2014

Culturally Competent LGBT Care

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Culturally Competent LGBT Care

By

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Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
Of the requirements for the degree of
DOCTOR OF NURSING PRACTICE

April 28, 2014

College of Nursing

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Abstract

Although recent efforts continue to improve the status of those in the lesbian, gay, bisexual and transgender (LGBT) community, individuals and families continue to suffer from discrimination and stigma in their everyday lives. Such experiences have both direct and indirect effects on the health of LGBT individuals leading to existing health disparities. As a result, a new impetus has developed to improve the quality of care by addressing the gap in LGBT health. Increasing cultural competency is one method by which to improve care and health outcomes. Using current evidence, an educational program was developed to promote the cultural competency of healthcare providers. The program was designed based on The Process of Cultural Competence in the Delivery of Healthcare Services, a theoretical framework by Dr. Campinha-Bacote (2013b). It was then implemented in three types of primary care practices, each in a culturally different geographic area - one in the Commonwealth of Massachusetts and the other two in the State of Georgia. The goal of the program was to increase the level of LGBT cultural competency among participating healthcare care providers as well as increased awareness and perceived practice value for other health care staff. This educational program showed positive results in improving the level of cultural competency of healthcare providers in all three settings and received high participant ratings with regard to practice value and willingness to recommend. Some differences among groups also provided information for further program development.

Keywords: cultural, competency, LGBT, health, primary care, providers, education
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Culturally Competent LGBT Care in the Primary Care Setting

**Background and Significance**

As stated in the American Nurses’ Association Code of Ethics (2001), nurses should practice “with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems”. In its hallmark report, “Crossing the Quality Chasm”, the Institute of Medicine (IOM) further presents a vision of health care that incorporates six specific aims, suggesting that care should not only be safe, effective, timely, and efficient but also patient-centered and equitable (2001). The term patient-centered means care delivery that is respectful and attentive to the patient’s values, preferences and needs while the term equitable refers to providing the same high quality care to all regardless of personal traits such as gender, age, socioeconomic status and ethnicity or race (IOM, 2001). Improving cultural competence would support these aims by improving the patient experience and reducing the potential for health disparities (Betancourt, Green, Carrillo, & Park, 2005).

**Problem Identification and Rationale**

Although efforts have been in place identifying and addressing the needs of diverse groups, those of the Lesbian, Gay, Bisexual and Transgendered (LGBT) community are still evolving. For example, the U. S. Department of Health and Human Services (2011) released a summary of recommendations and actions to improve the health of the LGBT community including national policy changes, new programs and additional funding to meet this aim. In March of 2011, the IOM also released a report presenting current research about LGBT health disparities, knowledge gaps and recommendations for improvement in care, and stated that “a lack of training for health care providers may lead to less than optimal care for LGBT”
individuals. The following year Healthy People 2020 (U. S. Department of Health & Human Services, 2012b) added a new and evolving topic area on LGBT issues which recommends “appropriately inquiring about and being supportive of a patient’s sexual orientation” to both increase the patient’s access to care, as well as the improve the patient-provider relationship. Another recommendation was to add LGBT care and cultural competency content and courses to medical education (U. S. Department of Health & Human Services, 2012b).

The importance of this education may further be heightened given the existing climate among health professionals and educators. For example, although LGBT nurses have been identified as one of the largest groups within nursing, many have themselves experienced homophobic reactions and discrimination in the workplace (Eliason, DeJoseph, Dibble, Deevey, & Chinn, 2011). However, overt homophobia is not always apparent to students in educational settings and may instead be infused with a subtler undercurrent of heterosexism (Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007). Sirota (2013) found that levels of acceptance and homophobia among nurse educators varied based on the age, religion, and degree of religious observance, geographic region, and sexual orientation of educators, as well as the degree of preparation and comfort in teaching LGBT related content. Such experiences and attitudes are inconsistent with the values and ethics of nursing.

A lack of education surrounding the LGBT community and health needs is also apparent. For example, in a study examining nursing and medical students’ knowledge about the LGBT population, 82% of students lacked necessary knowledge for the delivery of culturally competent care (Rondahl, 2009). Those scoring lower among student groups included nurses, males and those with religious affiliation, important considerations in the development of cultural competency training (Rondahl, 2009). However, medical education has also been found to be
lacking with medical schools reporting a median of five hours dedicated to LGBT related content among 176 medical schools (Obedin-Maliver et al., 2011). In a review of nursing literature discussing LGBT health, Eliason, Dibble, and DeJoseph (2010) found that only 0.16% of articles (8 out of approximately 5000) included LGBT related content in the top-10 impact nursing journals. This reflects what may be a heterosexist atmosphere in nursing and silence regarding the needs and care of LGBT patients, highlighting the need to incorporate LGBT related content into nursing education. In her article discussing these findings, Keepnews (2011, p. 167) suggests that “the time is right to raise the visibility of LGBT issues in nursing” in the areas of policy, research, practice and education. Similar education and training gaps occur among other important LGBT care providers such as those in mental health including psychiatry, social work, psychotherapy and psychology (Rutherford, McIntyre, Daley, & Ross, 2012). Nursing students have also begun to recognize and increase awareness regarding the need for LGBT culturally competent education (National Student Nurses Association, 2010).

Therefore, one step to improve patient-centered and equitable care for LGBT patients is to improve the cultural competence of primary care providers surrounding the LGBT community. This includes current attitudes and behaviors that affect the LGBT community as well as awareness of existing disparities. For example, in a population based study of adult health, lesbians, gays, and bisexuals reported higher levels of worry or tension, sexual victimization, asthma, activity limitation, drug use, and HIV testing (Conron, Mimiaga, & Landers, 2010). Still in another study, lesbian/bisexual women were more likely to have poor mental and physical health including higher rates of asthma, obesity, smoking, and excessive drinking along with decreased access to care and lower rates of utilizing preventive services and screenings (Dilley, Simmons, Boyson, Pizacani, & Stark, 2010). Bisexual/gay men had
comparable findings including poor mental health, increased rates of smoking, and limited physical activities while bisexuals of both sexes had the highest rates for each among all groups (Dilley et al., 2010). Sex related differences exist including higher risk of STIs and HPV among men who have sex with men due to unprotected sex and decreased access to care (Poynten et al., 2013) as well as higher rates of breast cancer among lesbian women due in part to lack of breast feeding, oral contraceptive use, and older age of child-bearing (Brandenberg, Matthews, Johnson, & Hughes, 2007).

Disparities in care can also exist regarding access and utilization of health services. For example, LGBT parents may have decreased access to health insurance benefits for their partners and/or non-biologic children (Badgett, 2008; Ponce, Cochran, & Pizer, 2010). Lesbians were also found to have lower routine screening rates, such as cervical screening and mammography (Tracy, Schluterman, & Greenberg, 2013) while gay men have limited access to preventive services for STI and HIV screening and treatment (CDC, 2011). Meanwhile, transgender people face additional hurdles including refusal of care by providers, lack of transgender care knowledge, harassment and overt violence (Grant et al., 2010).

To address this need, current evidence is available that can be used to develop an educational program for primary care providers. Some sources, such as clinical practice guidelines, are specific to improving LGBT care in the primary care setting, while others can be adapted for this use such as recommendations and programs developed for use in the acute care setting (Joint Commission, 2011). Additional sources of evidence include articles regarding the content, teaching and efficacy of cultural competency education for students and care providers.
Review of Literature

Appraisal of Research

A comprehensive search of the literature for evidence regarding cultural competence and the care of LGBT persons was completed. The following databases were used: Cochrane, PubMed of the National Library of Medicine, Cumulative Index of Nursing and Allied Health Literature (CINAHL), LGBT Life with Full Text, PsycARTICLES and Google Scholar. Search terms included homosexuality, female, male, bisexuality, transgender persons, cultural competency, primary health care, health care personnel, health care providers, discrimination, and homophobia. Articles regarding cultural competency education and training and culturally competent care delivery were found.

To begin, the literature included articles regarding cultural competency in nursing education. For example, in a descriptive study, Kardong-Edgren and Campinha-Bacote (2008) measured the cultural competency of 218 graduating nursing students from 4 nursing programs each in geographically different locations using different curricular methods and transcultural nursing theories. Cultural teaching methods included an integrated curriculum versus a freestanding course and theories included those by Leininger and Campinha-Bacote (Kardong-Edgren & Campinha-Bacote, 2008). Students from all groups scored within the “culturally aware” range suggesting no teaching strategy was more effective and that reaching the level of “cultural competency” may not be a realistic goal to be achieved by graduation (Kardong-Edgren & Campinha-Bacote, 2008). Next, in a descriptive article, Lim, Brown and Jones (2013) explore the current atmosphere surrounding LGBT health needs and identify strategies to enhance the integration of sexual orientation and diversity content into nursing education. The educational strategies include simulation, case studies and course development and while support strategies
include academic advising and recruitment of diverse faculty including those that are openly LGBT (Lim et al., 2013). Finally, in a literature review of 44 articles, Brennan, Barnsteiner, Siantz, Cotter and Everett (2012) sought to identify gaps and opportunities regarding LGBT related content for inclusion in nursing curricula to improve attitudes, skills and knowledge and the promotion of culturally competent care. The authors were able to identify focused teaching strategies for simulation, didactic and clinical settings, some of which included LGBT panels, videos showing LGBT experiences, and clinical experience with LGBT patients, as well as a comprehensive list of LGBT information and educational resources (Brennan et al., 2012).

Literature also included articles regarding the training of medical and other allied health students. Kelley, Chou, Dibble and Robertson (2008) implemented an LGBT health curriculum for medical students at the University of California at San Francisco, which included a syllabus, a one-hour patient panel, and a one-hour small group case study discussion. They evaluated the effectiveness of the program, which showed students increased their knowledge about sexual orientation, access to care and health needs, and increased their willingness to care for LGBT patients (Kelley et al., 2008). Next, Brondani and Paterson (2011) found that while no single method was ideal, a variety of teaching methodologies used to incorporate LGBT issues in dental curricula, including seminars, lectures, LGBT community discussion panels, and poster presentations, had a positive impact on dental students as exemplified in the students’ reflections. Similarly, Sales, Jonkman, Connor and Hall (2013) completed cultural competency training for 98-second year pharmacy students, 84 of which completed both pre and post-intervention surveys. Students were divided into three groups each receiving a different educational intervention- a lecture, case scenarios and patient simulation (Sales et al., 2013). Although each strategy significantly increased scores in one of the elements of cultural skill, cultural desire,
cultural empathy and cultural awareness, there was no significant improvement in cultural competency overall, suggesting that a combination of methods may be needed (Sales et al., 2013).

Additional evidence was reported regarding training for health professionals. Hanssman, Morrison and Russian (2008) used a mixed-method approach to assess the effects of provider training sessions on the care of transgender patients. The results of 55 post training surveys indicated an increased knowledge of culturally competent care for transgender individuals while qualitative findings provided suggestions for curriculum development (Hanssmann et al., 2008). Some specific recommendations included offering information that is relevant to providers to promote clinical competence (who needs mammograms), information regarding existing care barriers (unwelcoming environment or lack of insurance coverage), and tools to enhance provider-patient relationships (Hanssmann et al., 2008). Lie, Lee-Ray, Gomez, Bereknyei and Braddock (2010) completed a systematic review of seven studies measuring the ultimate effect of health professional cultural competency trainings on patient outcomes and found that although overall study quality and effect size were low to moderate without sufficient control for confounding variables, three studies demonstrated a beneficial effect while the remainder identified no harmful effects. The authors also proposed an algorithm to be used by educators to design and evaluate cultural competency training and its impact on reducing health disparities. Khanna, Cheyney and Engle (2009) found that a four-hour cultural competency training on ethnicity, language and race for 43 healthcare providers and administrators was effective based on increased post-test scores in the areas of cultural knowledge and cultural skill. Overall, multiple sources were identified providing information by which to develop and deliver effective cultural competency education programs for providers.
During the search of the literature, clinical practice guidelines were also found that included recommendations for improving overall LGBT health. Each guideline was then appraised by the student author using the Appraisal of Guidelines for Research and Evaluation (AGREE II) instrument (AGREE Research Trust, 2009). This tool was developed by teams of international experts in the development of practice guidelines and research to provide a standardized method by which to assess methodological rigor and developmental transparency, as well as to compare guideline quality (AGREE Research Trust, 2009).

To begin, Kaiser Permanente Diversity Council (KPDC) (2004) developed comprehensive guidelines that explicitly address the care needs of sexual minority groups with special sections on transgender health, intersexuality, obstetrics/gynecology, mental health, and child/adolescent health as well as major diseases such as HIV. Although the guidelines appear to be based on a substantial body of evidence, they suffer mostly from low developmental rigor (scoring 18 out of 56) as they lack information on the methods used to search for and apply that evidence to support the recommendations (AGREE RT, 2009; KPDC, 2004). The Gay and Lesbian Medical Association (GLMA) (2006), a national organization dedicated to improving equitable care for sexual minorities, also created guidelines for the care of LGBT patients including recommendations on creating a welcoming environment, increasing awareness of LGBT health needs, promoting sensitive and confidential communication, and caring for lesbian/bisexual women and gay/bisexual men. Although each section includes accompanying references, no evidence selection or recommendation methodology is discussed (AGREE RT, 2009). The Joint Commission (JC) (2011) developed an LGBT field guide for hospitals using an expert advisory panel to identify strategies to promote cultural competence, effective communication, and family-centered care. This multidisciplinary panel consisted of leaders
representing LGBT advocacy organizations, patient safety and health policy centers, as well as professional associations; however, no nurse was listed among the team (JC, 2011). Recommendations were then “expanded and augmented” by current research, other professional groups and regulatory standards (JC, 2011, p. 4).

Other general practice guidelines were found regarding LGBT care. For instance, *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health* (Makadon, Mayer, Potter & Goldhammer, 2007) provides a comprehensive source for primary care providers that includes all aspects of care and recommendations including methods to improve access to and utilization of care, history taking, provider communication, patient disclosure, prevention, and screening as well as treatment of mental and physical health needs for all ages and groups. Each chapter includes citations linking information and recommendations to research articles, however, no information on how literature was selected is presented. Meanwhile, McNair and Hegarty (2010) completed a systematic review of existing guidelines for the primary care of LGBT patients with a final review of 11 articles. The results revealed a low to moderate level of developmental rigor using the AGREE criteria (AGREE RT, 2009). However, guidelines included consistent themes such as increasing awareness, promoting clinician-patient communication, creating an inclusive environment, and developing documentation that reflects the needs of LGBT patients (McNair & Hegarty, 2010).

The search also resulted in guidelines that focused more specifically on groups including adolescents, lesbians and transgendered persons. For example, Adelson & American Academy of Child and Adolescent Psychiatry (AACAP) (2012a) developed care parameters for the care of lesbian, gay, bisexual, gender nonconformity and gender discordant youth based on evidence including population-based, multi-site, blinded and controlled studies. The guideline measures
high in rigor and development (50 out of 56), scope and practice (21 out of 21) and clarity and presentation (19 out of 21) (AGREE RT, 2009), and includes nine principles/parameters that are consistent with other guidelines such as confidentiality, family dynamics, psychosexual development, and increased psychiatric risk (Adelson & AACAP, 2012b). For example, Roberts (2006) reviewed the literature to identify the health care needs of lesbian women. The review included 93 articles and discussion of findings reflecting disparities in care, opportunities for improvement in the client provider relationship, and enhanced screenings focused on LGBT needs (Roberts, 2006). The author presented recommendations to improve primary care, including a links to guidelines in the systematic review previously discussed (Roberts, 2006). For example, Feldman and Goldberg (2006) developed practice guidelines for the primary care of transgender patients, including general medical care and care related to transgender issues such as the masculinization or feminization needs of female to male (FTM) or male to female (MTF) patients. The guidelines clearly present health recommendations for FTM or MTF including health concerns, appropriate history taking, preventive screenings, and hormone therapy (Feldman & Goldberg, 2006). However, developmental rigor is low to moderate (25/56) as is applicability (10/28) and editorial independence (3/14) (AGREE RT, 2009). Then, in a joint effort between the Massachusetts Department of Public Health and the Fenway Health Institute, Ratelle and Mayer (2005) developed a toolkit for clinicians on the care of men who have sex with men primarily focused on the reduction of STIs. The toolkit also provides guidelines regarding culturally competent care such as understanding sexual orientation and LGBT culture, creating a welcoming, safe practice environment, as well as explicit treatment recommendations (Ratelle & Mayer 2005). The guideline is useful in the care of men who have sex with men but has low rigor of development scoring only 18 of 56 in this area (AGREE RT, 2009).
Synthesis of Evidence

Overall, this literature review revealed that cultural competency education and training continues to be a focus in healthcare as a method by which to improve care outcomes. More recently, cultural competency education has grown to include the needs of the LGBT community and therefore research in this area is also developing. The literature included both research and non-research based evidence and varied in strength and quality (Johns Hopkins Hospital & Johns Hopkins University School of Nursing, 2013a; Johns Hopkins Hospital & Johns Hopkins University School of Nursing [JHH & JHUSoN], JHUSoN, 2013b). Overall, there was a lack of high-level, high-quality research-based evidence regarding cultural competency training, which was consistent with the findings in the systematic review (Lie et al., 2010).

However, themes and strengths did arise from the evidence. Foremost was the fact that all studies measuring the effectiveness of cultural competency training consistently demonstrated increased levels of cultural competency without any reported harmful effects. This was comparable with the findings in the systematic review (Lie et al., 2010). Results remained similar among all participant types, both students and professionals, as well as across all disciplines: nursing, medicine, pharmacy, mental health professionals. Also, several studies included similar cultural competency components. They included cultural awareness, attitudes, skill, empathy and knowledge in their measurements and findings (Kelley et al., 2008; Hanssman et al., 2008; Khanna et al., 2009). Their descriptions were relatively consistent with those described in Campinha-Bacote’s (2013b) theoretical framework regarding the process of cultural competency in healthcare. Two studies actually used this framework to guide their study (Sales et al., 2013; Kardong-Edgren & Campinha-Bacote, 2008).
Among evidence surrounding the teaching and learning of cultural competency, themes also arose. For example, effective teaching strategies included lectures, case scenarios, simulation, panel discussions (in person and on-line), and clinical patient encounters each of which was used to support the development of different cultural components (Sales et al., 2013; Brondani & Paterson, 2011; Lim et al., 2013). Content and topics frequently included in training and education courses consisted of information on sexual orientation and gender identity, social determinants of health (stigma and homophobia), barriers to care (discrimination, lack of spouse/partner insurance coverage), health disparities and associated risks among LGBT people, provider-communication (ability to complete a history), appropriate assessment, establishing trust, creating welcoming environments, and health needs for LGBT people (Brennan et al., 2012; Lim et al., 2013; Kelley et al., 2008; Hanssman et al, 2008).

Practice guidelines are available to support the delivery of culturally competent LGBT care through professional and health advocacy organizations. They include those for the general LGBT community as well as the unique needs of different subgroups. Overall, the guidelines scored low to moderate in the areas of developmental rigor, applicability and editorial independence according to the AGREE Research Trust (RT) (2009) criteria with the exception of those by Adelson and AACAP (2012) which specifically scored high in rigor of development by including very clear methods for searching, selecting, and evaluating evidence and the process to then develop recommendations to which the evidence was linked (AGREE RT, 2009). Otherwise, guidelines scored moderate to high in scope and purpose, stakeholder involvement, and clarity and presentation (AGREE RT, 2009). Similar results were identified in the high quality (JHUSoN, 2013a) systematic review of eleven guidelines by McNair and Hegarty (2010). These guidelines included consistent themes regarding content and recommendations including
methods to improve provider-patient communication, to create more welcoming and accessible environments, to increase awareness of effects of discrimination and associated health disparities, as well as the physical and mental health needs of diverse sexual minorities.

In general, the evidence points to the need for stronger and higher quality studies regarding cultural competency education and practice guidelines to better support the delivery of culturally competent LGBT care. Until that time arrives, the evidence surrounding cultural competency education and training is sufficient to provide a foundation for course development surrounding knowledge of sexual orientation, gender identity and diverse sexual minorities. Likewise, current practice guidelines can serve as valuable tools to improve current care delivery until newer and stronger evidence to support future guidelines becomes available. Both will extend the depth and breadth of culturally competent care available to the LGBT community while taking steps to close the gap of associated health disparities.

**Theoretical Framework**

Various nursing models of care are available that can provide a guiding framework for the delivery of culturally competent healthcare (American Association of Colleges of Nursing, 2011). One model is “The Process of Cultural Competence in the Delivery of Healthcare Services” by Josepha Campinha-Bacote (2013b). This framework describes the process by which individuals can become culturally competent and includes the following elements: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. To begin, *cultural awareness* includes a self-assessment and understanding of one’s own biases and those of existing discrimination, such as homophobia and heterosexism. Next, *cultural knowledge* involves education about cultural groups and their associated health values and beliefs as well as their disease patterns and existing disparities. *Cultural skill* applies to the ability to conduct an
interview and assessment that incorporates cultural aspects of the health problem. Meanwhile, *cultural encounters* are those opportunities when health care professionals are able to directly interact with patients and families from different cultural groups, in this case LGBT persons, to modify preexisting beliefs and prevent stereotyping. Lastly, *cultural desire* is that which stimulates the health professional to become engaged in the process of cultural competence.

This model has been used in a variety of areas, some of which include primary care (Paez, Allen, Carson, & Cooper, 2007), health literacy (Ingram, 2011), and nursing education (Kardong-Edgren & Campinha-Bacote, 2008; Hawala-Druy & Kill, 2012). As such, this framework can be utilized to design an education program that promotes the ability of primary care providers to more effectively meet the needs of lesbian, gay, bisexual and transgender patients within their cultural context. Course development can include targeted teaching strategies that specifically foster the integration and achievement of each element within the framework — *cultural awareness, knowledge, skill, encounters and desire* (Campinha-Bacote, 2013b). As a result, the educational program will promote and support each step in the process of cultural competence for primary care providers as a method to improve care for their LGBT patients.

**Methods**

**Setting**

The proposed settings for this educational program included a total of three primary care practices — one in the northeast state of Massachusetts and two in the southeast state of Georgia. The first location was a women’s health center in an urban location in western Massachusetts. The region is more politically liberal regarding the LGBT community including state laws supporting same sex marriage and protection of sexual orientation as a civil liberty
(Commonwealth of Massachusetts, 2013) as well as proximity to Northampton, MA which is home to a high concentration of same-sex households (Urban Institute, 2004). However, the center itself is affiliated with a faith-based organization and serves mainly women of lower socioeconomic means. Predominate ethnic and racial groups served include Latina and African American woman. Meanwhile, the immediate surrounding community is made up of people who are 46.8% White, 48.4% Latino, and 4.7% Black (U. S. Census Bureau, 2013c). The median annual income is low at approximately $33,915 with 31.3% living below poverty level while only 20.4% of persons over age 25 have bachelor degrees or higher (U. S. Census Bureau, 2013c).

The other two locations included distinctly different suburban areas within the metropolitan area of Atlanta, Georgia. Although the region includes a large LGBT community, it is still more socially conservative. For example, Georgia laws include no protection against discrimination based on gender identity or sexual orientation (Georgia Equality, 2012).

The first was a health services department at a private women’s college serving approximately 950 students ranging in ages from 18 to 22. Of the student body, approximately 40% are women of color while 10% of students are international. No information is available regarding sexual orientation or gender identity; however, there are organized LGBT groups and programs on campus. The community surrounding the school has one of the highest educational levels in the metropolitan area (68.5% with bachelors degrees or higher) and higher median household incomes ($73,602) although 14.9% live below the poverty level (U.S. Census Bureau, 2013a). Of the population, 71.4% are white, 20.2% are black and 2.9% are Asian, and 3.2% are Latino, and the remainder of mixed heritage (U.S. Census Bureau, 2013a). In addition, the immediate area is also home to a high concentration of same sex couples (Urban Institute, 2004).
The other was a primary care practice that provides care to over 16,000 patients over the age of 18 in an adjacent but more suburban county northeast of Atlanta. This area has a lower educational level (34.7% having bachelors degrees or higher) and lower median incomes ($63,076) although only 12.4% live below poverty level (U.S. Census Bureau, 2013b). Meanwhile this community is also more diverse with population that is 42.4% white, 25.5% black, 11.1% Asian, and 20.7% Latino (U.S. Census Bureau, 2013b). Having such different practices settings will allow comparison of the educational program’s effectiveness in differing cultural environments.

Sample

This project utilized a convenience sample consisting of all primary care providers from each of the practice settings who attended the LGBT cultural competence education programs. In total there were 13 providers who were included as sample subjects. This study group included various provider roles such as nurse practitioners (NP), certified nurse midwives (CNM), physicians (MD), and physician assistants (PA). Of this sample, six were employed by the women’s health center or the affiliated health system, including two CNMs, two NPs and one PA. Of this group, all were female, one Latina and the remainder all white. The student health service was staffed by two white female NPs who attended along with one student NP who was present at the time of the education program. Four providers from the adult primary care practice attended. They included two MDs and two PAs. Of this group, one is a White male while other three are African-American women. Most providers had been in practice for greater than ten years (with the exclusion of the student NP) and no providers were known to be openly LGBT. All providers in the sample were measured regarding their level of cultural competency and each completed a program evaluation survey.
Additional staff from the various practice settings and their affiliates were also invited to participate in the educational sessions. A total of 75 participants attended consisting of nurses, medical assistants, counselors, psychologists, chaplains, nurse educators, nursing students, and administrators. Although not included in the main study sample, all non-provider staff were surveyed to evaluate the program in order to identify what information they found to be helpful and valuable to their work or practice. The results could then be used for future program development.

**Stakeholders**

To execute this project key stakeholders were engaged during the program development and implementation process. To begin, each site had a practice manager who oversaw its operations and with whom the DNP student coordinated the details of implementation such as program scheduling and notifications as well as data collection. Next, those involved in the program such as LGBT actors and panelists were recruited, and over the course of the project development their input was sought out and their roles delineated. Lastly, the healthcare providers were recruited and notified regarding the program’s content, aims and value to their practice and patients’ health.

**Resources and Barriers**

Implementing the educational program surrounding LGBT cultural competency involved effective project management. This included identifying available resources and facilitators, as well as potential barriers and constraints. Therefore, anticipating potential reactions ranging from overt homophobia to subtler heterosexism among those involved in the project’s development and implementation was important to identify strategies early on to overcome these constraints. Although no overt homophobia was experienced, there was some perceived discomfort when
interacting with the practice manager for the primary care practice in Georgia. To address this, the DNP student author met in person with the practice manager and the physician who had initiated the planning by reaching out to the student author and expressing her interest in the LGBT cultural competency program. During this meeting, the student author provided an overview of the program and its objectives to increase buy in by answering questions, clarifying information and addressing concerns such as timing of the program. The meeting was beneficial and opened the lines of communication.

Other barriers included, existing time pressures and scheduling demands for primary care providers. Given the number of patients scheduled on a daily basis, practice managers expressed a need to keep the program limited to no greater than 90 minutes and each required sufficient advanced notice to schedule a date and time that would allow for all practice providers and staff to attend during office hours. This would limit financial implications such as avoiding paying overtime for hours outside of regular working hours. With this in mind, scheduling was adjusted for each practice setting to allow for the program to be delivered during office hours.

One barrier that was not anticipated was the inclement weather. The program at the college health service was delayed twice from late January, to early February and then to later February due to snow and ice storms and the closure of the college. Meanwhile, the student adjusted her flight schedule to travel a day earlier, anticipating a significant snowstorm in western MA. However, no change in schedule was required for that program that took place a day after the storm.

Meanwhile, supportive forces included practice managers and providers who expressed an understanding regarding the importance of cultural competency and the need to improve service to their LGBT patients. In each setting there was a key person promoting provider and
staff engagement and attendance at the educational program – the practice manager in the women’s health practice in MA, an MD in the family practice in GA, and an NP in the college health service. Valuable resources also included LGBT colleagues of the project coordinator who showed interest in the project early on and agreed to volunteer and serve as panelists in the program. Each provided incredible insight into the development and delivery of the program.

Project Plan

To improve the delivery of culturally competent care for lesbian, gay, bisexual and transgender patients, an educational program was developed for primary care providers and practice staff. The program was presented in each practice setting during office hours. The content of the program was drawn from current evidence with varied perspectives ranging from recommendations for nursing and medical education to clinical practice guidelines for the care of LGBT individuals. This information was then tailored for application in primary care settings and for the education of primary care providers and staff. The course design followed The Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2013b) by incorporating interventions supporting the development of each element.

Project Design

To execute the project, a cross-sectional, three-site intervention design with both quantitative and qualitative post-intervention measures of participant outcomes was used. The intervention consisted of a 90-minute program that included a 30-minute PowerPoint presentation (Appendix A) accompanied by a handout of slides for each participant. The content included information about existing barriers and disparities, sexual orientation and gender identity development, privacy and confidentiality concerns, and specific health needs within the LGBT population. Strategies to improve communications, including appropriate language,
terminology and screening questions were discussed as were recommendations to promote a more inclusive and welcoming environment. A packet of information (Appendix B) was also distributed that included reference materials, sample intake form questions, antidiscrimination statement, intervention checklists, and resources that could be accessed for additional information for both patients, staff and providers. The aim of the presentation was to increase the level of cultural knowledge (Campinha-Bacote, 2010b).

Next, the project coordinator found a 15-minute video developed by the American Medical Association (2013) outlining best practices on how to complete a culturally competent sexual history. The objectives of this video were to discuss strategies to conduct a more comprehensive sexual health history and how to implement them to improve the care of sexually diverse patients. It specifically emphasized using non-judgmental communication, open-ended questions and appropriate terminology while avoiding assumptions regarding the patient’s gender identity or sexual orientation. At the conclusion of the video, the project coordinator summarized the video to emphasize the key communication elements that were utilized. The purpose of this exercise was to support the development of cultural skill (Campinha-Bacote, 2013b).

A panel discussion was then held with a scheduled time of 30 minutes. However, in each setting the panel discussion ran over the designated time as participants continued to ask questions. The panel and project coordinator allotted extra time to accommodate this extension. Also, originally, a combination of three different LGBT individuals was to be included in panels for each setting. However, when speaking with the practice managers for the smaller presentations in GA, the project coordinator reduced the panel size to two members given the smaller room size and audience. The two member panels included a White Lesbian and an
African American gay male, both of who were also nurses. Meanwhile, the panel in MA was made up of three members: a white gay male who was a university administrator, a white female lesbian and social worker, and a white female lesbian and nurse. Unfortunately, after several attempts and conversations with different transgendered individuals, none that were available, felt safe or comfortable in participating in such a panel. The major theme was that they did not wish to revisit their journey or past-lived experiences having taken significant steps to reach the points at which they were currently,

In each setting, the panel members shared a brief vignette regarding an interaction he or she had experienced in which cultural competence, or lack thereof, made an impression on his or her own experience as either a clinician delivering care or as a patient or family member receiving it. Participants were then invited to ask questions of the panelists that arose during the course of their stories or the overall presentation. Different methods to submit questions were provided to ensure anonymity or comfort. For example, each participant was given a blank index card to write questions that were collected during the panel introduction. The project coordinator’s cell number was provided so that audience members could text questions to then be asked. However, participants were encouraged to and did ask questions directly to panel members to promote a dialogue format. During these sessions participants became very engaged as did the panel members. In each setting, questions became more personal and emotional as the panel discussion continued. This portion of the program provided a supportive forum by which participants were given the opportunity to experience cultural encounters in a learning environment (Campinha-Bacote, 2013b).

The final two constructs, cultural awareness and cultural desire, were also addressed (Campinha-Bacote, 2013b). Prior to the start of the presentation, the IAPCC-R (Campinha-
Bacote, 2013a) was distributed to each provider. All were instructed to consider each question and to rate their response as it relates to their own level of cultural competence. During the beginning of the presentation, all other participants were also asked to consider their own level of awareness by thinking about their current levels of understandings and past reactions to those different from themselves, in particular those from different sexual orientations or gender identities. These exercises provided an opportunity for each person to begin reflecting on existing biases and prejudices and to further ponder them during the course of the program, thereby increasing cultural awareness. Cultural desire, however, is based on the values of caring and love, as well as a personal passion and commitment to be open and respect others (Campinha-Bacote, 2003b). Therefore, this construct is one that was interwoven throughout each portion of the program in order to motivate participants through each step in the process of developing LGBT cultural competency.

**Ethical Considerations**

The human subjects in the project included healthcare providers and staff whose participation was voluntary and whose risk of harm is minimal. Therefore, approval by an Internal Review Board (IRB) was not specifically required (U.S. Department of Health & Human Services, 1979). However, the practice setting in Massachusetts did request review of the project by their IRB committee and approval was obtained (Appendix C) upon receipt of an email by the project coordinator stating no protected health information would be used and upon approval by the University of Massachusetts IRB (Appendix D). Still, given the sensitive nature of the subject matter, it was important to ensure privacy for participants and confidentiality of their information. No names were used in the course of data collection. Also, no pictures were
taken of those attending the program, nor any recording done of their discussions during the course of the program.

**Project Goals and Objectives**

Three methods of evaluation were introduced to measure the impact of this project. The first was a valid and reliable instrument that was developed to measure the level of cultural competency in healthcare delivery known as the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R©) by Campinha-Bacote (2013a). Permission was requested (Appendixes E - G) and obtained for use in this project (Appendix H & I). Higher scores on the IAPCC-R© would indicate higher levels of cultural competency. The second method of evaluation to measure cultural competency included primary care provider stories that took place following program attendance. Each was to be reviewed for themes reflective of increased cultural competency. Therefore, both of these tools were introduced as methods to measure the educational program’s effectiveness in meeting the main objective that was to increase the level of LGBT cultural competency among primary care providers. Three expected outcomes were associated with this goal (Table 1).

Table 1. Cultural Competency Outcomes

<table>
<thead>
<tr>
<th>Outcome # 1</th>
<th>All participants would demonstrate higher IAPCC-R© scores immediately following the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome # 2</td>
<td>All participants would either maintain or increase their IAPCC-R© scores four weeks later.</td>
</tr>
<tr>
<td>Outcome # 3</td>
<td>All stories received would express themes consistent with increased cultural competency.</td>
</tr>
</tbody>
</table>

The third method of evaluation was a participant survey used to evaluate the program (Appendix J). Higher scores would indicate a higher level of satisfaction with the program. The overall goals of the program were that participants would identify the value of LGBT cultural
competency education and their satisfaction with the program. There would be three outcome indicators based on this survey (Table 2).

Table 2. Program Evaluation Outcomes

<table>
<thead>
<tr>
<th>Outcome #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td># 4</td>
<td>All participants would rate each element in the program evaluation as “agree” or “strongly agree”.</td>
</tr>
<tr>
<td># 5</td>
<td>All participants would rate that the content and program was valuable to their practice as “agree” or “strongly agree”.</td>
</tr>
<tr>
<td># 6</td>
<td>Greater than 90% of participants will report increased awareness of LGBT needs.</td>
</tr>
<tr>
<td># 7</td>
<td>Greater than 90% of participants will report learning new and better ways to communicate with LGBT clients.</td>
</tr>
<tr>
<td># 8</td>
<td>Greater than 90% of participants would recommend the program to others.</td>
</tr>
</tbody>
</table>

**Program Costs**

Program costs included those associated with project development, implementation and evaluation (Appendix K). Development included the costs of printed teaching materials. Implementation included presentation equipment. The computer was available via the project coordinator and a colleague donated the use of a projector for the sessions in GA. For the session in MA, the practice manager arranged for a conference room with all necessary equipment installed with no associated fee. She was also able to order and provide snacks and refreshments for participants using monies within the practice’s budget. For the other two sites, the waiting area and a small internal conference room were used. Healthcare provider and staff attendance was voluntary. All sessions were held during office hours and paid for as regular worked hours for attendees at each practice site. Meanwhile, panelists volunteered their time; however, all were provided meals in connection with program planning and participation. The last implementation costs resulted from travel expenses to MA for the program coordinator. The costs of evaluation included purchase and delivery for the IAPCC-R© to be administered to 13 providers before and
after program and then again at the four week interval, which totaled the purchase of 39 tools. Overall, the program coordinator assumed the net costs of executing the project.

**Plan Timeline**

A Gantt chart is depicted in (Appendix L) reflecting the project work plan and timeline. Initial time for project development and planning were included beginning in late fall with the anticipation of project approvals. Coordination of program implementation occurred in late December to early January. Implementation then began in late January for the first site and continued in early February for the second and third sites. Preprogram and post program evaluation scores were measured simultaneously with each session. The four-week evaluation scores were completed one month following execution of the program. Time for evaluation of the program followed and included data analysis, synthesis and then finally the dissemination of results. The project timeline took place over the course of seven months.

**Data Collection**

Cultural competency was measured before and after the training program. The IAPCC-R® tool (2013a) was administered to all of the primary care provider participants immediately preceding and following the end of the program and then repeated four weeks later. The four-week time point allowed additional time for change in order to increase the strength and accuracy of capturing the effectiveness of the intervention. Each survey was scored in accordance with the guidelines and authorization for its use (Campinha-Bacote, 2013a). At the four-week interval, provider attendees were also invited to share a story/narrative regarding a care episode with a LGBT client that occurred since the program. Written stories could be submitted in person or electronically via email.
The program evaluation surveys were included in all hand out packets and introduced at the beginning of each presentation. All participants, including both providers and non-providers, were encouraged to complete the anonymous surveys. At the end of each session, surveys were collected and reviewed.

**Results**

**Cultural Competency Survey**

In total 13 healthcare providers attended the LGBT cultural competency education programs: four in the GA family practice, six in the MA women’s health setting, and three in the GA college health services setting. An IAPCC-R © survey was completed before and after each program and then repeated four weeks later. The project coordinator then scored all IAPCC-R© surveys according to the IAPCC-R© Scoring Key (Campinha-Bacote, 2013b). Each of the 25 values per tool were then entered into Excel by setting and time and further organized by construct according to corresponding items as defined on the IAPCC-R© Scoring Key (Campinha-Bacote, 2013b). Excel was then used to calculate total sums for cultural awareness, knowledge, skill, encounters, desire along with a total score for each survey. The data was then entered into SPSS for further analysis using RM-ANOVA to compare differences in mean scores between groups and over time, from pre-program, to post-program and then four weeks later. An outside statistician additionally reviewed data and statistical models for accuracy.

First, each construct was measured for effects among cohorts and over time (Figure 1.1). Beginning with cultural awareness (Table 3), providers from different settings reported significantly different levels of awareness (F (2)=4.24, p=.05). However, it appears there were no overall differences among groups in their report over time (F (1) =1.67, p=.23). Although post hoc testing is technically not permissible if the overall effect is not significant, given the small
sample size and the probability of Type II error, significant Post Hoc differences are presented.

Post hoc tests showed that pairs of groups had significant mean differences in cultural awareness at pre test and four week measurements. Pretest differences were present between the GA family practice and the MA women’s health setting (p=.05), mean differences of 2.42. Also at the four-week measure there were mean differences of 3.33 between the GA family practice and both the MA women’s health service and the GA college health services (p=.022). Additionally, there was no significant interaction between settings and time with regard to the level of cultural awareness (F(2)=.91, p=.43).

Table 3. Results of RM-ANOVA Cultural Awareness

<table>
<thead>
<tr>
<th></th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>2</td>
<td>4.24</td>
<td>.05</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>1.67</td>
<td>.23</td>
</tr>
<tr>
<td>Interaction</td>
<td>2</td>
<td>.91</td>
<td>.43</td>
</tr>
</tbody>
</table>

Figure 1.0 Mean Scores Cultural Awareness
Next, cultural knowledge (Figure 1.1) mean scores ($F (2)= .10, p = .91$) did not significantly differ among setting groups (Table 4). However, it appears there were significant differences among groups in their report over time ($F (1) = 6.75, p = .03$). Meanwhile, no interaction between settings and time was found in relation to the level of cultural knowledge ($F (2)= .10, p = .91$).

Table 4. Results of RM-ANOVA Cultural Knowledge

<table>
<thead>
<tr>
<th></th>
<th>df</th>
<th>$F$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>2</td>
<td>.10</td>
<td>.91</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>6.75</td>
<td>.03</td>
</tr>
<tr>
<td>Interaction</td>
<td>2</td>
<td>.10</td>
<td>.91</td>
</tr>
</tbody>
</table>

Figure 1.1 Mean Scores Cultural Knowledge

Mean scores for cultural skill (Figure 1.2) showed no differences among group settings ($F (2)= .28, p = .76$) but again there were significant differences among groups in their report of skill
over time (F (1) = 8.8, p=.01) (Table 5). However, no interaction between settings and time was found related to the level of cultural knowledge (F(2)=1.49, p=.27).

Table 5. Results of RM-ANOVA Cultural Skill

<table>
<thead>
<tr>
<th></th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>2</td>
<td>.28</td>
<td>.76</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>8.8</td>
<td>.01</td>
</tr>
<tr>
<td>Interaction</td>
<td>2</td>
<td>1.49</td>
<td>.27</td>
</tr>
</tbody>
</table>

Figure 1.2 Mean Scores Cultural Skill

Similar findings were identified surrounding cultural encounters (Figure 1.3). Mean scores (F (2)=.42, p=.67) did not significantly differ among setting groups, but again there were significant differences among settings over time (F (1) = 4.84, p=.05) with still no interaction
between settings and time (F(2)=.26, p=.78) (Table 6).

Table 6. Results of RM-ANOVA Cultural Encounters

<table>
<thead>
<tr>
<th></th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>2</td>
<td>0.42</td>
<td>.67</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>4.84</td>
<td>.05</td>
</tr>
<tr>
<td>Interaction</td>
<td>2</td>
<td>0.26</td>
<td>.78</td>
</tr>
</tbody>
</table>

Figure 1.3 Mean Scores Cultural Encounters

![Figure showing mean scores for cultural encounters over time for different settings]

Meanwhile, scores for cultural desire (Figure 1.4) did not show any significant differences with regard to levels of cultural desire (F (2)=.36, p=.71), nor were there any significant differences among groups in their report over time (F (1) =.84, p=.38), including no significant differences among pairs in post hoc tests (Table 7). Also, there was no significant interaction between settings and time (F (2)=.91, p=.43).
A total score was also measured to identify the overall change in the levels of cultural competency (Figure 1.5). Here, total mean scores did not show significant differences among group settings ($F (2) = .179, p=. 839$), however, they did show significant differences among groups over time ($F (1) = 11.61, p=.01$) (Table 8). Again, there was no significant interaction between setting and time in relation to the total cultural competency score ($F (2) =.20), p=.82$). However, all mean scores were higher at the four-week measurement when compared to baseline pretest scores (Table 9).
Table 8. Results of RM-ANOVA Overall Score

<table>
<thead>
<tr>
<th></th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>2</td>
<td>0.18</td>
<td>.84</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>11.61</td>
<td>.01</td>
</tr>
<tr>
<td>Interaction</td>
<td>2</td>
<td>0.20</td>
<td>.82</td>
</tr>
</tbody>
</table>

Figure 1. 5 Mean Scores Overall Cultural Competence

Table 9. Mean Total Cultural Competency Score by Setting Over Time

<table>
<thead>
<tr>
<th>Setting</th>
<th>Cultural Competency Score</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pretest M (SD)</td>
<td>Posttest M (SD)</td>
<td>4 weeks M (SD)</td>
</tr>
<tr>
<td>GA Family Practice (n=4)</td>
<td>74.25 (6.02)</td>
<td>87.00 (8.21)</td>
<td>80.25 (12.04)</td>
<td></td>
</tr>
<tr>
<td>MA Women’s Health (n=6)</td>
<td>78.67 (7.29)</td>
<td>84.67 (6.19)</td>
<td>86.00 (6.26)</td>
<td></td>
</tr>
<tr>
<td>GA College Health (n=3)</td>
<td>78.00 (8.72)</td>
<td>84.67 (7.37)</td>
<td>82.67 (4.62)</td>
<td></td>
</tr>
</tbody>
</table>

Finally, Wilcoxin Signed Ranks tests showed more positive ranks than ties with nine out of 13 (70%) showing that that their overall level of cultural competency as defined by the IAPCC-R ©
moved at least one level higher - from cultural awareness to cultural competence or cultural competence to cultural proficiency (Campinha-Bacote, 2013b).

Another planned method of evaluation for cultural competency was the collection of patient care stories at the four-week time frame. However, no stories were received, which may have been the result of a short time frame, as well as competing demands on providers’ time. However, providers did share brief anecdotal feedback regarding different patient interactions since their attendance at the education program. For example, one provider from the women’s health setting in MA stated she was more aware of the need to use gender neutral language when caring for transgender patients and had been able to practice this skill. Another provider from the GA college health service was caring for a transgender patient at the time of the four-week measure collection. She expressed her desire to improve her communication skills when interviewing such patients and the need to continue to learn more about how better to communicate with and care for transgender patients, including participation in additional conferences on this topic.

**Program Evaluation Survey**

Of the total 75 participants who attended the programs, 67 evaluation surveys were collected for an overall response rate of 89%. The women’s health practice in MA had 47 attendees and 39 surveys were collected for a response rate of 83% while the GA family practice (n=20) and college health service (n=8) each had 100% response rates. Across all elements in the program survey (Table 10), only five responses (<1%) were rated as “disagree” and 21 (<3%) as “neutral” (<3%) out of 804 total survey values, resulting in 97% overall agreement. Positive comments included “I think this should be required training for all staff”; “I learned
new ways to interact in a more open way” and “The program really gave me a great sense of awareness to help me better serve my patients.”

Of all 12 items surveyed, only two received less than 95% agreement ratings. The first was item #3, which inquired about whether or not program length was sufficient for learning. It received 6% disagreement and 9% neutrality ratings. Corresponding written comments included “wish it were longer”, “could have used more time”, “could always be longer”, and “too short”. The second was item #8, which inquired about whether the video was interesting or effective, with 6% neutral responses reported. Written feedback included “would be great to have more discussion time” and “increasing time with panelists would be great”. Finally, when comparing results by setting, no significant differences were identified between groups.

Table 10. Program Evaluation Survey (n=67)

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Mean*</th>
<th>SD</th>
<th>% Agree or Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Content well organized.</td>
<td>4.85</td>
<td>.36</td>
<td>100%</td>
</tr>
<tr>
<td>2. Content was valuable to my practice</td>
<td>4.70</td>
<td>.55</td>
<td>96%</td>
</tr>
<tr>
<td>3. Program length was sufficient for learning</td>
<td>4.40</td>
<td>.89</td>
<td>85%</td>
</tr>
<tr>
<td>4. Trainer effective communicator</td>
<td>4.94</td>
<td>.24</td>
<td>100%</td>
</tr>
<tr>
<td>5. Trainer kept program interesting</td>
<td>4.89</td>
<td>.31</td>
<td>100%</td>
</tr>
<tr>
<td>6. Trainer handled discussion effectively</td>
<td>4.85</td>
<td>.36</td>
<td>100%</td>
</tr>
<tr>
<td>7. Written materials were informative</td>
<td>4.79</td>
<td>.48</td>
<td>97%</td>
</tr>
<tr>
<td>8. Videos were interesting and effective</td>
<td>4.63</td>
<td>.60</td>
<td>94%</td>
</tr>
<tr>
<td>9. Panelists were interesting and effective</td>
<td>4.82</td>
<td>.42</td>
<td>99%</td>
</tr>
<tr>
<td>10. Increased my awareness of LGBT needs</td>
<td>4.79</td>
<td>.45</td>
<td>99%</td>
</tr>
<tr>
<td>11. Learned ways to communicate with LGBT clients</td>
<td>4.73</td>
<td>.59</td>
<td>96%</td>
</tr>
<tr>
<td>12. Would recommend program to others</td>
<td>4.84</td>
<td>.45</td>
<td>97%</td>
</tr>
</tbody>
</table>

*1.00 strongly disagree, 2.00 disagree, 3.00 neutral, 4.00 agree, 5.00 strongly agree

Discussion

**Healthcare Provider Cultural Competency**

The primary goal of this program was to improve the level of cultural competence among healthcare providers who attended the program. Data measuring each construct in the process of
CULTURALLY COMPETENT LGBT CARE

cultural competency (Campinha-Bacote, 2013b) support an educational program that includes focused content and teaching strategies to promote the development of each, especially cultural awareness and cultural skill. For example, data measuring cultural awareness indicated significant differences between groups, but it also showed that the group with the lowest score, which was the GA family practice group, had an even lower score at the four-week point than at baseline. Also, awareness for all three groups was the only element that showed no significant change over the course of the measurement period. Meanwhile, although data did show improvement in cultural skill levels following the program, the majority of the written comments requesting specific information surrounded methods to improve cultural skill, specifically around patient interviews and history taking, such as additional scripted phrases.

Also, although the data indicates higher scores for cultural knowledge, skill, encounters, desire and overall competency four weeks after the program when compared to baseline, most are lower than the measures immediately following the program. However, the MA women’s health setting not only sustained but showed higher scores for cultural skill, encounters and overall competency at four weeks while the GA college health service had one increased score on cultural knowledge. Interestingly, cultural encounters was the only element in which the GA family practice scored higher on at the four week measurement. As the most racially diverse provider group, cultural encounters with different groups outside of the LGBT community may be been included in the response. The decrease in scores suggests not only responder bias immediately following the program but also the need to include additional education sessions to support sustained improvement.

Methods to improve the sustainability of program interventions include future, ongoing education and adoption of recommendations presented. For example, practices expressed interest
in using program materials as part the orientation for new staff. They also stated they would use the information in the LGBT packet to make changes such as steps to develop more welcoming environments, inclusive intake forms and improved interview language, terminology and questions to communicate more effectively with LGBT patients (Appendix B). Practice staff and providers further stated they valued the resources and references in the LGBT packet and would be sharing them patients. In addition, practice staff and providers also reported their commitment to learning more about the clinical practice guidelines presented and including those recommendations into their practice to improve care to their LGBT clients.

Finally, data for all measures, except cultural encounters, were lowest among the GA family practice compared to those of the other settings both at baseline and four weeks later. Considering other existing differences among settings when developing and providing education, inclusion of the initial level of cultural competency in the program may be indicated. For example, during panel discussions, questions at different settings shared varying themes. In the GA family practice, questions included the influence of and conflict with religious beliefs, African American culture, and traditional Southern family values regarding sexual orientation. However, of all settings, this audience was most engaged, sharing personal stories and seeking advice from panelists and the speaker regarding how better to manage family issues as well as patient care. Meanwhile, the GA college health service group was smaller and made up mostly of professionals (NPs, psychologists, counselors) with higher educational backgrounds and greater experience regarding the LGBT community, therefore, questions focused more on mental health and communication needs in practice. On the other hand, the MA women’s health setting audience focused primarily on transgender care issues by asking questions related to recent clinical encounters and challenges with few questions related to sexual orientation, even within a
Catholic health system setting. Developing educational programs that are more customized may better accommodate learner needs and program effectiveness. However, overall the findings from this exploratory program evaluation provide clinically significant support for further program development, implementation and evaluation among larger provider groups to improve the level of cultural competency among healthcare providers.

**Cultural Competency Program Appraisal**

Another goal of this program was to increase the value of LGBT cultural competency training and its application to practice for all who attended the program, including non-provider staff. Data from the evaluation tool provided strong support that participants from all settings found the program to be valuable to their practice and worth attending as well as recommending the program to others. They also reported an increased awareness of LGBT needs and learning new ways and better ways to communicate with LGBT clients. Other affirmations of program value included invitations by different participants to return to provide additional sessions to other staff and additional, more focused presentations on topics introduced, as well as invitations to provide similar educational programs in different settings including a correctional system health setting in Massachusetts.

**Limitations**

As significant limitation in this study was the small provider sample size which limits sample power and statistical significance of the project findings. However, as an exploratory assessment, the findings in this small sample are clinically significant and provide information for further study with larger samples. The inability to secure a transgender panelist due to reported concerns surrounding safety and stigma have also have potential decreased impact surrounding transgender issues. Future methods to enhance conditions to include transgender
panelists will require further exploration. Another limitation was the program duration. During project development, practice managers requested a short time to accommodate provider needs and scheduling during office hours for all staff. However, each session went over the allotted time. Extending program to a longer time may increase the ability to improve the program efficacy. The short four week-time frame may also have been a limitation to allow for changes over time between baseline and final posttest four weeks later. Also, a larger sample size over a greater time frame may be required to more accurately assess program efficacy and cultural competency.

**Conclusion**

Improving the equity of care for all persons is a foundational tenet of nursing. Improving conditions for those who may be marginalized within society is central to this aim. The current thrust to dismantle existing health disparities is seen throughout current efforts including the U. S. Department of Health and Human Services’ Healthy People 2020 (2012a) campaign, which states that one of its overarching goals is to “achieve health equity, eliminate disparities, and improve the health of all groups”. The LGBT population is one such group. Barriers that may negatively impact that goal and contribute to existing disparities include the lack of culturally competent care, especially a lack understanding between health care providers and their patients (Betancourt, Green, & Carillo, 2002). Therefore, one recommended strategy to ameliorate this problem is to provide cultural competence education for health care providers and staff. As such, this education program provides one avenue by which to promote cultural competency in the primary care setting and improve the health of LGBT people.
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competency training in health professionals improve patient outcomes?: A systematic


What is cultural competence?

• A process by which one develops the ability to provide care to patients’ with diverse values, beliefs and behaviors
  - includes patient-centered care to meet patients’ social, cultural and/or linguistic needs
• Process includes developing cultural
  - awareness
  - knowledge
  - skills
  - encounters
  - desire
Why culturally competent care?

- Codes of ethics ~
  - “With compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (ANA, 2001).
  - “A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.” (AMA, 2001)

- Crossing the Quality Chasm ~
  - 6 aims of care: safe, effective, timely, efficient, patient-centered & equitable

How is care improved?

- Improving cultural competence would support these aims by
  - Improving the patient experience
  - Reducing the potential for health disparities
What is Sexual Orientation

- “enduring pattern of emotional, romantic, and/or sexual attractions to men, women or both sexes” (APA, 2013).
- 3 dimensions
  - Identity
  - Attraction
  - Behavior
- Fluid & can change over time
- Lesbian, gay, bisexual
- Prior to 1973, homosexuality = mental disorder in the DSM 11 (APA, 1973)

What is Gender Identity

- Refers to “one’s internal sense of being male, female or something else” (APA, 2011).
- Gender dysphoria replaced by gender identity disorder in DSM V (APA, 2013)
How prevalent is LGBT?

- Accurate data not always available
- Current estimate of 3.5% of adults in the US identify as lesbian, gay or bisexual and 0.3% as transgender = 9 million adults (Gates, 2011)
- Higher rates for same sex attraction 11% and same sex behavior (8.2%) (Gates, 2011)
- LGBT community a sexual minority
- Like other minorities, become a marginalized group

Invisible Sexual Minorities?

- Visible minorities
  - Ethnicity & race
  - Disabled
- Invisible minorities
  - Sexual orientation & gender identity
  - Uninsured
- End invisibility by knowing your patients
Minority Stress Model

- Stigma, prejudice and resulting discrimination create a hostile social environment for LGBT persons
- Lead to chronic stress
- Contribute to poorer mental & physical health
  - Proximal (subjective) stressors – individual perception
    - Internalized homophobia
    - Fear of disclosure
  - Distal (objective) stressors – outright actions
    - Bullying
    - Harassment
    - Anti-gay violence

(Meyer, 2003)

Social Influences on LGBT Health?

- **Youth**
  - Higher rates of victimization (bullying, harassment), emotional distress, depression and suicidality
  - Higher rates of adverse childhood experiences (abuse, dysfunctional homes, parental discord)
  - Increased levels of self-destructive behaviors
  - Higher rates of homelessness/family rejection
Social Influences on LGBT health?

**Adults**
- **High rates of discrimination**
  - 21% LGB reported discrimination in past year (second to AAs 24.6%)
  - Higher rates of discrimination associated with higher rates of mental disorders
- **Higher rates of workplace discrimination**
  - If open about LGB orientation or transgender identity
  - Resulting in lower incomes, employment & promotion opportunities
  - Lack of disclosure increases invisibility
- **LGBT diversity**
  - Includes all ages, ethnicities, races, levels of education, SES & belief systems
  - Can also be associated with additional stigma & discrimination

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Social influences on LGBT health?

**Families**
- **Increased rates of family rejection**
  - Leading to isolation
  - Increased prevalence of depression, suicidality, substance abuse & sexual risk taking
- **Fear of disclosure & discrimination**
  - When parents seeking care for children
  - Due to shame or stigma
- **Adoptive families face challenges**
  - Limited protection and recognition
  - Including the presumption of parentage for the non-biological parent
  - Implications for the care and support of their children
- **Hurdles regarding the ability to make healthcare decisions**
  - For care of partners/spouses
  - End of life decisions
CULTURALLY COMPETENT LGBT CARE

Social Influences on Health Services

- Decreased insurance coverage/ability to pay
  - Non-spousal partners
  - Non-biologic children
  - Highest among transgender persons
- Decreased access to care
- Decreased rates of screening
  - CA - Mammography, PAPs, prostate
  - STIs - HIV, HPV
- Decreased utilization of preventive health services
- Delay/postponement of care
  - Fear of discrimination/disclosure

Barriers to care

- Homophobia - "extreme and irrational aversion to homosexuality and homosexual people"
- Heterosexism - "discrimination or prejudice against homosexuals on the assumption that heterosexuality is the normal sexual orientation"
- Transphobia - irrational aversion to transgender or transsexual people
- All Impact the level of trust and communication!
  - Lower rates of disclosure especially among men of color
LGBT Health Education Gap

- 82% of students lacked knowledge to deliver culturally competent care (Kovari, 2004)
- A median of 5 hours dedicated to LGBT related content among 176 medical schools (Cebul-Reed et al., 2011)
- Only 0.16% of articles (8/5000) included LGBT related content in the top-10 impact nursing journals (Mason, Dibble, and DeCleene, 2010)
- Suggest existing heterosexism/homophobia and need for increased visibility in research, practice & education
- Increased education can increase knowledge and improve attitudes & behaviors to improve care

Additional Barriers

- Provider/staff bias and attitudes
- Refusal of care delivery
- Overt violence/harassment
- Legal barriers – Denial of spousal benefits or parental rights, blood relatives override of decisions
- Lack of knowledge of LGBT care needs
- Homophobia/heterosexism among educators
- Lack of provider education/training
LGBT Health Disparities

- Depression, sadness
- Suicide
- Living alone, isolation
- Homelessness
- Substance abuse
- Smoking
- Heavy ETOH use/abuse
- Poorer overall health
- Asthma
- Activity limitation
- HIV testing
- Obesity
- Added CV risk factors
- Cancer
- Violence
- Sexual victimization

LGBT Health Disparities

- Lesbians
  - Obesity, CV risk
  - Breast/cervical CA screening/rates
- Gay men
  - HPV & HIV/STIs, anal cancer
  - Eating disorders
- Bisexuals
  - Higher rates among LGB
- Transgender
  - Highest rates among all groups
  - HIV (4x national rate), attempted suicide (41%), smoking
- Youth
  - Hazardous ETOH drinking, substance abuse, smoking
  - Suicidal ideation/attempted/ deaths
  - Increased suicidality
  - > 4X more likely to attempt (24.7%)
- Elders
  - Isolation
  - Lack of social services
- All
  - Substance abuse, smoking
  - Depression, anxiety
Current Knowledge & Future Research

LGBT Health Objectives
Overarching LGBT Health Needs

- Increasing awareness of LGBT community
- Creating an inclusive clinical environment
- Promoting clinician – patient communication
- Developing documentation that reflects the needs of LGBT patients
- Improved knowledge of LGBT healthcare
- Increased provider & staff training
- Population health measures
  (McHale and Hegarty, 2010).

1. Increasing awareness of LGBT community

- Begins with self reflection/awareness
  - How do you react when you learn someone is LGB?
  - Or expressing their gender in a nonconforming way?
  - Assess your own biases & attitudes in a safe place
- What are your values & attitudes
  - Personal?
  - How do they compare to professional values?
- Continue to seek learning opportunities
  - Education
  - Experiences
2. Create welcoming environment

- First impressions are big!
- Display posters with images that reflect LGBT life and LGBT friendly symbols
- Brochures relevant to LGBT individuals
- Post or disseminate non-discrimination statement/policy
- Unisex bathrooms
- Visibility of open LGBT staff
- Commemorate LGBT events e.g. Pride Day, World AIDS Day
- LGBT friendly forms
  - Relationship vs. marital status
  - Partner vs. husband or wife
  - If asking about gender (male or female) add transgender option

3. Promoting clinician – patient communication

- Non-judgmental & affirming approach
- Prepare how to treat a transgender patient
  - Gender – neutral language that is inclusive
  - Anticipate h/o traumatic healthcare experience – build trust
  - Avoid unrelated probing – explain reasons for questions
- Follow patient's lead and/or ask what terms they prefer
- Interview skills
  - Open ended questions
  - Inclusive of partners & non-biologic parent
  - Normalize sexual history (ask ALL patients)
3. Promoting Patient Provider Communication con’t

✧ Avoid assumptions
✧ Disclosure – facilitate process, direct inquiry r/t sexual behavior/identity, respect non disclosure
✧ Ask patient to clarify terms
✧ When discussing sexual practices/safer sex, avoid heterosexist or gender conforming language
✧ Don’t be afraid to tell your patients of your inexperience
✧ Be willing to become educated by your patients-especially transgender
✧ Assure confidentiality

Confidentiality

✧ Fear of disclosure & being “outed”
✧ Employers, family
✧ Display confidentiality statements
✧ Encourage patient-provider disclosure
✧ Key elements
   ✧ Information covered
   ✧ Who has access to medical record & when
   ✧ Tests results
   ✧ Policy on sharing information with insurance companies
   ✧ Examples when confidentiality is not possible
✧ Can be displayed and/or given to patients to sign
LGBT Issues to Discuss

✧ Degree of being out and to whom
  ✧ Correlates with degree of mental health
  ✧ Identity and behavior don’t always match
  ✧ What is the family of choice?
    ✧ Partnered/married?
  ✧ Becoming parents
    ✧ Adoption, insemination, biologic parent
    ✧ Health care decision making

4. Developing documentation that reflects the needs of LGBT patients

✧ Intake forms that include gender and sexual orientation inform that is inclusive *

✧ Clinical notes to include sexual orientation & gender identity
  ✧ (paper & EHR)

✧ Inform patient of what is written

✧ Ask & document emergency contact, healthcare decision makers (for all ages)
CULTURALLY COMPETENT LGBT CARE

Where to Find More Information:

- LGBT Practice Guidelines
- Financial planning for LGBT support groups
- HIV in same sex relationships
- Body image, weight, exercise, diet
- Coming out issues & fears of being "outed" to employers/innuendos
- Counseling & support groups
- Prevention/screening & safer sex
- Sexual health
- Preventing HIV
- Women-ovary, ovarian/breast CA
- HIV and other sexually transmitted infections
- Impact of discrimination on health

5. Improved knowledge of
Lesbians/WSW

- Cancer Screening
  - Same Pap smear guidelines
  - Still at risk for HPV
  - Same breast guidelines
  - Underutilize due to decreased need for contraception/nulliparity
- Sexual Health
  - STI screening
    - Lower rates of GC & RPR
    - Don’t assume only female partners
  - BV is common
  - HSV-1, trichomonas
  - HPV vaccination
- Obesity
  - WT management
  - Emphasis on improving health
  - Nutrition, exercise

- Cardiovascular health
  - Screen for DM, HTN
  - Reduce ETOH & smoking cessation
- Pregnancy & Fertility
  - Lower rates of pregnancy
  - Refer to counseling regarding pregnancy (artificial insemination)
  - Legal issues e.g. parenting non biologic parent
  - Supportive counseling for families –higher risk of discrimination

Gays/MSM

- Sexual health
  - Risk assessment
  - Frequent screening q 3-6 mos: syphilis, GC, chlamydia, & HIV (CDC)
  - HPV/HAV/HBV vaccination
- Cancer
  - HPV (Pap) screening/
    - Anal cancer
  - Prostate, testicular & colon screenings
- Body image
  - Eating disorders
  - Diet/exercise
- CV risk
  - Smoking cessation, ETOH, substance abuse
  - Heart screening

3/22/14
Transgender

✦ Psychosocial screening
  ✦ Lack of employment/insurance
  ✦ Interrupted/avoidance of medical care
  ✦ Alternative gender confirmation therapies
  ✦ Black market hormones, silicone injections
  ✦ Extreme poverty, social isolation, interrupted education
  ✦ Violence/trauma (PTSD), survival sex, self-destructive behaviors

✦ Most important in prevention & screening
  ✦ Provide care for anatomy that is present
  ✦ In respectful & affirming manner that recognize the patient’s gender identity

Transgender

✦ Cancer screening
  ✦ Transwomen (MTF), past/current hormone use:
    ✦ Breast
      ✦ Mammography >age 50 with additional risk factors
    ✦ Prostate
      ✦ PSA falsely low in androgen deficient setting
      ✦ Digital rectal exam on all transwomen with new visit
      ✦ Pap smears in neovaginas are not indicated
  ✦ Transmen (FTM), past/current hormone use:
    ✦ Breast
      ✦ Annual chest wall/axillary exam
      ✦ Mammography not needed after chest reconstruction
      ✦ but needed if only reduction done
    ✦ Cervical
      ✦ If hysterectomy w/ h/v high grade cervical dysplasia
      ✦ and/or CA, Pap of vaginal cuff q 3 yrs
      ✦ If no hysterectomy (or only ovaries removed), follow Pap guidelines for natal females
Transgender

✧ Cardiovascular
✧ Transwomen
  ✧ Starting feminizing hormones in 1-3 yrs
  ✧ SBP ≤ 130 and DBP ≤ 90 and LDL ≤ 130
  ✧ Currently on estrogen
  ✧ Monitor for CAD/cerebral vascular disease
  ✧ If preexisting risk, use lower doses, transdermal route, omit progestin
  ✧ Monitor BP q 1-3 mos. to target ≤130/90
  ✧ Consider adding spironolactone
✧ Lipids
  ✧ Target LDL ≤ 135 for low to moderate risk, ≤90 for high risk
✧ Transmen
  ✧ Not currently on testosterone – follow same guidelines non transgender
  ✧ Planning to start testosterone 1-3 yrs
  ✧ SBP ≤ 130 and DBP ≤ 90 and LDL ≤ 130
  ✧ Currently on testosterone
  ✧ Same as for transwomen on estrogen

Transgender

✧ Musculoskeletal Health
✧ Transwomen
  ✧ On Estrogen
  ✧ Exercise may help maintain muscle tone
  ✧ Ca & Vit D
  ✧ Pre-architectomy
  ✧ Post-architectomy if not on estrogen
✧ Transmen
  ✧ On testosterone
  ✧ Prevent tendon rupture with gradual weight training
  ✧ Ca & Vit D
  ✧ Testosterone <5-10 yrs NO oophorectomy
  ✧ Testosterone use WITH oophorectomy, cont. testosterone
  ✧ Bone density screening
  ✧ > age 60 testosterone <5-10 yrs
  ✧ > age 60 if testosterone > 5-10 yrs
Transgender

● DM
  ● Transwomen on estrogen
  ● Annual FBS, AIC/GTT impaired glucose tolerance
  ● Include insulin sensitizing agent
  ● Decrease estrogen dose if difficulty controlling wt. or BS
  ● Transmen on testosterone
  ● Consider screening (by patient history) for PCOS

Transgender

● Diet & lifestyle
  ● Transmen
    ● May carry extra wt. to obscure breasts/hips which also limits activity level
    ● Increased metabolic demands on testosterone
    ● Intake adjusted to male age and activity level
  ● Transwomen
    ● Eating disorders to develop a thinner build
    ● May perceive exercise as masculine and avoid it
Transgender

- Sexual Health
  - HIV & HBV/HCV prevention
  - STIs – neo vaginas, culture not PCR swabs
  - Fertility reduction may be permanent if on cross-sex hormones even temporarily
  - Libido – affected by hormones
  - Contraception-testosterone not a contraceptive
  - Silicone injections
  - Screen for unsafe practices
  - Thyroid screening
  - Endocrine imbalances from sex hormone use

Adolescents Youth Guidelines

- May not identify using specific labels (conformity)
- Still building identity
- Inquire about
  - Bullying, harassment
  - Risk-taking behavior (unprotected sex, exploitation, truancy, homelessness)
  - Hazardous ETOH drinking, substance abuse
  - Suicide, depression, anxiety
  - HIV/AIDS, STIs
- Provider referrals to LGBT-inclusive services for at risk youth
- Include peer-based support groups
Elders

- Health needs
  - Information limited
  - Increased rates of illness, esp mental health, substance abuse, HIV/AIDS
- Need to rely on family of choice caregivers (less likely to have children)
- SNFs often fail to protect LGBT elders
- Lack of visitation policies and medical decision making laws

- Elder housing discrimination
- End of life & Advanced Directives
- Survivorship challenges & financial insecurity
- Feel unwelcome in aging programs

Mental Health Highlights

- Homosexuality & gender discordance are NOT a mental illnesses
- Sexual orientation & gender identity cannot be altered through therapy - attempts can be harmful
- Stigma has negative effects on LGBT mental health
- Promote healthy psychosexual development, especially youth
- Respect & understanding the unique experiences & needs of LGBT persons/families
- Assess & understand impact of family dynamics & culture
- Recognize diversity within the LGBT community
- Provide culturally competent care
6. Increased staff training

- Importance of confidentiality & privacy
- Increased awareness of & comfort with LGBT patients
- Nondiscrimination policy that includes sexual orientation & gender identity
- Support visibility of LGBT employees
- Establish & circulate office standards of respect
- Designate on-site LGBT resources person to answer questions
- Referrals to LGBT-identified or friendly providers

Con’t Increased Staff Training

- Train staff to
  - use patients’ preferred pronouns and names
  - listen to patients and follow lead on how they describe themselves – builds trust
  - avoid using the word “gay” or other labels
  - develop basic understanding of LGBT health issues
7. Population Health Measures

✧ Marketing practice/service to LGBT community
✧ Health promotion efforts that target LGBT needs
✧ Community outreach – relationship with LGBT agencies
✧ Elimination of barriers to care
✧ Advocacy

Culturally competent LGBT care

✧ Start by reflecting on your own attitudes about sexuality and gender
✧ Learn more about the LGBT community
✧ Learn more about LGBT health & care needs
✧ Increase your comfort communicating with sexual minorities
✧ Cultural competence is a process that will continue
Taking a Sexual History

- Why is it important?
  - You won’t know what your patient needs unless you ask
  - Patients who are out to their providers
    - are more likely to seek & participate in preventive care
  - Is part of PREVENTION
    - Prevent STIs, reduce disease & deaths
    - Identify & treat sexual problems
    - Improves well being/mental health
    - Improves our relationship with our patients
    - When we are compassionate about & interested in their sexual problems

Sexual History

1. Assess at every for every new patient, annual prevention or problem visits with related symptoms*
2. Assure confidentiality & explain importance
3. Methods
   1. Private & quiet space 1:1 with provider
   2. On paper by patient and reviewed with provider
4. Should be part of overall, comprehensive risk assessment
   a. Focus on HIV, STIs & hepatitis
   b. Use of substances
5. Approach
   1. Nonjudgmental
   2. Start with less threatening questions
   3. Avoid using labels/disapproving words
Sexual History

6. Don’t Assume!
   - Sexual orientation
     - all heterosexual
     - based on outward appearance
     - based on behavior or gender of partner
   - Sexual behavior
     - based on sexual identity
     - based on age (many elders are active)
     - based on relationship status
     - hasn’t changed since previous visit
     - bisexuality is just a phase
   - A sexual orientation for transgender patients

Sexual History

7. Ask specific behavior questions
   - Normalizing
   - Explorative
   - Not presumptive
8. Respect patient’s choice to decline answering
9. Summarize at end of interview e.g. risks identified
Taking the Sexual History ~ AMA video
Panel Discussion

Thank You!
References


CULTURALLY COMPETENT LGBT CARE

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CULTURALLY COMPETENT LGBT CARE


3/22/14


Culturally Competent LGBT Care

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7. Cultural competence at the front desk article
Welcoming Environment Checklist

- Display posters with images that reflect LGBT life

- Display LGBT friendly symbols

- Brochures relevant to LGBT individuals
  1) LGBT organizations
  2) Health concerns (mental health, STIs, substance abuse, hormone therapy
  3) Parenting/adoption
  4) Advanced Directives, Dual Power of Attorney
  5) Local health agencies

- Post or disseminate non-discrimination statement/policy that includes

- Provide unisex bathrooms

- Support the visibility and recruitment of openly LGBT staff

- Acknowledge/observe relevant days e.g. World AIDS Day

- Staff training to support LGBT cultural competence
Sample Antidiscrimination Statement/Signage

We provide care for patients without discrimination including but not limited to discrimination on the basis of

Race/Ethnicity
Age
Sex/Gender
Sexual Orientation
Socioeconomic Status
Religion
Insurance Status
Country of Origin/Immigration Status
Physical Ability
LGBT Sensitive Intake Form Questions

I. LGBT friendly form recommendations
   o Inquire about relationship vs. marital status
   o Partner vs. husband or wife
   o If asking about gender (male or female) add transgender option
   o Use neutral pronouns

II. Sample Questions

A. Gender & Sex

1. What is your current gender identity?
   □ Male
   □ Female
   □ Transgender Male/Transman/FTM
   □ Transgender Female/Transwoman/MTF
   □ Genderqueer
   □ Additional category (please specific): __________
   □ Decline to answer

2. What sex were you assigned at birth?
   □ Male □ Female □ Decline to answer

3. What pronouns do you prefer? ______________________

4. Sex/Gender: □ Male □ Female □ Transgendered □ Decline to answer

5. What is your gender? (check all that apply)
   □ Male
   □ Female
   □ Transgender, male to female
LGBT Sensitive Intake Form Questions

- Transgender, female to male
- Transgender, do not identify as male or female

6. Are you transgender?
- No
- Yes, transgender male to female
- Yes, transgender female to male
- Yes, transgender, do not identify as male or female

B. Relationship Status

6. Relationship/Marital Status: (e.g. single, married, partnered, living together, divorced, widowed)

C. Sexual Orientation

1. How do you identify in terms of sexual orientation?
- Lesbian
- Gay
- Bisexual
- Heterosexual woman
- Heterosexual man
- Decline to answer

2. How do you identify in terms of sexual orientation?

3. Are you attracted to:
- Men
- Women
- Both

4. Do you consider yourself to be:
- Straight (heterosexual)
- Lesbian
- Bisexual
- Gay
LGBT Sensitive Intake Form Questions

D. Sexual History

1. Are you sexually active?

2. With whom have you had sex? □ Men □ Women □ Both

OR

3. In the past year, with whom have you had sex?

□ Men only
□ Women only
□ Both men and women
□ I have not had sex over past year

4. Do you have a primary sexual partner? □ Yes □ No

5. Do you have casual sexual partners? □ Yes □ No

6. Do you have (check all that apply):

□ Oral sex □ Vaginal sex □ Anal sex

7. When is the last time you had sex without a condom/barrier device?

8. When is the last time you were tested for HIV? _______ Result ______

E. Gender/Sex Transitioning

1. Do you have any questions, concerns or comments about your gender or gender identity (femaleness/maleness)? □ Yes □ No
   If yes, please list here.

   ____________________________________________________________

2. Are you taking hormones for the purpose of gender or sex transitioning? □ Yes □ No
LGBT Sensitive Intake Form Questions

3. If yes, please list names of hormones and how long you have been taking each.

<table>
<thead>
<tr>
<th>Name</th>
<th>How long?</th>
<th>Complications/Side effects?</th>
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<tbody>
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</tr>
</tbody>
</table>

4. Have you had any sex reassignment surgery? □ Yes □ No
   If yes, please list here.

5. Do you have any questions about gender transitioning? □ Yes □ No
   If yes, please list here.
Glossary of Terms

1. Bisexual- one whose sexual or romantic attractions and behaviors are directed at members of both genders to a significant degree
2. Coming out - a figure of speech for LGBT people’s disclosure of their sexual orientation and/or gender identity (Riley, 2010)
3. Cross-dresser (transvestite) – an individual who wears clothes and adopts behaviors associated with the opposite sex for emotional or sexual gratification
4. Drag queen or king – one who cross-dresses in women’s on men’s clothing and adopts a hyper feminine or hyper masculine presentation
5. Female-to-male (FTM) – the transition of a person who has changed their body and/or lived a gender role from a birth assigned female to an affirmed male. Also referred to as trans male or transman
6. Gay- an attraction and/or behavior focused exclusively or mainly on members of the same sex or gender identity, a personal or social identity based on one’s same-sex attractions and membership in a sexual minority community
7. Gender dysphoria- a condition where there is a marked difference between the person’s expressed gender and the gender others would assign him or her for at least 6 months (DSM V).
8. Gender identity- one’s internal sense of being male, female or other gender
9. Gender presentation – the expression of gender which may or may not correspond with one’s gender identity or assigned sex
10. Genderqueer – one who does not conform to stereotypical gender roles and may choose to live outside gender norms, may or may not use hormonal/surgical options
11. Gender role conformity or nonconformity – the extent to which a person’s gender expression either adheres or does not adhere to the associated cultural norms associated with that person’s sex respectively.
Glossary of Terms

12. Heterosexual – opposite sex attraction, sexual behavior and/or sexual orientation that focuses exclusively or mainly on members of the other sex or gender identity

13. Homophobia – the manifestations of sexual prejudice, stigma, and/or self-stigma based on one’s homosexual or bisexual orientation

14. Heterosexism – the manifestation of discrimination or prejudice against homosexuals on the assumption that heterosexuality is the normal sexual orientation

15. Homosexual – same sex attraction, sexual behavior and/or sexual orientation identity that focuses exclusively or mainly on members of the same sex or gender identity

16. Intersex – a term used for people who are born with external and/or internal genitalia that vary from typical male or female genitalia or a chromosomal pattern that varies from XX or XY

17. Lesbian – a term that refers to females with same sex attraction and sexual behavior and/or sexual orientation identity

18. Male-to-female - the transition of a person who has changed their body and/or lived a gender role from a birth assigned male to an affirmed female. Also referred to as trans woman or transwoman

19. Queer – in contemporary use, a term used to signify inclusivity and unity for people who are gay, lesbian, bisexual, transgender, intersex or any other non-heterosexual sexuality or gender identity. Historically a derisive term for LGBT people.

20. Sex - 1. A biologic construct referring to genetic, hormonal, anatomical, and physiologic characteristics of males and females. Sex is typically assigned at birth based on appearance of genitalia. 2. All phenomenon surrounding erotic arousal or sensual stimulation of the genitalia or erogenous zones.

21. Sexual orientation – encompasses sexual attraction, behavior and identity toward men, women or both.
Glossary of Terms

22. Transsexual – a medical term applied to persons who seek hormonal and sometimes surgical treatment to modify their bodies so they may live full time as member of the sex opposite of their birth assigned sex.

23. Transgender – refers to persons who cross or transcend culturally defined categories of gender, not a medical term, avoid using term as a noun but as descriptive term

24. Transition – a period of time when a transgender or transsexual person is learning how to cross live socially as a member opposite of their assigned sex at birth. At times including the early use of hormones

25. Transman - a person who has changed their body and/or lived a gender role from a birth assigned female to an affirmed male. Also referred to as trans male or FTM

26. Transwoman – a person who has changed their body and/or lived a gender role from a birth assigned male to an affirmed female. Also referred to as trans woman or MT
Resources & References

Web-based LGBT Resources

Biexual Resources Center
http://www.biresource.org

Gender Education and Advocacy, Inc.
http://www.gender.org

Human Rights Campaign
http://hrc.org

It Gets Better
http://www.itgetsbetter.org/

Movement Advancement Project

National Gay and Lesbian Task Force
http://www.thetaskforce.org

National Association of LGBT Community Centers
http://www.lgbtcenters.org

National Center For Transgender Equality
http://transequality.org

Parents, Families, and Friends of Lesbians and Gays
http://www.pflag.org

The Trevor Project
http://www.thetrevorproject.org/

Youth OUTReach
http://www.lambda.org/youth.htm

Media Resources

Documentaries:
Be Like Others ~2008
Brother Outsider: the Life of Bayard Rustin ~ 2003
The Celluloid Closet ~ 1995
She’s a Boy I Knew ~ 2007
Soldier’s Girl ~ 2003
Resources & References

Southern Comfort ~ 2001
The Times of Harvey Milk ~ 1984
Trembling Before G-d ~ 2001
Word is Out ~ 1977

Based on Real Life:
Boys Don't Cry ~ 1999
Milk ~ 2008

Written Resources


Support Hotlines

Gay, Lesbian, Bisexual and Transgender Helpline
(888) 340-4528, Monday-Friday 6p-11p EST

National Suicide Prevention Lifeline: 1-800-273-TALK (8255); Press # 1 if you are a Veteran

Clinical References


Resources & References


Practice Guidelines


Resources & References


Appendix C

Certification
Human Research Subjects Determination

TO: Celeste Surreira
FROM: Mary Ann Lowen, M.D.
Chair, Mercy Medical Center IRB
DATE OF CERTIFICATION: August 25, 2013
SUBJECT: LGBT Education/Training to Care Providers

We are in receipt of your request for approval to conduct research in connection with your Capstone Project for the University of Massachusetts DNP Program: LGBT education/training to care providers as a method by which to increase their level of cultural competency with regard to the care of LGBT patients. The nature of your proposed research purports to qualify for an exemption under 45 CFR §46.101(b)(2) as research in which the only human subject involvement entails the use of survey procedures for which no personal identifiers will be used, and for which disclosure of the subjects’ responses could not reasonably place the subjects at risk of criminal or civil liability or be damaging to the financial standing, employability or reputation of the subjects.

Consequently, this correspondence shall constitute approval of your request, pending formal approval by the University of Massachusetts Institutional Review Board.

Prior to conducting any research, we will require you to forward written confirmation of the approval by the University of Massachusetts Institutional Review Board in addition to your written statement attesting that no protected health information will be gathered or used in connection with your research.

Thank you for your interest in SPHS and we wish you the best of luck with your Capstone Project.
Appendix D

University of Massachusetts Amherst
Human Research Protection Office
70 Butterfield Terrace
Amherst, MA 01003-9242

Office of the Vice Chancellor for Research and Engagement

Celeste Surreia, MS, RN, CNL
1100 Ashbury Dr
Decatur, GA 30030

Dear Celeste Surreia,

Thank you for providing the UMASS IRB with a description of the activities you will be carrying out for your DNP scholarship project. As the synopsis provided below indicates, your project does not meet the definition of generalizable research but falls into the category of education and training. Because the evaluation at the end of your training is only being used to evaluate the effectiveness of the training rather than fulfilling a broader research project or collecting personal information about individuals, your project does not require IRB approval.

******************************************************************************

Project focus:

1. This project purpose is to deliver LGBT education/training to care providers as a method by which to increase their level of cultural competency with regard to the care of LGBT patients. Increasing culturally competent care is an aim of the IOM and the TIC and serves as a method by which to reduce health disparities and improve the health status of LGBT persons.

2. The training will be a 90 minute session for care providers. There will be a lecture type presentation with written materials, 2 short videos and a small panel discussion. The topics will include social determinants of health for the LGBT community, associated disparities, LGBT cultural care needs, and evidence-based interventions.

3. A brief survey will be given to the attendees before and after the training to evaluate the effectiveness of the trainings.

Participation is voluntary for providers and staff. However, given the sensitive nature of the subject matter, it is important to ensure privacy for subjects and confidentiality of their information. To do so, names will not be collected but instead a unique numerical identifier will be used on evaluation tools and surveys. No pictures will be taken of those attending neither the program nor any recording of their discussions during the course of the program.

******************************************************************************

If you have any questions, please do not hesitate to contact me.

Thank you for checking in with the IRB and good luck with your DNP project.

Sincerely,

Margaret Burggren
Associate Director,
Human Research Protection Office

cc: Emma Dunden
December 23, 2013

Dear Dr. Campinha-Bacote,

I am now writing to request permission to utilize the IAPCC-R© in my capstone scholarly project entitled Culturally Competent LGBT Care. I have developed cultural competency training surrounding the care of the LGBT community for primary care providers using your framework The Process of Cultural Competence in the Delivery of Healthcare Services. Therefore, as I expressed in my initial letter earlier this year, my intent is to measure the effectiveness of my program by measure their IAPCC-R© score (level of cultural competency) immediately before and after my program and then 4 weeks later. I will deliver the training at three separate practice sites, one on January 23rd, another on January 29th and the last on February 6th, 2014. I will be hand administering each of these pre and post training. I look forward to utilizing both your framework and tool in my work and thank you for your contribution and dedication to transcultural nursing.

Sincerely,

Celeste Surreira, DNP(c), MS, RN, CNL

University of Massachusetts Amherst

College of Nursing
January 6, 2014

Dear Dr. Campinha-Bacote,

I am now writing to request permission to utilize the IAPCC-R© in my capstone scholarly project entitled Culturally Competent LGBT Care. I have developed cultural competency training surrounding the care of the LGBT community for primary care providers using your framework The Process of Cultural Competence in the Delivery of Healthcare Services. Therefore, as I expressed in my initial letter earlier this year, my intent is to measure the effectiveness of my program by measure their IAPCC-R© score (level of cultural competency) immediately before and after my program and then 4 weeks later. I will deliver the training at three separate practice sites, one on January 23rd, another on January 29th and the last on February 6th, 2014. I will be hand administering the pre and immediate post training measurement for 2 of the practice sites. One of the practice sites, I will provide the tool to the RN practice manager to administer 3 days prior (January 20th, 2013) for the premeasurement. I will also deliver/mail the tool for the 4-week post training measurement to each practice manager who will then administer it to each provider in each of the 8 practice settings. To allow time for administering and collecting the tool, I am requesting a time frame from 1/20/2014 to 4/30/2014. I look forward to utilizing both your framework and tool in my work and thank you for your contribution and dedication to transcultural nursing.

Sincerely,

Celeste Surreira, DNP(c), MS, RN, CNL

University of Massachusetts Amherst
March 5, 2014

Dear Dr. Campinha-Bacote,

I am now writing to request permission to utilize the IAPCC-R© in my capstone scholarly project entitled Culturally Competent LGBT Care. I have developed cultural competency training surrounding the care of the LGBT community for primary care providers using your framework The Process of Cultural Competence in the Delivery of Healthcare Services. Therefore, as I expressed in my initial letter earlier this year, my intent is to measure the effectiveness of my program by measure their IAPCC-R© score (level of cultural competency) immediately before and after my program and then 4 weeks later. I will deliver the training at three separate practice sites, one on January 23rd, another on February 6th, and the last on February 26th. I will hand administered the pre and immediate post training measurement for 2 of the practice sites. One of the practice sites, I provided the tool to the RN practice manager to administer 3 days prior (January 20th, 2013) for the premeasurement. I will also deliver/mail the tool for the 4-week post training measurement to each practice manager who will then administer it to each provider in each of the 3 practice settings. At this point, I did have an additional participant and so will need 3 additional tools to complete the 4-week measurement. I will be able to hand administer each of these tools. To allow time for administering and collecting the tool, I am requesting a time frame from 1/20/2014 to 4/30/2014. I look forward to utilizing both your framework and tool in my work and thank you for your contribution and dedication to transcultural nursing.

Sincerely,

Celeste Surreira, DNP(c), MS, RN, CNL
Appendix H

Date: January 6, 2014

To: Ms. Celeste Sureria
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

RE: Contractual Agreement for Limited Use of the IAPCC-R

This letter grants permission to Ms. Celeste Sureria to use my tool, *Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R)* to assess the level of cultural competence of 12 primary care providers (PCPs) in the project entitled, “Cultural Competent LGBT Care.” I have received $492 for 36 tools for testing of these 12 PCPs over three intervals at three different practice sites in which 17 tools will not be personally hand-administered and hand-collected personally by her.

**TIME FRAME:** Permission to use the IAPCC-R is time-limited from January 20, 2014 through March 31, 2014. **Upon April 1, 2014 all unused tools must be destroyed.** If Ms. Celeste Sureria finds that there are more participants than expected in the training sessions, she will need to submit another formal letter of request to use my tool and purchase additional tools.

**ONSITE ADMINISTRATION:** This onsite and offsite permission only grants administration of 19 IAPCC-R tools via an onsite pencil and paper administration in which Ms. Celeste Sureria personally hand-distributes these tools to each participant and then personally hand collects the tools immediately following its completion. The offsite permission only grants administration of the remaining 17 IAPCC-R tools via an internal or external mailing or delegation to another person for administration.

**RESTRICTIONS OF COPYING:** Ms. Celeste Sureria agrees that the IAPCC-R nor any of its 25 items cannot be copied or reproduced for any other reason. This includes, but not limited to, being copied in formal or informal publications, in her Capstone project paper, a dissertation or thesis, in an academic paper, handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic formats. The IAPCC-R is only to be used for the above purpose of administering it in this above study for 12 participants.

**PUBLICATIONS:** Ms. Celeste Sureria agrees that any publications (formal or informal) or presentations of the findings of the study using my tool will be shared with me.
GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY’S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney’s fees and costs.

Signature: [Signature]
Joseph A. Capuinha-Bacote, PhD

Date: January 6, 2014
Appenndix I

Date: March 10, 2014

To: Ms. Celeste Surreria

From: Dr. Josephna Campinha-Bacote

President, Transcultural C.A.R.E. Associates

RE: Contractual Agreement for Limited Use of the IAPCC-R

This letter grants permission to Ms. Celeste Surreria to use my tool, Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) to assess the level of cultural competence of 3 additional primary care providers to complete her study entitled, "Culturally Competent LGBT Care." I have received $24 for these 3 additional tools to complete this study.

TIME FRAME: Permission to use the IAPCC-R is time-limited to be used only from March 11, 2014 to April 30, 2014. Upon May 1, 2014 all unused tools must be destroyed.

ONSITE ADMINISTRATION: This onsite permission only grants administration of the IAPCC-R via an onsite pencil and paper administration in which Ms. Celeste Surreria personally hands the tool to each participant and then personally collects the tool immediately following its completion. Ms. Celeste Surreria agrees that the IAPCC-R cannot be administered in an offsite format such as in on an online course, internal or external mailings, or via an Internet website offering.

RESTRICTIONS OF COPYING: Ms. Celeste Surreria agrees that the IAPCC-R and any of its 25 items cannot be copied or reproduced for any other reason. This includes, but not limited to, being copied in formal or informal publications, a dissertation or thesis, in her Capstone scholarly project, in an academic paper, as handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic formats. The IAPCC-R is only to be used for the above purpose of administering in this above study for 3 participants.

PUBLICATIONS: Ms. Celeste Surreria agrees that any publications (formal or informal) or presentations of the findings of the study using my tool will be shared with me.
of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY'S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney's fees and costs.

Signature [Signature]
Josephine Campanha-Bacote, PhD
Date [Date]
March 10, 2014
Appendix J

Program Evaluation Survey

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The content was well organized.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The content and program was valuable to my practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The program length was sufficient for my learning needs.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4. The trainer was an effective communicator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The trainer kept the program alive and interesting.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. The trainer handled discussion effectively.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. The written teaching materials were informative.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. The videos were interesting and effective.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. The panelists were interesting and effective speakers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. This program increased my awareness of the needs of LGBT clients/patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I learned new and better ways to communicate effectively and sensitively with LGBT clients/patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I would recommend this program to others.</td>
<td></td>
<td></td>
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Comments:
## Appendix K

### Program Budget Plan

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<thead>
<tr>
<th>Item Description</th>
<th>Cost/Unit</th>
<th>Total Quantity</th>
<th>Total</th>
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<tbody>
<tr>
<td>Hand paper and folders</td>
<td>1 packet</td>
<td>1</td>
<td>$25.45</td>
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<tr>
<td>Bound packets</td>
<td>$2.50 each</td>
<td>42</td>
<td>$251.49</td>
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<tr>
<td>IAPCC-R® non hand administered</td>
<td>$20</td>
<td>17</td>
<td>$340</td>
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<tr>
<td>IAPCC-R® hand administered</td>
<td>$8 each</td>
<td>22</td>
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<tr>
<td>IAPCC-R® delivery costs</td>
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<td></td>
<td>$45</td>
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<tr>
<td>Panelists meals/refreshments</td>
<td>varied</td>
<td>6</td>
<td>$189</td>
</tr>
<tr>
<td>Flight travel</td>
<td>$304</td>
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<tr>
<td>Mac thunderbolt adapter</td>
<td>$26.99</td>
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<tr>
<td>LCD projector</td>
<td>$450</td>
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<tr>
<td>Computer</td>
<td>$1100</td>
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<tr>
<td>Car rental</td>
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<td>3 days</td>
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<tr>
<td>Presenter/Student Time</td>
<td>$0/hour</td>
<td>336 hours</td>
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<td>Actors/Panel members (5)</td>
<td>$0/hour</td>
<td>14 hours</td>
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<tr>
<td>Provider time</td>
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<tr>
<td>2 CNMs</td>
<td>$60/hour</td>
<td>(2 x 1.5) = 3 hours</td>
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<td>7 NPs</td>
<td>$60/hour</td>
<td>(7 x 1.5) = 10.5 hours</td>
<td>$630.00*</td>
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<td>2 Primary Care MD</td>
<td>$95/hour</td>
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<td>2 PAs</td>
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<td>(2 x 1.5) = 3 hours</td>
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<td>Total project costs</td>
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<td>Less donated/covered costs</td>
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<td>Net project cost</td>
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## Appendix L

### Project Gantt Chart

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<td>Develop Program</td>
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<td>Coordinate Implementation</td>
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<td>Pre Program Measure</td>
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<tr>
<td>Execute &amp; Teach Program</td>
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<td>X</td>
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<td>Immediate Post Program Measure</td>
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<td>Four Week Post Program Measure</td>
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<td>Program Evaluation/Data Analysis</td>
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<td>Dissemination of Results</td>
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