Per Ostmo: So now it is my pleasure to introduce our presenters and today we have three. First is Mariana Tuttle. She is a research fellow at the University of Minnesota Rural Health Research Center. She has contributed to research on rural health issues across the lifespan, from maternal and child health, to aging and older adults. Her research has also included work on sexual orientation and gender identity, living alone, access to care for rural residents and evaluation of rural health grant programs. Next we have Madeleine Pick. She is also a research fellow at the University of Minnesota Rural Health Research Center and the Flex Monitoring team. Her work is focused on quality of care and best practices in critical access hospitals and access to healthcare for rural residents. She has also contributed to work addressing needs of marginalized populations, including the health and wellbeing of rural LGBTQ+ residents and language interpreter services at critical access hospitals.

And third, we have Dr. Carrie Henning-Smith. She is an associate professor in the Division of Health Policy and Management at the University of Minnesota School of Public Health. She is also the deputy director of the University of Minnesota Rural Health Research Center and the University of Minnesota Rural Health Program. She is an associate editor at the Journal of Applied Gerontology and the Journal of Rural Mental Health, and the former chair of the Journal of Rural Health Editorial Board. Her work focuses on health equity for rural residents, with particular attention to older adults, marginalized populations, and social wellbeing. So now I'm going to hand things over to our presenters. Carrie, you're up first.

Carrie Henning-...: Thank you so much. Per, it's really an honor to be here with all of you today. I am delighted to be able to share about this important and exciting work that we have been doing and continue to be doing. So today is really just going to be a snapshot of some of the work that we've done in this project. We'll end the presentation by giving you an idea of where you can go to find more details on everything that we're talking about today. And I just want to say, stay tuned because we will continue to have some work coming out in this really important area. I'm going to start by acknowledging our incredible team who worked with us at the University of Minnesota Rural Health Research Center on this project. We had a great group of experts who did wonderful work on this project and continue to work on it. And then I want to acknowledge the funding and support that we get from the Federal Office of Rural Health Policy to do this work.

Here's a roadmap of where we're headed today. I'm going to start with just some basic background information to tee up why this work is so important. I'm then going to go through some of the secondary data analysis that we did on rural LGBTQ health. I'm then going to pass it on over to my colleagues, who will talk about the key informant interviews that we did, and case studies that we did and are continuing to work on. And finally, we expect to have plenty of time for discussion, so I hope that you will be thinking of questions as we go. You're also welcome to, as Per said, pop them into the chat and the Q&A as we move

along. We're really looking forward to hearing your thoughts on all of this too. I know there's a lot of wisdom and expertise in this virtual space together today.

So some background, because this is a rural health Gateway webinar, I know for sure that I'm preaching to the choir and I don't need to tell any of you this, but I still think it helps to frame this work in this way and to get everyone on the same page to start out. Rural residents tend to have poorer health outcomes and more limited access to care than urban residents. For instance, rural residents have higher mortality rates from the five leading causes of death and COVID-19 mortality rates have been higher in rural communities, significantly higher cumulatively over the course of the pandemic. Rural residents face many barriers to care, including hospital closures, higher rates of uninsurance, limited access to broadband internet, and greater travel distances. We could obviously spend the whole hour just talking about this, but again, I'm sure that I'm preaching to the choir and this is not new information for any of you.

Meanwhile, lesbian, gay, bisexual, transgender and queer and questioning or LGBTQ individuals, also experience disparities in health and healthcare. I want to pause here just for a second to say a note on terminology. We're going to be using LGBTQ or LGBTQ+ often throughout this presentation, but I want to acknowledge that that term is somewhat limited and evolving. This is a broad and diverse and heterogeneous community. We could also acknowledge two-spirit, intersex and other members of the community, but because the language that's often used in policy and research is LGBTQ, that's what we're going to be using today. And we'll try and be as specific as we can as we go through when we're talking about different groups and different populations.

Some of those health disparities in health and healthcare, include higher rates of psychological distress and mortality. There is a large body of literature showing this, giving empirical evidence for this and trying to explain some of the reasons why, which often land on being under-resourced, stigmatized, discriminated against and experiencing minority stress. LGBTQ individuals also face barriers to high quality healthcare, and those include homophobic and transphobic environments and policies. So we have these two different bodies of research, both of which are robust and provide a lot of empirical evidence for issues that we need to be concerned about in health equity for rural residents and for LGBTQ individuals.

Despite those two big bodies of research, the research on the intersection between them is somewhat limited. There is not all that much research looking at health and healthcare at the intersection of rurality, sexual orientation and gender identity. And that's where this study comes in, we sought to address that gap and to add to the small body of research that was out there, by examining rural differences in health, bisexual orientation and gender identity, unique challenges and opportunities for rural LGBTQ health and exemplar case studies to address LGBTQ health.

I want to just note the trajectory of where this presentation is going. I'm going to be talking about a lot of inequities and a lot of disparities, it's going to feel a little bit like a doom and gloom story, but we're going to end with some positive examples and case studies where there is really incredible and good work going on. There is so much strength among rural residents and so much strength among LGBTQ individuals and we certainly do not want to make this a deficits only presentation. We want to highlight that strength. We want to highlight creativity and innovation that's happening in this area. So I'm going to be talking a lot about inequities, but we'll end hearing a lot of good news stories.

So as promised, I'm going to walk us through some of the secondary data analysis that we've done for this project. We used multiple national surveys in our work, this is just an example of some of the surveys that we've used, the BRFSS, Behavioral Risk Factor Surveillance System, the National Health Interview Survey, and the Health Information and Trends Survey. We found and identified data sets based on those that include information on sexual orientation, sometimes on gender identity, that's more limited and on rurality or some measure of geographic location. Having those parameters, needing to be able to see both rurality and LGBTQ identification in the data, limited us somewhat. There are lots and lots of national data sources out there that don't provide one or the other of those, but these are three data sources that include both rurality and sexual orientation. In the case of the BRFSS, it also includes gender identity, so we were able to do national secondary data analysis with those surveys.

Using those, we identified differences in health and access to care along a variety of measures. We conducted a variety of analyses using survey weights to estimate nationally representative estimates. I'm going to be sharing just a few examples of some of our findings from this, but as I said, at the end of the presentation, we will point you toward where you can find resources with more detail and all of these findings in their published form if you want to refer to them.

First of all, I'm going to talk about differences in self-rated health, by sexual orientation and morality. I mentioned that gender identity is not available in a lot of national surveys and that includes the National Health Interview Survey. So we can't say anything about transgender populations or non-binary populations here, but we can say something about whether people identify as lesbian, gay, or bisexual, versus identifying as heterosexual. We can also see those same measures in the BRFSS, and we wanted to see how these two really giant national surveys compared when looking at self-rated health. Self-rated health is such a standard measure that we use in public health and it's been empirically linked to mortality and other health outcomes, so it's an important signal about how people are doing and how they feel about their own health. What we found is that in both surveys, there was some slight difference, but the poorest self-rated health was among rural LGB individuals, lesbian, gay, and bisexual individuals.

We also found that if we look among rural only, those differences became even more pronounced. This is comparing at the top, rural only and on the bottom, urban only for stratified analyses, and we found that the groups that were most likely to report having fair or poor health were rural, lesbian, gay and bisexual individuals. In the BRFSS, a quarter of rural, lesbian, gay and bisexual individuals said that they had fair or poor health. That's compared with less than 20% of rural heterosexual individuals and about 20% and 16% of urban individuals respectively. The same story bore out in the National Health Interview Survey, although even more extremely, we found that more than 30% of lesbian, gay, and bisexual rural individuals reported having fair or poor health in the NHIS, compared with less than 20% of rural heterosexual individuals and less than 15% of urban individuals of any sexual orientation.

Next, we used the National Health Interview Survey to look at differences in rates of chronic condition diagnoses by rurality and sexual orientation. There are a lot of numbers on this screen, I'm not going to walk us through all of them. As I said, you can find all of these results in a published policy brief if you would like to dig into them in a little more detail, but I will walk us through a few of these results. On the very left-hand side is a list of all of the different chronic condition diagnoses that we looked at. The question in the National Health Interview Survey asks people if they've had a healthcare provider tell them that they have any of these diagnoses. And then the first three columns after that, look at differences among rural individuals by sexual orientation. The last three columns look at differences among urban individuals, by sexual orientation.

Worth noting in both rural and urban populations, we see incredible inequities between lesbian, gay and bisexual individuals and heterosexual individuals, with LGB individuals reporting higher rates of chronic condition diagnoses along almost every measure. And some of those rates are especially pronounced among rural LGB individuals. We found that nearly 44% of rural, lesbian, gay, and bisexual individuals reported having been diagnosed with anxiety, compared with less than 17% of rural heterosexual individuals. 54% of rural, lesbian and gay and bisexual individuals reported having been diagnosed with depression, compared with fewer than 18% of rural heterosexual individuals. The inequities go on and on, you can see them in this slide and in the published policy brief that you can find on the Gateway that we'll reference at the end of this presentation.

In looking at chronic conditions, it was important to us not only to look at individual diagnoses of specific conditions, but also to try to understand the cumulative impact because we know that having comorbid conditions is associated with really significant challenges in accessing care and in the type of care and intensity of care that someone needs, as well as associated with quality of life and ultimate health outcomes. So here we compared urban and rural by sexual orientation, so our four different groups here again, and we look to see the number of chronic condition diagnoses that people reported. Zero in that light blue, one chronic condition in that kind of royal blue, two, chronic conditions in the white, and three or more chronic condition diagnoses in the

black. The group most likely to have three or more chronic condition diagnoses was rural, lesbian, gay and bisexual individuals, where more than 40% of them had three are more chronic condition diagnoses. The group least likely to have three or more chronic condition diagnoses and most likely to have zero chronic condition diagnoses were urban heterosexual individuals.

We also looked to see differences in social wellbeing. We know that social connectedness, social wellbeing is such a vitally important measure of health and of how people are feeling. It's also associated with mortality and with a variety of other health outcomes. If people are not feeling socially supported and socially connected, it has implications for a number of health outcomes, mortality, high blood pressure, cognitive impairment, immune functioning, and on and on and on.

This is also from the National Health Interview Survey and people were asked how much they feel like they receive the social support that they need. They could say anything between always and never. And here we found the lowest rates of social support among rural LGB individuals, they were the most likely to say, or the least likely, I'm sorry, to say that they always get the social support that they need, at less than a third of rural LGB individuals saying that they get the social support they need. Rural heterosexual individuals were the most likely to say that they always get the social support that they need at more than 55%. Clearly there is something happening related to social support and social wellbeing, along the lines of sexual orientation even among rural residents.

We also looked, with the National Health Interview Survey, to see how people reported whether their levels of social support had changed during COVID. This was an interesting supplement that was added to the NHIS during COVID, and it asked people how much they felt like their social support had changed over the past 12 months, over the period, the first 12 months or so that COVID had come into our lives. And people were asked, do you feel like you have more social support now, about the same or less social support? And here we found that rural LGB individuals were the most likely, with nearly a quarter of them to say that they have less social support than they had before the pandemic. Again, these findings are available in a brief that we did just on social wellbeing by sexual orientation and rurality, and you can find that on the Gateway.

Next, I'm going to go through some findings, looking specifically at mental health, when I was going through the rates of chronic conditions, I highlighted the rates of depression and anxiety that were so startlingly high among rural LGB individuals. We knew that we couldn't leave it at that and we wanted to be able to dig into this in a little more detail. And so we wrote a policy brief specifically looking at diagnoses of depression and anxiety. Here this chart shows the rates at which people say they've not been diagnosed with either depression or anxiety, that they've been diagnosed with depression only, with anxiety disorder only, or with both depression and anxiety disorder.

It won't surprise you, based on the findings that we already went over, that rural LGB individuals were the most likely to say that they've been diagnosed with both depression and anxiety disorder, at nearly 40%, and they were the least likely to have no diagnosis of either condition. In the NHIS, people are also asked if they're feeling depressed, what level of depressed feelings do they have the last time they had an episode of feeling depressed. They could say that they felt a little depressed, between a little and a lot and a lot. And again, we find the worst inequities and the highest rates of depressed feelings among rural LGB individuals. Second highest is urban LGB individuals. And rural and urban heterosexual individuals look very similar in their levels of depressed feelings.

We know that having a diagnosis of depression or anxiety disorder means that it's incredibly important that people have access to timely, affordable, and high quality care. That might include medications, that might include other sorts of mental health care, and it includes access to a usual source of care like a primary care provider. So we looked at those different measures, whether people said that they had a usual source of care, whether people said that they needed but could not afford medication in the past 12 months, and whether people delayed mental healthcare because of cost in the past 12 months. There is a lot on this slide too, and so I won't go through every last number, but let me just say in short, that what we found are that rural LGB individuals, especially those who had been diagnosed with both depression and anxiety disorder, reported the biggest barriers to care. For instance, 25.5, more than a quarter, 25.5% of rural LGB individuals with depression and anxiety disorder diagnoses, said that they had delayed mental healthcare because of cost in the past 12 months.

Moving on to the next slide. Oh, highlighting those there. I'm going to briefly touch on some work that is in process. So this is not something that we've published yet, but we are working on publishing, so this is a sneak peek for all of you. This is looking at differences in access to care for transgender and gender nonconforming adults, using data from the BRFSS. Again, I said that the National Health Interview survey does not have measures of gender identity, but the BRFSS does. And so here we were able to look at morality and gender identity and compare differences in access to care across a variety of measures, which was really exciting.

What we found was that across all respondents, rural and urban together, transgender or gender nonconforming individuals were more likely to report all types of access measures, that they couldn't see a doctor due to cost, that they were less likely to say they have any health insurance coverage, they were less likely to say they have a doctor or healthcare provider, and they were less likely to say that they had a checkup in the last year, compared with cisgender respondents. When we look only by rural respondents or by urban respondents, we find that the rates of inequities stay consistent, but because of relatively small sample sizes, we only picked up on statistically significant differences for rural transgender respondents, in the measure of whether or not they could see a doctor due to cost, where transgender rural respondents were nearly twice as

likely as their cisgender rural counterparts to say that cost was a barrier to seeing a doctor. Next, I'm going to pass it off to my colleague Mariana Tuttle, who's going to share information on the key informant interviews that we did.

Per Ostmo: Thank you, Carrie. This is a good moment to pause and answer a couple questions that are in the Q&A. So we touched on this briefly, but the first question is for the survey results, did you look at prior years? I'm curious to see if COVID made the numbers worse. And I know that it was the year 2019 and 2020, was there anything prior to that?

Carrie Henning-...: It's a really, really good question. We didn't, most of the work that we did was using 2019 or 2020 data. In some cases we only used the 2020 data. And this is largely because of data limitations that we have, in the public files of the NHIS, rurality has only been released for the past few years. It's really new, so we were able to get that with 2019, but we're not able to really go back in time on rurality. And sexual orientation itself is a relatively new entrée into the NHIS, it was added in 2013, so you certainly could go back and look at how that's changed over time, but to be able to see rurality there, you would need to go into an RDC and do work with the restricted data.

Per Ostmo: Thank you, Carrie. The next question is, I see lower statistics for rural LGBTQ+ folks with heart disease, cholesterol and other similar physical ailments, than heterosexual folks. Was it cross analyzed with provider healthcare access?

Carrie Henning-...: No, it's a great question and I think there, as I said, the work that we did here is really just scratching the surface of the work that can and should be done in this space. I think that there's also something happening there by age. Some of the rural LGB respondents were younger on whole, than the rural heterosexual respondents, and so I think some of that is playing out in our rates of chronic conditions. And that's really a next important step to do some of this and age adjust for it and also to cross compare with access to care measures. There's a lot of good next steps and I hope that others on the webinar are excited to take some of those up too, there's so much important work to be done here.

Per Ostmo: Thank you. The next question, maybe we want to circle back to this one, but I'm going to present it. What public education campaigns, in addition to this webinar, do rural LGBTQIA2S+ affinity groups or organizations do to support persons from similar backgrounds? And if we want to save this to the end, we can do that.

Carrie Henning-...: Yeah, I might save it, only because I think that that is going to feel really relevant to the work that we're going to talk about with the key informant interviews and the case studies, where we're going to get to highlight some of the work of incredible organizations that focus specifically on rural LGBTQ populations.

Per Ostmo: All right. Two more questions and then we're going to move on here.

Carrie Henning-...: Okay.

Per Ostmo: When might the analysis of transgender care access be put out?

Carrie Henning-...: Oh, your guess is as good as mine. It's been under review at a journal for a few months now and we are waiting eagerly to get our reviewer comments from that so that we can get it published. We recognize the urgency there and we are doing some other work. We have a policy brief that will be finalized soon and this will be published sooner than those other results I showed, that looks at differences in familial support by gender identity and rurality. And so it's a different dimension of health certainly, than the access to care measures I showed, but is looking specifically at the health and wellbeing of rural transgender individuals. So stay tuned for that, I expect that to be out within the next month or two.

Per Ostmo: All right, and we're going to do one more question and then move on to our next presenter. So did you include any variables to account for states with laws and policies that prohibit health insurance discrimination by gender identity, sexual orientation or both, or state laws allowing insurers to reviews gender affirming care?

Carrie Henning-...: Not in these analyses, and that's another really important question. We're going to show you at the very end, a commentary that we did, where we talked more directly about state laws and differences by state. It's really a moving target in such an important area, especially when it comes to transgender health and access to gender affirming care. In the work that we did, we were somewhat limited by both access to data on the NHIS, we can't see state on the public files and need to go into the RDC to be able to see state there. And in the BRFSS, it could be done, but you end up with relatively small samples and it gets to be a little bit dicey to slice people into small sample cell sizes. But I think an important next step and one I would love to see someone do.

Per Ostmo: All right, perfect. We can move ahead with our next presenter.

Mariana Tuttle: Great. Thanks, Carrie. And thanks everyone for the wonderful questions. So whenever we can, we like to compliment our quantitative data analysis with some qualitative components. Data obviously tells quite a bit of a story, but it's different to actually speak to real humans doing this work. So there are a couple of pieces that we'll go through in the qualitative side of things today, and we'll start with key informant interviews. And for those, we spoke with 14 individuals from organizations located across the US, with largely national foci on LGBTQ issues. They included organizations dedicated to support, education, capacity building, direct service provision and work in communities. And some organizations are involved specifically in physical or mental health services and all were able to speak to how their work related to health and wellbeing and rural LGBTQ individuals. None of the organizations completely focused on rural individuals, but all noted the importance of including rural individuals and rural communities in their work.

Next slide please. We will look at the challenges here. And among our key informants, the top two challenges that were noted by the respondents, were the lack of resources and challenges with cultural competency in rural communities. The top one, lack of resources, mostly related to the lack of resources to support LGBTQ individuals in rural communities, sort of broadly, especially when compared to the breadth of resources that are available in more urban communities. And it also included kind of general responses about lack of resources in rural communities, including lack of broadband, transportation, housing, as well as lack of resources for providers and higher joblessness in rural areas. And cultural competency encompasses the challenges that are faced in rural communities due to a lack of cultural competency often experienced in rural communities with providers, healthcare providers. Respondents were noting concerns with providers not having up-to-date information for treating LGBTQ patients, or who may not be a affirming providers. And they specifically called out a lack of knowledge for the care of transgender and gender diverse or gender nonconforming individuals in rural areas.

Other prominent themes were attitudes, which included the fear from LGBTQ+ folks, as well as stigma and discrimination and targeting of LGBTQ individuals, that negatively impacted their health and wellbeing. And access, which referred to some of the general lack of access concerns felt in rural areas, difficulties accessing care, lack of providers, high costs and delaying care. Next slide. I just wanted to share a couple of key informant sort of illustrative quotes that really highlighted the top two themes. The top one there speaks to lack of resources and the quote underneath references challenges with cultural competency, and I'll read them here today, so just we're all on the same page.

The top one, "There are just fewer resources available to rural areas. When we think about being a minority within an already underserved rural area, it compounds barriers that people experience. From a health and mental health perspective, there's a lack of LGBT open and affirming providers within more rural settings." And regarding cultural competency, "If there's discrimination or lack of cultural competency at the doctor, there may be no alternative in town. Discrimination is not uniquely rural, but when it happens in rural areas, the impact is much more profound." And moving on here for recommendations for policy changes, we asked key informants about what they would do to improve, what policies would they suggest to improve physical and mental health and wellbeing for rural communities. And the top two themes that emerged were for policies related to non-discrimination and for policies to improve education. And non-discrimination was most often the first recommendation from participants, and that essentially focused on improving non-discrimination laws and other protections for LGBTQ+ folks, both individuals, both federally and on state and local levels.

This also included specific recommendations for assuring the implementation of existing non-discrimination and harassment policies, as well as addressing these outside of healthcare, in schools, in housing and jobs, et cetera. And in terms of

education, the focus of those policies was to improve and to mandate training for providers and healthcare staff, to focus on how best to provide care for LGBTQ patients, whether that's through medical school, through on-the-job training or continuing education. I think also noted a need to increase awareness in rural communities about LGBTQ individuals in their community and to promote diversity within the community. And a couple of other themes included funding and resources and access, which focused really on telehealth as an essential provider for rural patients, to ensure their ability to access affirming providers if there weren't any in their rural areas. And data, just stressing the importance of collecting sexual orientation and gender identity data.

So next slide please. I wanted to close our section on key informant interviews by sharing this quote. I think it highlights an attitude that is all too prevalent, especially among non-rural folks working in the LGBTQ+ space. So I'll read it and then ... "There's a problematic assumption among many people that if you're LGBTQIA+, you'd want to move to urban areas, but many people would prefer to remain in their rural communities, but just need access to services there." And the reality is that LGBTQ+ people shouldn't have to leave their home to be seen and accepted and included and celebrated for who they are. Rural spaces are becoming increasingly more diverse and more vibrant places to live, as people are welcomed as their full selves into small towns and rural communities across the country. I think that's really a win-win.

And I also think this quote provides a bit of a segue into the second half of our qualitative work, which is focused on our case studies. So the goal of these case studies was to highlight rural organizations or programs which are embracing LGBTQ individuals and actively working to support their health and wellbeing in the rural communities. For these case studies, we spoke with 13 individuals, which translated into four different case study series, which are just groupings of similarly themed case studies. So we had a series on inclusive healthcare, on nonprofit community centers, on youth and family supports, and on small town pride celebrations. But for the purposes of time today here, I'll just share briefly about the first one, on inclusive healthcare, and then my colleague Madeleine will share on supporting youth. So this first case study is on improving access to LGBTQ+ friendly care in rural areas and we looked at two different organizations who are doing that kind of work.

They're operating at two different levels, one's a national level and one is a state or commonwealth, in this case, level organization, to do the same kind of work. So the Pride of Rural Virginia is a great-funded initiative of the Virginia Rural Health Association. And the program began with an assessment in the form of something called community chats or community conversations. There were conversations that VRHA hosted all across the commonwealth of Virginia, inviting individuals that identify as LGBTQIA+, which is their terminology that they use, or as an ally or advocate in the community, as well as healthcare providers to come together and to brainstorm how to improve healthcare access quality of healthcare and resources for the LGBTQ+ community in their

rural areas. And out of these chats came the realization that there was a need for holistic LGBTQ+ cultural sensitivity, cultural competency, cultural wellness training for rural healthcare providers and clinic staff.

And they've been finalizing the development of the curriculum and hoping to begin delivering it across Virginia in the coming months. As an organization. VRHA is uniquely positioned in that they are rurally focused, rather than being LGBTQ+ centric, in some ways that could help them have the clout that might bring hospitals and healthcare clinics across rural Virginia to want to opt into this training. So we will stay tuned and are excited to get updates as we have some. And another example, so I'll go on to the next slide here, is an organization working to improve inclusive healthcare access on the national level and specific with transgender and gender diverse folks, is called Rural TransECHO. This is a program that's run through a large national organization called the National LGBTQIA+ Health Education Center, it's run out of the Fenway Institute. But it's rural focused and it's specifically trans health focused, and their goal is to improve access to affirming healthcare for transgender and gender diverse individuals in rural areas.

It's a brand new-ish initiative, I say brand new, but it was a year ago, so I guess time flies, and started in January of 2022. Their initial cohort of 80 participants came from 11 rural healthcare centers, across nine different states, and the participants received a totally virtual training on a monthly basis and they're grouped together in the cohort for additional peer support, as well as support from the educators at the Fenway Institute. And one thing that both Pride of Rural Virginia and Rural TransECHO organizations and respondents noted, was that it was really, really important to have representation from all clinic staff, or staff at all clinic levels, not just clinician providers, not just healthcare workers. Those who work at the front desk, in janitorial positions, folks who staff all kinds of elements across the healthcare clinic are all equally part of the experience that the LGBTQ+ person or patient has while visiting the clinic. And that wraps up our case study on improving access to care and I will turn it over to my colleague, Madeleine, to share about organizations supporting rural LGBTQ+ youth.

Madeleine Pick: Thanks, Mariana. So this is a little bit of a preview of a case series that's going to be coming out soon. As Mariana said, we have four cases in this series, I'm just going to be talking about two of them as a little preview. And these kind of fall into this broad definition of health that includes talking about inclusion and social support as key contributors to health. And these case studies also provide really key resources to help youth and young adults access affirming care and support them through that process. So just wanted to kind of make that quick connection back to how this fits into kind of the bigger picture of health. The first case study I'm going to talk about is called STARS, and this is at Lakeview High School in Cottonwood, Minnesota. STARS is an acronym that stands for safe, trust, acceptance, respect and support.

So this is a high school club, often these are called GSAs, which used to stand for Gay Straight Alliance, now more commonly used, Gender Spectrum Alliance. They use different acronyms. So anyway, they call themselves STARS for those different values. Their goals are to support LGBTQ+ students and staff, and to provide education for the school and community. They are a relatively new club, they started in 2021, when a student had asked the staff member that we spoke with, to be an advisor for the group. And so they're still kind of focusing on helping students feel comfortable, getting to know each other and kind of decide where they want this group to go. But they've had a lot of really cool successes so far. One of these includes this green star sticker that I have a picture of here.

And so teachers and staff are welcome to place these on their classroom doors or on their name tags, to kind of indicate to others that they are a safe person to go to, that they're a supporter of the club, that they'll support LGBTQ+ students or staff if they have questions, or want to talk through anything, as kind of a subtle symbol to those who know what it means, without being completely outed if they're not ready to be. And that was a big focus for the club as well, is confidentiality. Students are asked, when they join the club, to keep what gets discussed there within the group, in case people aren't ready to be out more publicly or they're not out to family or friends. And they also have kind of a guideline of topics that they want students to stay away from discussing, like religion and politics.

They just leave those out of the group and are still kind of working toward what else they want to do in terms of activities and programming. But they've had a lot of great one-on-one conversations with classmates and recruiting has been a big part of their initial goals in getting up and running. They have currently about 14 staff members that are included, are involved in the club and they have about 30 students and that's out of, they have just over 600 students from kindergarten through 12th grade, they have them all in one school. So that's a pretty big number for just being the high school club. They're also looking for ways that they can get involved with some of the younger grades and some of the younger students, since they do have that connection, being all in one physical space. So we're excited to kind of see how their program develops and it was a great opportunity to chat with them about what they've been able to do so far. Next slide please.

The second case study I'm going to talk about, is the LGBTQ+ Center at Southwest Minnesota State University. This is in Marshall, Minnesota, which is actually very close to Cottonwood, and they've worked really closely together, the university and the high school that we just talked about. So the LGBTQ Center aims to provide a safe space and support for LGBTQ+ students and staff and faculty. They have a physical space on campus that is shared with the Women's Center, and so they collaborate often with the Women's Center and the LGBTQIA+ club and other campus organizations, to put on different events and programming, and they also offer a lot of resources. As I mentioned in particular, this center provides key resources to helping students, college

students access care or if they have questions about how to fill out forms and things like that, related to their gender identity. For example, the center really strives to support them through that and support staff and faculty as well, to better support their students.

One of the very cool things that we talked with them about was they held what they called Queer Prom in 2022. They're hoping to make this an annual event. Their event was a huge success, they had over 50 people in attendance and this was open to college students, as well as college age young adults in the community, even if they're not students of the school, and also older high school kids. They had to turn down chaperones because they had so many people want to help out and volunteer for the event.

They had like 10 different people reach out to try to deejay for the event and they worked really hard to make it a very safe and inclusive experience for everyone. They kind of paired people up or put them in groups if they didn't have someone to go with and wanted to go with the group. And they said everyone kind of looked out for each other to make sure everyone was safe and included and had a good time. So that was a really cool story and a cool thing that they did. I'm excited to see if they are able to continue doing that on an annual basis. We think that would be great. Next slide, please.

So I'm just going to kind of summarize what we have talked about today, as we come to a close here. As Carrie talked about, we found inequities in health and healthcare access by rurality, sexual orientation and gender identity in these large national surveys, across multiple measures. Rural LGBTQ residents report some of the poorest health outcomes and the most barriers to healthcare access. And we want to acknowledge too, that these disparities are likely further impacted by other intersecting identities, such as race, ethnicity, immigration status, income, et cetera. Unfortunately, because of some of these data limitations, it's hard to get down to that level to look at all of those intersecting identities, but we know from other research that it's likely that these are having a big impact as well. Next slide.

Despite these challenges, we've identified some innovative strategies in rural areas to address rural LGBTQ Health, but going forward, further investment is needed in a number of areas, we just wanted to highlight a few that we think are really important, and this is an area that I think would be great to hear from some of you on the call as well. For one thing, we need more robust data collection, that includes rurality, sexual orientation, and gender identity. As Carrie mentioned, these national surveys that we often use, in particular tend to lack information on gender identity, that's been a big area of focus for a number of folks. But having the rurality measures in there as well, is really necessary for the work that we're doing.

We also need investments in training for healthcare staff and other community-based organizations in LGBTQ Health. We heard a lot about barriers with cultural competency and culturally sensitive providers, and we need more

support for those efforts. And last but certainly not least, is we want to acknowledge that it's important to address social and political determinants of health, specifically for rural LGBTQ residents. We know that none of these things exist in a vacuum and there's a lot of other forces at play here that also need to be addressed.

And then we just wanted to highlight some of our publications that have come out of this work, and there's still a few more to come, as Carrie mentioned. So we have currently these four policy briefs on our website and on the Gateway. These are largely focused on the secondary data analysis that Carrie went through, so if you're interested in digging into more of that, this is where you can find them, as well as some other things that we didn't get a chance to talk about too much today. Next slide please.

We also have our case studies and we will have the one that I talked about on youth and family supports added to this list as well, but we have the other three on our website and on the Gateway, that Mariana mentioned as well. So we have the case series on LGBTQ friendly care. We have one on community organizations and then the small town pride celebrations. We also have a commentary available on Health Affairs Forefront, where we talk a lot about some of these big findings that we've found, as well as kind of the next steps and what we think will help move this work forward. So that can be found here.

And then just to kind of highlight these things that will be coming out, we will have products coming out on rural, urban differences in cancer screening by sexual orientation, specifically focusing on mammography. As Carrie mentioned, we also have the product on rural, urban differences in emotional support for transgender and gender diverse youth, as well as this case study series on youth and family support. And there may be more to come, this project has really snowballed into a lot of different products, which we're really excited about and there's a lot of work that has to be done yet. So next slide. Those are all of our slides, so I will just say thank you to everyone and then we will answer some of the questions here.

Per Ostmo: Perfect. Thank you so much, Madeleine. So right off the bat, I would like to say that the chat is open. Please take this opportunity to drop your relevant resources, browse the chat, there's lots of great stuff in there. So take a moment and look at what everyone else is sharing. First question here for our speakers, it is exceedingly difficult to get data on the trans community, due to fear and unwillingness to disclose their identity in some cases and spaces. Is there any advice on how to deal with this difficult to reach population?

Carrie Henning-...: Yeah, it's absolutely true, and we don't have great data. There are limited data resources out there that have information on gender identity. I would say that the onus is on us as researchers, to make it safe and comfortable and okay for people to disclose their gender identity. I think the reason that someone might not feel safe is because of all of the harm that's been done, especially to transgender communities across the country. And I think that some level of

distrust is understandable, and perhaps even warranted. So I think that it's really important that as researchers, we're using data appropriately and thoughtfully and for good and not for harm. There's also a community of researchers and thought leaders who have focused on this specific issue and how to best, most accurately, most appropriately and most safely ask about gender identity. So for anyone who's interested, I would really encourage you to look into that literature.

We allude to it in some of our work, especially the health affairs piece that Madeleine mentioned, you can look at that and we talk a little bit about data safety and data inclusivity there, and point to some other resources on best practices. And then of course, as individual researchers, there's only so much we can do about data that's collected at the national level. And some of this requires some input and guidance toward our national agencies that collect data, NCHS, the census, the CDC, and on and on, to make sure that they are using best practices, that they are using questions that are most up to date and that are informed by the community that they're looking to ask questions to and about, and make sure that those are grounded in science and real world application.

Per Ostmo: Thank you, Carrie. The next question, in your research, did you uncover actions that individual providers can do at their level, to become better providers for LGBTQ plus communities?

Carrie Henning-...: I love this question so much. I think just by asking it, I'm assuming that this is coming from a provider, maybe it's not, but it just feels to me like asking this question is the first step toward answering this question. I think being self-reflective, looking for educational opportunities and then seeing that this is not something that you have to go at it alone. I think the resources that were shared in our case studies and our key informant interviews, provide some ideas of communities and organizations that you can plug into. I've noticed that the chat is being populated with incredible resources too. So look into those, connect with people, see if there is a training that could be brought into your healthcare organization. And I also want to say, I don't know that we touched on this very directly in this presentation, but the issue of inclusivity and safety in healthcare settings goes beyond just the healthcare provider.

And so if there's training that's provided, it's really important that anyone who's working in that healthcare setting is included in that, front desk staff, custodial staff, lab technicians, everyone should be included in training like that. But I would say reference some of the resources that have already been put into the chat because they're incredible. I knew that we would have a wealth of knowledge in this webinar and we do, and I'm looking forward to learning from some of the things that have been dropped in there. Mariana and Madeleine, I don't know if there's anything else you want to add there.

Per Ostmo: All right, we have time for a couple more questions. Were there any findings that LGBTQ rural folks who were older adults, above the age of 60 or so, to have

any unique disparities compared to their younger counterparts, in either the quantitative or qualitative data?

Carrie Henning-...: Oh, it's such a good question. We didn't dig into this very much, mostly because of data limitations. Once we get into these big national data sources, even though the sample is big on the national level, once you look at the sample only among rural, it gets much smaller. And then once you look at folks who are rural and identify as LGB, which is the identification we can see most often, it gets much, much smaller. And so we did look a little bit to see if we could slice things by age, and the sample just got a little too small to be able to do that very well and very reliably. But I think it's an important area.

I want to highlight the work of Sage, which has been thinking about supporting older adults who identify as LGBTQ for much longer than we have. And they do incredible work. And we are actually, I don't know if there's anyone from Sage on this call, I am happy to plug the work that you do, but they've been thinking about work in rural spaces, they were involved in our key informant interviews, and we're going to be meeting with them soon to talk a little bit more about this. So I would say look for the work that they'll be doing too.

Mariana Tuttle: And someone actually, I don't know if it's somebody from Sage, but Sasha in the chat put their link, Sage Care's link to the website. So hopefully that's a resource for folks as well, because that was what popped into my head too, Carrie.

Carrie Henning-...: Good.

Madeleine Pick: It looks like Elise Hernandez is on as well.

Carrie Henning-...: Oh yes. Hi, Elise. Thank you for being here.

Per Ostmo: Okay, Carrie, can you move to one further slide? We're just about wrapped up here for the day, so I want to remind everyone that if you subscribe to Gateway's research alerts, our email Listserv, you'll be notified when the slide deck recording and transcript and all these great chat resources, they will all be archived on our website by the end of the day Friday, but if you're a subscriber, you'll get that notification. We also have some exciting other research coming up. There is a chart book coming from the University of Southern Maine about ambulance deserts, so we're very excited about that one. And we're going to answer one last question here. Are there any literature or recommendations for addiction recovery services for LGBTQ populations and to train providers and staff? I guess that could be for any of our speakers or for anyone in the chat.

Carrie Henning-...: Yeah, I was going to say, that's not something that we looked into specifically in this project, there's only so much you can do in a 12-month project, but I'm guessing that someone in this webinar knows a good answer to that. So I look forward to seeing what that mysterious someone puts into the chat.

Per Ostmo: All right. I want to make sure to thank all of our presenters for being here today. Madeleine, Carrie, Mariana, thank you so much for presenting. Thank you for our audience and all of our attendees for submitting excellent questions. I will capture the chat box and share these resources when we share the slide decks on Friday. And thank you all for being here. I hope you come to future Gateway webinars. All right, goodbye everybody.