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Improving Care for Transgender Veterans Through Staff Education

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MS, Walden University, 2009

BS, Northern Arizona University, 2007

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The VHA Directive 1341 (2018a): *Providing Health Care for Transgender and Intersex Veterans,* outlines care for transgender patients. Staff members at the project site lacked knowledge of the directive and available resources, making their care of transgender veterans inefficient. The purpose of the project was to implement staff education about the directive and resources to increase transgender patient visits and access to care. The practice-focused question asked whether the development and implementation of staff education about the national directive and transgender services would affect the number of transgender patient visits in a 2-month period. The Iowa and Community Readiness Models provided structure for the practice change. The Community Readiness Assessment tool was used to assess staff education needs regarding transgender services. The results indicated that staff have knowledge about community experts, no knowledge about federal funding, and inadequate knowledge about support from staff and leaders, qualified professionals, and laws/practices. The staff education about Lesbian, Gay, Bisexual, Transgender (LGBT) resources tool was created and disseminated via meetings and e-mail. ICD-10 codes for gender identity disorder were evaluated for the number of transgender patient visits, which showed an increase in visits by 0.7 per month. Recommendations include continuing staff education during LGBT events and ICD-10 data reports. The implications of this study for positive social change include the potential to increase transgender patient visits to the site, which could lead to quality, comprehensive care to promote health and prevent disease.

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Dedication

I dedicate my work on this project and achievement of my doctoral degree to my daughters, Ebony Jenkins and Janessa Jenkins. They have sacrificed valuable time with me to support my educational endeavors throughout their lifetime. They have encouraged and supported me to further my education when I did not think I had the ability to go on. I became a nurse to provide for my daughters, but I completed this project and my doctorate because of their love and support of me.

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Throughout my years of completing my doctoral project and writing this paper, I have received a great deal of support, guidance and advice.

I want to thank my husband, Dennis Henrickson, for supporting my educational goals and keeping me motivated. I could not have completed this project without his technological support and ensuring that I was able to work no matter where we were, even if it meant providing internet access on vacation. My husband has always provided me support and encouragement when I needed it most.

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Table of Contents

List of Figures

Section 1: Transgender Care

Introduction

The roles of gender have strong cultural, as well as biological and psychosocial components; however, even with this knowledge, health needs of the transgender population have been met with many barriers to care and have received insufficient research (Dean et al., 2000). The Institute of Medicine's (IOM) Committee on Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues and Research Opportunities (2011) recommended a research agenda for National Institutes of Health (NIH) data collection on sexual orientation and gender identity through the U.S. Department of Health and Human Services, and created the goal of improving the health, safety, and well-being of LGBT individuals through Healthy People. The Veterans Health Administration (VHA) issued *Directive 1341*: *Providing Health Care for Transgender and Intersex Veterans* (2018a) to meet this goal, and it outlined generally acceptable standards of medical health care for transgender patients. Despite having this national directive for transgender care, many VHA staff and providers are not aware it exists or what services for care are available. My objective in this project was to provide education to staff regarding transgender services available at the Veterans Affairs Medical Center (VAMC), knowledgeable staff will create a welcoming environment, thereby increasing transgender patient visits. The potential for positive social change will occur when staff are properly educated on the available transgender services creating a welcoming environment and increasing patient visits. In Section 1, I will present the problem statement, purpose, nature of the project, and the significance of the project.

Problem Statement

The VHA Directive 1341 (2018a): *Providing Health Care for Transgender and Intersex Veterans,* outlines care to include generally acceptable standards of medical health care for transgender patients. The VHA directive mandates care for transgender and intersex patients at any point of transition, including those who have had sex reassignment surgery outside of VHA, considering surgical intervention, and those who do not wish to undergo reassignment surgery but self-identify as transgender. VHA does not provide sex reassignment surgery. Transgender veterans began to present to the VHA requesting specific and standardized care for transitioning from one gender to another. Rosentel, Hill, Lu, and Barnett (2016) found that transgender veterans were met with long delays to care, had to travel long distances for services, had lack of knowledge regarding coverage of transition-related care, provider insensitivity, harassment, and violence, and providers lack knowledge of care and services. Many VHA medical centers and clinics were not prepared for providing specific primary and mental health care or support to transgender individuals, despite the national directive or having the resources to create a program.

Staff and providers had not received adequate education on the national directive, the services that are available, how to guide patients to access the services, or LGBT cultural competencies. As patients present to the VHA requesting the services, they are met with staff who lack the knowledge to provide the care which creates patients feeling unwelcomed and barriers to receiving care. Sherman et al. (2014) found that one third of LGBT veterans did not find the VHA as a welcoming environment, and 58 participants

requested three specific interventions for care at the VHA. The participants requested the creation of support group or class for LGBT health care issues, mental health services to address shame, counseling regarding relationships, advice on coming out, communication with health care providers, and a patient advocate for LGBT issues.

The VAMC that was my focus of the doctor of nursing practice (DNP) project has the following services: primary care for maintaining wellness, health issues/screenings, medical interventions for transitioning including cross-sex hormone therapy (CSHT), and pre/postoperative evaluations; mental health services for addressing mental health issues, relationships, coming out, and communication; speech therapy for vocal changes, vocational rehabilitation for employment and school; and social work for assistance with changing vital documents. The staff at the VAMC lack the knowledge and education of these resources making their care of transgender veterans inefficient.

Purpose

My purpose in this DNP project was to develop and implement staff education regarding the national directive and available transgender services and resources to increase the number of transgender visits and access to care. There are no protocols in place to educate staff on the available transgender resources and services at the VAMC. The practice gap was the lack of knowledge of staff regarding these resources and services, which created a missed opportunity for comprehensive, quality care for transgender veterans due to patients feeling uncomfortable in the environment. Uniform practices for staff education of available transgender resources and services will provide a bridge for the practice gap. The resources at the VAMC were compiled into printed

material and disseminated at staff meetings, as well as through the facility intranet and email blast. The practice-focused question was: Does the development and implementation of staff education regarding the national directive and transgender services compared to not having any education on services affect the number of transgender patient visits in a 2-month period?

Nature of Doctoral Project

The DNP project included me, the DNP student, gathering transgender services information from the following sources of evidence: the national LGBT Health Program, VHA directives and policies, the Human Rights Campaign, and The Joint Commission. I used a community readiness assessment (CRA) and had representation from the staff as a target group for implementation. Community readiness is the degree to which a community is willing and ready to take-action on an issue and the assessment should be conducted with at least six key respondents who work directly with the community members (Oetting et al., 2014). The Community Readiness Model (CRM) is the most appropriate way to conduct a needs assessment for education of staff for transgender services at the VAMC. Several individuals at the VAMC have had transgender veterans scheduled into their clinics since the VHA Directive 1341 (2018a): *Providing Health Care for Transgender and Intersex Veterans* was issued, including a primary care nurse practitioner (NP), mental health NP, psychologist, LGBT veteran care coordinator (VCC), social work executive, and women's health program coordinator. A team was formed with these individuals and the DNP student to develop an educational plan using the CRM and the CRA tool designed by Pennsylvania State University (2017) to guide

the discussion (Appendix A). I obtained approval of the staff educational plan from senior leadership for dissemination to staff. The encounters for transgender patient visits were measured based on the following *International Classification of Diseases, Tenth Revision* (ICD-10) codes: F64.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment (WHO, 2018). Reports were generated pre/postimplementation of the DNP project through the VAMC Quality and Performance Improvement (QPI) program analyst.

Significance of Project

The doctoral project is significant to transgender veterans to obtain quality, comprehensive care for health promotion and disease prevention in a health care system were the resources exist. Health disparities of the LGBT population lead to many health and safety issues, including increased suicidal attempts, homelessness, decreased health screenings, higher risk of human immunodeficiency virus (HIV) and sexually transmitted diseases (STD), and high rates of substance abuse (OHPDP, 2014). LGBT youth are two to three times more likely to attempt suicide, and older LGBT individuals risk isolation, lack of social services, and do not have sufficient access to culturally competent providers (Dean et al., 2000). Health disparities in the LGBT population are a concern in any health care system, but there is an increased significance related to military personnel and veterans. For 18 years, gay men and lesbians were barred from serving openly in the military until the repeal of the *Don't Ask, Don't Tell* (DADT) policy. The policy created many hurtful, stigmatizing experiences, as well as some dishonorable discharges (Sharpe & Uchendu, 2014).

My doctoral project is significant to health care providers to provide efficient, comprehensive care to transgender patients through the support of the health care system's services and directives. The VHA not only has many patients who served under the DADT policy, but many providers and staff served in the military under this policy as well. The resulting bias makes creating a welcoming culture in the VHA both urgent and challenging (Sharpe & Uchendu, 2014). Through staff education of the national directive and available resources, providers will have a better understanding of the VHA's stance on care of transgender patients and help to overcome bias of this patient population.

My doctoral project is significant to nurses as culturally sensitive nursing practice and management of resources is integral to the care of all patients. Nursing programs offer little education related to the care of transgender patients, which leaves the responsibility to health care systems. Through staff education of transgender services, nurses will be better equipped with interventions to provide quality, comprehensive care.

Transferability of my DNP project could be extended into other practice areas such as family planning clinics, speech pathology, and suicide prevention. The national directive provides guidance for these practice areas and the services they provide would be valuable to transgender patients. Positive social change can be created through staff education of the national directive and transgender services, which will increase cultural competency for caring for transgender veterans, thereby transgender veterans may feel safer in seeking out health care,

Summary

In 2011, President Obama repealed the DADT policy that barred lesbian and gay individuals from serving openly in the military, and the VHA issued a directive to standardize treatment services for transgender veterans in 2011; however, making the change at local levels has been more challenging (Kauth, Shipherd, Blosnich, Brown, & Jones, 2014). VHA staff and providers lack the knowledge of the national directive and transgender resources available to provide efficient, comprehensive care to transgender patients. My objective is to provide education to staff regarding transgender services available at the VAMC to create a welcoming environment and increase transgender patient visits and access to care. I used sources of evidence from the national LGBT Health Program, VHA directives and policies, the Human Rights Campaign, and The Joint Commission and collaborate with key staff individuals who work with transgender patients. The team used a community readiness assessment to guide discussion on the creation of a staff educational plan. I implemented and disseminated the plan after obtaining approval from senior leadership. The project holds significance for transgender veterans, health providers, nursing staff and has transferability to other practices areas such as family planning clinics, speech pathology, and suicide prevention. The potential for positive social change will occur with staff education, increasing cultural competency and providing a safe, welcoming environment for transgender patients. In Section 2, I will explain the concepts, models, and theories, relevance to nursing practice, local background and context, and my role as a DNP student.

Section 2: Background and Context

Introduction

Transgender patients have unique treatment needs and health disparities that lead to many health and safety issues, including increased suicidal attempts, homelessness, decreased health screenings, higher risk of HIV and STD's, and high rates of substance abuse (OHPDP, 2014). The practice gap was the lack of knowledge of staff regarding these resources and services, which created a missed opportunity for comprehensive, quality care for transgender veterans. The practice-focused question was: Does the development and implementation of staff education regarding the national directive and transgender services compared to not having any education on services affect the number of transgender patient visits in a 2-month period? My purpose in this study was to develop and implement staff education on the national directive and available transgender services and resources to create a welcoming environment and increase the number of transgender visits and access to care. The Iowa Model was used to provide structure for educating staff on the national directive and transgender services, along with the CRM to conduct a needs assessment for education of staff for transgender services at the VAMC. In Section 2, I will outline the utilization of the Iowa and Community Readiness Models, relevance to nursing practice, local background and context, my role as the DNP student, and the role of the team in the pursuit of educating staff on transgender services to increase visits and access for transgender veterans at the VAMC.

Concepts, Models and Theories

The Iowa Model of Evidence-based Practice (EBP) developed by the University of Iowa Hospital and Clinics (UIHC) Department of Nursing served as a guide for the project and the CRM to conduct a needs assessment for education of staff for transgender services (Iowa Model Collaborative, 2017; Oetting et al., 2014).

The Iowa Model

The Iowa Model provides substantial structure for the practice issue of educating staff on transgender services to improve the health, safety, and well-being of transgender veterans at VAMC (OHPDP, 2014) (Appendix B). The Iowa Model provides for adaptation of EBP protocols, conducting and evaluating of the exploratory design approach, and creation of change strategies for clinical staff training of transgender services. The model includes seven steps that begin with identifying triggering issues/opportunities; stating the question/purpose; forming a team; assembling, appraising and synthesizing the evidence; designing/piloting the practice change; integrating/sustaining practice change; and finally, disseminating the results (Appendix B).

The first step of the Iowa Model is the selection of a topic through identification of triggering issues and opportunities (Doody & Doody, 2011). A VHA national directive for transgender care called for treating transgender patients with respect and dignity, and outlined treatment services including primary care, management of hormones, mental health care, preoperative and postoperative care (Kauth et al., 2014). The implementation of services has been slow at the local levels due to lack of staff knowledge of services,

despite the national directive, which has led to inefficient care for transgender veterans. For this project, the topic I selected was staff education of transgender directive and services at the VAMC. The topic is a priority because this is a mandated directive from the national VHA program, but more importantly transgender veterans are unsure about what resources the VHA provides and have concerns about accessing care for transitioning through the VHA.

A practice question was formed using the population, intervention, comparison and outcome (PICO) model (Brown, 2014). The practice-focused question was: Does the development and implementation of staff education regarding the national directive and transgender services compared to not having any education on services affect the number of transgender patient visits in a 2-month period? The next step was to form a team that will develop, evaluate and implement EBP change, and should include members outside of nursing (Brown, 2014). In 2016, the VHA created a LGBT patient advocate called LGBT VCC to assist veterans with connecting to VA and community LGBT resources (VA, 2017). The team for the project included the LGBT VCC, women's health program coordinator, psychologist, primary care NP, mental health NP, social work executive, quality and performance improvement (QPI) program analyst, and me, the DNP student. The individuals chosen for the team have many years of experience working with veterans. The clinical portion of the team: LGBT VCC, who is a social worker, psychologist, primary care NP, and mental health NP have expertise working with the LGBT population.

For the fourth step, sources of evidence were assembled, appraised and synthesized through an exploratory design approach utilizing the community readiness model and community readiness assessment tool, guidelines from VHA, and ICD-10 encounter codes. The DNP project team completed the CRA. The information gathered from the CRA helped to guide discussion to create change strategies for staff education that can be utilized for designing a plan and piloting those changes. The next step included developing a staff educational plan, planning implementation, providing materials and resources for staff, and collecting and reporting baseline and post project data through the QPI program analyst (Iowa Model Collaborative, 2017).

The final step was to integrate and sustain the staff education program through the engagement of key personnel particularly the members of the DNP project team, hardwiring the change into the VAMC, and continued measurement of ICD-10 encounters through the QPI office (Iowa Model Collaborative, 2017). EBP education and mentoring as supported through senior leadership can be used to support staff education regarding transgender patient care interventions and outcomes. EBP language and educational processes need to be persistently integrated into conversations, meetings, and decision-making activities to affect health care delivery and nursing practice for transgender patients (Gallagher-Ford, 2014).

The Community Readiness Model

Community readiness is the degree to which a community is willing and ready to take-action on an issue (Oetting et al., 2014). The CRM created by the Tri-ethnic Center for Preventive Research at Colorado State University, integrates an assessment of the

community's culture and readiness for change, define issues and strategies, builds cooperation among systems and individuals, and creates change strategies (Carlson & Harper, 2011). I used the CRM for the DNP project because it addresses resistance to change, promotes community recognition and ownership, encourages local experts and resources, is efficient, inexpensive, and easy-to-use tool, and creates healthy vision for change (Plested, Jumper-Thurman, & Edwards, 2014). The first step in the CRM is identifying the issue. The issue for this study is the staff at the local VAMC, lack the knowledge and education of transgender resources making their care of transgender veterans inefficient, despite a national VHA directive. Next, it is important to define the community for the DNP project. The VAMC where the staff education was implemented was the community for the CRA. The CRA was conducted with key staff individuals from the VAMC community that are also members of the DNP project team. The next step was to score the CRA for the stage of readiness based on each of the six dimensions. This information guided discussion for the DNP project team in developing education for staff regarding the national directive and transgender services. Lastly, it was important to evaluate the effectiveness of the practice change through a report of ICD-10 encounters but may also include another CRA.

The CRM evaluates six dimensions of readiness known to be key factors in the community's ability to initiate and sustain positive change, these include: community efforts, community knowledge of efforts, leadership, community climate, community knowledge about the issue, and resources related to the issue (Carlson & Harper, 2011). The dimension of community efforts addresses to what extent are there efforts, programs,

and policies to address the issue. Community knowledge of the efforts addresses to what extent is the community aware of efforts, and are they accessible to all areas of the community. Leadership examines to what extent are leaders supportive of the issue. Community climate focuses on what is the prevailing attitude of the community regarding the issue. Community knowledge about the issue examines to what extent is the community aware of the causes, consequences and impact of the issue. Resources related to the issue addresses to what extent are local resources available (Carlson & Harper, 2011).

The CRM is the most appropriate way to conduct a readiness assessment for staff education of transgender services at the VAMC. The CRA tool designed by Pennsylvania State University was used for the DNP project (Appendix A). The CRA has 18 questions that address the six dimensions and can be answered in a 30-60-minute interview, with a scoring process for each answer (Rivera-Ramos, Oswald, & Buki, 2015). The questions are scored using the following point value 2 points for 'yes,' 1 point for 'somewhat,' and 0 points for 'no' (Appendix A). The CRA provided information to guide discussions for creating an action plan of staff education for transgender services (Oetting et al., 2014).

Relevance to Nursing Practice

Nursing has been slow to initiate research and policy changes regarding LGBT health concerns, which has led to a practice gap of inefficient care due to the lack of knowledge regarding resources and services for transgender patients (Lim & Levitt, 2011). Given the lack of knowledge about transgender populations and lack of training or education in medical and nursing schools, it becomes crucial to educate healthcare

professionals about transgender care through health care systems, particularly in the areas of endocrinology, urology, gynecology, plastics, surgery and emergency medicine (Strousma, 2014). While educating healthcare professionals would seemingly be the best answer to caring for transgender patients in practice, it is impractical to think this could be completed in enough time with all necessary specialty practice areas to provide adequate, safe, quality healthcare. The best way to provide safe, appropriate care to transgender patients is to provide staff education and cultural competencies in transgender care through clinics and/or healthcare centers with dedicated transgender protocols, such as the Fenway Center in Boston, MA, and the Gender Identity Veteran Experience (GIVE) Clinic at the VHA in Cleveland, OH (Taylor, 2015; Strousma, 2014).

Nurses are an integral part of creating a welcoming environment that consists of cultural sensitivity for transgender patients throughout the continuum of care (Hein & Levitt, 2014). Staff education of the national directive and transgender services is relevant to nursing practice in that it provides for cultural competency, decreases barriers to care, offers accurate and reliable patient education and resources, as well as increases access to care, particularly in the VA. The role and responsibility of nurse leaders is to create and support opportunities for implementing and sustaining evidence-based practice for strengthening transgender healthcare delivery and nursing practice. The DNP project supports nurses to increase knowledge of services to provide appropriate, quality care to transgender patients, thereby increasing their visits and access to care.

Local Background and Context

Many of the transgender issues in the VHA are similar to the private sector, but the increase in transgender patients in the VHA can be attributed to the repeal of DADT policy in 2011 and the issuance of the national directive (Kauth et al., 2014). Transgender veterans began to present to the VHA requesting specific and standardized care for transitioning from one gender to another. Although the exact number of transgender veterans is unknown since many veterans may not have identified themselves as transgender or intersex to their provider, a census conducted in 2000 estimated there are 101,000 LGBT military personnel, which can equate to a potential increase in the LGBT patient population at the VHA in the future (Gates, 2004). During the years of 2006-2013, there were 2662 veterans who identified as transgender or intersex, there was an increase of 985 new patients in 2011 with the implementation of the VHA national directive (Kauth et al., 2014). The increase in patients reflects an increase in documented diagnoses of gender dysphoria, as veterans who were eligible for VHA health care became aware of the ability to receive care for all their concerns.

The VHA Office of Patient Care Services created the LGBT Health Program in 2012 with the mission "the VHA strives to be a national leader in the provision of health care to LGBT veterans and assure that care is provided in a sensitive, safe environment at VHA health facilities nationwide (VA, 2018b)." VHA's commitment to LGBT Veterans includes promoting a welcoming health and work environment that is inclusive of LGBT Veterans and employees, and providing information, guidance and education to VHA providers about LGBT health issues (VA, 2018b). The role of the LGBT VCC was

created by the LGBT Health Program in 2016 to carry out this mission and commitment to LGBT veterans (VA, 2018a).

In 2017, the VHA LGBT Health Program tasked each VAMC to establish strategic plans with the following top priorities: create a safe environment; build a network of veteran stakeholders; complete assessment of needs; connect employees with cultural competency training; and ensure local websites provide resource information to LGBT veterans (VA, 2018b). The priorities for the strategic plans were based on the *VHA Directive 1341 Providing Health Care for Transgender and Intersex Veterans* (VA, 2018a), the criteria for LGBT programs from the Human Rights Campaign (HRC) *Healthcare Equality Index (HEI)* (2017), and The Joint Commission's *Advancing Effective Communication, Cultural Competency, and Patient and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender Community: A Field Guide* (2011).

The VHA LGBT Health Program has defined what services should be provided for transgender veterans requiring health care at the VA, however, the local VAMC facilities have had a difficult time getting these services implemented and providing the education to staff and patients. Several of the local VAMC patients have expressed their fear of disclosing their sexual orientation and/or gender identity to providers at the VHA. Some veterans have disclosed that their concerns are increased if the VHA staff member is also a veteran, who may have served under DADT. The VAMC where the DNP project was implemented was located in a city with a large LGBT population and many community resources. The VAMC has the services in place that are outlined in the strategic plan and national directive, but staff lack the knowledge of these resources. The

VAMC senior leadership is supportive of creating a welcoming environment, educating staff, and increasing services for LGBT veterans. The VAMC is affiliated with a university that has a LGBTQ clinic. These reasons helped to make the DNP project of educating staff on the national directive and transgender services successful.

Role of the DNP Student

I am a nurse practitioner working in primary care for the VHA, with LGBT veterans on my panel. I have a vested interest in creating a welcoming environment in the VHA for LGBT patients so that they will disclose all pertinent information that may be necessary for providing appropriate, quality care. Several of the DNP project team members are colleagues of whom I refer patients to for the care they provide, including the LGBT VCC, psychologist, and mental health NP. During my practicum, I was able to work with the women's health program coordinator, LGBT VCC, and psychologist on the Healthcare Equality Index (HEI) survey for the Human Rights Campaign (2017) and participate in the monthly LGBT team meetings.

As the DNP student, I was able to facilitate the DNP project to create a welcoming environment that benefited patients and health care professionals. My role in the doctoral project was to obtain ICD-10 encounter code reports prior to and post implementation of the project, conduct a CRA, identify resources and services, meet with the team to learn how to access and communicate the available resources, develop and evaluate a staff education plan, and disseminate the information to staff. First, I collaborated with the QPI program analyst to obtain reports for the encounters of transgender patient visits based on the following ICD-10 codes: F64.0-9 Gender Identity

Disorders and z87.890 Personal History of Sex Reassignment (WHO, 2018). The reports were generated pre-and postimplementation of the project.

Next, the CRA played an integral part in guiding the discussion for creating an action plan for implementing staff education. I conducted 30-60-minute interviews asking the 18 questions on the CRA tool and assist with the scoring after completion. According to Oetting et al. (2014), the CRM utilizes key respondents for interviews and recommends at least 6 individuals should be interviewed for the CRA. The individuals I interviewed were the primary care NP, social work executive, psychologist, and the LGBT VCC that are part of the DNP project team.

The DNP project included staff education of the national directive and services for transgender veterans. I gathered the information on mandated transgender resources and services from the following sources of evidence: the LGBT Health Program, VHA directives and policies, the Human Rights Campaign, and The Joint Commission. I collaborated with the women's health program coordinator, LGBT VCC, psychologist, primary care NP, mental health NP and social work executive to identify the resources and services that are currently available at the facility. After obtaining the information from sources of evidence regarding mandated resources and services and completion of the CRA, I coordinated a DNP project team meeting with the findings to ascertain how to access the current services, obtain needed services, and how to educate the staff on these resources. Based on the recommendations from the team, I prepared a presentation for senior leadership to obtain approval in implementing a staff educational plan regarding

the national directive and transgender resources. Once senior leadership has approved the plan, I disseminated the information to staff.

Role of the Project Team

The team members bring a plethora of experience related to working with veterans, and the clinical team members have an expertise working with the LGBT population which helped to bring the DNP project to completion. The project team was utilized to complete interviews for the CRA, identify services and resources in the VA, assist with following guidelines and criteria related to LGBT policies, approve a staff education plan, and assist with implementation of the educational plan throughout the VAMC. The team for the project included the LGBT VCC, women's health program coordinator, psychologist, primary care NP, mental health NP, social work executive, and QPI program analyst.

The LGBT VCC and women's health program manager helped with identifying resources and services currently available. The LGBT VCC, primary care NP, psychologist, and social work executive completed the CRA interviews. The QPI program analyst provided a report of encounters based on ICD-10 codes pre-and post-implementation of the standardized transgender program.

The project team provided the foundation for the implementation and support of the DNP project. The timeline for the Staff Education of Transgender Services is represented in Figure 1.

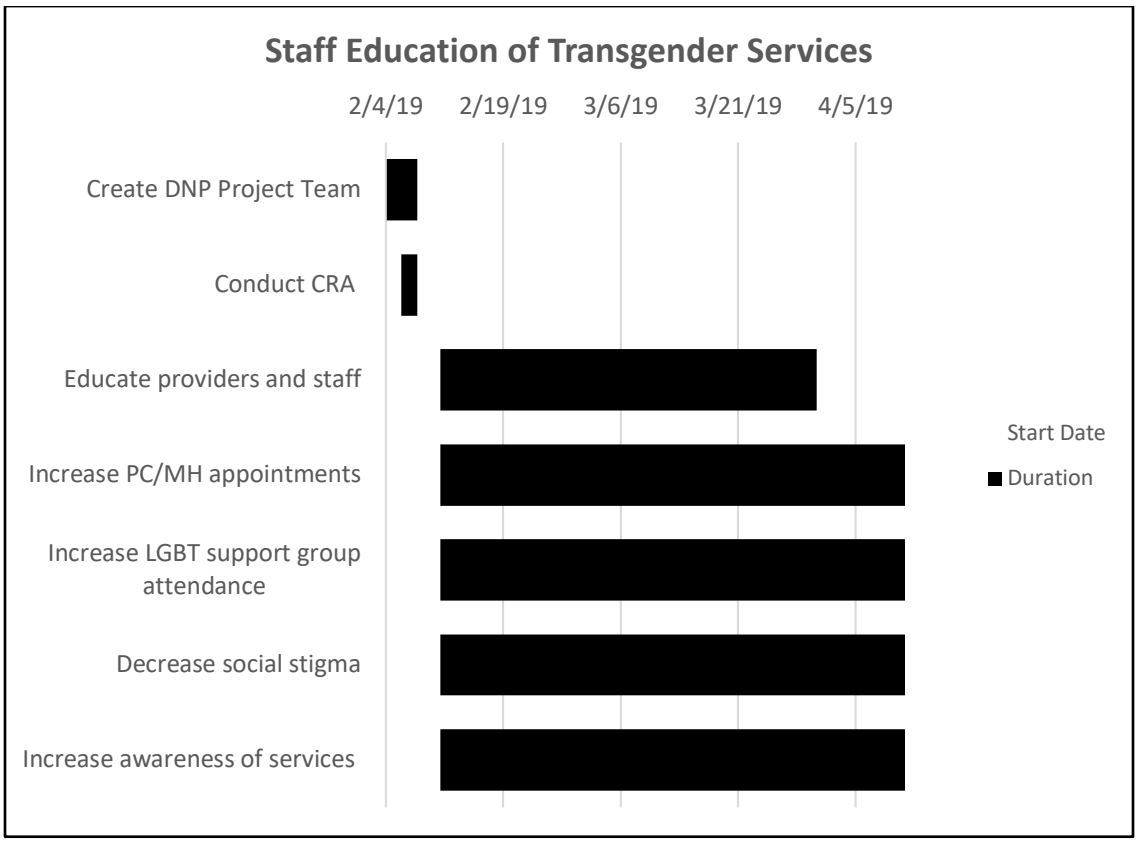

Figure 1. Staff education of transgender services timeline.

Summary

The DNP project to develop and implement staff education on the national directive and available transgender services and resources to increase the number of transgender visits and access to care utilized the Iowa Model to provide structure for practice change and the CRM conducted a needs assessment for education of staff for transgender services. Nursing has been slow to initiate research and policy changes regarding LGBT health concerns, which has led to a practice gap of inefficient care due to the lack of knowledge regarding resources and services for transgender patients making this project relevant to nursing. The local background and context identified the

current need for staff education regarding the national directive and transgender services, at the VAMC, as it relates to the national mission and commitment. As DNP student in the project, my role was pertinent because I am a nurse practitioner caring for transgender veterans in the VAMC and identified need for education of resources in patient care. My role of the DNP student included obtaining reports on ICD-10 encounter codes pre-and post-implementation of the project, conducting CRA interviews, identifying resources and services, obtaining senior leadership approval, collaborating with the team to implement and educate staff on transgender services. The role of the team was to participate in the interviews for the CRA, ensure guidelines and policies are followed, as well as approving and assisting with implementation of staff education. In Section 3, I will explain the practice-focused question, sources of evidence, evidence generated for the doctoral project, and analysis and synthesis.

Section 3: Collection and Analysis of Evidence

Introduction

According to the Office of Health Promotion and Disease Prevention (2014), most national and state surveys do not include sexual orientation or gender identity, thus, it is difficult to ascertain the actual number of LGBT individuals and assess their health care needs. It is imperative that a standardized transgender program is inclusive and meets the needs of LGBT individuals by staff being culturally competent in delivering information and services (Kettner, Moroney, & Martin, 2017). The practice-focused question was: Does the development and implementation of staff education regarding the national directive and transgender services compared to not having any education on services affect the number of transgender patient visits in a 2-month period?

Health care professionals that are competent in the culture of the population will have a greater opportunity for providing the necessary information in a way that gains the patients' understanding and provides a welcoming clinic environment that patients will access. Through an exploratory design, using the CRM, and measurement of encounters for the ICD-10 codes of F64.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment, a staff education plan of transgender services was implemented and evaluated (Oetting et al., 2014; WHO, 2018). In Section 3, I will outline the practice-focused question, and collection and analysis of evidence utilizing the CRM and ICD-10 codes for the DNP project.

Practice-focused Question

A national survey revealed that only 30-40% of transgender individuals receive routine health care (Unger, 2015). The lack of healthcare in the transgender population is of a great concern and creates missed opportunities for assisting patients through a safe transition with quality care. The practice-focused question was: Does the development and implementation of staff education regarding the national directive and transgender services compared to not having any education on services affect the number of transgender patient visits in a 2-month period? The practice gap was the lack of knowledge of staff regarding these resources and services, which created a missed opportunity for comprehensive, quality care for transgender veterans due to an unwelcoming environment. The evidence shows that current research for transgender care includes CSHT, safety and efficacy of sex reassignment surgery, but lacks the clinical care and the health impact of transitioning from one gender to another (Guarnero & Flaskerud, 2014). However, the best new practices in transgender care are related to dedicated healthcare professionals in dedicated transgender clinics and programs, thereby increasing appropriate, quality care (Strousma, 2014).

For the DNP project, the following conceptual and operational definitions have been developed:

1. Staff education of transgender resources program-Conceptual definition: education of nurses and providers regarding clinically appropriate, comprehensive, care for transgender veterans utilizing generally accepted standards of medical practice, including CSHT, mental health care, preoperative evaluation, postoperative and long-term care

following gender confirming/affirming surgery, to promote, preserve, or restore the health of the individual (VA, 2018b). Operational definition: identified by an exploratory design approach measured by utilization of the CRM and the CRA tool (Oetting et al., 2014; Appendix A).

2. Transgender Patient-Conceptual definition: a person whose gender identity differs from their birth sex (VA, 2018a). Operational definition: identified through utilization of ICD-10 codes: F64.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment (WHO, 2018).

3. Transgender patient visits- Conceptual definition: a person whose gender identity differs from their birth sex, who visits the VA facility (VA, 2018a). Operational definition: identified through *VHA Support Services Center Capital Assets* report, generated by QPI program analyst, as measured by ICD-10 encounter codes: F64.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment (WHO, 2018).

Sources of Evidence

Sources of evidence for this project were obtained through a systematic review of relevant published findings and conclusions from other researchers and scholars, CRA, and baseline data from ICD-10 encounter codes. Community readiness is the degree to which a community is willing and ready to take-action on an issue (Oetting et al., 2014). The CRM is the most appropriate way to conduct a needs assessment for education of staff for transgender services at the VAMC because it is efficient, inexpensive, easy-to-use, and encourages local experts and resources. Encounters for transgender patient visits

were measured based on the following ICD-10 codes: F64.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment (WHO, 2018). Reports of encounters were generated pre and postimplementation of program through the VAMC QPI program analyst.

Published Outcomes and Research

The systematic review of relevant published findings and conclusions from other researchers and scholars was conducted from 2015-2017, utilizing the following electronic databases EBSCO, CINAHL, PsycBooks, PsycINFO, PsychArticles, PsycTests, Psychology and Behavioral Sciences Collection, SocINDEX, and Library, Information Science & Technology Abstract. The key search terms and combinations used for the review were transgender, transgender patients, transgender clinics, transgender health care, transgender access to health care, transsexual, gender identity, gender nonconforming, military, veterans, patient education, sexual orientation, sexual health, Veterans Health Administration, Department of Defense, and LGBT, LGBT health care, LGBT research, LGBT specific providers, LGBT welcoming environment, nursing care, LGBT nursing, transgender nursing, and LGBT access to care. The research and professional organizations which were used for the review included the World Professional Association for Transgender Health (WPATH), Gay Lesbian Medical Association (GLMA), National LGBTQ Task Force, Transgender American Veterans Association, National Center for Transgender Equality, the National LGBT Health Education Center at the Fenway Institute, the VHA National LGBT Health Program, the University of California, San Francisco (UCSF), the University of Iowa Carver College

of Medicine (UICCM), the World Health Organization (WHO), and the Institute of Medicine (IOM).

According to Blosnich et al. (2013), the prevalence of gender identity disorder (GID) diagnosis nearly doubled over 10 years among VHA veterans. Blosnich et al. (2013) examined VHA electronic medical records from 2000-2011, then generated annual prevalence estimates and calculated incidence utilizing 2000 as the baseline year. The team cross-referenced GID cases with suicide-related events during the same time period. The results indicated a GID prevalence in the VHA higher than the estimates in the general US population, and the rate of suicide-related events among GID-diagnosed VHA veterans was more than 20 times higher than rates for VHA general population. The conclusion of this study was research is needed to examine how VHA utilization of new VA initiative for transgender care influences the suicide risk among transgender veterans. The study supports the project by showing the increase in gender identity disorder veterans and the need for transgender focused care in the VHA.

According to Carabez, Eliason, and Martinson (2016), to date there were no studies that focus on nurses' knowledge of transgender attitudes or health care needs. The qualitative analysis conducted by Carabez et al. (2016) interviewed 268 registered nurses in the San Francisco Bay area as part of a LGBT study. Carabez et al. (2016) focused on responses to 1 item, "Describe healthcare issues that are particular to transgender patients," which revealed three overarching themes of discomfort, transition, and harsh consequences of being transgender. Over half of the respondents expressed discomfort with transgenderism related to bathrooms, pronouns and many utilized dehumanizing

language (Carabez et al., 2016). Most respondents distinguished between transgender and non-transgender patients as either being on hormones or in some state of surgical procedures (Carabez et al., 2016). Many respondents felt as though mental health issues and stigmatization were due to being transgender, while some acknowledged mental health issues were due to stigmatization (Carabez et al., 2016). The findings of this study support the project because it revealed nurses' discomfort and lack of knowledge about transgender people and their health care needs.

Carlson and Harper (2011) used the CRM to provide framework for consultation with one local long-term care facility with 130 beds. The facility expressed interest in improving service to a diverse resident base, specifically LGBT older adults. Six employees consisting of a nurse, admissions coordinator, business administrator, social worker, aide, and nurse coordinator, were interviewed utilizing the CRA tool. The CRA scores indicate the readiness levels of the community members defined as: 9 most have extensive knowledge about local efforts, know the purpose, who the efforts are for and how the efforts work, and many know the effectiveness of local efforts; 8 most have heard of local efforts and familiar with the purpose, many know who the efforts are for and how the efforts work, and some know the effectiveness of local efforts; 7 many are familiar with the purpose, who the efforts are for, how the efforts work and a few members know the effectiveness of local efforts; 6 many are familiar with the purpose, who the efforts are for and how the efforts work; 5 some are familiar with the purpose, who the efforts are for and how the efforts work; 4 some are familiar with the purpose, 3 has vague awareness, 2 as misconception/incorrect knowledge, 1 as no knowledge

(Plested et al., 2014). The results showed a readiness score of 2 for community efforts, knowledge of community efforts, leadership, community knowledge about the issue and knowledge of resources related to the issue. The community climate dimension generated a readiness score of 3, with an overall readiness score across all dimensions of 2, which indicates there is a recognition of the issue as a problem, but no ownership of it as a local problem. It was concluded that the long-term care facility requires a clear vision for change. The study supports utilization and effectiveness of the CRA for the evaluation of LGBT knowledge in a community.

A white paper written by Dean et al. (2000) indicates there are social conditions impacting the health of the LGBT population, including a direct impact of stigmatization and prejudice, and failure to adequately address special needs of LGBT populations. Research and evaluation of the LGBT population is scarce in all sectors due to problems in recruitment of subjects and agreement of definitions of LGBT, which results in small studies that can be biased and uninformative for public health purposes. Health care delivery and access to care can be substandard or patients may remain silent about important health issues due to fear of stigmatization. Dean et al. (2000) identified bias from health care professionals and perception of such bias have been identified as personal or cultural barriers to care, which has led to reduction in help-seeking and quality of care. Dean et al. (2000) recommended monitoring the health of LGBT populations through the necessity of measuring sexual orientation and transgender identity surveys such as the National Health Interview Survey (NHIS). The study

supports the project by identifying stigmatization, lack of health care delivery and access to care for the LGBT population.

Gates (2004) found there is an information gap about the compatibility between homosexuality and service in the United States Armed Forces, therefore census data was utilized to estimate the size of the gay and lesbian population serving in the military. Gates (2004) evaluated data from the United States 2000 Decennial Census specifically 5% Public Use Microdata Sample (PUMS) representing one in 20 sample of American households. The analysis was based on the sample of men and women between the ages of 18-67. The same-sex couple sample for this age group included 28,772 men and 30,351 women. Of those, 83 men and 91 women reported active duty military service, 710 men and 714 women in reserve/guard training, and 3,735 men and 2,373 women in prior service in active duty (veterans). The estimates suggest more than 36,000 gay men and lesbian women are serving in active duty, representing 2.5 percent of active duty personnel. When guard and reserve are included this estimate is increased to 65,000 in uniform are likely gay and lesbian, accounting for 2.8 percent of military personnel. The project is supported by this study because it offers a census for potential LGBT veterans who will have a need for VHA LGBT health care.

Guarnero and Flaskerud (2014) describe the priority areas for LGBT research recommended by the IOM commissioned by the NIH in 2009. The IOM report indicated the health and healthcare needs of the LGBT community is an area of research that has been neglected, and fraught with methodological and ethical challenges. The five major areas of research with most pressing need as identified by the IOM include demographic

research, local influence, health care inequities, intervention research, and transgender specific health needs. Research should be guided by four conceptual perspectives including minority stress, development across the life course/span, intersectionality (the multiple roles and identities of individuals), and social ecology (family and community influence). Demographic research so far has been focused on gay men and lesbians, thus, future research would need to focus on bisexual and transgender individuals. Research is needed that addresses other LGBT issues such as depression, suicide and other mental health conditions, elevated rates of smoking, alcohol and other substances, and expanding into other differential diagnoses such as heart disease, cancer, and diabetes. The study supports the project by indicating needs and issues of the LGBT population that have been neglected and require further research.

Kauth et al. (2014) identified 2,662 transgender veterans across fiscal years (FY) 2006-2011 in the VHA, with the rate of increase of transgender veterans climbing steadily since FY 2008. In June 2011, VHA issued a national directive to standardize treatment services for transgender veterans with 985 new cases identified after the issuance of the directive. The data was collected from VHA Medical Statistical Analysis System for encounters with the codes of gender identity disorder in adolescent or adult, gender identity disorder not otherwise specified, and transsexuals. The study supports the project by identifying an increase in the number of transgender veterans and an issuance of a national directive to standardize care in VHA.

Lutwak et al. (2014) identified challenges for transgender individuals in the healthcare setting, including unique health risks, barriers to health care, and health

disparities. The prevalence of transgender individuals among veterans is higher than in the general population, however the unique needs of these veterans are understudied. Lutwak et al. (2014) report that LGBT health issues, particularly of the transgender population are inadequately covered in training programs for health care providers and support staff. The health care team is ill-prepared to understand or meet the clinical needs in a culturally sensitive manner. Negative experiences by transgender veterans result in barriers to care resulting in avoidance of care or delaying care as well as decreased preventive services, continuity of care, and life expectancy. VHA is committed to providing sensitive, patient-centered, and evidence-based care to all veterans including those who are transgender. While progress has been made to achieve this goal, much remains to be done. The study supports the project by identifying the issues of the health care team to provide care to transgender veterans and defining VHA's commitment to providing quality care to transgender veterans.

Evidence Generated for the Doctoral Project

Participants

According to *The Community Readiness for Community Change Tri-Ethnic Community Readiness Handbook (2nd Ed.)* by Oetting et al. (2014), interviews using the CRA tool should be conducted with at least 6 key respondents who work directly with the community members and can provide informed opinions about the issue. Individuals who work directly with transgender veterans at the VAMC were recruited to participate in the interviews, and told participation will be voluntary. Several individuals at the VAMC have had transgender veterans scheduled into their clinics since the VHA Directive 1341

(2018a): *Providing Health Care for Transgender and Intersex Veterans* was issued, including a primary care NP, mental health NP, psychologist, social work executive, LGBT VCC, and women's health program coordinator. These individuals have participated in the national VHA transgender education programs for clinical staff, are located throughout the VAMC facility and will be approached to participate in the interviews.

The primary care NP provides primary care services to transgender individuals including health screenings, wellness education, cross-sex hormone therapy, immunizations, and clinical support of health needs. The mental health NP provides mental health services to transgender patients including mood, alcohol/substance and tobacco screenings, interventions for mental health needs, and referrals for psychotherapy. The psychologist provides evidence-based psychotherapies and counseling services for transgender patients with mental health needs. The social work executive supervises the social work department and provides transgender patients with support for financial, employment and housing needs. The LGBT VCC is a VHA mandated position for assisting to coordinate LGBT veterans with services and resources in the VHA and community. The women's health program coordinator was initially the position mandated to advocate for LGBT veterans and continues to coordinate clinical care.

Procedures

Upon approval from the Walden IRB, I obtained a pre-project report from the VAMC QPI program analyst, which will include the ICD-10 encounter codes for F65.0-9

Gender Identity Disorders and z87.890 Personal History of Sex Reassignment. The data obtained from the QPI office will be stored in a Microsoft Word document titled, "ICD-10 Pre/Post Encounters," on the organization's computer system.

On the second Thursday of the month after obtaining IRB approval, I presented information regarding how to conduct interviews using the CRA tool (Appendix A) to the DNP Project team to recruit participants. The information included how to volunteer, the purpose of the interviews, how the information will be used, who to contact to participate in interviews, and the date of when the interviews will be conducted. Individuals were assured they can choose not to answer any questions that would make them feel uncomfortable.

The following Monday, I conducted interviews with the volunteer participants from the DNP Project Team, utilizing the CRA tool (Appendix A). The interviews took place in the office of the LGBT VCC. The questions from the CRA tool were asked of the participants and I recorded the numerical score given on a printed CRA tool form. The interviews lasted 30 minutes. Immediately following the interviews, I scored the interviews and placed the data into a Microsoft Excel Spreadsheet, titled "CRA Scores," in the organization's computer system. I shredded the printed CRA tool utilized to conduct the interviews after raw scores were entered into the computer.

I coordinated a virtual meeting with the DNP project team. The DNP project team was a multidisciplinary group of individuals assisting with me to implement and evaluate the project. The DNP project team assisted with reviewing the data from the CRA interviews, preimplementation ICD-10 encounter code data and assisted with identifying

an action plan for staff education of the national directive and transgender resources, including interventions for communicating and disseminating the information to the staff.

I presented the action plan to the facility senior leadership for approval. Once leadership approval had been obtained, I worked with medical media to produce handouts with resource and national directive information for staff education. I provided education and handouts at the monthly primary care and mental health staff meeting for a clinic that has four primary care providers, three mental health providers, and nurse case managers for each provider. After four weeks of providing staff education on the national directive and transgender resources, I obtained a post-implementation report from the QPI program analyst which will include the ICD-10 encounter codes for F65.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment. The data obtained from the QPI office was stored in a Microsoft Word document titled, "ICD-10 Pre/Post Encounters," on the organization's computer system. The DNP project team members had access to the data through assigned passwords.

Instruments

The CRA tool chosen for this project was retrieved from *The Clearinghouse for Military Family Readiness* (Appendix A). The CRA tool has 18 questions which address the six dimensions of the CRM and can be asked of individuals in a 30 to 60-minute interview, with a scoring process for each answer (Rivera-Ramos et al., 2015; PSU, 2017). The questions are scored using the following point value: 2 points for 'yes,' 1 point for 'somewhat,' and 0 points for 'no,' with greater than 31 points being strong for making a change, 24-30 is moderate and should proceed with caution; and less than 23 is weak

and should take time to build community support prior to change (Appendix A). Participants who work directly with transgender veterans voluntarily completed the interviews conducted by me using the CRA tool.

The validity of the CRA tool is largely difficult to assess due to the community and issue changing with each application and utilization of the tool. As Plested, Jumper-Thurman, & Edwards (2014) explain,

> The theory of the Community Readiness Model is a "broad scale theory." A broad scale theory deals with a large number of different phenomena, such as facts or opinions and a very large number of possible relationships among those phenomena. Although it is not possible to have a single test to establish construct validity for a broad scale theory, it is possible to test hypotheses that derive from the theory and if the hypotheses prove to be accurate, then the underlying theory and the instrument used to assess the theory are likely to be valid (Oetting & Edwards). This approach has been taken over the course of development of the Community Readiness Model and construct validity for the model has been demonstrated (Plested et al., 2014, p. 47).

The reliability of the CRA tool has much the same issue as testing the validity, however, consistency among respondents which reflects an accurate depiction of the community, and inter-rater reliability in scoring have led to proving the usefulness of the tool (Plested et al., 2014). The CRA analysis will provide information to guide discussion in creating an action plan for the staff education of transgender resources (Oetting et al., 2014).

Protections

The principles of the Health Insurance Portability and Accountability Act (HIPPA) were used to safeguard the privacy of the participants. The participants were recruited from the DNP Project team, and are individuals who provide direct care and advocacy for transgender veterans. The strategies for recruitment included a presentation of information at the DNP Project team meeting. The presentation explained how to volunteer, the purpose of the interviews, how the information will be used, and who to contact to participate in interviews. Individuals were given an opportunity to ask questions about the process, assured participation is voluntary and may withdraw from the interview at any time. Individuals were assured their responses are anonymous and their identifiers are confidential with the exception of identification of team role, such as primary care provider, mental health provider, social worker, etc. Individuals were assured they can choose not to answer any questions that would make them feel uncomfortable. Consent for participation was implied when an individual chose to complete an interview (Ferris, Holm-Hansen, & Kelly, 2011).

The scored data collected from the interviews was stored on a Microsoft Excel spreadsheet titled "CRA Scores" in the organization's computer system. The data collected from the QPI program analyst was stored on a Microsoft Word document titled, "ICD-10 Pre/Post Encounters" in the organization's computer system. Security of data was limited to team members through utilization of assigned passwords. The data collected from the CRA tool was numerical and participant information was confidential with the exception of a general identification of their role on the team.

Analysis and Synthesis

The first objective of the DNP project was to create staff education of the national directive and transgender services. The analysis and synthesis of information obtained from the interviews was collected using a CRA tool that provides a numerical value to the answers and allows for calculating a total score. The scores for each answer and total scoring was entered into a 2016 Microsoft Excel spreadsheet, titled "CRA Scores," utilizing descriptive statistics to organize and analyze the information (Appendix A). The information captured from the interviews helped to create an action plan for staff education of the national directive and transgender resources.

The second objective of the DNP project was to use staff education to increase transgender patient visits and access to care. The data obtained from the VAMC QPI Office including the ICD 10 codes: F64.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment was organized into a 2016 Microsoft Word document with pre and post program implementation (WHO, 2018). The document allowed for comparison of encounter codes before and after education of the national directive and transgender resources to evaluate if increase in staff knowledge of transgender resources leads to increased patient visits and access to care.

Summary

The practice-focused question was: Does the development and implementation of staff education regarding the national directive and transgender services compared to not having any education on services affect the number of transgender patient visits in a 2-month period? The literature review resulted in several articles that support a staff

education of the national directive and transgender resources. The literature indicates nursing has limited knowledge of transgender attitudes or health care needs. The evidence generated for the doctoral project came from participants who work directly with the transgender population, completing an interview using a CRA tool, with the ethical protections of privacy following HIPAA standards, and through voluntary participation. The analysis and synthesis of information from the CRA interviews was organized in a Microsoft Excel spreadsheet and ICD-10 code encounter data into a Microsoft Word document. The data was stored on the organization's computer system with the team being able to access through assigned passwords. Through a systematic review of sources, using the CRM, and measurement of encounters for the ICD 10 codes of F64.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment, a staff education plan of transgender services was implemented and evaluated. In Section 4, I will explain the findings and implications, recommendations, contribution of the DNP project team, and strengths and limitations of the project.

Section 4: Findings and Recommendations

Introduction

My purpose in this DNP project was to develop and implement staff education regarding the VHA Directive 1341 (2018a): *Providing Health Care for Transgender and Intersex Veterans*, available transgender services and resources to increase the number of transgender visits and access to care. The gap-in-practice was inefficient care due to the lack of knowledge regarding resources and services for transgender patients. The practice-focused question was: Does the development and implementation of staff education regarding the national directive and transgender services compared to not having any education on services affect the number of transgender patient visits in a 2-month period? The sources of evidence were generated through a systematic review of resources, using of the CRM and CRA tool, and a measurement of encounters for the ICD-10 codes of F64.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment. In Section 4, I will outline the findings and implications, recommendations, contributions of the doctoral project team, and strengths and limitations of the project.

Findings and Implications

The DNP project was initiated after approval from the Walden University Institutional Review Board (IRB) and the VAMC IRB. I met with the DNP project team and explained the project, including the CRA tool/interviews and comparison of data from the ICD-10 encounter codes pre/post implementation through QPI reports. The DNP project team included the LGBT VCC, women's health program coordinator,

psychologist, primary care NP, mental health NP, social work executive, and QPI program analyst.

I conducted 30-minute interviews utilizing the CRA tool with members of the DNP project team who volunteered to participate (Appendix A). The members who volunteered to complete the interviews consisted of a speech pathologist, social worker, psychologist, and primary care NP. I asked the members 18 questions related to the six dimensions of the CRM (Rivera-Ramos et al., 2015; PSU, 2017). I scored the interviews using the following point value: 2 points for 'yes,' 1 point for 'somewhat,' and 0 points for 'no' (Appendix A). The overall score of the CRA tool evaluates the readiness of the community for change with greater than 31 points being strong for change, 24-30 moderate and should make change with caution; and less than 23 weak and community support should be increased prior to change.

The analysis and synthesis of the results from the CRA interviews were completed with 2016 Microsoft Excel Analysis ToolPak, using descriptive statistics. The mean (*M*) was used as the measure of central tendency for the data as it provides the most information on the population for the interviews (Manikandan, 2011). The results of the CRA interviews revealed *M*=2 for the availability of community experts for advice and *M*=<1 for the available and sustainable funding. All the other categories had a mean ranging between 1.25-1.75 (Figure 2). The mean of 2 indicates the staff have knowledge that community experts are available for advice. The mean of less than 1 indicates that the staff have no knowledge of available or sustainable of funding. The categories that range between 1 and 2 indicate the staff have some knowledge but not enough to

definitely say support and commitment from staff, leaders and community, qualified professionals, and laws/practices/policies are available.

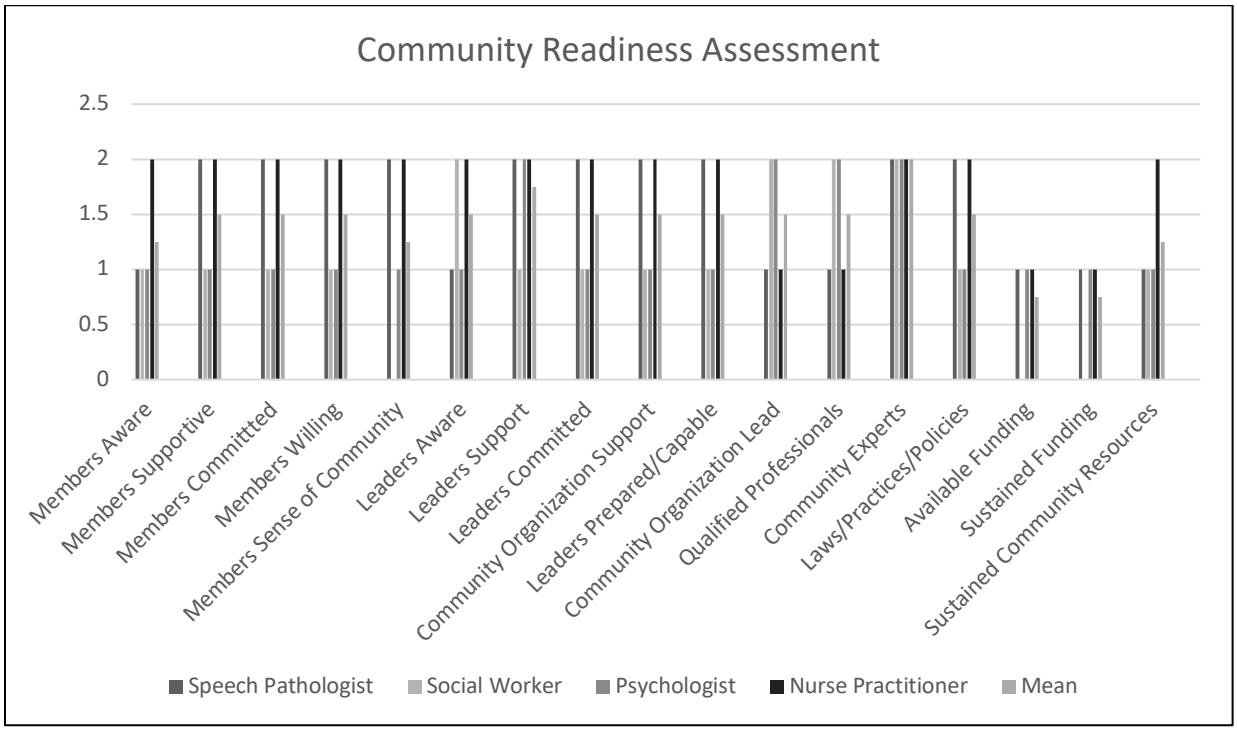

Figure 2. Community readiness assessment interview results.

The total score of the CRA interviews was *M*=24 indicating the project should be implemented while building facility support (Figure 3).

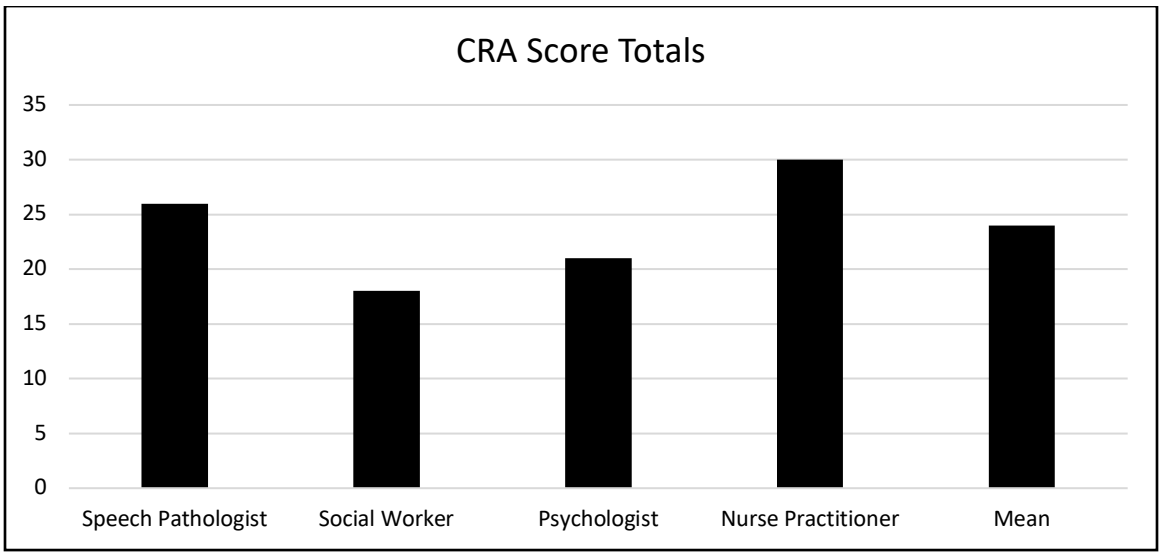

Figure 3. CRA score totals.

The implications of the CRA interviews reveal that the staff have knowledge of availability of community experts, but lack knowledge related to support and commitment from staff, leaders and community, qualified professionals, and laws/practices/policies, and no knowledge of funding. The total score of the CRA instrument indicates the DNP project should be implemented, but building facility support is recommended to assist with change efforts. The findings correlated with the literature that the utilization of the CRA tool is effective in evaluating the LGBT knowledge in a community and that staff has limited knowledge of transgender health care needs.

Next, I obtained a pre-implementation report from the VAMC QPI Office program analyst, which included the ICD-10 encounter codes for F65.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment. The pre-implementation report data was captured at the beginning of the fiscal year, extending from October 1,

2018-February 9, 2019 and provided baseline information for the DNP project. The total encounters during this five-month period was 14, with an average of 2.8 encounters per month (Figure 4).

ICD-10 Codes	Encounters	
	Oct, 2018-Feb, 2019	Feb, 2019-April, 2019
(F64.0) Transsexualism	0	0
(F64.1) Gender identity disorder in adolescence and adulthood	2	3
(F64.2) Gender identity disorder of childhood	1	0
(F64.8) Other gender identity disorders	0	1
(F64.9) Gender identity disorder, unspecified	11	3
(Z87.890) Personal history of sex assignment	0	0
Total:	14	7
Average per month:	2.8	3.5

Figure 4. Pre/Postimplementation ICD-10 encounter data.

The information from the CRA interviews and the pre-implementation ICD-10 encounter code data were shared with the DNP project team. After a discussion, the project team and I decided to create an informational sheet that contained staff education for describing the responsibilities of the LGBT VCC and their contact information, national directives and local policies, LGBT patient resources including primary care clinic, mental health support group, speech pathology, pharmacy support for cross-sex hormone therapy, and prosthetic equipment, LGBT employee resources and contact information, and VA websites (Appendix C). I gathered the information from the VHA Directive 1341 (2018a): *Providing Health Care for Transgender and Intersex Veterans*, which defines care standards and guidelines for transgender patients, and outlines the responsibilities of the LGBT VCC. I gathered information from the DNP project team on

current services available at the facility, how to consult/order services, and a contact for each area including primary care, mental health, speech pathology, pharmacy and prosthetics. I created the handout with the information obtained (Appendix C), which the DNP team approved.

The DNP team and I decided the information should be distributed through electronic material/handouts (Appendix C) by myself to the facility intranet administrator, a group email to the service lines, and an oral presentation at staff meetings. The DNP team recommended presenting information at clinic staff meetings with primary care and mental health staff in attendance after obtaining approval from senior leadership.

I obtained approval for methods of distribution of the transgender resource information from the senior leadership. Upon verbal approval from senior leadership, the handout information was distributed electronically to the facility intranet administrator, and through group email to primary care/mental health and specialty medicine service lines. I attended three staff meetings and provided an oral presentation at one meeting for the entire clinic staff, which included nursing, providers, clerical staff and social work, and at one meeting each for the mental health and primary care service lines for the VAMC. Handouts were provided at each meeting (Appendix C).

Two months after obtaining the pre-implementation ICD-10 encounter data and initiating the DNP project, I obtained the post-implementation ICD-10 encounter codes from the VAMC QPI Office program analyst. The post-implementation ICD-10 encounter code report covered the time period of February 10, 2019-April 6, 2019. The

data shows 7 encounters during this two-month period with an average of 3.5 encounters per month.

The implications of the pre/postimplementation ICD-10 encounter data supported the evidence that development and implementation of staff education on the national directive and transgender services increase transgender patient visits by 0.7 encounters per month. The findings correlated with the literature that staff education of the national directive and transgender resources are needed for transgender-focused care in the VHA. Staff education of transgender services effectively equip nurses and providers with interventions to provide quality, comprehensive care.

The DNP project has implications for positive social change within the VHA primary care and mental health clinics. Social change was realized when staff were educated on the national directive and services available to transgender care. Positive social change was realized with an increase in transgender patient visits, which ultimately leads to quality, comprehensive care for health promotion and disease prevention.

Recommendations

The DNP project data supports that effective staff education on the national directive and transgender services lead to increased transgender patient visits. The first recommendation is to continue staff education on transgender services and care at the VAMC, using the staff education on LGBT resources tool developed for the DNP project (Appendix C). The VHA Directive 1341 (2018a): *Providing Health Care for Transgender and Intersex Veterans*, which outlines the responsibilities of the LGBT VCC, offers the foundation for continuing the DNP project at the VAMC. The directive

mandates that the LGBT VCC role reports directly to senior leadership, supports the implementation of national and local policies for LGBT veteran health at the facility, ensure access to culturally competent care of LGBT veterans, create a welcoming environment, and provide education to staff about treatment of LGBT veterans (VA, 2018a).

The second recommendation is to have the LGBT VCC continue the education of the staff through oral presentations and group e-mails. The LGBT VCC participates in the monthly new employee orientation (NEO) in-services and could incorporate the DNP project education during this time. The LGBT VCC could provide the education to the staff facility-wide during events of LGBT awareness, such as LGBT Health Awareness Week in March, PRIDE month in June, and LGBT History Month in October. The LGBT awareness events are supported by the senior leadership and offer the LGBT VCC set intervals to be consistent with updating and delivering the education to staff.

The third recommendation is to continue to obtain ICD-10 encounter code reports from the QPI program analyst on a quarterly basis. The ICD-10 encounter code reports offer objective information on the number of transgender patient visits at the facility. The information from the encounter code reports can be incorporated to the education provided to the staff and for direct reporting to senior leadership.

Contribution of the Doctoral Project Team

The DNP project team consisted of individuals who have a plethora of experience working with veterans and expertise working with LGBT populations. The project team consisted of the LGBT VCC, women's health program manager, psychologist, primary

care NP, mental health NP, social work executive, and QPI program analyst. The project team contributed to the project by reviewing and assisting to interpret the data obtained from the CRA interviews and ICD-10 reports, identifying current transgender services and resources in the VA, advising on guidelines and criteria related to LGBT policies, providing input and approving the staff education plan, and assisting with implementation of the educational plan throughout the VAMC. Four individuals from the DNP project team volunteered to complete the CRA interviews, including the LGBT VCC, the primary care NP, psychologist, and social work executive. The QPI program analyst provided the reports for ICD-10 encounter codes pre-and post-implementation of the DNP project.

The DNP project team individuals are also members of the facility LGBT Work Group that meets on a monthly basis and chaired by the LGBT VCC. The LGBT Work Group plans to add the staff education on LGBT resources tool to the agenda as a recurring item (Appendix C). By keeping the educational tool on the agenda, the LGBT Work Group will be able to maintain and update the information as necessary, and schedule presentations for the staff.

Strengths and Limitations of the Project

The greatest strength of the project is the staff education on LGBT resources tool that was created based on the VHA directive on caring for transgender patients (Appendix C; VA, 2018a). Through the directive, the VHA has hardwired into their standards that education of staff and creating a welcoming environment is important and necessary, and mandated the role for the LGBT VCC at each VA facility. Another

strength of the project is the robust support from the senior leadership, the LGBT VCC, and the interdisciplinary DNP project team at the facility, who provided their expertise on the transgender veteran population and current services available. A third strength is that the facility has the transgender services and resources available, thus, it was not necessary to create any new services to complete the DNP project. Lastly, the facility has a QPI department that can readily create reports for ICD-10 encounter codes for objective data measurement.

A limitation to the DNP project is the LGBT VCC role is a collateral duty. The policy for the LGBT VCC role dictates that administrative time should be dedicated to the position, unfortunately this role does not always take priority over other duties (VA, 2018a). One limitation to the CRA interview findings is only four individuals volunteered to complete the CRA interviews. Oetting et al. (2014), recommended the CRA interviews should be completed with at least 6 individuals for a complete picture of the community. The four individuals who voluntarily completed the CRA interviews included the LGBT VCC, primary care NP, psychologist, and speech pathologist. The facility where the DNP project was implemented has several other services that care for transgender patients, such as speech pathology, physical therapy, and suicide prevention. In order to have a complete picture of the educational needs of staff, it would be preferred to also include CRA interviews of these other services. Another limitation to the findings of the ICD-10 encounter code data is the 2-month time period the DNP project was implemented. The CRA total score indicated that building facility support should occur, with a longer time

period better facility support and staff buy-in could be pursued, thereby potentially influencing the number of encounters.

Summary

The purpose of the DNP project was to develop and implement staff education regarding the national directive for transgender care and available transgender services to increase the number of transgender visits and access to care. The gap-in-practice was inefficient care due to the lack of knowledge regarding resources and services for transgender patients. The practice-focused question was: Does the development and implementation of staff education regarding the national directive and transgender services compared to not having any education on services impact the number of transgender patient visits in a 2-month period?

The sources of evidence were generated through a systematic review of resources, using of the CRM and CRA tool, and a measurement of encounters for the ICD-10 codes of F64.0-9 Gender Identity Disorders and z87.890 Personal History of Sex Reassignment. The findings of the CRA interviews indicated staff have knowledge of availability of community experts, but lack knowledge related to support and commitment from staff, leaders and community, qualified professionals, and laws/practices/policies, and no knowledge of funding. The CRA interview results indicated the DNP project should be implemented, while building facility support is recommended to assist with change efforts. Based on the information from the CRA interviews and support from the DNP project team and senior leadership, the staff education on LGBT resources tool was created and disseminated in three staff meetings and through group email. After a 2-

month period, pre- and post-implementation ICD-10 encounter code data reports were compared revealing an increase in transgender patient visits.

The strengths of the DNP project include hardwired guidelines from the national directive and mandated LGBT VCC role, support from senior leadership and DNP project team, and data available from the QPI department. The limitations of the project include limited availability of time for the LGBT VCC role, only four individuals completed the CRA interviews, and the two-month implementation period. In Section 5, I will outline the dissemination plan and analysis of self for the project.

Section 5: Dissemination Plan

Dissemination Plan

The results of the DNP project were disseminated to the DNP project team and the LGBT Work Group at their monthly meeting. I presented the information in a 10-minute oral presentation, using the visual aids of the Community Readiness Assessment (CRA) Interview Results (Figure 2), CRA Score Totals (Figure 3), and Pre/post-implementation ICD-10 Encounter Code Data (Figure 4). Following the presentation, the DNP project team and LGBT Work Group members were given an opportunity for questions and comments. The team and members provided feedback that the project was helpful in providing direction for education of staff on transgender care and to help meet strategic planning goals for creating a welcoming environment. The DNP project team agreed that the time allocated to the role of the LGBT VCC was a limitation to sustaining the education plan, but felt senior leadership would be supportive making this a priority. The LGBT Work Group voted to keep the staff education as a recurring item on the agenda to ensure it would be routinely updated and provided to staff.

Audiences for this DNP project would be the women's health program, family planning clinics, speech pathology, and suicide prevention. The national directive provides guidance for these practice areas to be included in transgender care, and the services they provide would be valuable to transgender patients. Nurses are essential to creating a culturally sensitive, welcoming environment for transgender patients throughout their care (Hein & Levitt, 2014). Staff education of the national directive and

transgender services is relevant to nursing practice in that it provides for cultural competency, decreases barriers to care, offers accurate and reliable patient education and resources, and leads to increased access to care. The nurse leaders are responsible for creating opportunities for implementing and sustaining EBP for strengthening transgender healthcare delivery and nursing practice. The DNP project supports nurses to increase knowledge of services to provide appropriate, quality care to transgender patients, thereby increasing their visits and access to care. Dissemination of the project findings through poster boards at the facility in primary care and mental health settings, and through regional nursing conferences can increase nursing knowledge to enhance care of transgender patients.

Analysis of Self

My professional experience includes the roles of nurse manager and project manager both in private sector and federal health care systems. These roles required creation and revision of policies and protocols, establishing and collaboration with multidisciplinary teams, evaluating and providing resolutions for ethical and legal issues, and routine communication/meetings with senior leadership. Because I had this experience, I felt comfortable in a leadership role. I had the confidence to function as a leader and collaborate with the DNP project team and senior leadership to complete the DNP project. Basic LGBT health education is lacking in the nursing field, which leads to discomfort and stereotypes in providing care to this population (Carabez et al., 2015). Growth as a leader, practitioner, scholar and project manager came from learning more

about the LGBT population, the differences and similarities of care between private sector and the VHA for this population.

The DNP Essentials that provided guidance for completion of the DNP project included Essential II – Organizational and Systems Leadership for Quality Improvement and Systems Thinking, Essential VII – Clinical Prevention and Population Health for Improving the Nation's Health, and Essential VIII-Advanced Nursing Practice (AACN, 2006). These DNP Essentials provided a guidance for evaluating epidemiological, biostatistical, and environmental data to develop, implement, and evaluate interventions to address health promotion/disease prevention efforts of the LGBT population. The DNP project required me to perform in the roles of practitioner and project manager by evaluating directives, current primary care and mental health services, and resources available for the transgender population, both at the facility and in the community. The DNP Essentials supported me as a scholar to utilize conceptual and analytical skills to evaluate the links among practice, organizational, fiscal, and policy issues for the delivery of care to LGBT Veterans, and develop and evaluate the care delivery services in physical and mental health for the transgender veteran population.

Although I started the project with a professional history of being in a leadership role, I gained a greater insight on utilizing the guidance of policy, team support, and resources when dealing with issues and concerns for vulnerable population in healthcare. At the beginning of the project, I felt confident that I understood the roles of practitioner, scholar, and project manager, and how to perform these roles, however, by the end of the project, I had gained a better understanding of these roles as they relate to being a

member of a team and providing guidance for decision-making, rather than the actual decision-maker. I feel my competency for developing and sustaining therapeutic relationships with patients and other professionals has grown with this project experience. The DNP project has been beneficial in enhancing my experience, knowledge, and proficiency of leadership, advanced nursing practice, promoting quality improvement, improving health outcomes, and health care policy as a practitioner, scholar, and project manager.

The DNP project was valuable for providing me with an insight into the layers of the scholarly journey. The completion of the DNP project was well supported by the facility and senior leadership, which provided a foundation to develop, implement, and evaluate interventions to address health promotion/disease prevention efforts, improve access and health outcomes, and address gaps of care for transgender veterans. One of the biggest challenges to the completion of the project is the time needed for all aspects to be approved for the various individuals, such as the DNP project team, senior leadership, facility IRB, and university committee/IRB. One solution for this challenge is to create a calendar for follow up deadlines with each individual or group to stay on track for completion of the project.

Currently, I am a nurse practitioner working in primary care for the VHA, with LGBT veterans on my panel. I have a vested interest in creating a welcoming environment in the VHA for LGBT patients so that they will disclose all pertinent information that may be necessary for providing appropriate, quality care. The completion of the DNP project has given me the confidence and self-assurance for my

future professional goal to be a preferred transgender patient provider. Based on the results of the DNP project, I am confident that transgender veterans will increase their visits to the VA and be able to place their trust in providers and care that they receive.

Summary

The completion of the DNP project was disseminated to the LGBT Work Group and DNP project team with positive feedback and ideas for sustaining the staff education that was developed for the project. Nurses are essential to creating welcoming, culturally sensitive environments. The women's health program, family planning clinics, speech pathology, and suicide prevention should be provided with the information and results of the DNP project to further promote a welcoming environment and increase transgender patient visits. The DNP project has provided me with the ability to grow in the roles of practitioner, scholar, and project manager through learning about and assisting to improve health care for a vulnerable population. It is my professional goal to be a preferred provider for transgender patients and they will have trust and confidence in the care that my colleagues and I provide.

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Appendix A: Community Readiness Assessment Tool

CLEARINGHOUSE FOR MILITARY FAMILY READINESS
SOUND SCIENCE * STRONGER SERVICE
A PENN STATE APPLIED RESEARCH CENTER

A Tool for Assessing Community Readiness

ASSESSING COMMUNITY READINESS

We have developed a tool that is intended to assist communities in reviewing the dimensions of readiness and determine if they are ready to address an identified need in their community (e.g., youth substance abuse). When using this tool, it is important that the community has already identified a need to address.

Please list the identified community need: _____

Instructions: Answer the following questions either individually or as a group (e.g., members of a local coalition or organization). If possible, include input from leaders within the community who have a good understanding of the identified need. For each response, please enter the correct point value in the column that corresponds to your answer. For example, if you answer yes, please enter a 2 in the yes column that corresponds to that question. If you answer somewhat, enter a 1 in the somewhat column or if no, place a 0 in the no column. Please see the question and sample "yes" response below. Next, complete the following 18 questions using the same 2, 1, or 0 response.

Sample Question and Response:

Community Profile Areas	Yes 2 Points	Somewhat 1 Point	No 0 Points
Is there a sense of community among community members?	*2*		

Community Profile Areas	Yes 2 Points	Somewhat 1 Point	No 0 Points
Community Knowledge & Efforts			
1. Are community members aware that this need should be addressed?			
2. Are community members supportive in addressing this need?			
3. Are community members committed to making positive change?			
4. Will community members be willing to get involved and help?			

5. Is there a sense of community among community members?			
Community Leadership & Stakeholders			
6. Are community leaders aware that this need should be addressed?			
7. Do or will leaders in the community support efforts to address this need?			
8. Are community leaders committed to making positive change?			
9. Will community organizations support efforts to address this need?			
10. Are leaders prepared and capable of addressing the need?			
Implementation Assistance			
11. Are there community organizations that could lead the effort?			
12. Are professionals with appropriate qualifications available to deliver the effort?			
13. Are there experts in the community that could advise the effort?			
Supports or Barriers			
14. Are there laws, practices, or policies that promote addressing this need in your community?			
Available Resources			
16. Is funding available in your community to implement and sustain a change effort?			
17. Is it probable that funding will be sustained over time?			
18. Is it probable that the community resources can be sustained over time?			
Total Yes Responses (2 Points Each)			
Total Somewhat Responses (1 Point Each)			
Total Points (Sum of all points)			

Discussion of Results

1. If you responded **No** to any of the questions highlighted in **blue**, we recommend that you stop moving forward with the change effort and focus on building community readiness. Our Exploring Community Strengths and Needs Tool can help you formulate a plan on how to move

forward in building the community support you need to reach a level of readiness that will assist your community in achieving the expected outcomes of your change effort.

Record your total score from the table above in the box below:

Total Score:

Result (Total Points)	Level of Community Support	Recommendations
>31	Strong	Move forward with your identified change effort. You have strong community support and the community is prepared to embrace a change initiative.
24-30	Moderate	Proceed with caution. You may want to build community support before moving forward. Use our "Exploring Community Needs and Strengths" tool to identify needs and weaknesses within the community to focus change efforts.
<23	Weak	Take some time to build community support before undertaking the identified change effort.

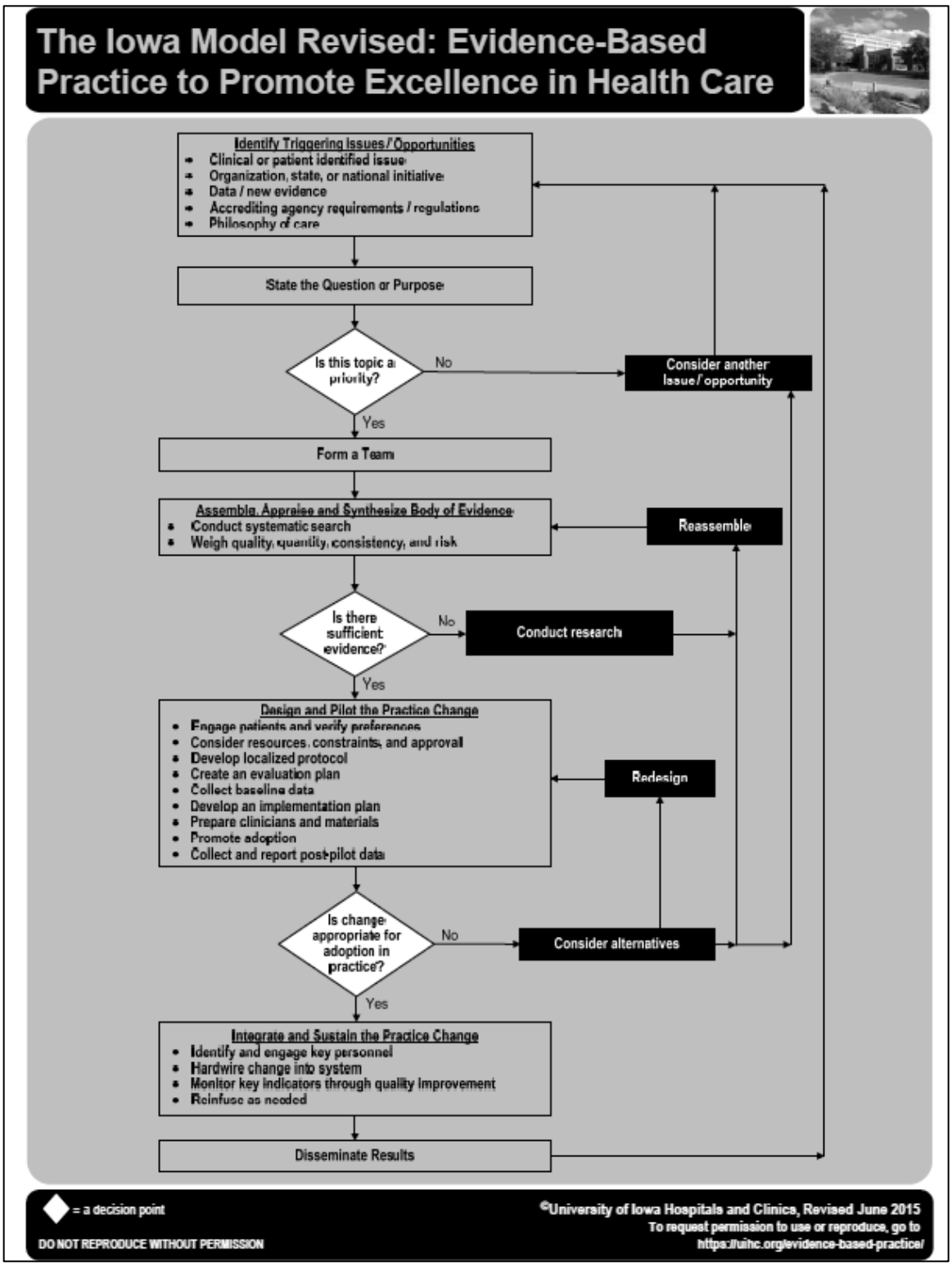
Our TA Specialists are available from 9 a.m. to 5 p.m. EST/EDT Monday through Friday. Use the information below to contact us!

Clearinghouse for Military Family Readiness
The Pennsylvania State University
Email: Clearinghouse@psu.edu
Website: http://www.militaryfamilies.psu.edu
Live Chat: http://www.militaryfamilies.psu.edu/assistance/live-chat
Phone: 1-877-382-9185

Please Note: This tool was developed based on the review of Literature and Tools related to Community Readiness. Please see our Community Needs and Readiness Reference sheet for a list of references.

This material is the result of a partnership funded by the Department of Defense between the Office of Military Community and Family Policy and the USDA's National Institute of Food and Agriculture through a grant/cooperative agreement with Penn State University

Appendix B: Iowa Model



Appendix C: Staff Education on LGBT Resources

Lesbian, Gay, Bisexual and Transgender (LGBT) Patient and Employee Resources

LGBT Veteran Care Coordinator:

- Established nationally in VHA in 2016
- At least 1 LGBT VCC per medical center/catchment as collateral duty
- Responsible for:
  - Implementation of LGBT health care policies
  - Point person for advocacy and resources for Veterans
  - Provides training and consultation to VA staff
  - Participates in LGBT-related outreach and community-based activities
  - Completes facility Healthcare Equality Index (HEI) survey for Human Rights Campaign
  - Reports to senior leadership.
- LGBT VCC:
  - NAME: contact by email or Skype

LGBT Directives/Policies and Funding

- VHA Directive 1340 "Provision of Healthcare for Veterans who identify as Lesbian, Gay, or Bisexual" -local policy MCM 16-209
- VHA Directive 2013-003 (currently being updated) "Providing Health Care for Transgender and Intersex Veterans" – local policy MCM 16-211

LGBT Patient Resources:

- Gender Confirming Clinic-primary care
- LGBT Support Group-mental health
- Mental Health care
- Speech Pathology
- Pharmacy
- Prosthesis: wigs, breast forms/bras, gaffs, shoes

LGBT Employee Resources:

- Special Emphasis Program Manager (SEPM): NAME
- EEO Manager: NAME
- EEO Specialist: NAME
- iSHare
- LGBTQ SEPM Luncheon for all employees.

LGBT Work Group:

- meets second Thursday of every month
- Consists of interdisciplinary group of staff from all clinics

LGBT Services Website: https://www.patientcare.va.gov/LGBT/index.asp

Local LGBT Pamphlet-found in VAMC Veteran Library, can be printed by medical media

Appendix D: Permission To Use Community Readiness Assessment Tool

Subject: Assessing Community Readiness Tool
Date: February 22, 2018 at 8:59:43 AM CST

Thank you for contacting the Clearinghouse for Military Family Readiness! We are happy that you are able to use our Assessing Community Readiness Tool. Please feel free to use it and any of our other resources and tools found on our website at https://militaryfamilies.psu.edu/program-implementation-toolkit/ All of our resources are free and available for public use!
Please let us know if you have any additional questions or if we can be of further assistance!

Sincerely,
Clearinghouse for Military Family Readiness at Penn State
The Pennsylvania State University
402 Marion Place
University Park, PA 16802
814-867-4491
military.families.psu.edu

Appendix E: Permission To Use Iowa Model

From: University of Iowa Hospitals and Clinics <noreply@qualtrics-survey.com>
Subject: Permission to Use The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care
Date: February 21, 2018 at 11:46:36 AM CST

Please contact UIHCNursingResearchandEBP@uiowa.edu or 319-384-9098 with questions.