, we don't have anybody. So why does it matter when the reality is, is you do... And so, if you can't see it, sometimes people are like, well, what does it matter? Do I need it? We all know that that's still not a reasonable answer for any organization in this day and age, but I think that is part of the challenge.”

All administrators agree that the hardest component in the work that they do comes to understand the costs, risks, and benefits, especially when attempting implement new practices or creating drastic organizational changes. When presented with many of these vignettes, many
expressed the possible risks that could come with implementing these recommendations. The following quotes are instances in which participants have brought up these concerns.

Participant Administrator 1

“It’s just really — with healthcare and all the different things we have to comply with I would say your biggest thing is time and needing to fit it in and what’s the right training? You know what I mean? Because any time you have provider staff that’s not focused on seeing the patient, you’re losing income and there’s people that’s not being helped. So, you have to put something compact enough to where it will make an impact but yet, you know, when I take my staff out to view a video or do a webinar, or bring somebody in, that is worth the benefit.”

Participant Administrator 9

“I think the barrier that we have is sort of the who will do it, you know what I mean? I think. And then what do we do with that information? So, part of it is OK, who's gonna ask the question? So, a lot of ours are employee engagement surveys include How do you feel about the hospital? How do you feel about your office? And that the people who do them are mostly interested in other factors. So that just never showed up on the survey. I think that's a barrier because those are the ones that we do, right? I don't know if that's because once we get the information, what do we do now? Right. Or if it's a, more of a question of once we get the information and um, or just. no one is thinking to ask.”

It seems that not only do these healthcare facilities are lacking in data that would provide them with justifications to make decisions based on the Health Equality Index. They also believe that they don’t have enough support if they do risk creating organizational changes in their healthcare facilities. Many felt that they wouldn’t know what the next steps are to take or believe that there is a more standardized procedure to do so. In addition, many have expressed the lack of resources and support within the city of Wichita. Some of them were not even aware of local resources like the LGBT Wichita Health Coalition even existed in this community. The lack of resources and support was mentioned in the following quote.
Participant Administrator 6

“You know, I'd say one of the barriers is probably just familiarity and knowledge of what's available because I had no idea that that health equity index, for example, existed or, or some of the materials that were available on making changes like that... I think the biggest barrier for us again, goes down to resources and um, we have a lot of projects on our plate and it's like if this is a small population, then you know, how do we make sure we balance putting some resources towards it to get where we need to go, but not putting too many towards it and kind of having other projects be compromised.”

Other than the need for data in the city of Wichita, health administrators had also mentioned policies that has improved inclusivity within their healthcare facilities. This was especially true for health care administrators who represented FQHCs. For example, because they receive federal funds, they also must comply with the Health Resources and Services Administration (HRSA). The following quotes describe an example in which HRSA have provided necessary support that improves the quality of healthcare for gender and sexual minorities.

Participant Administrator 7

“Our approach has been as a Federally Qualified Health Center, Um, we do have to follow federal guidelines and that way when it comes to, um, kind ADA protected classes, equal employment opportunity, you know, we have all these different, protected classes based on those guidelines, more specifically, HRSA has introduced gender identity questions. So, they are actually requiring us to collect gender identity data.”

Participant Administrator 6

“I believe we asked that as well [gender identity questions]. Now part of this is because -mainly it happened because it's mandated by HRSA. At least under the formal administration, I haven't heard if they pulled back on it, but we didn't change our process… all health federally qualified health centers are required or were required by the end of 2016 to start capturing this data... [when asked about how the process went to update the electronic health record and intake form] Yes that made it so much easier. We probably wouldn't have done it, if it wasn’t required to be honest because of the way that we function as a health
Because of federal policies, these two healthcare organizations were able to update their electronic health records without spending money on these expensive updates. The majority of the other healthcare administrators have said that updating the electronic health record is very expensive. These two quotes exemplify federal policies that has positively impacted their facilities. Furthermore, during the interviews, two administrators also brought up a suggestion that could help healthcare services support inclusivity to care. It is described in the two following quotes.

Participant Administrator 4

“What I do love about this is the idea of, you know, for them they're creating a center or they're creating an office within this organization that says, let's look at those things. Let's make sure we have policies... make sure there's ongoing resources to support staff and whoever the client is and creating that sense of inclusion that says we're going to overcome those barriers of access to this level of care if it's appropriate, and the hard part with something like this is that...they're not large enough to do something like this. They're not large enough to have an office or department, and so for this to happen there has to be someone who can develop resources, develop policies to do some sensitivity training. It'd be nice if within a community there could be a centralized organization that did that maybe even for a fee... So there's a need in our community to succeed, it's not just the organization's responsibility, but if we want to change this globally within a community or within the state, we need to create resources that help people with the development, with the tool, with the aptitudes so they could implement it if they didn't have the staff to do it on their own.”
Participant Administrator 9

“If people knew they could either…like contracting an external LGBTQ focused on ombudsman. Even if we said we were going to do this, I would have no idea where to find that. And so having a place that's resources or a model that people could follow or a place that you could kind of partner with I think would help because I think people would then feel like, ‘OK, I'm getting good advice about what to do and I'm not just sort of fumbling around and making something that will make me feel better’. … I think they could I think they would be. Especially, especially with the data that said here, we don't do as good a care for our patients that fall into these categories or we don't take as good care of our employees that fall into these categories for these reasons. I think they [the healthcare organization] would be open to that. I think it's, again, just sort of figuring out, ‘OK, well what do we do with that then?’”

Both administrators suggested a need for a center that provided these types of services, from providing trainings, to LGBT health-related educational resources and consultantship in terms of changing the organizational climate. Furthermore, both have implied that the organizations that they represent would be open and interested in utilizing such services to improve their services and the quality of inclusive care. This relates back to other administrators who expressed that they often don’t know what to do next when it comes to healthcare inclusivity. For example, if an anonymous employee survey were to be implemented with indicators that asked about gender identity and sexual orientation, what would the next steps be when the results come back in?

Lastly, the administrators also made several mostly positive comments about the vignettes that were presented in the interviews. About 3 administrators had asked if they could keep the vignettes because they found some ideas that they could implement in their own organization. The following quotes are examples in which the administrator seemed engaged while reading these vignettes.
Participant Administrator 3

“Since we don't identify, I don't know that we can, we, we can to, I would, I would be fine with a broader training or, but we don't identify who is a member of these specific groups. This is fascinating. I hadn't ever thought of any of this training could help disparities, barriers, stigma, medical decision making for gender and sexual minorities.”

Participant Administrator 4

“I don't know that we've gotten to the level of surveying our staff surveying actual identity or serving attitude and so there's a good suggestion in my mind here for us maybe asking that question.”

Participant Administrator 6

“I think part of that is what we're trying to work through with figuring out the health equity index requirements and we do to meet that. Um, but it's funny, I just had a meeting yesterday with one of my managers and she was talking about doing a, um, what we call a PDSA, which is kind of quality improvement template that you're probably familiar with those, so for LGBTQ and um, and we were just talking about, well, what does that mean? And it didn't really occur to me that it would be, um focusing on health disparities and so I think we can circle back and talk about that. So, um, but yeah, I think it's something that we're kind of working on and thinking about.”

Participant Administrator 7

“I think it's good exposure, I'd be interested to see your feedback from others. I mean that's your feedback, but I'd be interested in reading the report back and the other part like I said in previously, it makes me think of this question of why, why don't we?”

In addition, there was two administrators who expressed strong interest in participating the Health Equality Index. One of these administrators knew about the HEI before the interview and has been currently working to develop change within the organization so that the facility meets the recommendation developed by the Human Rights Campaign. This administrator also expressed that they were motivated because they strongly believe that having this status will help the healthcare center increase utilization among the gender and sexual minority population. The following quotes are the instances in which both administrators mentioned their interest.
Participant Administrator 6

“[I was] clued into the health equity index for the human rights campaign, so we're actually actively working on trying to achieve that designation…. [when asked about why they had a low number of gender and sexual minority patients] well I don't know because I haven't specifically looked into that, but I do think that, um, it could be a reputation issue. I think we're still working on changing the idea that [clinic] is like a healthcare facility of last resort. And the new building will help with that, but I think many people in the community think that we're just here to serve the uninsured and not the insured and we do also have, um, a perception issue related to some people feel like we only serve [a specific racial minority group], so we're trying to change that perception and that reputation… I think, you know, if we can get the health equity index designation, then that would help as well because I would be able to market that and make sure people knew that we were available.”

Participant Administrator 7

“Oh yeah you can send me information [about the HEI]. Just so I can see what we need to do to be in the book.”

Secondary Coding for Medical Administrators

After the opening coding was done, the themes were the organized into broader categories and into the cultural competence model (Betancourt, Green, Carrillo, 2002). For this section of the results, only the characteristics will be reported (see Appendix D for the themes and full definitions). After the codebook was developed, the research team coded each time the participant spoke. Inter-rate reliability was done with 25% of the medical administrator sample and therefore three transcripts were coded twice and found to have a moderate level of inter-rater agreement of .62, .60, and .72. 

The top five instances mentioned are the following: Lack of LGBT Health-Related Awareness and Education, Lack of LGBT Data, Small Healthcare Services, Lack of Institutional Resources, and Negative Attitudes Towards the LGBT Community. There was 56 instances where a medical administer expressed or mentioned a lack of LGBT awareness and education, 35 instances that mentioned a lack of LGBT health data, 32 instances that mentioned small
healthcare services, and 31 instances that mentioned a lack of institutional resources. Lastly, there was 27 instances in which negative attitudes towards the LGBT community were mentioned. See table 19 for a table of all of the themes related to medical administrators’ characteristics.

Table 19. Themes Related to Medical Administrators’ Characteristics

<table>
<thead>
<tr>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of LGBT Awareness and Education</td>
</tr>
<tr>
<td>Lack of Data</td>
</tr>
<tr>
<td>Small Healthcare Services</td>
</tr>
<tr>
<td>Lack of Institutional Resources</td>
</tr>
<tr>
<td>Negative Attitudes Towards LGBT</td>
</tr>
<tr>
<td>Conservatism</td>
</tr>
<tr>
<td>Positive Attitudes Towards LGBT</td>
</tr>
<tr>
<td>State Politics</td>
</tr>
<tr>
<td>Generational</td>
</tr>
<tr>
<td>Insurance Coverage</td>
</tr>
<tr>
<td>No Exceptional Minority</td>
</tr>
<tr>
<td>Federal Politics</td>
</tr>
<tr>
<td>Religion</td>
</tr>
<tr>
<td>Unaware of Current Organizational Policies</td>
</tr>
<tr>
<td>Confidence in Serving Minorities</td>
</tr>
<tr>
<td>Invalidation of Minority Identity</td>
</tr>
<tr>
<td>Progressivism</td>
</tr>
<tr>
<td>Corporate Healthcare services</td>
</tr>
<tr>
<td>University Settings</td>
</tr>
<tr>
<td>Denial of bias in Services</td>
</tr>
<tr>
<td>Institutional refusal of Investment</td>
</tr>
<tr>
<td>Comfortable Asking About Minority Identity</td>
</tr>
<tr>
<td>Concerns about HIPPA</td>
</tr>
<tr>
<td>Uncomfortable Asking About Minority Identity</td>
</tr>
<tr>
<td>Lack of Confidence in Serving Minorities</td>
</tr>
</tbody>
</table>

The Cultural Competency Model

All three sample populations ‘data were analyzed in three ways. First it was broken down by each policy that was mentioned in the interviews, then it was broadened by each vignette, and lastly it was broaden to the three factors of the cultural competence model (Betancourt, Green, & Carrillo, 2002). When it was broken down by each policy, it was done through each sample
population. Then it was organized by the highest number of instances mentioned for each policy or suggestions with the highest number of other mentions. For example, sexual and gender minorities talked the most about the lack of LGBT training in healthcare services, out of those instances the stigmatization of identity was brought up the most. To see what the top ten policies and procedures that sexual and gender minorities were talked about the most, see figure 18.

![Figure 18. The Policies and Procedures with the Most Instances from Sexual and Gender Minorities](image)

As for medical administrators, the most instances that were mentioned were related to the organizational climate. Within those instances, leadership was brought up the most. For students, the lack of LGBT health training was brought up the most. Within those instances, training was not a priority for healthcare was brought up the most. To see the top instances for medical providers, see figure 19, and for students, see figure 20.
Figure 19. The Policies and Procedures with the Most Instances from Medical Administrators

Figure 20. The Policies and Procedures with the Most Instances from Students
The data was analyzed by vignette, population, and the top mentions in the instances in where the vignette was mentioned. The vignettes were created based on the Human Rights Campaign’s HEI (HRC, 2017). The vignettes and criterias were organized based on the Cultural Competency Model’s three factors: Organizational, Structural, and Clinical (Betancourt, Green, & Carrillo, 2002). Vignettes 1-5 were categorized under Organizational Cultural Competency, Vignettes 6-9 were categorized under Structural Cultural Competency and Vignette 10 was categorized under Clinical Cultural Competency.

Organizational Cultural Competency. Vignette one referred to a non-discrimination policy and visitation rights for all of their patients. The sexual and gender minority sample population had 50 instances that mentioned this vignette. Out of those instances, they mentioned it was helpful 19 times. There 15 instances of mentions from the medical administrators sample population. Out of those instances, there was 8 mentions about communicating such policies. The student sample population had 16 instances of mentions about the first vignette. Out of those instances, they mentioned that it was not a priority for healthcare services 2 times.

In addition, data was also analyzed to see if there was instances of participants mentioning the lack of these policies that were found in the first vignette. Sexual and gender minorities had 41 instances with 12 mentions about these policies not being a priority for healthcare services. There was 7 instances from medical administrators, with 5 mentions that these policies were not a priority for healthcare services. For students, the lack of these policies were mentioned 8 times with 2 mentions of these policies being a necessity. See table 20 for a full list of the tops mentions for vignette one.
Table 20. Summary of Top Mentions for Vignette One

<table>
<thead>
<tr>
<th>Vignette One: Patient Non-Discrimination and Visitation</th>
<th>Lacking Patient Non-Discrimination and Visitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Minority Women and Gender Minorities (50 Instances)</td>
<td>Medical Administrators (15 Instances)</td>
</tr>
<tr>
<td>Helpful</td>
<td>19</td>
</tr>
<tr>
<td>Institution Level</td>
<td>16</td>
</tr>
<tr>
<td>Communicated</td>
<td>10</td>
</tr>
<tr>
<td>University Settings</td>
<td>7</td>
</tr>
<tr>
<td>“Fringe” Healthcare Services</td>
<td>6</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Vignette 2 referred to non-discrimination policies and benefits for gender and sexual minority employees. Sexual and gender minorities had 62 instances about this vignette with 21 mentions of these policies being helpful. For medical administrators, there were 16 instances with communicating these policies mentioned 9 times. Students only had 1 instance, with 1 mentioned that it was necessary. In terms of the lack of these policies that were brought up in vignette 2, sexual and gender minorities had 78 instances with 16 mentions about the societal and cultural level. For medical administrators, there were 15 instances with 7 mentions about insurance coverage. For students, there were 10 instances with 3 mentions of these policies being a necessity. See Table 21 for a full list of the top mentions for vignette two.
Table 21. Summary of Top Mentions for Vignette Two

<table>
<thead>
<tr>
<th>Vignette Two: Employee Non-Discrimination and Benefits</th>
<th>Lacking Employee Non-Discrimination and Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Minority Women and Gender Minorities (62 Instances)</td>
<td>Sexual Minority Women and Gender Minorities (78 Instances)</td>
</tr>
<tr>
<td>Medical Administrators (16 Instances)</td>
<td>Medical Administrators (15 Instances)</td>
</tr>
<tr>
<td>Healthcare Professional Students (1 Instance)</td>
<td>Healthcare Professional Students (10 Instances)</td>
</tr>
<tr>
<td><strong>Helpful</strong></td>
<td><strong>Society and Culture Level</strong></td>
</tr>
<tr>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>Communicated</td>
<td>Minority Identity</td>
</tr>
<tr>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Necessary</td>
<td>Insurance Coverage</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td><strong>Society and Culture Level</strong></td>
<td><strong>Insurance Coverage</strong></td>
</tr>
<tr>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Leadership</td>
<td>Necessary</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Individual Level</strong></td>
<td><strong>Insurance Coverage</strong></td>
</tr>
<tr>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Insurance Coverage</td>
<td>Necessary</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Institution Level</strong></td>
<td><strong>Negative LGBT Attitudes</strong></td>
</tr>
<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Necessary</td>
<td>Not a priority</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>LGBT Attitudes Positive</strong></td>
<td><strong>Pessimism</strong></td>
</tr>
<tr>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Providers</td>
<td>Necessary</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td><strong>Positive LGBT Attitudes</strong></td>
</tr>
<tr>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>No Tolerance for Discrimination</td>
<td>Necessary</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td><strong>Not a priority</strong></td>
</tr>
<tr>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
</tbody>
</table>

Vignette 3 referred to LGBT Employee Representation practices. For the sexual and gender minority sample, there was 40 instances about this vignette and about 11 mentions about performative allyship. For medical administrators, they has 13 instances and 5 mentioned about employment discrimination. For students, there was only one instance, with 1 mentioned about the university setting. In terms of the lack of these policies and procedures, sexual and gender minorities had 34 instances with 9 mentions about the societal and cultural level. Medical administrators had 12 instances, with 4 mentioned about these policies not viewed as a priority. For students, there was 4 instances with 1 mention of institutional refusal to invest in LGBT-related resources. See table 22 for a full list of the tops mentions for vignette three.
Table 22. Summary of Top Mentions for Vignette Three

<table>
<thead>
<tr>
<th>Vignette Three: Employee Representation</th>
<th>Lacking Employee Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Minority Women and Gender Minorities (40 Instances)</td>
<td>Medical Administrators (13 Instances)</td>
</tr>
<tr>
<td><strong>Society and Culture Level</strong></td>
<td>Communicated 5</td>
</tr>
<tr>
<td><strong>Performative Allyship</strong></td>
<td>Employee Non-Discrimination and Benefits 5</td>
</tr>
<tr>
<td><strong>Helpful</strong></td>
<td>Positive Attitudes Towards LGBT 4</td>
</tr>
<tr>
<td><strong>Negative Attitudes Towards LGBT</strong></td>
<td>Negative Attitudes Towards LGBT 4</td>
</tr>
<tr>
<td><strong>Institution Level</strong></td>
<td>Leadership 4</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>Organizational Climate 4</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>X</td>
</tr>
</tbody>
</table>

Vignette 4 referred to inclusive strategic planning practices, implementing an internal office of inclusion and diversity, and collaboration with outside organizations. There was 67 instances about this vignette by the sexual and gender minority population with 20 mentions of these policies being helpful. For medical administrators, there was 10 instances with 10 mentions about the leadership within healthcare services. For students, there was 5 instances with 3 mentions about patient-centered care services. In terms of lacking in these policies, there was 87 instances made by sexual and gender minorities with 13 mentions about the government level. For medical administrators, there was 17 instances with 4 mentions about the lack of LGBT health data. For students, there was 9 instances with two mentions of a lack of understanding or awareness about LGBT health issues. See table 23 for a full list of the tops mentions for vigenette four.
Table 23. Summary of Top Mentions for Vignette Four

<table>
<thead>
<tr>
<th>Vignette Four: Inclusive Strategic Plan and Office of Diversity and Inclusion</th>
<th>Lacking Inclusive Strategic Plan and Office of Diversity and Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Minority Women and Gender Minorities (67 Instances)</td>
<td>Medical Administrators (10 Instances)</td>
</tr>
<tr>
<td><strong>Helpful</strong></td>
<td>20</td>
</tr>
<tr>
<td><strong>Institution Level</strong></td>
<td>15</td>
</tr>
<tr>
<td><strong>University Settings</strong></td>
<td>12</td>
</tr>
<tr>
<td><strong>Society and Culture Level</strong></td>
<td>12</td>
</tr>
<tr>
<td><strong>Institutional-based Community</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>Community Level</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>Clinical Staff Training</strong></td>
<td>8</td>
</tr>
</tbody>
</table>

Vignette 5 referred to anti-LGBT practices including conversion therapy and supporting anti-LGBT political stances. For gender and sexual minorities, there was 36 instances with 19 mentions of negative attitudes against the LGBT community. For medical administrators, there was 3 instances with one mention of negative attitudes against the LGBT community. For students there was 3 instances with 2 mentions about religion. Participants also discussed how these cases are not as prevalent as it was before. For sexual and gender minorities there was 18 instances with 5 mentions about the societal and cultural level. For medical administrators, there was 8 instances with no mentions and for students there was 7 instances with 2 mentions about providers. See table 24 for a full list of the top mentions for vignette five.
Table 24. Summary of Top Mentions for Vignette Five

<table>
<thead>
<tr>
<th>Vignette Five: History of Anti-LGBT Policy Support and Providing Conversion Therapy</th>
<th>No History of Anti-LGBT Policy Support and Providing Conversion Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Minority Women and Gender Minorities (36 Instances)</td>
<td>Sexual Minority Women and Gender Minorities (18 Instances)</td>
</tr>
<tr>
<td>Medical Administrators (3 Instances)</td>
<td>Medical Administrators (8 Instances)</td>
</tr>
<tr>
<td>Healthcare Professional Students (3 Instances)</td>
<td>Healthcare Professional Students (7 Instances)</td>
</tr>
<tr>
<td>Society and Culture Level</td>
<td>34</td>
</tr>
<tr>
<td>Negative Attitudes Towards LGBT</td>
<td>19</td>
</tr>
<tr>
<td>Unhelpful</td>
<td>13</td>
</tr>
<tr>
<td>Religious</td>
<td>10</td>
</tr>
<tr>
<td>Minority Stress Distal</td>
<td>6</td>
</tr>
<tr>
<td>Minority Stress Proximal</td>
<td>6</td>
</tr>
<tr>
<td>Individual Level</td>
<td>6</td>
</tr>
<tr>
<td>Community Level</td>
<td>6</td>
</tr>
</tbody>
</table>

Structural Cultural Competency. Vignette 6 referred to access to healthcare services that cater to gender and sexual minorities. There was 41 instances made by the sexual and gender minority sample with 15 mentions about the university setting. For medical administrators, there was 11 instances with 1 mention about state politics. For students there was 3 instances that mentioned the small healthcare services once. The lack in access to healthcare services that caters to gender and sexual minorities were also talked about. There was 60 instances made by the sexual and gender minority sample with 11 mentions about the negative attitudes against the LGBT community. For medical administrators there was 16 instances with 2 mentions about religion. For students, there was 20 instances with 2 mentions of small healthcare services. See table 25 for a full list of the tops mentions for vignette six.
Table 25. Summary of Top Mentions for Vignette Six

<table>
<thead>
<tr>
<th>Vignette Six: Access to Healthcare Services Catered to LGBT</th>
<th>No Access To Healthcare Services Catered to LGBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Minority Women and Gender Minorities (52 Instances)</td>
<td>Medical Administrators (13 Instances)</td>
</tr>
<tr>
<td>Medical Administrators (6 Instances)</td>
<td>Healthcare Professional Students (9 Instances)</td>
</tr>
<tr>
<td>Institution Level</td>
<td>25</td>
</tr>
<tr>
<td>“Fringe” Healthcare Services</td>
<td>17</td>
</tr>
<tr>
<td>Helpful</td>
<td>11</td>
</tr>
<tr>
<td>Individual Level</td>
<td>9</td>
</tr>
<tr>
<td>Utilizing Healthcare Service</td>
<td>7</td>
</tr>
<tr>
<td>Community Level</td>
<td>7</td>
</tr>
<tr>
<td>University Settings</td>
<td>7</td>
</tr>
</tbody>
</table>

Vignette 7 referred to inclusive bathroom policies that prohibited harassment and access to gender neutral bathrooms. There was 52 instances made by sexual and gender minorities with 17 mentions about “fringe” healthcare services. There was 6 instances made by medical administrators with 6 mentions about positive attitudes toward the LGBT community. There was 9 instances made by students with 4 mentions about small healthcare facilities. In terms of lacking in bathroom inclusivity, there was 44 instances made by gender and sexual minorities with 18 mentions about the lack of LGBT health training. For medical administrators there was 13 instances with 5 mentioning the lack of awareness for LGBT-related issues. For students, there was 10 instances with 2 mentions about conservatism. See table 26 for a full list of the tops mentions for vigenette seven.
Vignette 8 referred to inclusive intake forms and electronic health records. There was 32 instances made by the sexual and gender minority sample with 14 mentions that it was helpful. For medical administrators, there was 12 instances with 3 mentions about federal politics. For students there was 12 instances with 2 mentions about the university. In terms about the lack of inclusive intake forms and health electronic records, there was 55 instances made by the gender and sexual minority sample with 21 mentions about the lack of LGBT-health related training in healthcare facilities. For medical administrators, there was 17 instances with 2 mentions about the lack of LGBT data. For students there was 7 instances with 2 mentions about providers. See table 27 for a full list of the tops mentions for vigenetette eight.

Table 26. Summary of Top Mentions for Vignette Seven

<table>
<thead>
<tr>
<th>Vignette Seven: Access to Gender Friendly Bathrooms</th>
<th>No Access to Gender Friendly Bathrooms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Minority Women and Gender Minorities (41 Instances)</td>
<td>Sexual Minority Women and Gender Minorities (60 Instances)</td>
</tr>
<tr>
<td>Medical Administrators (11 Instances)</td>
<td>Medical Administrators (16 Instances)</td>
</tr>
<tr>
<td>Healthcare Professional Students (3 Instances)</td>
<td>Healthcare Professional Students (20 Instances)</td>
</tr>
<tr>
<td>Institution Level</td>
<td>Institution Level</td>
</tr>
<tr>
<td>31</td>
<td>14</td>
</tr>
<tr>
<td>State Politics</td>
<td>State Politics</td>
</tr>
<tr>
<td>University Settings</td>
<td>University Settings</td>
</tr>
<tr>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Priority</td>
<td>Priority</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>“Fringe” Healthcare Services</td>
<td>“Fringe” Healthcare Services</td>
</tr>
<tr>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Helpful</td>
<td>Helpful</td>
</tr>
<tr>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Minority Stress Proximal</td>
<td>No Tolerance for Discrimination</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lack of Institutional Resources</td>
<td>Institutional refusal of Investment</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Government Level</td>
<td>Government Level</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Not Communicated</td>
<td>Not Communicated</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Not A Priority</td>
<td>Not A Priority</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Vignette 9 refered to community outreach with the gender and sexual minority community. There was 60 instances made by the sexual and gender minority sample with 27 mentions that it is helpful. For medical admistrators, there was 15 instances with 5 mentions about positive attitudes towards the LGBT community. For students, there was 4 instances with 2 mentions about other medical students. In terms of lack in LGBT community outreach, there was 72 instances made by sexual and gender minorities with 12 mentions about state politics. For medical administrators there was 11 instances made with 4 mentions about the leadership within healthcare services. For students there was 5 instances with 5 mentions about these practices not being a priority for healthcare services. See table 28 for a full list of the tops mentions for vigenette nine.
Clinical Cultural Competency The last vignette referred to clinical staff and executive board LGBT-related health training. There was 89 instances made by the sexual and gender minority sample with 13 mentions about these practices being helpful. For medical administrators, there was 21 instances with 4 mentions about the necessity of this practices. For students there was 10 instances, with 2 mentions about LGBT-related medical education. In terms of the lacking in training and education, there was 192 instances made by sexual and gender minorities with 22 mentions about distal minority stress. For medical administrators, there was 23 instances with 4 mentions about the lack of LGBT-related health data. For students, there was 36 instances with 10 mentions about lacking in education and awareness about the LGBT-related health issues. See table 29 for a full list of the tops mentions for vignette ten.
Lastly, the data was computing into three factors. Data from vignette one to five were computed as the Organizational factor of the cultural competency model. Vignette six to nine was computed as the Structural factor and ten was the only data incorporated to describe the Clinical factor. The factors were used to understand each of the sample populations.

**Overall Factors of Organizational, Structural and Clinical Cultural Competency**

Lastly, the data was computing into three factors. Data from vignette one to five were computed as the Organizational factor of the cultural competency model. Vignette six to nine was computed as the Structural factor and ten was the only data incorporated to describe the Clinical factor. The factors were used to understand each of the sample populations.

**Organizational Cultural Competency Overall.** For organizational cultural competency, there was 237 instances made by the sexual and gender minority sample population, 68 mentioned that organizational cultural competence was helpful. For medical administrators, there was 62 instances with 13 mentions of communicating practices and policies within organizational cultural competency. For students, there was 30 instances, with 5 mentions about
providers. See figure 21 for a diagram of all the mentions about the instances of organizational cultural competency.

![Organizational Cultural Competency Diagram]

The lack of organizational cultural competency was also analyzed. There was 247 instances made by gender and sexual minorities with 83 mentions about the society and cultural level. For medical administrators, there was 72 instances with 14 mentions about not being a priority for healthcare services. For students, there was 34 instances with 5 mentions about the necessity for these practices and policies related to organizational cultural competency. See figure 22 for the lack of organization cultural competency.
Figure 22. The Lack of Organizational Cultural Competency

**Structural Cultural Competency Overall.** The data was also analyzed with structural cultural competency. For gender and sexual minorities there was 185 instances with 89 mentions of the institutional level. For medical administrators, there was 44 instances with 6 mentions about positive attitudes towards gender and sexual minorities. For students, there was 28 instances with 6 mentions about small healthcare services. See figure 23 for structural cultural competency.
The lack of structural cultural competency was also analyzed. There was 231 instances made by gender and sexual minorities with 70 mentions about the societal and cultural level. For medical administrators, there was 57 instances with 10 mentions about the lack of awareness on LGBT-related health issues. For students, there was 47 instances with 8 mentions of it not being a priority for healthcare services. See figure 24 for more on the lack of structural cultural competency.
**Clinical Cultural Competency Overall.** The clinical cultural competency was also analyzed by each population. For sexual and gender minorities, there was 89 instances with 19 mentions about the institution level. For medical administrators, there was 21 instances with 4 mentions of leadership. For students, there was 10 instances with 2 mentions of the university settings. See figure 25 to see the top mentions per sample population for clinical cultural competency.
The lack of clinical cultural competency was also analyzed. For sexual and gender minorities, there were 192 instances with 22 mentions of minority stress (distal). For medical administrators, there was 23 instances with 5 mentions of leadership within healthcare services. For students, there was 36 instances with 10 mentions of the lacking in awareness and education about LGBT-related issues. See figure 26 for all of the top mentions by population about the lack of clinical cultural competency.
Figure 26. The Lack of Clinical Cultural Competency
Chapter 5

DISCUSSION

The purpose of this research project was to understand the following questions: 1) What are the structural barriers to adopting HRC’s recommended policies with the healthcare setting?, 2) What are the experiences of gender minorities and sexual minority women within a healthcare setting in the city of Wichita?, and, 3) What are the experiences of medical and physician assistant residency students in terms of gender and sexual minority health training? The following sections will describe what was found based on each research question.

Research Question 1

What are the structural barriers to adopting HRC’s recommended policies with the healthcare setting? First, the barriers in adopting these recommended policies come from a variety of different areas for medical administrators. One of the issues is a lack of resources to support and provide standardized procedures for medical administrators. As one participant mentioned, they didn’t know what to do next after they collect anonymous employee data with gender and sexual minority indicators. The majority of the participants had expressed their interest in improving healthcare services so that their gender and sexual minority patients can feel welcomed in the setting but doesn’t know where to begin in improving inclusivity. It was reflected in the number of instances mentioned. Overall, the most instances were a lack of awareness or education about LGBT-related healthcare, which was mentioned 56 times. If we looked at the instances in which no access to inclusive and safe bathroom facilities, one of the highest mentions is also the lack of awareness or education about LGBT-related issues. The overall instances of lacking in structural cultural competency (57 instances), one of the highest themes mentioned was also the lack of awareness and education (10 mentions). In summation, it
seems that medical administrators exemplified the lack of understanding for LGBT populations. This was also reflected in a previous study mentioned before; Israel, Walther, Gorcheva and Perry’s (2011) study with healthcare administrators, the lack of awareness and education was also an issue. There seems to be a disconnect in terms of having standardized procedures that could improve the organizational climate. Many have expressed that they have no need for policies because they know that their services are inclusive. This is seen in the findings when the lack of non-discrimination policies and protections for patients was mentioned 7 times with 5 mentioning that healthcare services in Wichita do not see this as a priority. Yet there has been evidence to suggest that employee and patient non-discrimination policies that protects gender and sexual minorities does make a difference in the quality of care for gender and sexual minorities (Choi & Meyer, 2016; Murphy, 2015).

Furthermore, their concerns of not knowing much about gender and sexual minority health was brought up when discussing the need for employee representation. Many have felt that they do not want to be perceived as an organization that is “trying too much” or they don’t want to treat one minority group as exceptional over the other. The findings reflect that when looking at the 13 instances about employee representation with five mentioning employee discrimination. They share similar concerns with gender and sexual minorities about looking like performative allies meaning healthcare organizations will try to fix issues of diversity by hiring minorities without understanding what are the real issues need to be fixed so healthcare services are inclusive.

Medical administrators also spoke about the barriers state and federal politics has influenced within their decisions pertaining to healthcare inclusivity. For example, there was a few agencies that collect data for the state and federal government in terms of funding and only
has the option to provide just “male and female” data making it difficult for the agencies to ask questions to their clients that are inclusive. There are also organizations that are restricted by the state government to follow the state’s non-discrimination policies for their employees. Unfortunately, in the state of Kansas, however, there are not policies that protect gender and sexual minorities as it “protects” religious freedom (Equaldex, 2018).

Another issue is the way LGBT- health inclusive resources are disseminated from a local to a national level. For example, one medical administrator explained that it was only recently that they learned about the HEI. From their perspective, the HEI is not widely advertised to healthcare facilities similar to the one they represent. The rest of the participants also expressed concern that they never heard about the HEI until their interview. In addition, some have expressed that this was also the first time they have heard about the LGBT Health Coalition in Wichita, KS. This was also reflected in the number of instances, for example, medical administrators mentioned that there was a lack of institutional resources 31 times. When the lack of employee benefits were brought up, medical administrators also mentioned the concern for insurance coverage 7 times. For many of these administrators, access to insurance coverage options is difficult, especially services that could cover gender affirming services. Many of these participants reported the need for support and expertise in understanding how they can be inclusive.

Another aspect, is the lack of understanding of the size of the gender and sexual minority population in the city of Wichita. Currently there is limited data on gender and sexual minorities in the city. Some of the more motivated healthcare administrators expressed how difficult it is to change policy or invest in inclusivity because there is no data that shows the need. Many have made assumptions that the community is small, yet, there were some gender and sexual minority
participants who said that the community is larger than one can imagine. One participant who is the founder of one of the support groups in Wichita said he personally knows over 200 gender minorities in the city of Wichita. Regardless of the size, it is pertinent information that will help administrators advocate to the executive boards they work with to move closer towards gender and sexual minority inclusivity. This was also found in the instances made by medical administrators. Lack of data was one of the top instances (35 instances). When looking at the lack of inclusive strategic plan and implementing a office for diversity and inclusion (17 instances), the lack of data was mentioned 4 times. In the lack of providing services catered to gender and sexual minorities and the lack of staff training pertaining to gender and sexual minority health, lack of data had of the most mentions as well. Lastly, when looking at the two factors from the cultural competency model, both clinical and organizational cultural competency, lack of data also had the most mentions.

Overall, the medical administrators, for the most part, expressed being open to new changes if it makes beneficial sense for their organization. This leads to how vital it is to make resources available to these organizations, especially in terms of reporting the gender and sexual minority population within the city of Wichita. In addition, there was at least two medical administrators who were interested in participating in the HEI and wanted to know more information about the process while the majority of the administrators asked to keep the vignettes so that they can brainstorm with the executive board on what they can do to be more inclusive.

**Research Question 2**

What are the experiences of gender minorities and sexual minority women within a healthcare setting in the city of Wichita? The study also aimed to understand the experiences of
gender minorities and gender minority women. As previously mentioned before, the gender and sexual minority community is not a monolith and is far more diverse in how they interact with others and their engagement with the gender and sexual minority community at large in Wichita. For example, when looking at instances where they mention they have a high connection with a community (18 instances), 10 mentions were about the gender and sexual minority community while 8 mentions were about communities had nothing to do with being a gender or sexual minority. This changes how one receives advice or information about the access of healthcare services. For example, when looking the instances in utilizing healthcare services (42 instances), the LGBT community and sharing information about inclusive healthcare services was mentioned 7 times. University settings was also mentioned 6 times. It seems the majority of the information pertaining to access to inclusive services exists more within the broader of community. Although there was an alternative way to receive advice via an online community forum which was mentioned 30 times with 6 mentions of sharing advice.

The internet is a venue healthcare organizations in Wichita should consider as an option in connecting with the gender and sexual minority community. Many of these participants figured out inclusive care because of the internet. This could be an opportunity for healthcare services to reach gender and sexual minorities who may not engage with the broader community. In addition, according to the research literature, there have been some indication of the effectiveness in using the internet as a resource for health promotion or communicating healthcare services for gender and sexual minorities (Mustanski, Greene, Ryan & Whitton, 2015; Rhodes, McCoy, Tanner, Stowers, Bachmann, Nguyen, & Ross, 2016; Harper, Serrano, Bruce, & Bauermeister, 2016).
In addition, it was concerning to look at the date of healthcare use and their perception of their own health and mental health. Although 54% reported their health is very good, 31% reported it was fair while 8% reported it was poor. With mental health, 54% reported it was fair. In addition, about 16% of the participants reported not seeing their primary care doctor for the past 3-5 years. In terms of STI testing, 23% of the participants reported never receiving a test and 39% reported being in the emergency room in the past year.

A few participants have said that it was because it is generational, meaning most young people do not seek primary care services. Yet, there could be underlying factors as to why a young gender or sexual minority would avoid having a primary care doctor. For example, in one study about gender and sexual minority healthcare utilization within a rural setting, gender and sexual minorities reported that the more prevalent barrier is the stigmatization that comes with their minority identity (Meyer, 1995). In addition, these findings are not surprising considering that 30% of the gender and sexual minority population, in general, do not utilize healthcare services nor own their primary doctor (Winter, 2012). Furthermore, they are likely to delay health services and treatment therefore having poor health outcomes (Mayer, Bradford, Makadon, Stall, Goldhammer, & Landers, 2008).

The research literature has indicated gender and sexual minorities have reported to not disclose their orientation or gender identity because of past overt and covert discrimination incidences with healthcare facilities (Krehely, 2009; Roberts & Fantz, 2014). Even when they do disclose, gender and sexual minority patients have reported feeling high levels of anxiety which stems from the fear of being refused health care services and/or being mistreated (Mollon, 2012; Roberts & Fantz, 2014; Stanton, 2013). The research literature has also been reflected in the findings. For example, when participants were asked about their experiences in discrimination.
About 92% of the participants reported internalized discrimination while 77% reported expecting discrimination from happening in religious organizations and healthcare services. When looking at the instances in which participants mentioned the expectation of rejection (46 instances), there was also five mentions of utilizing healthcare and 5 mentions of underutilizing healthcare.

Throughout the interviews there were cases in which participants stated that their medical providers had no knowledge of their actual minority identities. One participant, for example, who is a lesbian woman, had never told her medical providers that she is lesbian. This could be potentially harmful especially in relation to sexual minority health. As previously mentioned before, the minority stress model has been used to look at how minority stress could influence gender and sexual minorities decision to disclose their sexual orientation or gender identity to their healthcare providers (Durso & Meyer, 2013; Frost, Lehavot, & Meyer, 2015; Meyer, 1995, 2003). There was one study that indicated that non-disclosure to medical providers and clinicians significantly predicts negative changes in psychological wellbeing, even after a year later (Durso & Meyer, 2013).

The finding has also supported what was found in the research literature. When looking at the instances of which experiences in having their minority identity invalidated (84 instances), there was also 8 mentions of concealment of their identity. In addition experiences in discrimination (76 instaces) was also related to invalidation (17 mentions) and stigmatization of identity (10 mentions).When looking the instances of minority stress (distal; 211 instances), there was 15 mentions of concealment of identity while minority stress (proximal; 138) have 7 mentions about the lack of utilizing healthcare services.

Another pressing issue is that the majority of the healthcare services in this city were religious-based. Many of the participants had expressed their mistrust in those facilities due to
past experiences being discriminated by a church or by the healthcare service themselves. Many of the participants also have a expectation that they will be discriminated against once they entered a faith-based healthcare facility as reflected in the instances pertaining to healthcare services. Although there has been some positive relationships that many of the participants has had with healthcare entities that are faith-based, especially a local hospital where two participants have mentioned that they received high quality of care.

Moreover, there is a slight connection between minority stress and cultural competency within these findings. For example, when gender and sexual minorities mentioned the lack of LGBT-related health training or clinical cultural competency (192 instances), there was 22 mentions related to Minority Stress (distal). Furthermore, when participants mentioned disclosure of their identity, the top theme that was also mentioned was safe space (8 mentions). Indicating that gender and sexual minorities may likely disclose if they perceive a setting as a safe space.

Although there is a lack of healthcare services that cater to gender and sexual minorities, however, there is still some access. Many of the places that were mentioned in the interviews that provide gender and sexual minority inclusive services were often small non-profit healthcare services and healthcare services that often provide family planning care. One issue that emerged was that many of these places are known for providing abortion services which Wichita has had a long history of community members who actively are against abortion and have picketed in front of several of these healthcare places. Many of the participants expressed that this increases their expectation for rejection and fear for their safety. This was reflected in the instances of when they mentioned fringe healthcare services (79 instances) which also had 10 mentions of positive attitudes towards the LGBT Community.
The participants also perceived that politics, conservativism, and religion as the major forces in creating barriers to healthcare services. During the instances in which state politics were brought up (50 instances), there was 15 mentions about the negative attitudes towards gender and sexual minorities, 8 mentions about conservativism and 6 mentions about religion. The instances of the lack of organizational cultural competency also had 33 mentions of the role of the government level which encompasses state and federal politics. Whereas the lack of structural cultural competency (231 instances) had 70 mentions of the societal and cultural level which encompasses attitudes, political affiliation, and religion. Overall, participants perceived that these religious, political and anti-LGBT views does influence relationships by 40%, the government level by 47%, the community level by 21%, the institutional level (i.e. healthcare services) by 21%, and their individual life by 34%.

However, this study explored the innovative ways the gender and sexual minority community has done to ensure the protection of their community members. As discussed before, advice and sharing access to gender and sexual minority friendly healthcare services would not be without the grassroots efforts of seeking those services out. These communities have show the strength they have within their social network, whether it is checking on each other or telling members what restaurants are safe to eat at. Although there is still blatant and oppressive discrimination within the healthcare services in Wichita, these devastating incidences have been used as the forefront in the knowledge of inclusive or not so inclusive places.

**Research Question 3**

What are the experiences of medical and physician assistant residency students in terms of gender and sexual minority health training? Out of the three sample populations, healthcare professional students had the least number of instances within the interviews. In addition, these
interviews were shortest compared to medical administrators and gender and sexual minorities. Besides two students, the majority of the students did not have any clinical experience working with gender and sexual minority patients. Yet, many of these students expressed that they treat patients the same regardless of what their identities may be. This belief that they treat everyone the same can potentially lead to denial in biases that may negatively impact how students provide care to gender and sexual minorities. The instances also reflect this issue. The highest instances was related to their lack of awareness and education for LGBT-related health issues (54 instances). These instances also include times where these students expressed myths or not understanding inclusive language pertaining to gender and sexual minorities such as misgendering hypothetical patients and not understanding the terms for gender and sexual minority.

This lack of education and understanding is supported by the research literature. As previously stated before, academic medical institutions have been severely lacking in training future healthcare professionals on minority health which is problematic because students may not be prepared to provide care for gender and sexual minorities (Bonvicini, 2017). In fact, one survey examined at students within the United States and Canada where students who felt they were lacking education in sexuality, had sexual issues or were lacking sexual experience, were very likely to report that they felt unprepared to ask about a patient’s sexuality (Shindel et al., 2010). The current study has also indicated there may be limited access to LGBT-related medical education. Many of the participants have expressed that they need more training to improve their confidence in asking about gender and sexual identity. When students were asked about the lack of clinical training, there was 36 instances had 10 mentions of the lack of awareness and education about LGBT-related issues.
In addition, one aspect is the fact many of these students do not have an understanding of the organizational climate of the healthcare organizations they have worked in. Because of this lack of understanding there was only a few instances made for many of the policies was presented to them. Non-discrimination policies for patients for example, was only mentioned 16 times while non-discrimination policies for employees was only mentioned 1 time. One medical administrator also indicated how concern they are that they haven’t really talked to the medical and PA students about the values of their organization. Therefore, many of these students may have no knowledge about the values of the healthcare facilities could emphasize inclusivity.

However, there have also been two participants who explained they learned a lot about gender and sexual minority healthcare through shadowing a specific provider that specializes in LGBT health or through healthcare services cater to gender and sexual minorities. Other students also talked about the experiences they receive when they work at a volunteer based health clinic where practices geared towards gender and sexual minority inclusivity is encouraged. Two participants have talked about the benefit of having face to face panels with gender minorities which they explained has helped them keep an open mind.

Limitations

There are several limitations to be considered. First, the majority of the sample population were white, so narratives from gender and sexual minorities of color are excluded from the findings. Within the student and medical administrator sample population, the majority were Christains so it may have swayed their understanding of gender and sexual minority health, although the interviewer did not ask if their views influenced their decisions within the clinical settings. Furthermore, both groups were not diverse and may not have represented all of the healthcare services and healthcare professional programs. The research team was only able to
get one interview with one lesbian woman. The rest of the sexual minority women were bisexual or pansexual. So there isn’t enough data that fully captures the experiences of lesbian women.

**Recommendations and Future Study**

The first step that would really make an impact for this community really begins with data collection. Wichita is in need to fully capture what is needed in this community. In addition, the data is essential for healthcare administrators to make decisions in terms of investing in inclusivity within these services. Although the census has recently come out with an indicator for sexual minorities, there is still no indicators gender identity (Wang, 2017). Therefore, this area needs to be addressed through efforts from this community, not only through the efforts of healthcare facilities but also from community organizations, organizations that promote health equity, and at the insititutional level including universities.

Another need is consultantship. Many of the medical administrators said that it would be easier if they could rely on an organization have has that specific expertise. Wichita is need of an organization that can provide support for these healthcare facilities. This community has the perfect elements to foster an organization as such. There are strong gender and sexual minority advocates that have been doing this work for years. They have gone to healthcare facilities to train providers and has had years of experience in terms of health equity in the Wichita Community. It is important to find those strengths that are within the city of Wichita and invest them with resources, streghthening collaboration and increase medical expertise. Lastly, there is a need for studies looking at the gender and sexual minority population from an intersectional lens. This study, for example, is one of a kind however it has failed to capture the perspectives of gender and sexual minorities of color, especially Black and African Americans, Asian Americans, and Latinx Americans. There is a whole area to explore in capturing the unique
experiences of individuals who are often faced with several layers of oppression and minority stress.

Addressing the Lack of Education among Professional Students, and Implication for Other Healthcare Professional Students

With increase the capacity of existing LGBT-based organizations, perhaps a partnership may create the opportunity to open a clinic that caters to gender and sexual minorities and could provide a place where healthcare professional students an opportunity to fineese their clinical skills through real world experiences. Furthermore, there needs to be more effort made, especially among healthcare facilities that are inclusive, to teach these students about their organizational climate. This special attention may go beyond just providing an orientation day or a manual of organizational policies, communication has to be clearer. In addition, perhaps more education should be considered for these healthcare education programs to include skills in recognizing the organizational climate of each facility they work at as an essential component to their clinical training. While other healthcare-professional related educational programs were not included in this study. There is other disciplines in need of inclusive training related to gender and sexual minority issues and disparities (Bonvicini, 2017). For example, there is also a lack of training in term of gender and sexual minority health within clinical psychology programs (Bonvicini, 2017). This also pertains the psychology department and other departments at the university as well.

Several participants were familiar with the Psychology Department clinic, student health services, counseling and testing center and departments related to health and mental health through being a graduate student within the clinical psychology program or other health-related programs or through using the healthcare and mental healthcare services on campus. Many have
expressed the need for some changes within the university setting. For example, in the Psychology department, graduate students only receive one lecture about gender and sexual minority issues within a course that is about diversity. Yet, only a few steps away, the Office of Diversity and Inclusion offers free safe zone training. There is opportunity for collaboration with people from that office to develop trainings that could cater to the needs of the psychology department or other health-related programs within the university. In addition, the clinic also does not have access to safety when it comes to bathroom facilities. Perhaps there needs to be some reconsiderations to develop departmental policies that could protect someone from being harassed or discriminated against while using bathroom facilities.

**Conclusion**

Although more work is needed to change the landscape of the healthcare system within the city of Wichita, it is important to consider the positive aspects about this city. The community is very resilient and always looking out for one another. There is a sense of motivation to normalize the lives of these minorities. The surrounding university has been perceived as a safe space for many of these gender and sexual minorities which has been the source for healthcare utilization especially for those who are undergraduate and graduate students. It must also be recognized that many of these healthcare services are open and willing to change. The goal is to motivate their interests through support and expertise. It is vital to advocate to key stakeholders for healthcare inclusivity. In closing, here is a final quote from a sexual and gender minority individual who had the biggest impact and hit the hardest out of all the interviews.

“They'll ask you...well what's your, you know, religious identification, like in case something happens to you, you know, when you're under their care, like what is your...what are your demographics are basically so that they can get things appropriately, And I just think like if I die tomorrow, I want everybody to know I'm queer and I'm not going to like go hide and be like, oh no, that's my dirty little secret. that's who I am.”
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APPENDICES
Appendix A

Gender and Sexual Minority Interview Script

Facilitator:
Thank you for meeting with me for an interview. This is a research study designed to learn more about 1) your experiences with health and healthcare pertaining to your identity; and 2) to examine healthcare access within your community in Wichita, Kansas. This is a research study being conducted by Deborah Ojeda-Leitner (me), as principal investigator and Dr. Rhonda Lewis and community psychology doctoral students from Wichita State University, as co-investigators.

The overall goal of this research study is to learn more about gender and sexual minority healthcare. We want to see how Wichita’s healthcare facilities and academic medical institutions are addressing health disparities among gender and sexual minorities and if there are any barriers to inclusivity within healthcare.

You are invited to participate in this research study to share your experiences and input as a gender or sexual minority. Your insights will benefit healthcare facilities in Wichita, The Wichita LGBT Health Coalition, and the Human Rights Campaign. Your information will remain confidential. All participation is voluntary and participants in this research study are of consent age, 18+. You must be a transgender individual or a sexual minority woman (or both). In your packet, you will see a consent form. Signing the form, serves as your consent to be in the research study. Even if you decide to participate in this study, you may withdraw at any time. If you should decide not to participate, this will in no way affect your medical education.

There will also be interviews with about 8-12 residency students from different healthcare professions and 8-12 other healthcare administrators. In addition, we will be interviewing about 8-12 transgender individuals and sexual minority women to gain insights of their experiences. Each interview should last 90 minutes. Participants will complete a demographic questionnaire prior to the start of the interview, which should last 5 minutes. You may skip any question(s) you do not wish to answer. This interview will be recorded, all information gathered from this research study will be kept confidential by de-identifying all information so that no information collected can be identified by name to any person participating. The results of this study will be reported out in aggregate for all reports and research publications. At no time will your identity be revealed. Participation in this research study is voluntary. If you should decide not to participate, this will not affect your education at all.

If you have any questions regarding this study, please feel free to contact Deborah Ojeda-Leitner (me). Her (my email) is dxojeda@shockers.wichita.edu

Before we begin, please fill out this small demographic questionnaire that should take about 10 minutes.

Ready? Let’s begin!
I want to say thank you again for sharing your valuable insights.

Relationships and Community

1. What is it like to be a [Transgender individual or sexual minority woman] living in Wichita, Kansas?
   o **Probe:** Have there been any positive moments you want to share?
o **Probe:** Have there been any negative moments you want to share?

2. What does being part of a community mean to you?
   o **Probe:** Is there a community in Wichita, that you feel connection with? If so, can you describe the shared interests you have with this community?
   o **Probe:** How would you rate your connectedness with this community, from one being the poorest to ten being the best?
   o **Probe:** Have you felt a sense of belongingness among this community? How does that make you feel?
   o **Probe:** Are there any members of this community who shares the same experiences of gender identity and/or sexual orientation like yours?
   o **Probe:** Do you get advice from your community on where to go for healthcare or mental healthcare services, and how so?

3. What does social support look like to you?
   o **Probe:** What is your social support like? Do you have people you depend on for social support or in a time of need?
   o **Probe:** Can you describe a time where your social support helped you through a tough time?
   o **Probe:** Are there any people in your social support system who shares the same experiences of gender identity and/or sexual orientation like yours?
   o **Probe:** Do you get advice from your social support on where to go for healthcare or mental healthcare services, and how so?

**Experience in Discrimination**
Please turn to page 5 in your interview packet. On it is a table. Please check mark what is true for you. For example, you see the first one is “yourself”, we are asking if you have ever felt internalized discrimination against your gender identity or sexual orientation before, if you have, please make check mark on the box. Others include whether a family member has discriminated you, etc.

4. Besides health and mental healthcare service, do you want to share an account in where you been discriminated against?
   o **Probe:** Does your social support system play a role in providing support when you feel discriminated against and how so?
   o **Probe:** Does your community play a role in providing support when you feel discriminated against and how so?

**Healthcare experiences**
Next, we will talk about your experiences in receiving healthcare and mental healthcare services.

5. Can you share your past experiences in receiving healthcare services?
Probe: How are your experiences in the interactions with staff members in services, including the front desk? How about medical providers?

Probe: Have there been positive experiences, if so, how so?

Probe: Have there been negative experiences, if so, how so?

Next, you will be presented with vignettes about hypothetical healthcare facilities, these vignettes are in your information packet on page 4. Please turn to that page now. You will read the first vignette and I will ask you a few questions about the vignette. As you read each vignette, please think about how these cases relate to your experiences in healthcare and how these cases relate to them. Please describe what healthcare services within Wichita have done similarly and what haven’t they done.

Organizational Level

6. Have you’ve seen or heard of similar policies in the healthcare services within Wichita?
   o Probe: Does the policies include gender identity, sexual orientation, or both?
   o Probe: From the perspective of your services, are such policies a priority?
   o Probe: How have these policies been communicated to you clearly?
   o Probe: Are these policies helpful or not helpful, why or why not?

7. Have you’ve seen or heard of similar policies in the healthcare services within Wichita?
   o Probe: Does the policies include gender identity, sexual orientation, or both?
   o Probe: From the perspective of your healthcare services, are such policies a priority?
   o Probe: How have these policies been communicated to you clearly?
   o Probe: Are these policies helpful or not helpful, why, or why not?

8. Have you’ve seen similar practices in the healthcare services you’ve been to or heard of?
   o Probe: From the perspective of your services, are such practices a priority?
   o Probe: Are these practices helpful or not helpful, why, or why not?

9. Have you’ve seen similar strategies in any healthcare services within the city of Wichita?
   o Probe: Does the policies include gender identity, sexual orientation, or both?
   o Probe: From the perspective of Wichita’s healthcare services, are such strategies a priority?
   o Probe: Are these strategies helpful or not helpful, why or why not?
   o Probe: If there were any barriers such strategies, can you please describe them?

10. Have you’ve seen similar cases within Wichita’s healthcare services?
    o Probe: Have there been outside pressure related to gender and sexual minority health? Please describe such pressures.
    o Probe: Have there been pressure within healthcare services related to gender and sexual minority health? Please describe such pressures.
    o Probe: Are these type of healthcare services helpful or not helpful, why or why not
Structural Level

11. Have you seen or heard of healthcare services that provide such services within Wichita?
   - **Probe:** How have these services been communicated to you?
   - **Probe:** If there were any barriers to such services, can you please describe them?

12. Have you seen or heard of such bathroom facilities within healthcare services within Wichita?
   - **Probe:** How have the restrooms been communicated to you?
   - **Probe:** If there were any barriers to such restroom policies, can you please describe them?

13. Have you seen or heard of healthcare services within Wichita that have intake forms that are inclusive towards your identity?
   - **Probe:** Have you seen any mistakes before, if so how would you correct them?
   - **Probe:** If there were any barriers to such intake forms and electronic health records, can you please describe them?

14. Have you’ve seen or heard of healthcare services engaging with the gender and sexual minority community with Wichita? Can you describe one example?
   - **Probe:** If there were any barriers to engaging with the community, can you please describe them?

Clinical Level

15. Have you’ve seen or heard of healthcare services in within Wichita that have trained staff and medical providers to understand gender and sexual minority health?
   - **Probe:** From the perspective of healthcare services in Wichita, are such trainings a priority?
   - **Probe:** If there were any barriers to such trainings, can you please describe them?
   - **Probe:** How common or uncommon is it to share your sexual orientation and gender identity to a healthcare/mental health provider?
   - **Probe:** Can you share a time where you had to teach the provider?

16. Is there anything else you would like to share about what we talked about?

Thank you so much for sharing your insights. I appreciate your time for these difficult questions. The information we learned here today will help us better understand the barriers for healthcare inclusivity. This information will help us as we establish stronger relationships with healthcare facilities and people from the LGBT community. If you have any remaining questions you are free to contact Debbie Ojeda-Leitner (Me)
Thank you.

Interview/Script Medical Administrator

Facilitator:
Thank you for meeting with me for an interview. This is a research study designed to learn more about 1) your experiences with health and healthcare pertaining to gender and sexual minority inclusivity; and 2) to examine healthcare access within Wichita, Kansas. This is a research study being conducted by Deborah Ojeda-Leitner (me), as principal investigator and Dr. Rhonda Lewis as co-investigator.

The overall goal of this research study is to learn more about gender and sexual minority healthcare. We want to see how Wichita’s healthcare facilities and academic medical institutions are addressing health disparities among gender and sexual minorities and if there are any barriers to inclusivity within healthcare.

You are invited to participate in this research study to share your experiences and input as an administrator for healthcare organizations and services. Your insights will benefit healthcare facilities in Wichita, The Wichita LGBT Health Coalition, and the Human Rights Campaign. Your information will remain confidential. All participation is voluntary and participants in this research study are of consent age, 18+. You must be an administrator working for a healthcare organization or healthcare services. In your packet, you will see a consent form. Signing the form, serves as your consent to be in the research study. Even if you decide to participate in this study, you may withdraw at any time. If you should decide not to participate, this will in no way affect your medical education.

There will be interviews with about 8-12 residency students from different healthcare professions and 8-12 other healthcare administrators. In addition, we will be interviewing about 8-12 transgender individuals and sexual minority women to gain insights of their experiences. Each interview should last 90 minutes. Participants will complete a demographic questionnaire prior to the start of the interview, which should last 5 minutes. You may skip any question(s) you do not wish to answer. This interview will be recorded, all information gathered from this research study will be kept confidential by de-identifying all information so that no information collected can be identified by name to any person participating. The results of this study will be reported out in aggregate for all reports and research publications. At no time will your identity be revealed. Participation in this research study is voluntary. If you should decide not to participate, this will not affect your education at all.

If you have any questions regarding this study, please feel free to contact Deborah Ojeda-Leitner (me). Her (my email) is dxojeda@shockers.wichita.edu

Before we begin, please fill out this small demographic questionnaire that should take about 10 minutes.
Ready? Let’s begin!
I want to say thank you again for sharing your valuable insights.

Facilitator:
Do you have any questions before we begin?
First, I would like you to complete the demographic questions on the first and second page of the packet.
Please turn to the next page of your packet.
I AM NOW TURNING ON THE RECORDER; LET US BEGIN:

Let’s get started by describing who you are and what your role looks like in the healthcare organization you are representing.

Great!

Next, you will be presented with vignettes about hypothetical healthcare facilities, these vignettes are in your information packet on page 4. Please turn to that page now. You will read the first vignette and I will ask you a few questions about the vignette. As you read each vignette, please think about how these cases relate to your healthcare organization. I will ask you questions about how these cases relate to your experiences in the setting that you work in. Please describe what your workplace have done similarly and what haven’t your workplace have done.

Any questions?

Great! Let’s begin! (Note: not all probes will be asked, it just depends on their answers).

Organizational Level

1. Does this describe your organization? Why or why not? Please describe what policies your organization has implemented that protects gender and sexual minority patients.
   Probe: When has these policies been implemented?
   Probe: Does the policies include gender identity, sexual orientation, or both?
   Probe: From the perspective of the organization, are such policies a priority?
   Probe: How have these policies been communicated to patients and employees?
   Probe: If there were any barriers to implementing such policies, can you please describe them?

2. Does this describe your organization? Why or why not? Please describe what policies your organization has implemented that protects gender and sexual minority employees.
   Probe: When has these policies been implemented?
   Probe: Does the policies include gender identity, sexual orientation, or both?
   Probe: From the perspective of the organization, are such policies a priority?
   Probe: How have these policies been communicated to patients and employees?
   Probe: If there were any barriers to implementing such policies, can you please describe them?

3. Does this describe your organization? Why or why not? Please describe what practices has your organization implemented that supports gender and sexual minority employees.
   Probe: When has these practices been implemented?
   Probe: From the perspective of the organization, are such practices a priority?
Probe: If there were any barriers to implementing such practices, can you please describe them?

4. Does this describe your organization? Why or why not? Please describe what practices your organization has implemented that supports gender and sexual minority patients.  
   Probe: When has these strategic plans been implemented?
   Probe: From the perspective of the organization, are such strategies a priority?
   Probe: If there were any barriers to implementing such strategies, can you please describe them?

5. Does this describe your organization? Why or why not? Please describe whether your organization relates or not relate to such organizational history.  
   Probe: Has the organization changed since then and how so?  
   Probe: Have there been outside pressure related to gender and sexual minority health?  
   Please describe such pressures.  
   Probe: Have there been pressure internally related to gender and sexual minority health?  
   Please describe such pressures.

Structural Level

6. Does this describe your organization? Why or why not? Please describe such services your organization has implemented that caters to gender and sexual minority patients.  
   Probe: When has these services been implemented?  
   Probe: How have these services been communicated to patients and employees?  
   Probe: If there were any barriers to implementing such services, can you please describe them?

7. Does this describe your organization? Why or why not? Please describe the inclusivity in your organization’s restroom facilities.  
   a.  
   Probe: When has inclusive restrooms been implemented?  
   Probe: How have the restrooms been communicated to patients and employees?  
   Probe: If there were any barriers to implementing such restroom policies, can you please describe them?

8. Does this describe your organization? Why or why not? Please describe how your organization’s electronic health records and intake forms.  
   Probe: When has inclusive electronic health records and intake forms been implemented?  
   Probe: If there were any barriers to implementing such intake forms and electronic health records, can you please describe them?

9. Does this describe your organization? Why or why not? Please describe how your organization engages with the gender and sexual minority community.
Probe: Since when has the organization engaged with the gender and sexual minority community?
Probe: If there were any barriers to engaging with the community, can you please describe them?

Clinical Level

10. Does this describe your organization? Why or why not? If your organization requires or encourages employees and/or key senior executives to participate in gender and sexual minority patient-centered care trainings, please describe such initiatives.
   Probe: Since when did the organizations implement such trainings?
   Probe: How many hours of such training on average does the employees participate in? for key senior executives?
   Probe: From the perspective of the organization, are such trainings a priority?
   Probe: How have these training opportunities been communicated to and employees, how so?
   Probe: If there were any barriers to such trainings, can you please describe them?

11. How would you rate the staff’s confidence to assist patients from the LGBT community?
   a. How would you rate their awareness of the culture or the issues pertaining to LGBT health?
   b. Do you have specific examples you would like to share? (note: confidentiality)

12. How would you rate the providers’ confidence in providing services to patients from the LGBT community?
   c. How would you rate their awareness of the culture or issues pertaining to LGBT health?
   d. Do you have specific examples you would like to share? (note: confidentiality)

13. How would you rate the resident students’ (if you have them) confidence in providing services to patients from the LGBT community?
   e. How would you rate their awareness of the culture or issues pertaining to LGBT health?
   f. Do you have specific examples you would like to share? (note: confidentiality)

14. Is there anything else that you want to share about this topic, LGBT health?

Facilitator:
(Say at the close of the interview):
We have come to the end of this interview. I appreciate your time and responses to these difficult questions. The information we learned here today will help us better understand the barriers for healthcare inclusivity. This information will help us as we establish stronger
relationships with healthcare facilities. If you are interested in having your organization participate in the Human Rights Campaign’s Health Equality Index, please see me after the session. If you have any remaining questions you are free to contact Debbie Ojeda-Leitner (Me). Thank you.

Medical and PA Student Interview Script

Facilitator:
Thank you for meeting with me for an interview. This is a research study designed to learn more about 1) your experiences with health and healthcare pertaining to gender and sexual minority inclusivity; and 2) to examine healthcare access within Wichita, Kansas. This is a research study being conducted by Deborah Ojeda-Leitner (me), as principal investigator and Dr. Rhonda Lewis as co-investigator.

The overall goal of this research study is to learn more about gender and sexual minority healthcare. We want to see how Wichita’s healthcare facilities and academic medical institutions are addressing health disparities among gender and sexual minorities and if there are any barriers to inclusivity within healthcare.

You are invited to participate in this research study to share your experiences and input as a healthcare professional student in their residency. Your insights will benefit healthcare facilities in Wichita, The Wichita LGBT Health Coalition, and the Human Rights Campaign. Your information will remain confidential. All participation is voluntary and participants in this research study are of consent age, 18+. You must be a healthcare professional student in their residency. In your packet, you will see a consent form. Signing the form, serves as your consent to be in the research study. Even if you decide to participate in this study, you may withdraw at any time. If you should decide not to participate, this will in no way affect your medical education.

There will be interviews with about 8-12 residency students from different healthcare professions and 8-12 other healthcare administrators. In addition, we will be interviewing about 8-12 transgender individuals and sexual minority women to gain insights of their experiences. Each interview should last 90 minutes. Participants will complete a demographic questionnaire prior to the start of the interview, which should last 5 minutes. You may skip any question(s) you do not wish to answer. This interview will be recorded, all information gathered from this research study will be kept confidential by de-identifying all information so that no information collected can be identified by name to any person participating. The results of this study will be reported out in aggregate for all reports and research publications. At no time will your identity be revealed. Participation in this research study is voluntary. If you should decide not to participate, this will not affect your education at all.

If you have any questions regarding this study, please feel free to contact Deborah Ojeda-Leitner (me). Her (my email) is dxojeda@shockers.wichita.edu

Before we begin, please fill out this small demographic questionnaire that should take about 10 minutes.

Ready? Let’s begin!
I want to say thank you again for sharing your valuable insights.
Facilitator:
Do you have any questions before we begin?
First, I would like you to complete the demographic questions on the first to third pages of the packet.
Please turn to the next page of your packet.
I AM NOW TURNING ON THE RECORDER; LET US BEGIN:

Interview facilitator:
Let’s get started by describing who you are and what your experience have been like in your residency year. **Probe:** How many healthcare organizations have you worked with?

Great!

Next, you will be presented with vignettes about hypothetical healthcare facilities, these vignettes are in your information packet on page 4. Please turn to that page now. You will read the first vignette and I will ask you a few questions about the vignette. As you read each vignette, please think about how these cases relate to the healthcare settings you have worked in in your residency year. I will ask you questions about how these cases relate to your experiences in the settings you worked with. Please describe what your workplaces have done similarly and what haven’t your workplaces have done.

Any questions?

Great! Let’s begin! (Note: not all probes will be asked, it just depends on their answers).

**Organizational Level**

15. Does this describe the organization(s) where you practice your residency? Why or why not? Please describe such policies that protects gender and sexual minority patients.
   - **Probe:** Does the policies include gender identity, sexual orientation, or both?
   - **Probe:** From the perspective of the organization, are such policies a priority?
   - **Probe:** How have these policies been communicated to patients, employees, and resident students?
   - **Probe:** If there were any barriers to such policies, can you please describe them?

16. Does this describe the organization(s) where you practice your residency? Why or why not? Please describe such policies that protects gender and sexual minority employees.
   - **Probe:** Does the policies include gender identity, sexual orientation, or both?
   - **Probe:** From the perspective of the organization, are such policies a priority?
   - **Probe:** How have these policies been communicated to patients, employees, and resident students?
   - **Probe:** If there were any barriers to such policies, can you please describe them?
17. Does this describe the organization(s) where you practice your residency? Why or why not? Please describe such practices that supports gender and sexual minority employees.
   - **Probe:** From the perspective of the organization, are such practices a priority?
   - **Probe:** If there were any barriers to such practices, can you please describe them?

18. Does this describe the organization(s) where you practice your residency? Why or why not? Please describe what such practices that supports gender and sexual minority patients.
   - **Probe:** From the perspective of the organization, are such strategies a priority?
   - **Probe:** If there were any barriers such practices, can you please describe them?

19. Does this describe the organization(s) where you practice your residency? Why or why not? Please describe whether the organization(s) relates or not relate to such organizational history.
   - **Probe:** Has the organization changed since then and how so?
   - **Probe:** Have there been outside pressure related to gender and sexual minority health? Please
     - describe such pressures.
   - **Probe:** Have there been pressure internally related to gender and sexual minority health? Please
     describe such pressures.

**Structural Level**

20. Does this describe the organization(s) where you practice your residency? Why or why not? Please describe such services that caters to gender and sexual minority patients.
   - **Probe:** How have these services been communicated to patients and employees?
   - **Probe:** If there were any barriers to such services, can you please describe them?

21. Does this describe the organization(s) where you practice your residency? Why or why not? Please describe the inclusivity in the organization(s)’ restroom facilities.
   - **Probe:** How have the restrooms been communicated to patients and employees?
   - **Probe:** If there were any barriers to such restroom policies, can you please describe them?

22. Does this describe the organization(s) where you practice your residency? Why or why not? Please describe how the organization(s)’ electronic health records and intake forms.
   - **Probe:** If there were any barriers to such intake forms and electronic health records, can you please describe them?
23. Does this describe the organization(s) where you practice your residency? Why or why not? Please describe how your organization engages with the gender and sexual minority community.
   o **Probe:** If there were any barriers to engaging with the community, can you please describe them?

**Clinical Level**

24. If the organization(s) where you practice your residency requires or encourages employees and/or key senior executives to participate in gender and sexual minority patient-centered care trainings, please describe such initiatives.
   o **Probe:** How many hours of such training on average does the employees participate in? for key senior executives?
   o **Probe:** From the perspective of the organization, are such trainings a priority?
   o **Probe:** How have these training opportunities been communicated to and employees, how so?
   o **Probe:** If there were any barriers to such trainings, can you please describe them?

Great! Now I am going to ask you a few questions more specifically on your experiences in your healthcare and residency programs.

25. Is understanding gender identity and sexual orientation important to your medical residency practice? Why or why not?
   o **Probe:** As a medical provider, how would you rate your understanding on gender identity and sexual orientation?
   o **Probe:** How would you rate your ability in asking your patients about their sexual orientation or gender identity?
   o **Probe:** Has there been a time where a barrier has prohibited you from providing the best services for a patient that is part of the LGBT community? What happened? (Note: confidentiality)

26. Have you ever received any training or courses on LGBT health? How so?
   o **Probe:** Have you been exposed to this information about LGBT-related health disparities and healthcare needs? Where and in what format?
   o **Probe:** How would you rate your confidence in providing services to patients from the LGBT community?

27. Think back on your experiences in residency, how would you rate the staff’s confidence to assist patients from the LGBT community?
o **Probe:** How would you rate their awareness of the culture or the issues pertaining to LGBT health?

o **Probe:** Do you have specific examples you would like to share? (note: confidentiality)

28. Think back on your experiences in residency, how would you rate the providers’ you shadow confidence in providing services to patients from the LGBT community?

   o **Probe:** How would you rate their awareness of the culture or issues pertaining to LGBT health?

   o **Probe:** Do you have specific examples you would like to share? (note: confidentiality)

Facilitator:

(Say at the close of the interview):

We have come to the end of this interview. We appreciate your time responses to these difficult questions. The information we learned here today will help us better understand the barriers for healthcare inclusivity. This information will help us as we establish stronger relationships with healthcare facilities. If you have any remaining questions you are free to contact Debbie Ojeda-Leitner (Me)

Thank you.

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**Questionnaires/ Interview Packet**

**Sexual and Gender Minority Interview Packet**

Name: ______________________________________

Date: ______________________________________

**Demographics**

1. What is your gender identity? (check all that applies)
   - □ Male
   - □ Female
   - □ Transgender Male/ Trans man
   - □ Transgender Female/ Trans woman
   - □ Genderqueer
   - □ Other (please specify)
   - □ Decline to answer
2. What sex were you assigned at birth? (check one)
   □ Male
   □ Female
   □ Decline to answer

3. Sexual Orientation- do you consider to be:
   □ Heterosexual/ Straight
   □ Lesbian
   □ Gay (male)
   □ Asexual
   □ Bisexual
   □ Questioning
   □ Other (please specify) _____________
   □ Prefer not to answer

4. How would you describe your race? (check all that apply)
   □ American Indian/Alaskan Native
   □ Asian/ Asian American
   □ Black/African American
   □ Hispanic/Latino
   □ White/Caucasian
   □ Biracial
   □ Other (please specify)
   □ No answer

5. What is your age? _____________

6. What is your annual income?
   □ Less than $10,000
   □ $10,001 - $20,000
   □ $20,001 - $30,000
   □ $30,001 - $40,000
   □ $40,001 - or More
   □ I don't know
   □ No answer
   □

7. Are you a veteran or active duty military?
   □ Yes
   □ No
   □ No answer
8. Are you currently...
   - Single
   - Married
   - Divorced
   - Cohabiting
   - Widowed
   - Other: ____________________
   - No Answer

9. What is your religion?
   - No Religion
   - Christian (including the Church of England, Catholic, Protestant, and all other Christian denominations).
   - Buddhist
   - Hindu
   - Jewish
   - Muslim
   - Sikh
   - Other, please specify_________________

Healthcare Services History

Using the scale below, please respond to each of the following statements. There are no right or wrong answers. Do not spend too much time on any one statement and please be open and honest in your responses. If you feel uncomfortable answering a question, feel free to skip.

10. In general, you would say that your physical health is....
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

11. In general, you would say that your mental health is....
   - Excellent
   - Very Good
   - Good
   - Fair
12. The last time I saw a primary care doctor....
   - Within the past year
   - Two years ago
   - Three years ago
   - Five years ago
   - More than five years ago
   - Never

13. The last time I was sexual transmitted infection tested...
   - Within the past year
   - Two years ago
   - Three years ago
   - Five years ago
   - More than five years ago
   - Never

14. The last time I received other preventative services like pap smears, prostrate exams or breast examinations....
   - Within the past year
   - Two years ago
   - Three years ago
   - Five years ago
   - More than five years ago
   - Never

15. Last time I used emergency care service (i.e. the ER) ...
   - Within the past year
   - Two years ago
   - Three years ago
   - Five years ago
   - More than five years ago
   - Never

Health Professional Student Interview Packet

Name:___________________________________
Date:__________________________________
Demographics

16. What is your gender identity? (check all that applies)
   - Male
   - Female
   - Transgender Male/ Trans man
   - Transgender Female/ Trans woman
   - Genderqueer
   - Other (please specify)
   - Decline to answer

17. What sex were you assigned at birth? (check one)
   - Male
   - Female
   - Decline to answer

18. Sexual Orientation- do you consider to be:
   - Heterosexual/ Straight
   - Lesbian
   - Gay (male)
   - Asexual
   - Bisexual
   - Questioning
   - Other (please specify) ____________
   - Prefer not to answer

19. How would you describe your race? (check all that apply)
   - American Indian/Alaskan Native
   - Asian/ Asian American
   - Black/African American
   - Hispanic/Latino
   - White/Caucasian
   - Biracial
   - Other (please specify)
   - No answer

20. What is your age? ______________

21. What is your annual income?
   - Less than $10,000
   - $10,001 - $20,000
   - $20,001-$30,000
$30,001-$40,000
$40,001- or More
I don't know
No answer

22. Are you a veteran or active duty military?
Yes
No
No answer

23. Are you currently...
Single
Married
Divorced
Cohabiting
Widowed
Other__________
No Answer

24. What is your religion?
No Religion
Christian (including the Church of England, Catholic, Protestant, and all other Christian denominations).
Buddhist
Hindu
Jewish
Muslim
Sikh
Other, please specify_________________

25. What is your healthcare training?
Physician Assistant
Medical Doctor

26. Check the type(s) of setting(s) that you have experience working in.
Inpatient
Outpatient
Outpatient (multiple locations)
Other, please specify_______________
27. Check the type(s) of ownership of the healthcare setting(s) that you have experience working in.

- Religiously affiliated
- Other not-for-profits
- Investor, corporation
- Investor, partnership
- Investor, individual
- City
- City-county
- County
- State
- Hospital district or authority
- Federal, Veterans Health Administration
- Federal, Department of Justice
- Federal, other
- Other, please specify

---

**Medical Administrator Interview Packet**

Name: ________________________________
Date: ________________________________

**Demographics**

28. What is your gender identity? (check all that applies)

- Male
- Female
- Transgender Male/ Trans man
- Transgender Female/ Trans woman
- Genderqueer
- Other (please specify)
- Decline to answer

29. What sex were you assigned at birth? (check one)
☐ Male
☐ Female
☐ Decline to answer

30. Sexual Orientation- do you consider to be:
☐ Heterosexual/ Straight
☐ Lesbian
☐ Gay (male)
☐ Asexual
☐ Bisexual
☐ Questioning
☐ Other (please specify) _____________
☐ Prefer not to answer

31. How would you describe your race? (check all that apply)
☐ American Indian/Alaskan Native
☐ Asian/ Asian American
☐ Black/African American
☐ Hispanic/Latino
☐ White/Caucasian
☐ Biracial
☐ Other (please specify)
☐ No answer

32. What is your age? ______________

33. What is your annual income?
☐ Less than $10,000
☐ $10,001 - $20,000
☐ $20,001 - $30,000
☐ $30,001 - $40,000
☐ $40,001 - or More
☐ I don't know
☐ No answer
☐ 

34. Are you a veteran or active duty military?
☐ Yes
☐ No
☐ No answer

35. Are you currently...
☐ Single
☐ Married
☐ Divorced
☐ Cohabiting
☐ Widowed
☐ Other
☐ No Answer

36. What is your religion?
☐ No Religion
☐ Christian (including the Church of England, Catholic, Protestant, and all other Christian denominations).
☐ Buddhist
☐ Hindu
☐ Jewish
☐ Muslim
☐ Sikh
☐ Other, please specify_________________

37. What is the type of the setting that you represent?
☐ Inpatient
☐ Outpatient
☐ Outpatient (multiple locations)
☐ Other, please specify _________________

38. What is the ownership type of the healthcare setting that you represent?
☐ Religiously affiliated
☐ Other not-for-profits
☐ Investor, corporation
☐ Investor, partnership
☐ Investor, individual
☐ City
☐ City-county
☐ County
☐ State
☐ Hospital district or authority
☐ Federal, Veterans Health Administration
☐ Federal, Department of Justice
☐ Federal, other
☐ Other, please specify___________
Appendix B

HEI 2018 Rating System and Methodology

In 2015, the Healthcare Equality Index announced a change in its scoring mechanism. After nine years of promoting LGBTQ-inclusive care, the HEI showed great success in getting hospitals and other healthcare facilities across the nation to adopt the LGBTQ-inclusive policies included in the “Core Four” Leader Criteria. While having the policies from the Core Four in place are foundational, for healthcare facilities to provide truly inclusive LGBTQ patient-centered care, they must also adopt many of the policies and practices found in the Additional Best Practices section of the HEI survey.

Four new core objectives went into effect with the HEI 2017:

- **Ensure foundational protection** for patients, visitors and staff in patient and staff policies and provide cultural competency training on LGBTQ-inclusion
- **Demonstrate progress toward inclusion on LGBTQ patient care** and support
- **Cultivate an inclusive workforce by providing LGBTQ-inclusive employee support and benefits**
- **Demonstrate public commitment** to the LGBTQ community

### Criteria 1 – Non-Discrimination and Staff Training

This criteria encompasses what was previously considered the Core Four Leader Criteria.

**All questions in this section are scored and must be met in order to attain Leader status.**

<table>
<thead>
<tr>
<th>Patient Non-Discrimination</th>
<th>5 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. LGBTQ-inclusive Patient Non-Discrimination Policy</td>
<td>5 points</td>
</tr>
<tr>
<td>• Policy must include the terms “sexual orientation” and “gender identity and expression” (or “gender identity”)</td>
<td>5 points</td>
</tr>
<tr>
<td>b. Patient non-discrimination is communicated to patients and staff</td>
<td>5 points</td>
</tr>
<tr>
<td>• Policy is shared in two ways with the public, typically online and in-print</td>
<td>5 points</td>
</tr>
<tr>
<td>• Policy is shared with staff in at least one way.</td>
<td>5 points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equal Visitation</th>
<th>5 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Equal Visitation Policy</td>
<td>5 points</td>
</tr>
<tr>
<td>• Policy must allow the patient’s visitor of their choice</td>
<td>5 points</td>
</tr>
<tr>
<td>b. Equal Visitation Policy is communicated to patients and staff</td>
<td>5 points</td>
</tr>
<tr>
<td>• Policy is shared in two ways with the public, typically online and in-print</td>
<td>5 points</td>
</tr>
<tr>
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<td>5 points</td>
</tr>
</tbody>
</table>

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<tr>
<th>Employment Non-Discrimination</th>
<th>5 points</th>
</tr>
</thead>
<tbody>
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<td>a. LGBTQ-inclusive Employment Non-Discrimination Policy</td>
<td>5 points</td>
</tr>
<tr>
<td>• Policy must include the terms “sexual orientation” and “gender identity or expression” (or “gender identity”)</td>
<td>5 points</td>
</tr>
<tr>
<td>b. Employment Non-Discrimination Policy is shared with the public</td>
<td>5 points</td>
</tr>
<tr>
<td>• Policy is shared with the public in at least one way.</td>
<td>5 points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Training</th>
<th>5 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Training in LGBTQ Patient-Centered Care</td>
<td>5 points</td>
</tr>
<tr>
<td>• For first year facilities, key senior executives must complete the <em>LGBTQ Patient-Centered Care: An Executive Briefing</em> training provided by the HEI. OR</td>
<td>5 points</td>
</tr>
<tr>
<td>• Returning facilities must complete at least 25 hours of staff training in LGBTQ-related topics, either clinical or broader training</td>
<td>5 points</td>
</tr>
<tr>
<td>b. HEI training options promoted to staff</td>
<td>5 points</td>
</tr>
<tr>
<td>• Facilities must make training options available through the HEI known to staff throughout their facility.</td>
<td>5 points</td>
</tr>
</tbody>
</table>
The Ten Vignettes
Organizational Level

1. The Community Health Network implemented policies that protect gender and sexual minority patients within their outpatient and inpatient clinics. The organization changed their policies to include a gender and sexual minority non-discrimination policy, an equal visitation policy that allows visitors of the patient’s choice and a policy that informs patients of their right to designate a person of their choice so that same-sex partnerships are not excluded. These policies are clearly communicated to employees and patients.

2. To support their gender and sexual minority employees, The Family Heath Center of Springfield established non-discrimination policies for gender and sexual minority employees. They ensured to clearly communicate this policy to all employees and their patients. In addition to a nondiscrimination policy, they also improved their employment benefits to cater to their gender and sexual minority employees. These benefits include health insurance for same sex partners and that covers necessary gender transition-related treatment and equal bereavement leave in the event of the death of a same-sex partner. In addition, they have written gender transition guidelines that educates their employees and encourage support for gender transitioning employees.

3. Pella Regional Health Center (PRHC) conducted a diversity-related employee evaluation that asked for employee’s gender identity and sexual orientation. They found that they had a lack of gender and sexual minority employees and the few who specified that they are gender and sexual minorities indicated feeling “unwelcomed” within their work environment. To address this, PRHC made one of their priority to focus on hiring more gender and sexual minorities including opening high level visible leadership positions for gender and sexual minorities. In addition, they housed an officially recognized gender and sexual minority employee group, commemorating a “LGBTQA Holiday” at the facility. They also continued to employ surveys and anonymous surveys to assess their efforts to improve the workplace for gender and sexual minority employees.

4. The Waverly Health Center had their annual strategic planning retreat over the summer with the focus on inclusion and diversity. Since the board included gender and sexual minority diversity as part of the mission, the executive board applied reducing health disparities among gender and sexual minorities to the goals within their strategic plan. To address these health disparities, they implemented a diversity and inclusion office, an internal advisory committee that focused on gender and sexual minority patient care issues, access to external health resources available to gender and sexual minority patients, and printed materials that support gender and sexual minority patients. In addition, they have contracted an external LGBTQ-focused ombudsman.

5. The Fairview Community Health Center announced that they will be revoking gender and sexual minority practices and policies after a controversy surrounding one of their doctors who has been recommending conversion therapy to transgender patients. The organization itself has been advocating for public policies or regulations that would be detrimental to gender and sexual minority equality. The CEO often provides health charitable contributions, and public support to organizations whose primary mission includes advocacy against gender and sexual minority equality or care.
Structural Level

6. Taylor Rural Health just recently opened new healthcare services that specifically cater towards gender and sexual minority patients. These services include gender transition therapy, proper sexual health education based on sexual orientation, and patient navigators that provide patient navigation and advocacy services to gender and sexual minority patients.

7. At Morris Health Center, patients have easy access to gender neutral bathrooms. In addition, patients are ensured that gender minorities are protected to use a restroom of their choosing. The center has a no tolerance policy on harassing people in bathrooms.

8. Eastern Health Center had made data collection about their patients’ sexual orientation and gender identity a priority through their intake forms. Data is also collected through their electronic health records that offer options to capture patient’s current gender identity if it differs from the sex they were assigned at birth using a two-step process (i.e. first asking current gender identity and then asking sex assigned at birth), explicit options for capturing patient’s sexual orientation, explicit options for recording parents that are inclusive of same-sex parents and other diverse families, and options for recording relationship status with an un-married partner.

9. For years, St. Tammany Community Health Center has been engaging with the surrounding sexual and gender minority community. In fact, the executive board have been vocal in publicly supporting gender and sexual minority equality with policymakers at the city, state, and federal level. In the past they have hosted several gender and sexual minority related events like National Coming Out Day within their facility. They have also recently started a marketing campaign that targeted the gender and sexual minority community and have developed their own LGBTQ-specific logo. The quality improvement department have been conducting surveys to understanding the needs of gender and sexual minority patients. In addition, the organization has also collaborated with outside LGBTQ organizations and community members to assess gender and sexual minority needs or concerns through a community advisory board, and have been supporting gender and sexual minority health-related research with local universities.

Clinical Level

10. Key senior executives from Peak Vista Health Center went through several hours of gender and sexual minority patient-centered health training. Because they found the information helpful for their employees, they required their employees to take at least 25 hours’ worth of clinical or broader trainings about gender and sexual minority health. These trainings include health disparities, barriers, stigma, medical decision making for gender and sexual minorities and confidential patient information about their gender identity and sexual orientation.
Appendix C

What is it like to live in Wichita Kansas?

- Harassment/Discrimination
  - Public harassment
- Inauthentic “privilege”
  - Passing
  - Hiding identity
  - Fitting in
    - State level conservative influence
  - Out in only queer spaces
  - Double “identities”
- Safer in numbers
- Safer in University
- No parental support
  - Lack of generational passing of resources
- Justified discrimination
  - Giving people a pass
  - Need for representation/need for social cohesion of broader community

Community

- Defined as network with shared interests or experiences
- Yearn for community
- Isolation
- “Different” Community- outside of LGBT
  - Low connectedness/belongingness
  - Several types:
    - Based on Hobbies
    - Old friends
    - State University
    - Religious
  - No need for resources or lack of.
- LGBT based communities
  - High connectedness/belongingness
  - Safe Space
    - Vulnerability
    - Respect
    - Understanding
    - Shared experiences
    - Confidentiality
  - 3 types
    - Grassroots
    - Institutional
Online Resources

Types of Resource disseminating
- Gate keeper: Tweet
- Sharers: Retweet
- Self-Researchers

Types of resources
- Where to get tested
- Advice
- HRT-surgery
- Friendly providers
- Places to not go
- Providers to not go

Social Support

Types of Social Support
- Smaller clique from LGBT community
- Family Support
  - Adopted
  - Biological
- Core Group of Friends
  - Friends with benefits
- Romantic Relationships
- Pre-transition relationships

Online use
- Long distance
- Immediate communication with support

Healthcare Experiences

Negative
- To Educate/ invalidate
- Denial (refusal) of care
- Lack of Patient centered care
- “Sex Negative”
  - Sex-related stigma
- Non-disclosure
  - Gender Identity
  - Sexual orientation
- Heteronormativity
- Cisnormativity
- Delay in Care
- Double Stigma
- Religious Beliefs
- Hidden identities vs. Visual identities Vs double identities
  - Deadname
  - Misgender
  - Fear of Physician
  - Mistrust- doubt of healthcare+

- Positive
  - To educate/validate
  - Patient centered care
  - “sex positive”
  - Disclosure
    - Gender Identity
    - Sexual Orientation
  - Blatant oppression vs microaggressions

Basic Codes
- Helpful/Unhelpful
- Communicated/Not
- Perceived priority/ not
- SO/GI/ or both

Organizational (1-5)
- Barriers
  - State Politics
  - Federal Politics
  - Trump
  - Attitudes in Leadership
  - Progressive/Conservative
  - Money
  - Religious
  - Lack of funds, resources, time
  - Refuse to endorse
- Optimistic LGBT Health Future
- Perception of non-discrimination policy
  - GM/SM
- Fear, disclosing identities
- Increase health utilization
- Healthcare services
  - Non-profits vs. Corporate
  - Secular/ religious
  - Small vs. large
- Perceptions of the size of LGBT community
- Lack of data
• Attitudes towards LGBT
  o Positive
  o Negative
• Non-discrimination policies- employees
• Mismatched identification
  o Insurance/ state ID
• Employee benefits
• Healthcare coverage of partners
• Equal bereavement
• Guidelines of gender transition for employees
• Desire that is perceived unattainable
  o “that’s a fantasy”
• Employee Representation
• Marriage status
  o Polly erasure- excluding
  o Bi-erasure- excluding
• Perceived employer evaluation
• LGBTQ hiring
• Recognizing of housing
• LGBT Party
• Tokenizing
• Performative Allyship
• Work placement discrimination
• Safe Space
• Outing
• Millennials are open
• Older generation closed minded
• Institutional perceived benefits of ODI
• Perceived strategic plan
• Implementation of mission statements
• ODI
• Internal advisory committee
• Collaboration with external LGBTQ entity
• Experienced workplace discrimination
• Perception of conversion therapy in Wichita
• Experienced conversion therapy (friend or self)

**Structural (6-9)**
• Closeted ally- advocating secretly
• Internal phobia with marginalized
• Increased dysphoria
• Risk behaviors
• No tolerance for harassment in bathrooms- perceived
• Access to gender neutral bathroom/ no access
• Perception of no tolerance for harassment signs in bathroom
• Access to LGBTQ clinics (perception to the cater)
• Big vs. small
• Validation/not validation
• Two process
• Perception of inclusive intake form
• Perception of inclusive EMR
• Perception of outreach to LGBTQ community

Clinical (10)
• Perception existing/lack of training for exec members
• Perception/ lack of training employees

Minority Stress Model

Minority Stress (Distal- Prejudice events)
• Harassment/ Discrimination
  o Public harassment
  o Work placement discrimination
  o Experienced work place discrimination
  o Experienced conversion therapy (friend or self)
  o Blatant oppression vs microaggressions
• Negative Healthcare experiences
  o To Educate/ invalidate
  o Denial (refusal) of care
  o Lack of Patient centered care
  o “Sex Negative”
    • Sex-related stigma
  o Heteronormativity
  o Cisnormativity
  o Delay in Care
  o Double Stigma
  o Religious Beliefs
  o Tokening
  o Performative Allyship
• Invalidation of Identity
  o Deadname
  o Misgender
  o Polly erasure- excluding
  o Bi-erasure- excluding
Internal phobia within LGBT Community
Outing

**Minority Stress (Distal)**

- Concealment of Identity
  - Inauthentic “privilege”
  - Passing
  - Hiding identity
  - Fitting in
    - State level conservative influence
  - Out in only queer spaces
  - Double “identities”
  - Hidden identities vs. Visual identities Vs double identities
  - Non-disclosure in Healthcare
    - Gender Identity
    - Sexual orientation

- Expectation of Rejection
  - Fear
- Internalized phobias
  - Justified discrimination
  - Giving people a pass
    - Need for representation/need for social cohesion of broader community

- Desire that is perceivedly unattainable
  - “that’s a fantasy”

**Coping and Social Support**

- Community/ Social Support
  - High connectedness/belongingness
  - Low connectedness/belongingness
  - Safe Space
    - Vulnerability
    - Respect
    - Understanding
    - Shared experiences
    - Confidentiality
  - Yearn for community

- Individual
  - Optimistic LGBT Health Future
  - Risk behaviors

- Positive Healthcare Experiences
  - To educate/validate
  - Patient centered care
  - “sex positive”
Disclosure
- Gender Identity
- Sexual Orientation

Health outcomes/Mental Health Outcomes
- Isolation

Ecological Model

Individual
- Minority Identity- Gender identity/Sexual Orientation

Relationships/Close Social Support
- Types of Social Support
  - Smaller clique from LGBT community
  - Family Support
    - Adopted
    - Biological
  - Core Group of Friends
    - Friends with benefits
  - Romantic Relationships
    - Marriage status
  - Pre-transition relationships
- No parental support
  - lack of generational passing of resources
- Online use
  - Long distance
  - Immediate communication with support

Community
- “Different” Community- outside of LGBT
  - Low connectedness/belongingness
  - Several types:
    - Based on Hobbies
    - Old friends
    - State University
    - Religious
  - No need for resources or lack of.
- LGBT based communities
  - 3 types
• Grassroots
• Institutional
• Online

□ Resources
• Types of Resource disseminating
  o Gate keeper: Tweet
  o Sharers: Retweet
  o Self-Researchers
• Types of resources
  o Where to get tested
  o Advice
  o HRT-surgery
  o Friendly providers
  o Places to not go
  o Providers to not go
  o Increase health utilization
  o Safer in numbers
  o Safer in University
  o Perceptions of the size of LGBT community
    □ Lack of data

Institutions
• Healthcare services
  o Non-profits vs. Corporate
  o Secular/ religious
  o Small vs. large
• Institutional perceived benefits of ODI
• University Settings
• Barriers
  o Attitudes in Leadership
  o Money
  o Lack of funds, resources, time
  o Refuse to endorse
• Closeted ally- advocating secretly

Policies and Government
• Barriers
  o State Politics
  o Federal Politics
  o Trump
  o Progressive/Conservative
• Mismatched identification
  o Insurance/ state ID
Societal/ Culture
- Religious
- Millennials are open
- Older generation closed minded
- Attitudes of LGBT

Cultural Competence Model

Basic Codes
- Helpful/Unhelpful
- Communicated/Not
- Perceived priority/ not
- SO/GI/ or both

Organizational (1-5)
- Perception of non-discrimination policy
- Non-discrimination policies- employees
- Employee benefits
- Healthcare coverage of partners
- Equal bereavement
- Guidelines of gender transition for employees
- Employee Representation
- Perceived employer evaluation
- LGBTQ hiring
- Recognizing of housing
- LGBT Party
- Perceived strategic plan
- Implementation of mission statements
- ODI
- Internal advisory committee
- Collaboration with external LGBTQ entity
- Perception of conversion therapy in Wichita

Structural (6-9)
- No tolerance for harassment in bathrooms- perceived
- Access to gender neutral bathroom/ no access
- Perception of no tolerance for harassment signs in bathroom
- Access to LGBTQ clinics (perception to the cater)
- Two process
- Perception of inclusive intake form
• Perception of inclusive EMR
• Perception of outreach to LGBTQ community

Clinical (10)
• Perception existing/lack of training for exec members
• Perception/ lack of training employees

Minority Stress Model

Minority Stress (Distal- Prejudice events)
• Harassment/ Discrimination
  o Public harassment
  o Work placement discrimination
  o Experienced work place discrimination
  o Experienced conversion therapy (friend or self)
  o Blatant oppression vs microaggressions
• Negative Healthcare experiences
  o To Educate/ invalidate
  o Denial (refusal) of care
  o Lack of Patient centered care
  o “Sex Negative”
    • Sex-related stigma
  o Heteronormativity
  o Cisnormativity
  o Delay in Care
  o Double Stigma
  o Religious Beliefs
  o Tokenizing
  o Performative Allyship
• Invalidation of Identity
  o Deadname
  o Misgender
  o Polly erasure- excluding
  o Bi-erasure- excluding
• Internal phobia within LGBT Community
• Outing

Minority Stress (Distal)
• Concealment of Identity
  o Inauthentic “privilege”
  o Passing
  o Hiding identity
• Fitting in
  - State level conservative influence
• Out in only queer spaces
• Double “identities”
• Hidden identities vs. Visual identities Vs double identities
• Non-disclosure in Healthcare
  - Gender Identity
  - Sexual orientation

• Expectation of Rejection
  - Fear
• Internalized phobias
  - Justified discrimination
  - Giving people a pass
  - Need for representation/need for social cohesion of broader community
• Desire that is percievedly unattainable
  - “that’s a fantasy”

Coping and Social Support
• Community/ Social Support
  - High connectedness/belongingness
  - Low connectedness/belongingness
  - Safe Space
    - Vulnerability
    - Respect
    - Understanding
    - Shared experiences
    - Confidentiality
  - Yearn for community
• Individual
  - Optimistic LGBT Health Future
  - Risk behaviors
• Positive Healthcare Experiences
  - To educate/validate
  - Patient centered care
  - “sex positive”
  - Disclosure
    - Gender Identity
    - Sexual Orientation

Health outcomes/Mental Health Outcomes
• Isolation
Ecological Model

Individual
- Minority Identity- Gender identity/Sexual Orientation

Relationships/Close Social Support
- Types of Social Support
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    - Marriage status
  - Pre-transition relationships
- No parental support
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- Online use
  - Long distance
  - Immediate communication with support

Community
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    - Based on Hobbies
    - Old friends
    - State University
    - Religious
  - No need for resources or lack of.
- LGBT based communities
  - 3 types
    - Grassroots
    - Institutional
    - Online
  - Resources
    - Types of Resource disseminating
      - Gate keeper: Tweet
      - Sharers: Retweet
      - Self-Researchers
• Types of resources
  o Where to get tested
  o Advice
  o HRT-surgery
  o Friendly providers
  o Places to not go
  o Providers to not go
  o Increase health utilization
  o Safer in numbers
  o Safer in University
  o Perceptions of the size of LGBT community
    ▪ Lack of data

Institutions
• Healthcare services
  o Non-profits vs. Corporate
  o Secular/religious
  o Small vs. large
• Institutional perceived benefits of ODI
• University Settings
• Barriers
  o Attitudes in Leadership
  o Money
  o Lack of funds, resources, time
  o Refuse to endorse
• Closeted ally-advocating secretly

Policies and Government
• Barriers
  o State Politics
  o Federal Politics
  o Trump
  o Progressive/Conservative
• Mismatched identification
  o Insurance/State ID

Societal/Culture
• Religious
• Millennials are open
• Older generation closed minded
• Attitudes of LGBT
Cultural Competence Model

Basic Codes
- Helpful/Unhelpful
- Communicated/Not
- Perceived priority/not
- SO/GI/ or both

Organizational (1-5)
- Perception of non-discrimination policy
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- Employee Representation
- Perceived employer evaluation
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Structural (6-9)
- No tolerance for harassment in bathrooms- perceived
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- Two process
- Perception of inclusive intake form
- Perception of inclusive EMR
- Perception of outreach to LGBTQ community

Clinical (10)
- Perception existing/lack of training for exec members
- Perception/ lack of training employees
Appendix D

Sexual and Gender Minority Definitions

Minority Stress Model

Minority Stress (Distal- Prejudice events)

- **Theme: Harassment/ Discrimination:** Public harassment, Work placement discrimination, Experienced work place discrimination, Blatant oppression vs microaggressions and outing.
- **Theme Stigmatization of identity:** sex-related stigma, double stigma. Expression of stigma toward person’s identity, sexual activities, livelihood based on identity
- **Theme: Invalidation of Identity:** anything that mentions deadnaming, misgendering, poly erasure, bi erasure. Heteronormativity. Cisnormativity. Internal phobia within LGBT Community

Minority Stress (Distal)

- **Theme: Concealment of Identity:** Inauthentic “privilege”, Passing, Hiding identity, Fitting in and Out in only queer spaces. Double “identities’”- meaning only mentioning one identity. Hidden identities vs. Visual identities Vs double identities, and Non-disclosure in Healthcare.
- **Theme: Expectation of Rejection:** Fear of physician/ Institutional level, community level. Etc. Expectation of discrimination
- **Theme: Internalized phobias:** Internalized oppression. Dysphoria. Justifying discrimination Giving people a pass

Coping and Social Support

- **Community/ Social Support**
  - **Theme: Connectiveness/ belongingness:** High connectedness/belongingness (>5) Low connectedness/belongingness (5>)
  - **Theme: Safe Space:** Vulnerability, Respect, Understanding, Shared experiences, Confidentiality.
  - Yearn for community
- **Individual**
  - **Theme: Optimism:** optimistic of LGBT Health Future, any mentions of things getting better.
  - **Theme: Pessimism:** belief that things won’t change. Desire that is perceived unattainable- “that’s a fantasy”
  - **Theme: Risk behaviors**
  - **Theme: Health utilization**, delay in services, stop going to a healthcare service.

Health outcomes/Mental Health Outcomes

- **Theme: Isolation**
Ecological Model

Individual
  o Theme: **Minority Identity:** any mention of Gender identity/Sexual Orientation

Relationships/Close Social Support
  o Theme LGBT: relationships and communities based on shared minority Identities
  o Theme: Not LGBT: Friends, old friends, friends with benefits, shared different hobbies but not LGBT based.
  o Theme: **Family:** biological or adopted
  o Theme: **Romantic Relationships:** Partnerships- any mentions of marriage status

Community
  o Theme: **Work Space:** any mention of work
    o 3 levels of community
      • Theme: **Grassroots:** started by individuals
      • Theme: **Institutional:** Started by institutions (i.e. university)
      • Theme: **Online:** access of the internet for community/social support.
      • Theme **Types of Resource disseminating**
        o **Gate keeper:** Tweet- person who actively seeks resources.
        o **Sharers:** Retweet- doesn’t actively seek resources but receives them and also passes them along
        o **Self-Researchers:** Doesn’t receive resources but seeks information on their own for their own care- i.e. googling resources.
      • Types of resources
        o **Theme: Sharing Access to inclusive healthcare:** where to get tested, friendly providers, places to go. Where to get STD testing
        o **Theme: Sharing Advice:** general advice and health education.
  o Theme: **Safety:** Safer in numbers. Safer in University- feeling physically safe.
  o Theme: **Lack of data:** mention of perceived size of LGBT community. Not knowing how many there are or knowing how many there that aren’t perceived by the general public.

Institutions
  • Theme: “Fringe” Healthcare Services: mentioned of small, or non-profits.
  • Theme: **Corporate Healthcare services:** private healthcare entities, often large.
  • Theme: **University Settings:** any mention of any university entities, including medical academia and the office of diversity and inclusion.
  • Theme: **Lack of Institutional Resources:** Lack of funds, resources, time.
• Theme: Institutional refusal of Investment: Refuse to endorse.
• Theme: Closeted ally - advocating secretly

Policies and Government

- Theme: State Politics: any mention of state, local politics
- Theme: Federal Politics: any mention of federal politics
- Theme: Trump: any mention of the name trump or the president of the US
- Theme: Progressive/Conservative: any mention of loud minority, or blue vs red. Any mention of either politics
- Theme: Mismatched identification: mentions of gender identity and Insurance/ state ID.

Societal/ Culture

- Theme: Religious: Any mention of faithbased/ religion. Any religion
- Theme: Generational Culture: mentioned of Millennials are open and Older generation closed minded.
- Theme: Attitudes of LGBT: negative or positive attitudes towards LGBT
- Theme: Representation: Any mention of LGBT representation, whether it is lacking or not.

Cultural Competence Model

Basic Codes: Themes

- Theme: Helpful/Unhelpful: if mentioned if its beneficial or helpful or not.
- Theme: Communicated/Not: if it was clearly communicated or not
- Theme: Perceived priority/ not: if they think that healthcare services find it a priority or not

Organizational

- Theme: Perception of non-discrimination policy-Patients/lack of: Non-discrimination policy to protect patients
- Theme: Non-discrimination policies- employees/ lack of: Non-discrimination policy to protect patients
- Theme: Employee benefits/lack of: Healthcare coverage of partners, Equal bereavement, Guidelines of gender transition for employees
- Theme: Employee Representation/ lack of: LGBT Party, LGBTQ hiring, Perceived employer evaluation
- Theme: Internal diversity and inclusion entities/ lack of: ODI, Internal advisory committee
• Theme: Perception of conversion therapy in Wichita
• Theme: Experienced conversion therapy (friend or self)

Structural (6-9)
• Theme: Access to gender neutral bathroom/ no access
• Theme: Perception of no tolerance for harassment signs in bathroom
• Theme: Access to LGBTQ health services (perception to the cater)
• Theme: Perception of inclusive intake form and EMR: any mention of the Two step process. Etc.
• Theme: Perception of outreach to LGBTQ community- have seen healthcare services involved in pride events, marketing to LGBT, and engagement with the community. Collaboration with external LGBTQ entities.

Clinical (10)
• Theme: Perception existing/lack of training for exec members
• Theme: Perception/ lack of training employees: Having to educate professionals
• Theme: Patient centered care/ Lack of Patient centered care: any mention of where health professionals treated LGBT patients with respect. They are open minded on identity and behaviors like sexual activities.
• Theme: Disclosure of identity: any mention of sharing identity
• Theme: Denial of Healthcare: refusing healthcare due to identity, stigma
• Theme: Performative Allyship: Any fake disingenuous attempt to care about LGBT. Any tokenism mentioned.

Medical Administrators Definitions
• Theme: Minority Identity- any mention of Gender identity/Sexual Orientation
• Theme: Lack of data: mention of perceived size of LGBT community. Not knowing how many there are or knowing how many there that aren’t perceived by the general public.
• Theme: Small Healthcare Services: mentioned of small, or non-profits.
• Theme: Corporate Healthcare services: private healthcare entities, often large.
• Theme: University Settings: any mention of any university entities, including medical academia and the office of diversity and inclusion.
• Theme: Lack of Institutional Resources: Lack of funds, resources, time.
• Theme: Institutional refusal of Investment: Refuse to endorse.
• Theme: State Politics: any mention of state, local politics. If its politics in general, code it as state and not as federal.
• Theme: Federal Politics: any mention of federal politics
• Theme: Progressive/Conservative: any mention of loud minority, or blue vs red. Any mention of either politics
• Theme: Religious: Any mention of faithbased/ religion. Any religion
- **Theme: Generational Culture**: mentioned of Millennials are open and Older generation closed minded.
- **Theme: Attitudes of LGBT**: negative or positive attitudes towards LGBT
- **Theme: Unaware of Current Policies**: Medical Admin doesn’t remember certain policies
- **Theme: Lack of LGBT Awareness/Education**: code if mentioned if others (providers or students) are not aware or educated in LGBT health AND if the student themselves expressed being uninformed- i.e. not knowing what gender or sexual minority terms mean.
- **Theme: Denial of bias in Services**: code if they mention “we treat patients like patients” no matter what. Doesn’t think there is an issue even if there is no inclusivity structures in place. Also, any mention of if it doesn’t affect me, its not happening at all- even if they are talking about other people’s beliefs
- **Theme: Confidence**: whether they or others have the confidence to work with LGBT patients.
- **Theme: Insurance Coverage**: when insurance coverage is mentioned as a barrier.
- **Theme: Comfortable/ Uncomfortable Asking Identity**: Any mention of feeling comfortable or uncomfortable in asking patients about gender identity and sexual orientation. Also concerned about asking patients or future employees because they don’t want to offend or discriminate
- **Theme: No Exceptional Minority**: Doesn’t want to cater to one minority group over another.
- **Theme: HIPPA**: Any mention of HIPPA

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### Cultural Competence Model

#### Basic Codes: Themes

- **Theme: Necessary/Unnecessary**: if mentioned if its beneficial, important, or necessary or not.
- **Theme: Communicated/Not**: if it was clearly communicated or not
- **Theme: Perceived priority/ not**: if they think that healthcare services find it a priority or not
- **Theme: Students**: Any mention of other students
- **Theme: Providers**: Any mention of providers they work with
- **Theme: Leadership**: any mentioned of leadership/ executive board

#### Organizational

- **Theme: Perception of non-discrimination policy-Patients/lack of**: Non-discrimination policy to protect patients
- **Theme: Non-discrimination policies- employees/ lack of**: Non-discrimination policy to protect patients
- **Theme: Employee benefits/lack of**: Healthcare coverage of partners, Equal bereavement, Guidelines of gender transition for employees
- **Theme: Employee Representation/ lack of**: LGBT Party, LGBTQ hiring, Perceived employer evaluation
- **Theme: Perceived strategic plan/lack of**: Implementation of mission statements- targeting lowering health disparities.
- **Theme: Internal diversity and inclusion entities/ lack of**: ODI, Internal advisory committee
- **Theme: Perception of conversion** therapy in Wichita
- **Theme: Organizational Climate:** Any mention of the organization’s culture. i.e. like how open minded they are. etc.
- **Theme: No tolerance for Discrimination:** when administrator says they wouldn’t allow discrimination or anything against LGBT patients.

### Structural (6-9)

- **Theme: Access to gender neutral bathroom/ no access**
- **Theme: Perception of no tolerance for harassment signs in bathroom**
- **Theme: Access to LGBTQ health services** (perception to the cater)
- **Theme: Perception of inclusive intake form and EMR:** any mention of the Two step process. Etc.
- **Theme: Perception of outreach to LGBTQ community:** have seen healthcare services involved in pride events, marketing to LGBT, and engagement with the community. Collaboration with external LGBTQ entities.

### Clinical (10)

- **Theme: Perception existing/lack of training for exec members**
- **Theme: Perception/ lack of training employees:** Having to educate professionals
- **Theme: Patient centered care/ Lack of Patient centered care:** any mention of where health professionals treated LGBT patients with respect. They are open minded on identity and behaviors like sexual activities.
- **Theme: Denial of Healthcare:** refusing healthcare due to identity, stigma

### Students Definitions

- **Theme: Invalidation of Identity:** anything that mentions deadnaming, misgendering, poly erasure, bi erasure. Heteronormativity. Cisnormativity. Internal phobia within LGBT Community
- **Theme: Minority Identity:** any mention of Gender identity/Sexual Orientation
- **Theme: Lack of data:** mention of perceived size of LGBT community. Not knowing how many there are or knowing how many there that aren’t perceived by the general public.
- **Theme: small Healthcare Services:** mentioned of small, or non-profits.
- **Theme: Corporate Healthcare services:** private healthcare entities, often large.
- **Theme: University Settings:** any mention of any university entities, including medical academia and the office of diversity and inclusion.
- **Theme: Lack of Institutional Resources:** Lack of funds, resources, time.
- **Theme: Institutional refusal of Investment:** Refuse to endorse.

- **Theme: State Politics:** any mention of state, local politics. If its politics in general, code it as state and not as federal.
- **Theme: Federal Politics:** any mention of federal politics
• **Theme: Progressive/Conservative:** any mention of loud minority, or blue vs red. Any mention of either politics
• **Theme: Religious:** Any mention of faithbased/religion. Any religion
• **Theme: Generational Culture:** mentioned of Millennials are open and Older generation closed minded.
• **Theme: Attitudes of LGBT:** negative or positive attitudes towards LGBT
• **Theme: Unaware of Organizational Climate:** student doesn’t know the policies or the culture and views of LGBT in the healthcare organization whether they didn’t read it in the manual or it wasn’t communicated.
• **Theme: LGBT Medical education:** existing or lacking health education in medical/PA school.
• **Theme: Lack of LGBT Awareness/Education:** code if mentioned if others (providers or students) are not aware or educated in LGBT health AND if the student themselves expressed being uninformed- i.e. not knowing what gender or sexual minority terms mean.
• **Theme: Denial of bias in Services:** code if they mention “we treat patients like patients” no matter what. Doesn’t think there is an issue even if there is no inclusivity structures in place. Also any mention of if it doesn’t affect me, its not happening at all- even if they are talking about other people’s beliefs
• **Theme: Confidence:** whether they or others have the confidence to work with LGBT patients.
• **Theme: Location:** mentioning rural and non-rural settings.
• **Theme: Insurance Coverage:** when insurance coverage is mentioned as a barrier.
• **Theme: Comfortable/ Uncomfortable Asking Identity:** Any mention of feeling comfortable or uncomfortable in asking patients about gender identity and sexual orientation.
• **Theme: No Exceptional Minority:** Doesn’t want to cater to one minority group over another.

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**Cultural Competence Model**

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• **Theme: Perceived priority/ not:** if they think that healthcare services find it a priority or not
• **Theme: Students:** Any mention of other students
• **Theme: Providers:** Any mention of providers they work with
• **Theme: Hands on LGBT health experience:** Any mention of having LGBT health experience during clinical rotations or working with/shadow health providers.

**Organizational**

• **Theme: Perception of non-discrimination policy-Patients/lack of:** Non-discrimination policy to protect patients
• **Theme: Non-discrimination policies- employees/ lack of:** Non-discrimination policy to protect patients

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228
• Theme: Employee benefits/lack of: Healthcare coverage of partners, Equal bereavement, Guidelines of gender transition for employees
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