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Rural Service Providers' Perceptions of Cultural Responsiveness to LGBT Older Adults

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**Rural Service Providers' Perceptions of Cultural Responsiveness to LGBT
Older Adults**

By

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University-University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

This qualitative study was conducted to assess how senior care facilities are responding to LGBT older adults in rural communities. While reviewing previous literature, the following themes were found: discrimination and health disparities, families of choice and social support, challenges in rural communities, and cultural responsive services. This study interviewed seven social workers and one social work designee. Seven of the participants worked at rural nursing homes and one participant worked at a rural assisted living in Minnesota. Many of the results were also found within previous research. The major themes include: limited diversity in rural settings has slowed progress towards implementing changes, staff strengths with LGBT older adults, potential barriers with staff and other residents, addressing concerns of staff and non-LGBT residents, and resident to resident harassment would be handled the same regardless of sexual orientation or gender identity. Implications of this study are integrated into how they relate to social work policy, practice and research.

Key words: LGBT, older adult, cultural responsiveness, rural Minnesota

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Introduction

By 2030, it is estimated there will be more than five million lesbian, gay, bisexual, and transgender (LGBT)¹ older adults in the United States (Fredriksen-Golden & Espinoza, 2014). LGBT older adults have experienced different historical and social experiences during their lives when compared to their non- LGBT peers. As a result, many LGBT older adults have lived a lifetime of stigmatization and only recently has their culture started to gain more acceptance (Concannon, 2007). The LGBT silent generation (those who grew up during the depression and WWII) were severely stigmatized and treated as criminals. The LGBT community experienced homosexuality being listed as a psychiatric disorder until 1973 (Concannon, 2007). The LGBT baby boomers have endured similar challenges but being the more outspoken group; they have experienced more progress toward social change (Fredriksen-Goldsen, Kim, Shiu, Goldsen & Emlet, 2014).

A majority of literature pertains to the health and social needs of older adults, but little information has been gathered about the social and health needs of LGBT older adults. (Concannon, 2007). Unfortunately, minority groups are less likely to be included in gerontological research, causing significant gaps in knowledge about LGBT older adults (Fredriksen-Golden & Espinoza, 2014).

Fortunately, there have been more advances in the past couple of years, such as the nationwide legalization of gay marriage. Before the legalization of gay marriage, studies had shown a decline in psychological distress in states that had advanced legal rights for the LGBT population (Fredriksen-Golden & Espinoza, 2014). Research has determined legally recognized

¹ Q is often added to LGBT as an initialism for queer. Q will not be used in this paper out of respect for the older LGBT population, who historically experienced the word as a discriminative term.

relationships provide better outcomes in both physical and mental health (Fredriksen-Golden & Espinoza, 2014).

LGBT older adults have additional challenges as they age and become more vulnerable. They face other challenges when seeking care due to a history of discrimination (Concannon, 2007). More information about the unique needs and challenges for this group are slowly emerging.

Health People is a nation-wide initiative that sets goals every decade for improving the health of all Americans. For the first time in 2010, the LGBT population was identified as a United States national health priority. The initiative concluded there is insufficient data on the health of LGBT Americans (Fredriksen-Goldsen et al., 2014).

From 2013-2016, The National Survey of Older Americans Act Participants (NSOAAP) had inquired about sexual orientation (Loewy, 2017). The inquiry was withheld in 2017. In 2017, Congress also reversed the decision to include LGBT data in the 2020 Census and the American Community Survey (Loewy, 2017). Without this data, we continue to lack knowledge about what supports are needed for the LGBT older adult community (Loewy, 2017).

Much of the current research focuses on LGBT older adults in urban settings. The purpose of this study is to further explore senior care facilities social workers' perceptions of cultural responsiveness to LGBT older adults in rural Minnesota. This research topic will be addressed through a qualitative study designed to interview social workers in rural senior care facilities.

Literature Review

The literature surrounding the discussion of needs for LGBT older adults provides insight and direction to understand if rural long-term care facilities are ready to provide safe and well-informed care. The significant themes found in the reviewed literature include discrimination and health disparities, families of choice and social support, challenges in rural communities, and culturally responsive services.

Discrimination and Health Disparities

LGBT older adults have a history of enduring stigmatization from their peers, the federal government, the military and medical providers (Porter & Krinsky, 2014). Evidence strongly correlates stigmatization with abuse (Sullivan, 2014). Over half of LGBT older adults report experiencing victimization, homophobic violence, or verbal harassment in their lifetime (de Vries & Croghan, 2014).

Research has shown the LGBT baby boomer generation reports more incidents of victimization and discrimination compared to members of the silent generation (Fredriksen-Goldsen et al., 2014). These differences may correlate with the social shifts that occurred with the boomer generation, resulting in more boomers disclosing sexual orientation (Fredriksen-Goldsen et al., 2014). Being open about sexual orientation increases the likelihood of a positive identity but also raises the possibility of discrimination and victimization (Fredriksen-Goldsen et al., 2014). However, the silent generation has experienced a negative sense of sexual identity when compared to boomers primarily due to fear of disclosing sexual orientation (Fredriksen-Goldsen et al., 2014). When an individual cannot fully reveal their identity, healthcare can be negatively impacted.

A majority of LGBT older adults do not believe they receive the same health and social services when compared to heterosexuals (Landers, Mimiaga & Krinsky, 2010). LGBT older adults who disclose their sexual orientation to providers report more positive experiences, but due to fear of discrimination, they are reluctant to reveal their sexual orientation (Jenkins-Morales et al., 2014).

A majority of medical professionals report they have encountered derogatory comments made about LGBT patients by other professionals or witnessed below average care (Sullivan, 2014). As a result, LGBT older adults are five times less likely to access health services (Concannon, 2007). The lack of comfort with revealing sexual orientation may result in missed opportunities for health screenings and preventative care (Whitehead, Shaver, & Stephenson, 2016).

For the LGBT population, mental health quality of life increases when an individual has a positive sense of sexual identity (Fredriksen-Goldsen et al., 2014). Individuals who have better mental health are also more likely to seek out preventative care (Fredriksen-Goldsen et al., 2014). However, discrimination and victimization generate poor physical and mental health within this population (Fredriksen-Golden & Espinoza, 2014). Depression rates for gay men were found to be 2.5 times higher, and for lesbians 1.5 times higher than the general population. (Brennan-Ing, Seidel, Larson, & Karpiak, 2014). When compared to heterosexual individuals, suicidal ideation was nearly three times higher for gay and bisexual men and two times higher for lesbian and bisexual women (de Vries & Croghan, 2014).

Compared to LGB older adults, transgender older adults experience higher risks of stress, poor mental health, poor physical health, and disability (Fredriksen-Goldsen et al., 2014).

Transgender individuals are also more likely to experience refusal of care by providers (Jihanian, 2013). This risk increases for transgender individuals from an ethnic minority (Jihanian, 2013).

In general, sexual minorities have been found to have an increased risk of substance abuse and chemical dependency (Barefoot, Rickard, Smalley & Warren, 2015). Lesbians have been found more likely to have increased alcohol intake when compared to heterosexual women. Gay and bisexual men are more likely to report using illicit drug use when compared to heterosexual men. Overall the LGBT population reports higher rates of tobacco use (Whitehead et al., 2016). These statistics may indicate this community may be using substances as a method of coping with continued discrimination; however, this theory would need to be further researched.

Compared to heterosexual women, lesbians have poorer quality of healthcare and an increase in obesity rates (Brennan-Ing et al., 2014). This can increase the risk for diabetes, certain cancers and heart disease (Brennan-Ing et al., 2014). Patterns in research have found that lesbians are significantly less likely than heterosexual women to receive preventive services such as pap smears (Porter & Krinsky, 2014). Pap smear recommendations are not different based on sexual orientation; however, it has been found that women who disclose sexual orientation are more likely to receive pap smears (Whitehead et al., 2016). Lack of preventive services may have resulted from historically being excluded from medical research or avoiding services due to previous negative experiences (Cohen & Murray, 2006).

Some present-day health disparities could be a result of reduced access to healthcare over a lifetime (Jihanian, 2013). Before anti-discrimination laws, individuals could have also experienced employment discrimination, resulting in lack of access to overall earnings and health insurance (Whitehead et al., 2016). Despite expansions in the Affordable Care Act, sexual

minorities are still more likely to be uninsured (Whitehead et al., 2016). Lack of insurance further complicates preventative health screenings (Whitehead et al., 2016).

Families of Choice and Social Support

LGBT individuals are more likely to be single compared to the heterosexual population (de Vries & Croghan, 2014). It is important that families of choice and informal caregivers are recognized as supports for LGBT older adults (Fredriksen-Golden & Espinoza, 2014). Families of choice usually consist of close friends, neighbors, or other individuals found in a person's support system (Brennan-Ing et al., 2014).

In a study conducted by Brennan-Ing, Seidel, Larson, and Karpiak (2014) of the older LGBT sample, 63% reported living alone, 21% lived with a partner or spouse, and 16% lived with undisclosed other people. Among gay and bisexual men, 71% lived alone, and 39% of lesbians lived alone. Less than one-third of participants reported having a living child. In older gay and bisexual men, 25% reported at least one child and 48% of lesbians and bisexual women reported at least one living child (p. 36). A study conducted by the National Gay and Lesbian Task Force found that 90% of older lesbians and gays did not have children compared to 20% of the general population (Cohen & Murray, 2006).

In heterosexual relationships, caregiving assistance is usually obtained from the spouse or adult children (Croghan, Moone & Olson, 2014). In contrast, a MetLife study found approximately two-thirds of LGBT baby boomer respondents said they would turn to family of choice for a wide variety of care needs (de Vries & Croghan, 2014). As friends go through the aging process too, having less caregiving options in the community places a higher risk of needing to admit to a long-term care setting (Croghan et al., 2014). Research has consistently

found LGBT older adults are less likely to have an available caregiver when compared to the general population (Croghan et al., 2014).

Social networks for LGBT older adults usually consist of other LGBT individuals (Orel, 2014). Having involved friends increases optimal mental health (Brennan-Ing et al., 2014). When compared to the rest of the older adult population, LGBT individuals in the silent generation are more likely to rely on peer support, but they are also less likely to disclose their sexual identity causing them to have less support and feel more isolated (Fredriksen-Goldsen et al., 2014).

Access to social care networks assist people in aging independently and maintaining a better quality of life (Fredriksen-Goldsen et al., 2014). Research has shown LGBT older adults have an overwhelming interest in communities and social groups specifically for LGBT older adults (Orel, 2014).

In a study by Brennan-Ing, et al. (2014) 51% of LGBT older adults indicated the need for someplace to socialize. The unmet need for socialization opportunities increases the likelihood of isolation and loneliness (Brennan-Ing et al., 2014). Isolation and loneliness often increase the risk for depression which can lead to suicidal ideation.

Those in the silent generation have been found to have a lower level of community networks and are less likely to be in a relationship compared to the boomer generation (Fredriksen-Goldsen et al., 2014). Social isolation also may be more severe for LGBT older adults from different ethnic backgrounds due to the increased chance of also being separated from their racial or ethnic communities (Portz et al., 2014). A lack of socialization opportunities increases if an LGBT older adult needs to move into a retirement community or a nursing home.

A history of stigmatization and discrimination toward the LGBT community has created a system of institutionalized stigma that has integrated into the elder care service system (Porter

& Krinsky, 2014). Many will not disclose their sexual orientation if moving into a retirement care facility (Landers et al., 2010). Perceived or intentional heterosexism and homophobia can cause emotional distress causing some individuals to return to the “closet” and experience further marginalization (Sullivan, 2014).

Current literature indicates LGBT older adults want services to support them as they age, yet they fear intolerance and neglect from social institutions and professionals in traditional settings (Carlson & Harper, 2011). Across multiple studies, it was found that older lesbians and older gay men preferred to live in housing with members of the LGBT community and to have it staffed with individuals who were sensitive to LGBT aging needs (Cohen & Murray, 2006).

One research assessment discovered 21% of LGBT Baby Boomers and 19% of the LGBT silent generation experienced property damage due to homophobia (Jenkins-Morales et al., 2014). Those having the option to live in LGBT senior housing, rank comfort and less isolation as some of the most common reasons to seek out these types of communities (Jenkins-Morales et al., 2014). Having LGBT senior housing options provide a sense of inclusiveness, safety, and a more supportive environment (Jenkins-Morales et al., 2014).

LGBT senior housing has also provided more ease for individuals who have been “closeted” their entire lives and now feel safe to disclose their status for the first time (Sullivan, 2014). LGBT couples can also live free of societal judgment; something that is not always found in traditional retirement communities (Sullivan, 2014). If an LGBT older adult needs to access more care support, moving to a traditional nursing home could provoke more fears.

A study which surveyed 29 nursing homes, found more than half of direct care staff were judgmental or intolerant of homosexuality (Porter & Krinsky, 2014). A 2011 survey conducted by the National Senior Citizens Law Center (NSCLC) discovered 43% of LGBT older adults

reported witnessing or experiencing physical or verbal harassment from staff or other residents in long-term care settings (Jihanian, 2013). Similar research found 68% of LGBT older adults had been verbally assaulted and 19% had been physically assaulted when orientation or gender identity were disclosed (Porter & Krinsky, 2014).

The NSCLC survey also discovered approximately 80% of LGBT older adults felt they could not disclose their sexual orientation in a long-term care setting due to fear of discrimination by staff and other residents (de Vries & Croghan, 2014). Caregivers and service providers agreed at the same rate (de Vries & Croghan, 2014). It is not surprising that a majority of gay men and lesbians prefer to have a choice of separate accommodations in long-term settings (Concannon, 2007). Nursing facilities are not the only concern as some LGBT older adults may encounter homophobic caretakers providing services within their home (Landers et al., 2010). LGBT housing options and specific services are more likely to be found in urban settings which could increase disparities for rural LGBT older adults.

Challenges in Rural Communities

An estimated 12% of same-sex couples are thought to reside in rural communities (Barefoot et al., 2015). Rural culture is often linked to traditional gender roles, hetero-normative families, and conservative conformity (Carlson & Harper, 2011). A study of rural communities found 92% of sexual minorities overheard antigay speech, 51% reported being bullied, and 22% experienced physical violence or harm (Barefoot et al., 2015).

LGBT individuals are three times more likely to choose healthcare providers that possess LGBT specific knowledge (Whitehead et al., 2016). Rural communities often lack community-based LGBT resources, which can often increase isolation for this population (Barefoot et al., 2015). There is a considerable amount of evidence showing LGBT older adults move into urban

areas to have access to specific services, avoid discrimination within those services, and to have access to more social supports (Rowen, Giunta, Grudowski & Anderson, 2013). Those desiring to stay in their community but seeking more service choices also travel to urban areas to receive health care (Whitehead et al., 2016). Traveling long distances to a provider becomes another barrier for older adults trying to access responsive health care (Whitehead et al., 2016).

Multiple studies have also revealed over 22% of rural physicians sometimes felt uncomfortable treating LGBT patients (Rosenkrantz, Black, Abreu, Aleshire, & Fallin-Bennett, 2016). Rural LGBT patients have been found to request HIV testing less frequently due to anticipated lack of confidentiality and fear of speculation in a rural community (Rosenkrantz et al., 2016). The stigma in some rural communities can result in a lack of cultural responsiveness from providers and can increase levels of anxiety and distrust when accessing healthcare (Rosenkrantz et al., 2016).

Research has found LGBT older adults in rural communities are also more reluctant to disclose sexual orientation (Barefoot et al., 2015). One study found nearly 20% of rural LGBT participants reported living with partners of the opposite sex (Lee & Quam, 2012). Providers should not assume LGBT adults in rural areas will disclose their identity because they have historically hidden their sexual orientation as a means of survival within the community (Lee & Quam, 2012).

Development and implementation of diverse services need to be continually addressed, but readiness and knowledge regarding the need may be more challenging in rural regions (Carlson & Harper, 2011). Having culturally responsive LGBT policies and attitudes can still be welcoming, regardless of identity disclosure.

Culturally Responsive Services

Older LGBT individuals continue to be discriminated against when they are expected to fit into mainstream service delivery, and their unique needs are not recognized (Concannon, 2007). LGBT older adults may encounter both ageism and heterosexism when they want to access health care services (Espinoza, 2016). In general, many health providers ignore older adults' sexuality. As a result, discussing sexual orientation may also cause further discomfort for a provider (Carlson & Harper, 2011). Providers may have their own unaddressed biases which may result in intentional or unintentional negative interactions with patients (Foglia & Fredrikse-Goldsen, 2014). A study including 184 agency representatives found 46-56% were unsure if their organization served LGBT older adults (Moone, Cagle, Croghan & Smith, 2014). This is heavily influenced by heterosexual assumption (Concannon, 2007). Having the knowledge and awareness that some older adults are LGBT is essential for providers being responsive to LGBT older adults (Jihanian, 2013).

One study from 2011, found that only two percent of aging service providers offered services specific to LGBT older adults (Brennan-Ing et al., 2014). A similar study conducted in 2010, surveyed directors of Area Agencies on Aging across the United States. The results indicated less than 10% offered services specifically for LGBT older adults and only 12% had implemented outreach to LGBT older adults. The same study found more than 20% of agencies were uncertain or assumed LGBT older adults would not be welcome in aging service agencies (Jihanian, 2013). These results illustrate a dire need for providers to implement evidence-based strategies to develop LGBT cultural responsiveness (Porter & Krinsky, 2014).

Research has found a significant correlation between both nursing students and nurse's knowledge of LGBT health concerns and an increased comfort and willingness to provide

service to LGBT individuals (Cornelius & Carrick, 2015). Previous research has found similar evidence in the relationship between greater knowledge of LGBT healthcare and a more positive approach to address LGBT patient needs (Cornelius & Carrick, 2015).

Nursing home referrals, assessments, and review processes continue to be practiced poorly with inappropriate language that remains to be non-inclusive to LGBT individuals (Concannon, 2007). A study that surveyed 109 nursing home administrators found within their intake forms, only 25% of facilities inquired about gender identity and only 7% asked about sexual orientation. In the same study, 53% stated they would not be changing intakes forms to ask gender identity, and 76% would not change forms to seek sexual orientation (Mihalko, n.d.).

Cultural responsiveness is described as a skill that allows providers to give culturally respectful care to individuals of cultures different than their own (Porter & Krinsky, 2014). Cultural responsiveness can be increased by engaging with another culture and acquiring knowledge specific to another culture (Portz et al., 2014). Providers and caregivers must become aware of their assumptions, values, and beliefs, and be willing to learn to be comfortable with another culture (Portz et al., 2014).

Comprehensive training programs that educate staff on understanding how social policies and professional practices have continued to oppress LGBT older adults appear to be effective to help staff become knowledgeable and tolerant of the lifestyles of LGBT older adults (Concannon, 2007).

The Open-Door Project developed a study to determine the effectiveness of an LGBT older adult cultural responsiveness training and administered the survey to ten aging service providers. Within the study, all ten agencies found the more knowledge providers had about LGBT issues, the more they served their clients efficiently. The agencies also reported learning

how to work with LGBT clients and integrating knowledge with professional responsibility, helped them to provide better service regardless of personal beliefs. The knowledge gained from LGBT responsiveness training assisted the agencies in further examining and improving policies to become more LGBT friendly (Landers et al., 2010). Currently, only the state of California requires cultural responsiveness training through their Health Facilities Training Bill (Moone et al., 2014).

Culturally sensitive care has been proven to provide better health outcomes for patients (Porter & Krinsky, 2014). Research has found organizations can meet standards of care for LGBT older adults by inclusive policies, useful communication skills, inquiring with open-ended questions, providing a welcoming environment, and using gender-neutral language (Carlson & Harper, 2011). The simple act of using images and text that includes LGBT older adults in marketing materials speaks volumes to the openness of the service provider (Jihanian, 2013). Providers may also consider placing statements indicating they are open to the LGBT community in their mission statement. Agencies that are regarded highly competent as LGBT service providers are up-to-date on current research and legislation. They also participate in events related to LGBT issues (Portz et al., 2014).

It is important to continue investigating inclusion processes that avoid alienating LGBT service users (Concannon, 2007). Research has shown that many service providers are unaware of LGBT specific issues but still suggest they are inclusive (Portz et al., 2014). They continually did not acknowledge LGBT older adults have different needs than heterosexual older adults (Portz et al., 2014). These same providers did not see a reason to change any current practices, claiming they treat everyone the same, regardless of differences. Providers who are unaware of specific population differences are more likely to be unfamiliar with diverse needs within a

group (Portz et al., 2014). Social workers have the unique opportunity to have a significant role in educating other healthcare staff regarding the specific needs and concerns LGBT older adults encounter. This study will analyze senior housing social worker's perceptions of cultural responsiveness to services for LGBT older adults.

Conceptual Framework

The concepts used to describe the approach for this study include the Minority Stress Theory and the Community Readiness Model. Minority Stress Theory conceptualizes that minority groups encounter unique stressors which increase their vulnerability (Shilo, 2014). For the LGBT community, stressors have accumulated due to discrimination and stigmatization. These stressors may include expectations to fit into a heteronormative society, reluctance to disclose identity/orientation, and expectations of rejection (Shilo, 2014). These stressors can lead to maladaptive ways of coping such as avoiding medical care or substance abuse. Adaptive methods of coping could include developing families of choice and selectively seeking social support within the LGBT community for safety purposes (Shilo, 2014).

The Community Readiness Model, which was developed by the Tri-Ethnic Center for Prevention Research at Colorado State University, looks at a community's culture and assesses the willingness for change (Carlson & Harper, 2011). The readiness to change is examined by looking at community efforts, knowledge of the efforts, leadership, community culture, community knowledge of the issues, and local resources to enhance effective change (Carlson & Harper, 2011). Utilizing these two theories assisted this researcher in identifying how these models influence one another.

Methods

Research Design

The purpose of this study was to analyze rural senior care providers perceptions of cultural responsiveness for services provided to LGBT older adults. This study used a qualitative interview schedule to collect data from participants. A qualitative design was chosen because it would provide in-depth information about a topic of which little is known. The St. Catherine University Institutional Review Board, research chair, and committee members approved this project.

Sample

Inclusion criteria for this study included social workers or social work designees, who were currently practicing at senior care facilities in rural communities within Minnesota. Rural communities were classified as populations of 50,000 or less. All the communities sampled consisted of a population below 20,000.

Social work designees are common in rural areas when facilities are unable to hire a licensed social worker to fulfill the role. Social work designees do not have the same education requirements as social workers, or they have completed higher education in another field. To be referred to as a social worker, an individual must have at least a bachelors' degree from an accredited social work program (National Association of Social Workers, 2016). All participants were female.

Purposive sampling was used for initial recruitment of participants. Purposive sampling is utilized when you purposely choose a particular sample (Grinnell, Williams & Unrau, 2016). Participants were identified by using The Minnesota Nursing Home Social Workers Association (MNHSWA) public website. The website lists contact information for Presidents, Treasurers and Board Representatives from different regional chapters throughout Minnesota. Members and

representatives of MNHSPA consist of professionally degreed individuals who are currently practicing in senior care settings or have in the past. Three MNHSPA members participated in this study. To gain more participants, the researcher utilized the Minnesota Department of Health 2017 Licensed and Certified Health Care Facilities Directory. Participants were identified by systematic random sampling where the researcher picked every 15th facility. If the city's population was under 50,000, the researcher collected contact information for a social worker on the facilities website. All participants were asked to refer 1-2 social workers at rural senior care facilities, who were not employed at their own facility. Ten potential participants were contacted, unfortunately none of the referred participants responded to requests for participation. All participants were contacted by email.

A total of 45 individuals were contacted, 16 from the MNHSPA website and 19 from the Department of Health and Human Services website. This total also includes the 10 referred individuals. The final sample included eight participants which consisted of seven social workers and one social work designee. The participant who identified as social work designee obtained a bachelor's degree in gerontology. Seven participants worked at long-term care facilities and one participant worked at an assisted living facility.

Protection of Human Subjects

To ensure the study was ethically conducted, several measures were taken to protect participants from potential harm associated with participating in the study. Approval from the St. Catherine University Institutional Review Board was obtained. A consent form was created based on the template used by the St. Catherine University Institutional Review Board and was approved by the research committee before the implementation of this study (See Appendix A).

The consent form consisted of background information regarding the purpose of the

study, procedures, risks, benefits of participating, confidentiality, informed voluntary consent, and contact information for the researcher and the St. Catherine University Institutional Review Board.

Data Collection

The interview consisted of eight open-ended questions designed to gather a variety of responses (See Appendix B). The researcher created the interview schedule by reviewing relevant literature and constructing the questions from the research. A copy of the interview schedule was sent with the consent form when participants agreed to participate in the study. Once the consent form was received by the researcher, a telephone interview was scheduled. The telephone interview was audio recorded on a password protected device.

Data Analysis

The researcher used the grounded theory approach to analyze the data. The grounded theory approach is used as a comparative analysis when there is more than one participant (Padgett, 2008). The data was collected and recorded during the interview. The audio recordings were transcribed verbatim. The transcribed data was coded by observing a pattern of phrases within the data. The interviews were assigned a letter, and the same letter was recorded after each phrase pattern. The phrase patterns were organized according to interview questions. Themes were easily determined when all phrases were organized under the interview questions.

Strengths and Limitations

This study was conducted with participants located in different regions throughout the state of Minnesota. Having various regions throughout the state provided a comprehensive representation of rural areas in Minnesota. Qualitative interviewing collected data gathered from human experience, which captures intimate details about the topic. Conducting this study may have served as a form of advocacy if the rural senior care facilities had not considered implementing changes to be more inclusive of LGBT older adults.

The interviews did not take place in person, which is preferred in qualitative research. Due to the limited time for this study, the sample size was limited to eight participants, thereby only providing a glimpse of perceptions of cultural responsiveness in rural senior care facilities. All of the participants were female, so this research lacks a male perspective. Only one assisted living participant provided their perspective.

Results

This research answered the question of rural service providers' perceptions of cultural responsiveness to LGBT older adults. Five main themes were discovered after recording participants' perceptions and investigating response patterns. Those themes include: limited diversity in rural settings has slowed progress towards implementing changes, staff strengths with LGBT older adults, potential barriers with staff and other residents, addressing concerns of staff and other residents, and resident to resident harassment would be handled the same regardless of sexual orientation or gender identity.

Limited diversity in rural settings has slowed progress towards implementing changes

All the participants within this study described their facilities/communities as being "predominately white older adults" with "little to no diversity." More than half of the participants described residents as being "Caucasian Christian farmers." A couple of the participants stated they will occasionally admit residents who are Native American or Latino. The assisted living facility reported most of their residents are Caucasian, but they do have some residents who are Native American, African American, Latino and Asian. All of the participants stated they did not have any current resident who identified as LGBT.

Three participants acknowledged having past residents who identified as being gay or lesbian. Participant A questioned,

[I wonder what happened to those several people we have assisted. Now they would be older and I'm wondering where they went or where they are finding their support community.... Then you wonder, did we do okay? Was short term okay but not long term or you know, for staying with us...I don't know].

Seven participants did not see a current need to have staff training specific to LGBT cultural awareness. Participant D stated, “We just have not identified as having a need for that specific training.” Participant E stated, “We just don’t have any LGBT residents here, so we are not needing that kind of training or that kind of stuff.” Participant C, who disclosed they have had some experience with the gay and lesbian older adults stated, “I haven’t come across any issues with staff being bias against gays or lesbians. We have not had any bi or trans, but we have had lesbians.” Participant B, who disclosed she was a part of the LGBT community voiced, “The fact that you contacted me made me think more about it; I think it will bring about change.”

One participant reported implementing some changes. Participant G acknowledged, “There have been some different trainings and staff have been educated on different things they could do specifically for the LGBT population.” Overall, a majority of participants reported facilities will make changes when the need has been identified.

Two facilities have made policy and admission paperwork changes. The other six facilities in this study have not implemented changes to be more inclusive of LGBT older adults. Participant G disclosed, “Different policies were changed to include the LGBT population and some language was altered.” Participant A disclosed,

[We have attempted to adjust our forms or paperwork and we ask about spouses or significant others. We don’t use terms that would be gender specific. We talk about support people or preferred representative and those kind of things, instead of wife or husband or something that would have kind of a connotation that goes along with it].

All participants reported they are not encountering many, if any LGBT older adults, so they do not see the need to make changes or any further changes at this time. Participant C explained, “We probably don’t see it as much as the metro, the metro probably sees it all the time.”

Participant G, who also said they had made changes stated, “I know it is going to be coming, and we will certainly be working with it.” Participant E reported, “We have never had any issues or encounters where they would need to change policies, marketing, or paperwork.” Participant A said, “It is not a priority. We will address issues when we encounter the LGBT population. We try to identify all concerns at time of admission.” All the participants reported changes or further changes will be made at their facilities, when the need has been identified.

Most participants reported not having any services or providers in their rural community who identified as being LGBT friendly or provided services specific to the LGBT population. Participant B said, “A larger town nearby has a provider who advertises they are comfortable working with the LGBT population.” Participant H has heard of a “small local advocacy group which has just started, but it is mainly for the younger population.”

Overall, all participants voiced they do not see many older adults, if any, who disclose they are part of the LGBT community, therefore, LGBT specific services are rare in rural communities.

Staff strengths with LGBT older adults

No participants reported their facilities had advertised so potential LGBT residents would know they are a LGBT friendly facility. However, they expressed they want their facilities to be welcoming to LGBT older adults. All participants expressed LGBT older adults would be welcomed to their facility and treated the same as everyone else. Participant E said, “We do not want them to have to be worried or scared that they are going to be treated differently.” Participant B said, “We deal with tough situations as they arise, we are not here to judge, we are here to deal with health care issues. We are focused on the care of the person...with any kind of diversity.”

Participant G expressed,

[Well I think the exposure all around is increasing more every day so I think it would help them, like when people are exposed to that population in their immediate family or know somebody or have access to learning about different populations and do different education on things like that. So I just think from a staff perspective, that we could certainly provide what they need to feel or meet that requirement of comfort for them].

This same participant indicated her facility had made some changes to be more inclusive of LGBT older adults.

Participant C, who acknowledged having a previous resident who identified as a lesbian stated,

[The wife came in and she was terminal and the experience as far as the staff and everything, it didn't make a difference. They just observed what their preferences were, respected their wishes and their rights, and it was normal. Just like any other person].

Participant F, who also acknowledged having a past resident who was open about his orientation stated, "Honestly, I didn't notice any difference as far as how he was treated, how staff treated him, or other residents treated him." Another participant expressed, "It doesn't matter if you are straight or gay, you are still a person needing help." Participant H said, "Staff would still be hospitable, welcoming, you know, care for them in the same way they would care for somebody else."

One participant disclosed she is lesbian and two other participants acknowledged having staff who identify as being part of the LGBT community. Participant F said, "I think staff could maybe be going through some of the same experiences. They may understand where they are coming from because we have staff that are LGBT." Participant C stated, "We have a staff

person who is gay and was welcomed to the facility. They helped to establish there are no issues here.” The same participant stated, “We have so many volunteers and staff that maybe lesbian, gay, bi, or transsexual and we don’t know it, so it wouldn’t affect our care that we provide.”

Half of the participants expressed they feel younger staff are more open to diversity. Participant H said, “Younger staff have more experience with LGBTs.” Participant A said, “Younger people are more accepting.” Participant H said,

[I feel like most of our younger staff have probably had some interaction with the population, at some point in their lives...whether its college or high school. So, I feel like its maybe a little bit more normative to them, so I don’t think they would have any issues.” Participant C stated, “I think the population of people that are coming into work for us these days are a lot more diverse, as far as their beliefs.]

Potential barriers with staff and other residents

Six out of the eight participants expressed potential for staff to be biased towards LGBT older adults. Participant F expressed, “Staff may struggle due to their own prejudices and religious backgrounds.” Participant H stated,

[We do have some staff who are older, and I feel like that may be a challenge to them, depending on the era they grew up in and how they view the LGBT community because you know, from their past, they may have different viewpoints. So, that could be a challenge].

A couple of participants voiced concerns over the lack of private rooms and private bath rooms in facilities and how that could affect other residents and limit welcoming LGBT older adults. Participant F said, “There are definitely possible prejudices that could arise like statements from other residents, maybe even some discrimination. Like they might not want to

share a room with the person, maybe they wouldn't want to eat at the same table with the person, things like that." Half of the participants expressed the possibility for other residents being prejudiced towards LGBT older adults. Participant D stated, "There is potential for discrimination. For some, in their mind, this is not an option. We are very black and white in this age group." Participant B expressed, "You have people that are biased and judgmental in the community and like I said, those things show up in the nursing home too." Participant B spoke about residents who may not have the capacity to know the harm they could do. She said, "Resident's with early dementia may lack a filter; they may not intend to be mean, inappropriate, or judgmental. They used to be able to not act on thoughts."

Participant G was the only one to question the possibility of staff being biased when assisting an LGBT person. When asked if staff would have any challenges while providing care, she responded, "I guess I don't. No. Maybe that is me being naïve, I don't know."

Addressing concerns of staff and other residents

Half of the participants expressed addressing the needs and concerns of staff and other residents who would encounter an LGBT older adult. Participant H said, "If staff had an issue, they would be able to bring that to their supervisor's attention to seek further education or if they feel uncomfortable or anything, they would be able to have the support to work through that." When speaking to the same participant about LGBT cultural responsiveness training, she responded,

[If it was identified as something, there are lots of trainings and speakers and people you know through Care Providers or Leading Age that have the resources to do that diversity training and just really being open to staff and honest with them, you know? "We

understand this can be uncomfortable maybe because we are not used to it here, but here are the resources and this is how we will help you.]

When Participant D was asked about challenges for direct care staff, a clarifying question was also asked by the researcher, “If a staff member was being biased, would they be removed from caring for that person? The participant answered, “Until education or further maybe um... for their feelings or for other interventions to be found.” When inquiring about challenges for staff members, participant A answered,

[I think one of our experiences that we have had in the past was that some of the young men had questions when we had served somebody, some of our staff, and we talked about it. It’s just like taking care of everybody else and we have men that take care of men and men who take care of women and that sexual orientation hasn’t been a... that has never been a...well how do we approach this kind of question? So, why for this person, is it that? So, we have done some of that initial training and staff are like, “Do we do anything different?” It’s like you know, you have never asked me, should I not go in and take care of this woman, so why would we...you know what I mean? So I think we, I think that our director of nursing and I, we’ve worked well as a group for trying to respect that and not to make the staff uncomfortable and then trying to have genuine conversation about the individual that would be coming to our facility about how we can...how we can best respond to their needs, you know if there is any level of discomfort].

Participant F expressed some concern and curiosity with how to address transgender residents:

[Because we are seeing more people with the transgender and identifying their gender that they are born with versus the gender they may feel, you know, they relate to now,

later on after they have transitioned kind of thing and how to identify that respectfully um how that's going to play a field in the medical field, do I put male/female in my documentation? How do we pass that on to the hospital and emergency room in that kind of situation? To make sure they are aware, you know? How do I even get that conversation going?]

Participant G commented on hypothetically addressing a resident who may struggle with biased feelings toward a LGBT individual,

[We would provide education to that resident, maybe to their family members, maybe just assign different one on one periods to talk about their feelings. To learn better ways to channel their frustrations about it or their stresses about it, what they are feeling about it. Just get to the bottom of what they are feeling and how we can help them cope with that].

Resident to resident harassment would be handled the same regardless of sexual orientation or gender identity

All long-term care facilities are required to have policies for reporting resident to resident incidents. In this study, all long-term facilities reported similar responses if there was resident to resident harassment. It was often reported that residents would be separated, and safety protocols would be put into place. Participant C reported,

[In a resident to resident altercation, obviously we make sure everyone is safe and that they are separated and then identify what was the trigger to that. Was it intentional? Was it not intentional? Then develop a plan of care from that, based on the situation].

Participants from long term care facilities commonly reported they would review if roommate changes needed to occur or dining room seating arrangements need to be altered. A

couple of long term care facilities also stated, depending on the situation, they may refer residents to mental health services or reeducate residents who were perpetrators. Participant D provided a summary of statements other participants also disclosed as part of their protocol, “Remove them from the situation, educate both parties, offer further education on abuse or harassment to staff to alleviate that potential reoccurring situation, continue to monitor, refer to psych facilities for both individuals as needed.”

All of the long-term care participants provided similar responses, likely influenced by requirements from the Department of Health and Human Services. All of the long-term care facility participants also stated if an LGBT resident was harassed by another resident, they would follow the same protocols for investigating and reporting.

The assisted living participant reported “our lease states any harassment or discrimination will not be tolerated, after three write ups, you’re out. If extreme verbal or physical aggression occurred, the police would be called.” The participant also reported they would address harassment toward a LGBT resident the same, “We would take that just as serious as harassment against anybody.”

Discussion

The results of this research indicate service providers have limited diversity in their facilities and they do not see the need to make changes until they encounter more LGBT older adults. There is a possibility that some of the older adults entering these facilities are choosing not to reveal their orientation. Previous research found LGBT older adults admitting to facilities often chose not to disclose their sexual orientation due to fear of neglect, discrimination or they have remained “closeted” their entire life (Sullivan, 2014). Previous research has found nearly 20% of rural LGBTs have reported living with partners of the opposite sex (Lee & Quam, 2012). Previous research also indicates LGBT individuals are more likely to be single (De Vries & Croghan, 2014). Although unknown, there is a possibility that some of the residents at these facilities who have never married, could be members of the LGBT community who historically have chosen not to disclose part of their identify as a protective factor.

Some of the participants acknowledged they have provided care to someone from the LGBT population in the past. A majority of the participants did not see the need to make changes to address LGBT older adults or implement staff training which is LGBT specific. These results align with the literature that found over half of nursing home administrators did not anticipate making changes to their practice to be more inclusive of LGBT older adults (Mihalko, 2014). Some participants acknowledged they were unsure how to address certain issues that are LGBT specific and staff have previously asked if they should be doing anything different for an LGBT resident. Previous literature has indicated LGBT individuals are three times more likely to choose healthcare providers who possess LGBT specific knowledge (Whitehead et al., 2016).

The results of this study indicate senior care facilities should prepare to implement inclusive practices now. Participants indicated they are anticipating more of the LGBT

population to be admitting to their facilities in the future and some reported having already served LGBT residents.

This research also aligns with previous research which has found rural communities often lack community-based LGBT resources. Only one facility identified a LGBT resource in their community. One participant acknowledged a provider who advertised as LGBT friendly in a larger town nearby. The lack of LGBT specific community resources and providers who identify as being LGBT friendly may have caused some LGBT individuals to move to urban areas that have access to these specific services. If accurate, this phenomenon could also be causing rural providers to be seeing less people who identify as LGBT.

A majority of the participants acknowledged they have not made changes to be more inclusive and facilities that have made alterations do not anticipate making more changes to be more inclusive at this time. Participants indicated their facilities are not doing anything to attract LGBT residents. All participants believe their staff would be welcoming to LGBT older adults and could meet their needs. All participants also indicated they would treat LGBTs the same as everyone else. Literature indicates LGBT older adults are further marginalized if their unique needs are not recognized (Concannon, 2007). Facilities that do not see the need for change but want to be perceived as welcoming could be undermining their ability to be seen as a facility that could meet the needs of a potential LGBT resident. The simple act of displaying a rainbow decal or indicating openness to the LGBT community through marketing efforts, could provide some level of comfort to a LGBT older adult seeking supportive care.

Treating everyone “the same” could indicate some heterosexual normative behavior from the staff and other providers. Previous research has also found providers that are unaware of LGBT specific issues and treat everyone the same, regardless of difference are not aware of

diverse needs (Portz et al., 2014). When diverse needs are not recognized, LGBT residents are further marginalized and specific health, social and emotional needs are more likely to go unmet.

A majority of participants also anticipated staff and other residents could be biased when caring for an LGBT older adult. This result aligns with other research that found more than half of direct care staff were intolerant or judgmental of homosexuality (Porter & Krinsky, 2014). This result also correlates with older adult's reluctance to disclose their sexual orientation in long-term care facilities because they fear discrimination by staff and other residents (De Vries & Croghan, 2014).

A few participants also mentioned addressing biases or discomfort of staff and other residents who may struggle providing services to LGBT residents. Participants believed older staff may struggle more with providing care for an LGBT resident. Participants stated they would provide education and support for those who may find themselves having a personal dilemma as it pertains to caring for LGBT residents. This result strongly indicates the need for cultural responsiveness training for staff. Previous research supports this concept. Cultural responsiveness training programs that educate staff and help them understand how professional practices and social policies have oppressed LGBT older adults have been effective in helping staff become more tolerant and knowledgeable about LGBT older adults (Concannon, 2007).

A few participants indicated they have staff who are LGBT who have been welcomed to the facility by other staff and residents. This is a positive indication of change that may be occurring in facilities caring for older adults. LGBT staff could provide reassurance for an LGBT older adult needing care. If facilities are not implementing policies that are inclusive to LGBT older adults, it could also send a mixed message to staff who are LGBT.

Half of the participants thought younger staff were more open to providing care to LGBT older adults because they have had more exposure to the LGBT community. Participants described how the younger generation is more open to diversity in general. Staff who are open to diversity could change how LGBT older adults feel about accessing service needs in the future. Two of the rural facilities have made minor changes to be more inclusive of the LGBT population. This is also a promising indicator that LGBT individuals may have less barriers when accessing rural services in the future.

In the state of Minnesota, long- term care facilities have similar protocols for filing vulnerable adult reports to the Department of Health and Human Services. If resident to resident harassment occurs, lead staff are responsible for documenting and investigating the incident and have five days from the initial report to complete required information to submit to the Department of Health and Human Services. Assisted living facilities do not require the same reporting guidelines as the MN Department of Health and Human Services. However, all mandated reporters such as social workers, are required to report incidents that have been reported to them that involve neglect or abuse inflicted on a vulnerable person. The results were not surprising when participants indicated they would address a resident harassing a LGBT resident the same as any other incident that may place a person in harm.

Implications for Social Work Practice

A major implication of this study was the need to educate others, so they can provide culturally responsive services to LGBT older adults. Social workers have a professional commitment to continue self-initiated education and pass that education onto others to promote social justice. Participants also acknowledged LGBT older adults may encounter barriers with staff and other residents. If staff are more informed, they can pass knowledge onto other residents who may stigmatize the LGBT community.

Implications for Social Work Policy

Social workers have a unique advantage to work with marginalized populations and advocate for the underserved by using their informed practice to cultivate change in policies. Changes at the local level are often easiest to implement and may only begin with one person advocating for the need by passing facts onto others. Social workers can advocate by contacting the administrators at care facilities or contacting local legislators to work toward developing policies and practices that are more inclusive of the LGBT older adult community.

Implications for Research

Sexual orientation and gender identity are unique, but the concepts are often associated with each other. Future studies could focus on barriers and perceptions of culturally responsive care provided to gender non-conforming and transgender individuals in rural senior care facilities. Future research could seek out experiences of LGBT older adults who previously admitted to senior care facilities in rural communities or experiences of LGBT residents who are currently residing in senior care facilities. Studies could also further investigate if rural LGBTs are moving to metropolitan areas to seek joining a larger LGBT community or to attempt to locate services specific to the older LGBT community.

Conclusion

The older adult population is rapidly increasing and will for years to come. There is no better time than the present, to increase knowledge about marginalized groups and strive to eliminate barriers. Our society needs to acknowledge what has gone wrong in the past, further examine the need to make positive changes, and implement those positive changes. No one should have to fear victimization or discrimination, especially as they age and become more vulnerable. Aging is a challenging process, and everyone deserves to age with dignity and respect.

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Appendix A

ST CATHERINE UNIVERSITY Informed Consent for a Research Study

Study Title: Rural Service Provider Perceptions of Cultural Responsiveness to LGBT Older Adults

Researcher(s): Lisa Twomey, BSW, LSW

You are invited to participate in a research study. This study is called Rural Service Provider Perceptions of Cultural Responsiveness to LGBT Older Adults. The study is being done by Lisa Twomey, a Masters' student at St. Catherine University/University of St. Thomas in St. Paul, MN. The faculty advisor for this study is Rajean P. Moone, Ph.D., Graduate School of Social Work at St. Catherine University.

The purpose of this study is to gather rural social workers perceptions on how long-term care facilities are responding or preparing for cultural responsiveness to LGBT older adults. This study is vital because LGBT older adults needs and concerns have gone largely unacknowledged. A majority of studies have focused on urban areas, and little information has been gathered about rural preparedness for LGBT older adults. By gathering further information from rural social workers, I anticipate finding if rural long-term care facilities are ready to meet the needs and concerns of LGBT older adults. This study could impact rural LGBT older adults and their level of comfort if they need to access long-term care facilities in the future, based on policies and level of cultural responsiveness at long-term care facilities. Approximately eight to ten people are expected to participate in this research. Below, you will find answers to the most commonly asked questions about participating in a research study. Please read this entire document and ask questions you have before you agree to be in the study.

Why have I been asked to be in this study?

You have been asked to be in this study because you:

- Currently, work as a social worker/designee in a senior care facility.
- The long-term care facility is in a rural area (50,000 people or less)
- You can refer one additional social worker who meets the same criteria, who is not at your current place of employment.

If I decide to participate, what will I be asked to do?

If you meet the criteria and agree to be in this study, you will be asked to do these things:

- Complete is a 15-30-minute interview over the phone,
- Provide the names of 1-2 social workers you think would be good participants for the study.

In total, this study will be done by phone, and the interview will last approximately 15-30 minutes. The interview will be completed in one session.

What if I decide I don't want to be in this study?

Participation in this study is entirely voluntary. If you decide you do not want to participate in this study, please feel free to say so, and do not sign this form. If you choose to participate in this study, but later change your mind and want to withdraw, directly notify me and you will be removed immediately. You may withdraw until February 28, 2018, after which time withdrawal will no longer be possible. Your decision of whether to participate will have no negative or positive impact on your relationship with St. Catherine University, nor with any of the students or faculty involved in the research.

What are the risks (dangers or harms) to me if I am in this study?

The risks in this study are minimal. You may experience discomfort if you have undiscovered or known biases toward individuals who identify as lesbian, gay, bisexual, or transgender.

What are the benefits (good things) that may happen if I am in this study?

There are no direct benefits to you for participating in this research. This study may benefit rural LGBT older adults in the future if cultural responsiveness is not currently being addressed in rural long-term care facilities.

Will I receive any compensation for participating in this study?

You will not be compensated for participating in this study.

What will you do with the information you get from me and how will you protect my privacy?

The information that you provide in this study will be recorded on the phone. The recording will be transcribed to a word document. Participants will be numbered, and names of participants and their current work location will not be used, or audio recorded. Geographic area (ex: Northwest, not city) may be used. I will keep the research results on a password-protected computer, and only I will have access to the computer. Two professional committee members and the research chair may have access to the transcripts while I work on this project. I will finish analyzing the data by April 30, 2018. I will then destroy all transcripts, audio recordings, and other identifying information that can be linked back to you. These documents and recordings will be destroyed no later than May 30th, 2018.

Any information that you provide will be kept confidential, which means that you will not be identified or identifiable in any written reports or publications. If it becomes useful to disclose any of your information, I will seek your permission and tell you the persons or agencies to whom the data will be furnished, the nature of the data to be provided, and the purpose of the disclosure; you will have the right to grant or deny permission for this to happen. If you do not allow consent, the information will remain confidential and will not be released.

Are there possible changes to the study once it gets started?

If during this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these results.

How can I get more information?

If you have any questions, you can ask them before you sign this form. You can also feel free to contact me at (218) 731---- or twom9419@stthomas.edu. If you have any additional questions

later and would like to talk to the faculty advisor, please contact Dr. Rajean P. Moone at rpmoone@skate.edu. If you have other questions or concerns regarding the study and would like to speak to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@skate.edu.

You may keep a copy of this form for your records.

Statement of Consent:

I consent to participate in the study and agree to be audiotaped.

My signature indicates that I have read this information and my questions have been answered. I also know that even after signing this form, I may withdraw from the study by informing the researcher.

Signature of Participant

Date

Signature of Researcher

Date

Appendix B

1. Describe the population your facility currently serves.
 - a. Any diversity?
2. What does it mean to be an “LGBT friendly” or “LGBT welcoming” provider?
 - a. Does your community have service providers or organizations that identify as being LGBT friendly or provide services specifically to the LGBT population?
3. Has your facility made any changes to better serve the LGBT community? (ex. policies, marketing, etc.) If yes, please explain. If no, do you anticipate future changes? Please explain.
4. Describe what experiences an LGBT older adult might encounter if they were open about their orientation/identity in your facility?
5. Overall, what strengths do you think direct care staff would possess when providing care to an LGBT resident?
 - a. Are there any challenges direct care staff might face in providing care?
6. What types of cultural responsiveness training have been implemented at your facility?
 - a. Do trainings address service specific to the LGBT population?
7. How does your facility address resident to resident harassment?
 - a. Describe how your facility would address a resident harassing another resident who identified as LGBT.
8. Do you have any other information or perceptions that have not been discussed?

Appendix C

Original email script for initial participants:

Hello,

My name is Lisa Twomey and I am a graduate student at St. Catherine University/University of St. Thomas in the School of Social Work Master's program. I am conducting research on rural service provider perceptions of cultural responsiveness to LGBT older adults. I am inviting you to participate because of your role as a social worker and your experience working with older adults in a rural long-term care setting.

Participation in this study includes a 15-30 minute audio recorded phone interview. If you are interested in the study I will follow up with the consent form and the research questions for your review prior to the interview. If you decide to participate, I ask that the consent form is signed and returned. Once I receive the consent form, I will contact you to schedule a phone interview. If you decide to participate, I ask that you please identify one other rural senior care social worker/ designee, who is not currently at the same long-term care facility and would be willing to participate in this study.

If you have any questions or would like to participate, I can be reached at (218) 731---- or twom9419@stthomas.edu.

Thank you for your time,
Lisa Twomey, LSW