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Attitudes Toward LGBTQ Individuals in the New Jersey Health Sector

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This is to certify that the doctoral dissertation by

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2020

Abstract

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MHA, Walden University, 2014

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Dissertation Submitted in Partial Fulfillment

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Abstract

People who identify as lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) often experience bullying and discrimination. Additionally, LGBTQ individuals feel invisible within the workforce due to inadequate legal protections. The stress of LGBTQ stigma compounded with the high stress levels experienced by healthcare workers has been linked to the effectiveness of health organizations, negatively influencing the quality of care provided to patients. The purpose of this cross-sectional quantitative study was to examine the knowledge and attitudes of healthcare workers toward LGBTQ individuals. Guided by the systems theory framework, the attitudes of 227 healthcare workers toward homosexuality and healthcare delivery to LGBTQ individuals in New Jersey were explored using the Homosexuality Attitude Scale collection tool. The variables of gender, job role, religiosity, and healthcare setting were examined for correlation with attitude using inferential statistics analysis in SPSS. Results indicated religiosity had a significant influence on healthcare workers' attitudes toward homosexuality. Findings from this study might be used to develop cultural competency programs to address negative attitudes toward homosexuality among healthcare workers with the intent of positively influencing the lives of both LGBTQ patients and employees. Through the commitment of healthcare administrative leadership to creating an organizational culture of inclusion, acceptance, and willingness to care for LGBTQ patients, positive social change can be achieved.

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Dedication

I dedicate my dissertation to my beloved and late mother who sadly passed during my doctoral journey. My mother was an amazing woman who dedicated her life to her family. She was a caring and compassion nurse who treated all those she cared for with dignity and respect. She had a strong work ethic and taught me honest hard work would always prevail. She was the constant I could always count on, always there to listen when things weren't going well, and my life's greatest cheerleader celebrating my every win. Despite her passing, she continues to be the cornerstone of my perseverance and resilience.

Acknowledgments

I would like to extend my dearest gratitude to my wonderful family for the love and support through this journey, especially my husband, Tom and my daughters, Cassidy, Allison, Shannon, and Ava. I would also like to thank my father, siblings, other family members and friends for their encouragement and support.

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Chapter 1: Introduction to the Study

Introduction

Discrimination and harassment based on gender identity or sexual orientation is a pervasive problem around the world (United Nations, 2011). Protections under the law have progressed human rights of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) persons but have been inadequate to achieve the change necessary to impact health disparities stressing the need for future research to improve the health of the LGBTQ population (Grigorovich, 2013; Meyer, 2016; Mehta, 2017).

During 1980-2009, consistent discrimination against LGBTQ employees by other state and local employees were found across 49 states (Sears & Mallory, 2011). Discrimination and harassment based on gender identity or a person's sexual orientation is prohibited by and against employment laws in New Jersey (Equal Employment Opportunity Commission, n.d.). According to a nationwide study conducted by Harris Poll (2017), 56% percent of the LGBTQ workers reported being bullied repeatedly at their job, 41% of LGBTQ workers left their job due to bullying, 72% of LGBTQ workers did not report bullying to their human resources, and one out five attributed health issues to being bullied in the workplace. The trends of hate and violence towards LGBTQ continue to increase. In 2017, a total of 52 incidents were reported, which is a weekly homicide due to hate violence of LGBTQ persons. These numbers are likely to be higher due to the misidentification or lack of capturing victim's sexual orientation and gender identity (National Coalition of Anti-Violence Programs, 2018).

Background of the Problem

The United States is a country where LGBTQ people and their allies have made progress through advocacy to promote legal and political gains; however, federal law does not prohibit discrimination based on sexual orientation (SO) and gender identity (GI) (Human Rights Watch, 2018). The Movement Advancement Project (2018) informed 50% of the LGBTQ population lives in states that do not prohibit employment discrimination based on SOGI; 37 states have no law providing LGBTQ healthcare insurance protections in the private sector and four states have laws that permit medical professions to decline to serve LGBTQ patients based on religious exemptions. The U.S. Department of Health and Human Services (2018) declared the creation of "The Conscience and Religious Freedom Division," which provides health care providers conscience rights into not having to performing procedures that are against their moral or religious beliefs. Advocacy groups suggest the creation of this division could further add to the discrimination and stigma against LGBTQ patients (Lambda Legal, 2018). There is evidence in the literature supporting higher religiosity correlates to greater negative attitudes toward homosexuality (Bostanci, 2015; Ng, Gill, Koh, Jambuathan, & Subash, 2015; Patrick, 2013; Smith, 2017). There is potential for legal issues for healthcare organizations that deny care based on religion. For example, a New Jersey hospital was sued for refusal of performing a routine hysterectomy because of the individual was transgender, citing a violation to both New Jersey Law Against Discrimination, which prohibits discrimination on the basis of sex a gender identity and Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of sex (Lambda Legal, 2017).

Healthcare workers are exposed to excessive amounts of intimidation behavior (Chassis & Loeb, 2013) and LGBTQ healthcare professionals experience being bullying in the workplace and witness poor care of LGBTQ patients (Eliason, Streed & Henne, 2018). The majority of LGBTQ workers do not report the bullying behavior to human resources (Career Builder, 2017; Lee et al., 2014). Verbal bullying can often escalate to physical violence (Occupational Safety and Health Administration [OSHA], 2015). Workplace violence-related injuries in healthcare accounted for nearly as many injuries as all other industries combined between 2011-2013 ([OSHA], 2015).

The health sector presents barriers to LGBTQ patients, such as discriminatory care which is associated with mental health disorders (Marcus, 2014; Qureshi et al. 2018) lack of provider knowledge on specific LGBTQ care issues, (Abdessamad, Yudin, Tarasoff, Radford, & Ross, 2013; Quinn et al., 2015) and other lack of service options or needs which deter health care access (Lisy, Peters, Schofield & Jefford, 2018; Romanelli & Hudson, 2017). Evidence in the literature supports formal training for specific job roles including medical schools on LGBTQ primary care issues (Eliason, Dibble & Robertson; 2011; Abdessamad et al., 2013), for nursing schools to support LGBTQ patient care (Carabez Pellegrini, Mankovitz, Eliason, & Dariotis, 2015; Strong & Folse, 2015), and for LGBTQ cultural competency training for all health care staff (Donaldson & Vacha-Haase, 2016; Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers, 2010; Quinn et al., 2015; Radix & Maingi, 2018; Seelman, Miller, Fawcett & Cline, 2018; Thornton; 2018).

The literature review on LGBTQ workers' experiences who work within the United States health sector is limited. The health care environment is not only an issue for the LGBTQ

patient but for the LGBTQ healthcare workers who experience personal harassment and discriminatory care of LGBTQ patients (Eliason, DeJoseph, Dibble, Deevey & Chinn, 2011; Eliason et al., n, 2011). Women were found more accepting of homosexuality compared to men (Barringer & Lynxwiler, 2013). Cultural training was found to have a positive impact on attitudes and knowledge (Bristol, Kostelec, & MacDonald, 2018) and more positive attitudes were reported after clinical educational interventions (Strong & Folse, 2015).

The results of this study might be used to promote social change by advancing LGBTQ health research with the knowledge of the needs of cultural training of health care workers in the state of New Jersey. The findings from this research could promote future interventional research focusing on implementation of cultural competency and negative attitudes based on religiosity and aim to change behavior to have a positive influence on the lives of both LGBTQ patients and LGBTQ healthcare employees in New Jersey. High reliability organizations (HROs) promote a zero-harm environment, as well as commit to zero tolerance of any workplace violence or any disruptive behaviors that may contribute to an individual's physical, mental, or emotional harm. A culture of safety exists when healthcare staff is empowered to report incidents without fear of retaliation.

Problem Statement

People who identify as LGBTQ often remain invisible within the workforce due to inadequate legal protections (Bell, Özbilgin, Beauregard, & Sürgevil, 2011; McLaughlin, Hatzenbuehler, Keyes, 2010) or work policies and procedures that would make LGBTQ employees feel safer (Eliason, et al. 2011). Stigma, prejudice, and discrimination contribute to an unhealthy work environment (Meyer, 2003) and minority stress contributes to already

stressful conditions of working in the healthcare setting (Eliason et al., 2018). Multiple studies found providers knowledge lacked LGBTQ specific healthcare needs (Schabath et al., 2019; Shetty et al., 2016) and that staff would benefit from cultural training (Donaldson & Vacha-Haase, 2016). It is important for organization leaders to foster diversity and inclusion within the work environment (Meyer, 2003). Mental health problems can be the result of stress associated with stigma (Bostwick, Boyd, Hughes & West, 2014).

Healthcare workplace safety climate perceptions have been found to be linked to reported stress levels, turnover intent, and job satisfaction (McCaughey, DelliFraine, McGhan & Bruning, 2013). People in New Jersey were found to be the most stressed of people from all states based on U.S. Census' American Community Survey data for 2012-2016 (Zippia, 2018). The stress of LGBTQ stigma compounded with the high stress levels experienced by healthcare workers has been linked to the effectiveness of organizations, negatively influencing the quality of care provided to patients (Koinis, Giannou, Drantaki & Angelaina, 2015; Moll, 2014). Recommendations in the National Institutes of Health FY 2016-2020 Strategic Plan from the summary of the Institute of Medicine (2011) include training and research for the cultural competency of employees working with people in clinical settings with considerations of minority stress, life course, intersectionality (i.e., race, ethic, socioeconomic, and geographic diversity), inequities in health care, and social influences on the lives of LGBTQ people. Furthermore, data regarding SO and GI should be collected in electronic health records.

Purpose of the Study

The purpose of this quantitative study was to investigate healthcare workers' attitudes toward homosexuality in the New Jersey health sector to determine a correlation, if any, with

gender, job role, healthcare setting. The Homosexuality Attitude Scale (HAS) was used to explore the attitudes of healthcare workers in New Jersey toward homosexuality and healthcare delivery to LGBTQ individuals. Demographic information was also collected.

Research Questions and Hypotheses

RQ1: What is the relationship between healthcare workers' attitudes towards homosexuality and healthcare workers' gender?

(Ho): There is no statistically significant relationship between healthcare workers' attitudes toward homosexuality and healthcare workers' gender.

(HA): There is a statistically significant relationship between healthcare workers' attitudes toward homosexuality and healthcare workers' gender.

RQ2: What is the relationship between healthcare workers' attitudes towards homosexuality and their job role?

(Ho): There is no statistically significant relationship between healthcare workers' attitudes toward homosexuality and job role.

(HA): There is a statistically significant relationship between healthcare workers' attitudes toward homosexuality and job role.

RQ3: What is the relationship between healthcare workers' attitudes towards homosexuality and healthcare workers' religiosity?

(Ho): There is a no statistically significant relationship between healthcare workers' attitudes toward homosexuality and healthcare workers' religiosity.

(HA): There is a statistically significant relationship between healthcare workers' attitudes toward and healthcare workers' religiosity.

RQ4: What is the relationship between healthcare workers' attitudes towards homosexuality and the type of facility in which the healthcare worker is employed?

(Ho): There is a no statistically significant relationship between healthcare workers' attitudes toward homosexuality and type of facility in which the healthcare worker is employed.

(HA): There is a statistically significant relationship between healthcare workers' attitudes toward homosexuality and type of facility in which the healthcare worker is employed.

Theoretical Framework

Systems theory was developed by Karl Ludwig von Bertalanffy, who is known for his seminal work general systems theory—a concept of "wholeness" that implies the need to take a granular view into the parts of the whole, the processes of these parts, and their inter-relationships for an overall understanding of the entire system (Anderson, 2016; Bertalanffy, 1972). The approach to understanding how systems develop is to understand their ability to change (Bertalanffy, 1996) and how outcomes can be influenced by interventions after understanding behavior patterns over time (Anderson, 2016). The healthcare setting is considered a complex system; thus, in the system's approach, creating an ability to view smaller segments of the system allows for a greater understanding of some components and their interrelationships to other components (Tenbensel, 2013). Decomposition is the process of characterizing a system into smaller functional subsystems or components and defining the relationships between them (Kannampallil, Schauer, Cohen, & Patel, 2011). A system's design keeps the patient in the center of the care and the different disciplines involved in the care work

collaboratively throughout the patient's healthcare journey (Kannampallil et al., 2011; Rexhepi, Ahlefedt, & Perlesson, 2015). The healthcare system has various access points in of care delivery, including (a) teaching hospitals and/or community hospitals, (b) physician offices, (c) ambulatory surgical centers, (d) urgent care, (e) clinics, (f) home care, (g) hospice, and (h) rehabilitation centers. The patient may journey through different areas within the health care systems in which practitioners from different disciplines involved in the delivery of the patient care will need to communicate effectively to ensure positive health outcomes (Rexhepi et al., 2015).

Conceptual Framework

Minority stress is the conceptual framework used to understand the causes of stigma, prejudice, and discrimination in the social environment and the causes of physical and mental health problems of LGBTQ individuals (Meyer, 2003). Minority stress can be separated into two different categories: distal and proximal causes. Hiding one's GI or SO can be proximal stress because of the stress an individual experience during the psychological processes; distal stressors can be related to objective events or conditions based on an individual's perception (Meyer, 2003). Internalized homophobia is found to be high in those who also have high levels of minority stress (Meyer, 2003) and may represent negative lifelong experiences of the internalized antigay prejudiced internal conflict of non-heterosexual feelings, which could impact depression and relationship problems (Frost & Meyer, 2009). Coping is a central concept in the minority stress model and some strategies for community connectedness and "outness" have been found to be significantly correlated to internalized homophobia in the study of 396 LGBTQ participants (Frost & Meyer, 2009).

Nature of the Study

The nature of this study was a cross-sectional quantitative approach. Data was collected through on online survey using SurveyMonkey from participants who were found through the professional LinkedIn network. The HAS is a likert scale used to measure people's attitudes about homosexuality, which was the dependent variable. Gender, job role, religiosity, and healthcare setting were the independent variables. SPSS 25 was used for statistical analysis.

Definitions of Key Terms

Asexual: The lack of sexual attraction or desire for other people (Human Rights Campaign, n.d.).

Bisexual: A person emotionally, romantically, or sexually attracted to more than one sex, gender, or GI though not necessarily simultaneously, in the same way or to the same degree (Human Rights Campaign, n.d.).

Cisgender: A term used to describe a person whose gender identity aligns with those typically associated with the same sex assigned at birth. (Human Rights Campaign, n.d.).

Internalized homophobia: Internalized anti-gay stereotypes, beliefs, stigma and internal conflict of non-heterosexual feelings whether or not they identify as LGBTQ (Frost & Meyer, 2009).

Coming out: The process in which a person first acknowledges, accepts or appreciates their sexual orientation or gender identity and begins to share with others (Human Rights Campaign, n.d.).

Gay: A person who is emotionally, romantically, or sexually attracted to members of the same gender (Human Rights Campaign, n.d.).

Gender dysphoria: Clinically significant distress that is caused by a person's assigned birth gender not being the same as the gender with which they identity (Human Rights Campaign, n.d.)

Gender identity (GI): One's innermost concept of self as male, female, or a blend of both or neither; how individuals perceive themselves and what they call themselves. One's GI can be the same or different from their sex assigned at birth (Human Rights Campaign, n.d.).

Healthcare Facility: The major components that comprise the heath care sector ambulatory health care services (e.g., physician offices, medical laboratories, diagnostic imaging centers, and kidney dialysis), hospitals and nursing, and residential care services, including mental and substance abuse care (New Jersey Department of Labor and Workforce Development, 2018).

Heterosexism: Refers to beliefs and attitudes that normalize opposite sex over same sex partnerships (Averett & Jenkins, 2013).

Homophobia: The fear and hatred of or discomfort with people who are attracted to members of the same sex (Human Rights Campaign, n.d.).

Intersex: An umbrella term used to describe a wide range of natural bodily variations. In some cases, these traits are visible at birth, and in others, they are not apparent until puberty. Some chromosomal variations of this type may not be physically apparent at all (Human Rights Campaign, n.d.).

Job Role: Occupations found in the healthcare industry (New Jersey Department of Labor and Workforce Development, 2018).

Lesbian: A woman who is emotionally, romantically, or sexually attracted to other women (Human Rights Campaign, n.d.).

LGBTQ: An acronym for lesbian, gay, bisexual, transgender and queer (Human Rights Campaign, n.d.).

Outing: Exposing someone's lesbian, gay, bisexual, or transgender identity to others without permission (Human Rights Campaign, n.d.).

Queer: A term people use to express fluid identities and orientations (Human Rights Campaign, n.d.).

Questioning: A term used to describe people who are in the process of exploring their sexual orientation or gender identity (Human Rights Campaign, n.d.).

Religiosity: Defined as the frequency of attendance at religious services and more traditional or dogmatic religious views (Grey, Robinson, Coleman, & Bockting, 2013).

Sexual Orientation: One's emotional or physical attraction to the same and/or opposite sex (Equal Employment Opportunity Commission, n.d.).

Transgender: Individuals whose gender identities, expression, and/or lived experience differs from and may transcend what is typically associated with the sex they were assigned at birth (Human Rights Campaign, n.d.).

Transphobia: The fear and hatred of, or discomfort with, transgender people (Human Rights Campaign, n.d.).

Workplace violence: Defined as violent acts including physical assaults and threats of assault directed toward persons at work or on duty, including verbal violence, threats, verbal abuse, hostility, and harassment ([OSHA], 2015).

Assumptions and Limitations

The methodological assumptions of systems theory are based on two premises: (a) looking at the problem in terms of the whole and (b) understanding the environment is an essential part of the system in which it interacts (Cordon, 2013). This study involved a cross-sectional design to determine cause and effect and only provides a snapshot of the variables at the time of data collection (Levin, 2006).

Providers may work in multiple different healthcare settings. For example, a primary care physician may round on patients in the morning in a hospital, then see patients in private practice, and later that afternoon sees patients at a nursing home as the medical director. The assumption is some providers work in multiple settings. The limitation of this study is only the primary role and facility where they spend most of their time will be captured and some roles may be missed entirely.

The other assumption is that respondents will answer the research questionnaire truthfully. However, the sensitive nature of the questions may present as a limitation of the study. Another limitation of this study is that only healthcare workers in the state of New Jersey were surveyed, which may limit generalizability to all healthcare workers within the United States and may not provide ample sampling of the all health care variables of the population (Levin, 2006).

Significance

This research can help with understanding the effects and impact of attitudes toward homosexuality from the perspective of workers in the healthcare industry and how their work environment intersects and is influenced by other variables, building on systems theory (National

Institute of Health, n.d.). The application of systems theory to the healthcare setting is a practical approach used to help understand the complexity of healthcare delivery. The information provides insight into the current cultural environment to detect patterns of attitudes toward homosexuality across the healthcare sector within a state that has protections for LGBTQ individuals and has been historical in both legal and social inclusion of LGBTQ individuals (Hasenbush, Flores, Kastanis, Sears & Gates, 2014).

Warning signs of workplace violence due to underreporting may not necessarily lead to a violent act, but it can result in other consequences impacting employee performance and wellbeing (Department of Labor, n.d.). The information is useful for healthcare system leaders to identify potential risks and can guide positive interventions to protect their human capital and reduce legal liability (Frankel et al., 2006; Meneghel et al., 2016; OSHA, 2015).

A just organizational culture can be achieved by creating a healthcare environment wherein caregivers believe they have a voice and feel safe and supported (Frankel, Leonard, & Dehman, 2006). Organizational climate specifically, psychosocial safety climate, contributes to underlying risks factors that may increase or decrease physical health and safety (Baily, Dollard, McLinton & Richards, 2015; Spector, Yang & Zhou, 2015. The application of social change to promote LGBTQ inclusion and reduce health disparities derived from discrimination can impact both an organization's workforce performance and provide a benefit to the LGBTQ community, especially when accessing care at different areas within a healthcare system. Social inclusion is hindered by discrimination and stigma, which can prohibit equity in employment and effect organizational culture. By exploring people's actions, beliefs, and needs, we learn of different viewpoints by giving people a voice, which is essential to gaining knowledge (Ravitch & Carl,

2016). The central aspect of caring in is rooted in one's ability to transfer empathy, support, and other resources to the LGBTQ community to promote health outcomes, increase job satisfaction, and develop work resilience (Meneghel et al., 2016).

The results of this study may provide healthcare system leaders with information regarding the presence of discrimination, which could aid in the development of policies and programs in alignment with the organization's mission to promote diversity and inclusion. Healthcare systems can transform their culture by measuring and monitoring employee feedback and determining if any prejudice exists. The advancement of learning from all employees across all roles within the healthcare system provides knowledge from all perspectives, which can help or hinder the steering of strategy and mission goals alignment (Meyer, 2003; Studer, 2013).

The identification sexual prejudice is also important because LGBTQ stigma can manifest in workplace violence, which impacts the healthcare industry four times more than private industry and adversely impacts organization performance (OSHA, 2015). The best way to ensure the safety of employees is to understand if one's workplace is at risk, considering many incidents of workplace violence go unreported (OSHA, 2015).

Summary

In Chapter 1, an introduction to the study was followed by a discussion of the problems faced by LGBTQ individuals, including discrimination within the workplace and how this can lead to unhealthy work environments—especially in health care. I explained the purpose of the study, the theoretical context of systems theory and its application to the healthcare system, the nature of the study, definitions of terms, assumptions and limitations, and significance. Chapter 2 includes the literature review, which contains a discussion of evidence within the literature to

support the significance of the study. In Chapter 3, I further describe the nature of the study, including the research questions, hypotheses, methodology, operationalization of the variables, and the data analysis. Chapters 4 and 5 include the study results, discussion of the findings, and future recommendations.

Chapter 2: Literature Review

Introduction

Discrimination and harassment based on GI and SO is a ubiquitous problem around the world (United Nations, 2011). Protections under the law have progressed human rights of LGBTQ persons but are inadequate to achieve the change necessary to impact health disparities, placing strong need for future research to improve the health of the LGBTQ population (Grigorovich, 2013; Mehta, 2017; Meyer, 2016).

During 1980-2009, consistent discrimination against LGBTQ employees by other state and local employees were found across 49 states (Sears & Mallory, 2011). Discrimination and harassment based on a person's GI or SO is prohibited by employment laws in New Jersey (Equal Employment Opportunity Commission, n.d.). According to a nationwide study conducted by Harris Poll (2017), 56% percent of the LGBTQ workers reported being bullied repeatedly at their job, 41% of LGBTQ workers left their job due to bullying, 72% of LGBTQ workers did not report bullying to their human resources, and one out five attributed health issues to being bullied in the workplace.

People who identify as LGBTQ often remain invisible within the workforce population because of inadequate legal protections and the fear of coming out (Bell et al., 2011; McLaughlin et al., 2010). Stigma, prejudice, and discrimination contribute to an unhealthy work environment; these are the health disparities are the foundation of the minority stress model (Meyer, 2003; Meyer, 2016). Mental health problems can be the result of stress associated with stigma (Bostwick et al., 2014). The stress of LGBTQ stigma compounded with the high stress

levels experienced by healthcare workers may impact an organization's effectiveness and have a negative influence on the quality of care provided to patients (Eliason et al., 2018; Moll, 2014).

In this review, studies were examined pertaining to the LGBTQ populations, minority stress, workplace discrimination, attitudes towards homosexuality in the healthcare setting, and health disparities of LGBTQ persons. In addition, studies pertaining to high-reliability health organizations, systems theory, research, and practice were reviewed.

Literature Review Strategy

The literature review developed with searches conducted through the EBSCO database. Specifically, the following academic databases; Thoreau, Academic Search Complete, Science Direct, ProQuest, PsycARTICLES, LGBT Life with Full Text, and Google Scholar. To conduct the literature review in this section, keywords and phrase searches included *lesbian, gay, bisexual, transgender, queer, questioning, LGBTQ, general systems theory, systems theory, minority stress,* and *high-reliability organizations.* Refined secondary searchers were used to narrow the number of hits using these key phases: *healthcare systems, integrated care delivery, homosexuality, homophobia, diversity in the workplace, organizational culture, stigma, discrimination, workplace bullying, workplace equality, workplace injury,* and *workplace violence.* An analysis of these peer-reviewed journal articles, limited textbooks international, LGBTQ non-profit advocacy resources, global, federal, and state secondary data were used for reference purposes and to identify existing gaps within the literature.

Theoretical Foundation

The theoretical framework begins with the review of the literature of systems theory and the application to the healthcare setting. There is robust literature on the application of systems

theory to the healthcare system, but only one article was found that focused on marginalized populations using systems theory as the theoretical foundation. Karl Ludwig von Bertalanffy developed systems theory. Bertalanffy's seminal work is known as general systems theory—a concept of "wholeness," which implies the need to take a granular view into the parts of the whole, the processes of these parts, and their inter-relationships for an overall understanding of the entire system (Anderson, 2016; Bertalanffy, 1972). The approach to understanding how systems develop is to understand their ability to change (Bertalanffy, 1996) and how outcomes can be influenced by interventions after understanding behavior patterns over time (Anderson, 2016).

Systems Theory Approach to Healthcare Systems

The healthcare setting is considered a complex system; thus, in the systems approach, creating an ability to view smaller segments of the system allows for a greater understanding of some components and their interrelationships to other components (Tenbensel, 2013). Decomposition is the process of characterizing a system into smaller functional subsystems or components and defining the relations between them (Kannampallil et al., 2011). A system's design keeps the patient in the center of the care and all the different disciplines involved work collaboratively throughout the patient's healthcare journey (Kannampallil et al. 2011; Rexhepi et al., 2015). The healthcare system has various access points in of care delivery, including (a) teaching hospitals and community hospitals, (b) physician offices, (c) ambulatory surgical centers, (d) urgent care, (e) clinics, (f) home care, (g) hospice, and (h) rehabilitation centers. The patient may journey through different areas within the healthcare systems in which practitioners

from different disciplines involved in the delivery of the patient care will need to communicate effectively to ensure positive health outcomes (Rexhepi et al., 2015).

The Patient Protection and Affordable Care Act and Reconciliation Act, passed in 2010, provided funding available to introduce the electronic health record (EHR) technology with the intent to stimulate patient access to care with insurance exchanges and has transformed the way care teams communicate (Fitzpatrick, Butler, Pitsikoulis, Smith, & Walden, 2014). The addition of the insurance exchanges is targeted health improvement outcomes with quality reporting, case management, and stimulation of growth with services such as the medical home model and health and wellness promotion (Fitzpatrick et al., 2014). Under Title XVII of the Social Security Act, the accountable care organization (ACO) was created as the vehicle to promote patient population health and transform service delivery for partnerships, such as hospitals, primary care physicians, other ACO professionals that make up the medical home (Patient Protection and Affordable Care Act, 2010). The ACO members work together to achieve goals of quality, cost and care Medicare fee-for-service beneficiaries with the potential for shared savings if certain meaningful use criteria are met (Patient Protection and Affordable Care Act, 2010). The policy goal and shared incentive programs of the meaningful use criteria were implemented to improve the healthcare systems adoption and use of the EHR in stages to help enhance quality, reduce medical errors, reduce cost, and promote a patient safety culture (Walker, Huerta, & Diana, 2016). Accurate and complete data collection into the EHR can change healthcare delivery and influence progress towards achieving health goals on both individual and population levels (Bosse, Leblanc, Jackman, & Bjarnadottir, 2018).

Data Collection of Sexual Orientation and Gender Identity

In October 2015, the Centers of Medicaid and Medicare Services (CMS) and the Office of the National Coordinator for Health Information Technology require data collection of birth sex, SO and GI data for stage 3 meaningful use and to establish consistent policies about what information to record and workflows for patients to disclose the information confidentially, especially to improve care for transgender patients and in order to ensure proper revenue cycle management efficiencies with coding and billing (Cahill, Baker, Deutch, Keatley, & Makadon, 2016; CMS, 2017). There are approximately 5,000 hospitals that receive payment from CMS for the services they provide; if they fail to comply with the requirements of stage 3 meaningful use the results are reductions in the payments received from CMS and potentially delays their healthcare system's ability to address LGBTQ health disparities (Bosse et al., 2018).

The purpose of data collection is to directly utilize the information to improve the health of the LGBTQ population, which have lower life expectancies compared with their non-LGBTQ counterparts (Bosse et al., 2018). Training and education of physicians and staff is essential to facilitate dialog surrounding SO and GI appropriate clinical interview questions, as well as assigning role access to the information and where the information should be located in the EHR. For example, social history should be located in the EHR rather than in demographics (Thompson, Weathers, & Karnik, 2016) and how to safeguard patient privacy and confidentiality (Alper, Feit & Sanders, 2013). The need for systematic collection of SO and GI data within all the healthcare settings is necessary to advance and improve the LGBTQ population's outcomes (Bosse et al., 2018; Institute of Medicine, 2011). GI should be asked a two-part question—birth sex and current GI—to ensure proper preventative care surveillance (Alper et al., 2013; Goedert,

2017). Data collection of SO and GI and an understanding of other demographics and interactions of intersectionality can help to mitigate and improve the health of the LGBTQ population (Gates, 2018). Maragh-Bass et al. (2017) surveyed both LGBTQ and non-LGBTQ patients and providers on their views on SO and GI data collection and found that 80% of the providers believed SO data collection would offend patients, whereas only 11% of the patients reported they would be offended. Additionally, patients found it more important for their primary care providers to know the SO of all patients compared to emergency room providers, who believed it more important to know the SO of all their patients. The research highlights the importance of consistent SO and GI data collection across all points of access to ensure a patient-centered approach for the LGBTQ patient throughout the healthcare system (Maragh-Bass et al., 2017).

Approximately 4.1%, or 10 million, adults identify as LGBTQ. Delaying or eliminating LGBTQ data collection is an obstruction in understanding and abilities to improve the well-being of LGBTQ persons (Gates, 2017, 2018). Other challenges exist where SO and GI data are not being collected. The U.S. Census Bureau and other national surveys cause underreporting of sexual identity (Thornton, 2018). A proposed bill called the Census Equality Act of 2017-2018 recommended the collection of SO and GI questions to be added to census forms but will not happen until 2030 and only if passed into law (Senate Bill 3314, 2017-2018).

Another example of issues of data collection that hinders advancing LGBTQ health is that the nation's cancer data infrastructure is not equipped to receive information about the experiences of the sexual gender minority population within the healthcare system and how to meet their needs from EHRs (Schabath et al., 2019). Results of a large national longitudinal

study revealed that young bisexuals were at higher risk than heterosexuals for cancer related risk behaviors, that gay men were more likely to vomit for weight control, be physically inactive and use tanning booths, as well as have higher lifetime prevalence of sexually transmitted infections compared to heterosexuals (Rosario et al., 2016). These findings support the need for national surveillance data on cancer morbidity and mortality by SO for continued surveillance (Rosario et al., 2016). Cancer care experiences of sexual and gender minorities reported both positive and negative healthcare behaviors, fear of sexual identity disclosure, fear of homophobia, inadequate support groups, unmet needs for patient-centered care specific to LGBTQ information, feelings of invisibility, isolation, and frustration throughout the cancer care continuum (Lisy et al., 2018).

Discriminatory actions that hinder LGBTQ patients from seeking care happen during intake or experienced during healthcare related visits include insensitivity or refusal to touch them—all of which contribute to significant differences in health outcomes (Brandes, 2014).

Lesbian and bisexual women have higher rates of cardiovascular disease, gynecologic cancer, and breast cancer, and gay and bisexual men experience more body issues and eating disorders (Goedert, 2017). Other studies have used a systems approach to institute intimate partner violence screening with the focus on integrated health care advocacy of service delivery to support identification and intervention with the use of the EHR and interdisciplinary teams, but lacked SOGI data (Miller, McCaw, Humphreys & Mitchell, 2015). In a systematic review of 42 studies, LGBTQ intimate partner violence and sexual abuse were as high or higher than the general population and LGBTQ patients found barriers to assistance, such as fear of coming out and low confidence in provider's ability to assist (Brown & Herman, 2015).

Healthcare systems service issues present barriers to LGBTQ patients in addition to discriminatory care, which is associated with mental health disorders (Marcus, 2014) lack of provider knowledge on specific LGBTQ care issues (Abdessamad et al., 2013; Quinn et al., 2015), and other lack of service options or needs, which deters healthcare access (Lisy et al., 2018; Romanelli & Hudson, 2017).

A systematic review of 19 studies relating to sexual and reproductive health needs with the provision family planning services to lesbian, gay, bisexual transgender queer/questioning, intersex, and asexual (LGBTQIA) individuals found barriers to care around accessing care, client experience, negatives attitudes towards lesbian and gay clients, and lack of provider knowledge, and none of which investigated interventions to improve the health outcomes in LGBTQIA family planning services (Klein et al., 2017). In 2010, the first national study of LGBTQ baby boomers was conducted with 10,000 respondents between the ages of 40-61Of those respondents, 27% reported concern about discrimination as they aged and 19% had little or no confidence they would be treated with dignity and respect by healthcare professionals, and lesbian and bisexual woman were less financially prepared for end-of-life planning and options (Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers, 2010). Other issues around family planning are linked to access to leave for working LGBTQ people and inclusive policies to care for loved ones. In a 2018 survey conducted across the United States of 5,433 LGBTQ respondents, one in five did not take leave for fear it would disclose their identity to their employer, 71% reported not taking the full amount of time needed to care for family members or to manage their own health due to their financial situation, and 45% reported their employer had LGBTQ-inclusive leave policies (Human Rights Campaign Foundation, 2018a).

Conceptual Framework

The research on homosexuality is grounded in social psychology literature and highlights inequality due to dominant groups providing ideas or norms in which society judges all members (Hubbard & Hegarty, 2014). In this section of the literature review, Thoreau and LGBT Life with Full text were searched using the following key Boolean phrases: *LGBT physicians, LGBT residents, LGBT nurses, LGBT clinicians and LGBT healthcare workers*, 213 peer-reviewed hits were returned within the last five years. Duplicates were eliminated from the results leaving 78 articles for review. The remaining abstracts were with reviewed, articles were excluded, only studies that focused on the LGBTQ healthcare workers and training of healthcare workers which included the collection of SOGI data, nine articles met the inclusion criteria (see Table 1).

Minority Stress Model

Minority stress is the conceptual framework used to understand the causes of stigma, prejudice, and discrimination in the social environment and the causes of physical and mental health problems of LGBTQ individuals (Meyer, 2003). Minority stress can be separated into two different categories: distal and proximal causes. Hiding one's gender identity or sexual orientation can be proximal stress because of the stress an individual during the psychological processes and distal stressors can be related to objective events or conditions based on an individual's perception (Meyer, 2003). Internalized homophobia is found to be high in those who also have high levels of minority stress (Meyer, 2003) and may represent negative lifelong experiences of the internalized anti-gay prejudiced internal conflict of non-heterosexual feelings which could impact depression and relationship problems (Frost & Meyer, 2009). Coping is a central concept in the minority stress model and some strategies for community connectedness

and “outness” have been found to be significantly correlated to internalized homophobia in the study of 396 of lesbian, gay and bisexual participants (Frost & Meyer, 2009).

A Global Perspective on LGBTQ Discrimination

According to the United Nations (2011), human rights violations have been recorded in all regions of the world to include murder, kidnappings, assault, rapes, psychological threats and other cruel and degrading treatment towards people based on their sexual orientation or gender identity or if perceived to be homosexuality or transgender. Laws within seventy-six countries penalize individuals due to sexual orientation and gender identity with judgment ranging from short-term to life imprisonment and the even the death penalty (U.N. 2011). The U.N. resolution to protection against violence and discriminate based on sexual orientation and gender identity was adopted, but 18 countries voted against despite the call of duty of States to protect all human rights and fundamental freedoms (United States, General Assembly, 2016). Violence and discrimination are types of violations which shed crucial light on the needs of marginalized populations and the influence of states to support social change. In Malawi, same-sex conduct is criminalized against LGBTQ people who experience daily violence and discrimination in all aspects of their lives, including seeking healthcare which is a barrier for those needing HIV treatment and services (Human Rights Watch, 2018). The International Lesbian, Gay, Bisexual, and Trans and Intersex Association (2017) surveyed 116,000 respondents in 75 countries, including Hong Kong and Taiwan to identify if there was a correlation in knowing someone belonging to sexual and gender minorities has a significant positive effect on attitudes, in states that criminalize same sexual relations, 46% agreed that equal rights and protections should be inclusive of sexual orientation in non-criminalizing states the number rose to 60%.

The United States has been a country where LGBTQ population and their allies have made progress through advocacy to promote legal and political gains however, federal law does not prohibit discrimination based on SO/GI (Human Rights Watch, 2018). The Movement Advancement Project (2018) informs 50 % of LGBTQ population lives in states that do not prohibit employment discrimination based on sexual orientation or gender identity; 37 states have no law providing LGBTQ inclusion healthcare insurance protections in the private sector and four states with laws that permit medical professions to decline to serve LGBTQ patient service based on religious exemptions. The U.S. Department of Health and Human Service (2018) announced the creation of "The Conscience and Religious Freedom Division" which provides health care providers conscience rights into not having to performing procedures that are against their moral or religious beliefs. Advocacy groups suggest the creation of this division could further add to the discrimination and stigma against LGBTQ patients with governmental guidance on how to get away with it (Lambda Legal, 2018). The social and political environment in states that do not have sexual orientation and non-discrimination policies have a direct correlation with social acceptance of LGBTQ compared to those who have been found to be living in social and political climates that are less accepting (Hasenbush et al., 2014).

The IOM (2011) study examined the health status of LGBTQ populations in three life stages: childhood and adolescence, early/middle adulthood, and later adulthood and found a consistent pattern of experience of levels of violence, victimization and/or harassment compared to heterosexual counterparts across the life course which contributes to chronic high levels of stress. A national United States study found post-traumatic stress disorder found LGBTQ people are at higher risk compared to their heterosexuals which were attributed to social stigma and

discrimination due to exposure to violence beginning at an early age (Roberts, Austin, Corliss, Vandermorris & Koenen, 2010). The Youth Risk Behavior Surveillance (YRBSS) data is used to compare the prevalence of health-related behaviors among subpopulations of students, however in the 2017 report only 30 states and 21 large urban school districts included the question on sexual identity which is important to learn about the health-related behaviors that contribute to negative health outcomes among sexual minority youth (Kann et al., 2018). New Jersey is a state that did not include sexual minority in the 2017 YRBSS (Kann et al., 2018). New Jersey is a state that did not include sexual minority in the 2017 YRBSS (Kann et al., 2018). It is unknown how many sexual minority youths reside in the state of New Jersey.

The LGBTQ Patient

For a better understanding of individual LGBTQ experiences, disparities and mental health concerns, we must understand the experiences of discrimination faced and the barriers presented due to the mistrust with many health care systems (Joint Commission, 2011). A systematic review of seventy-seven studies between January 1997 and March 2017 explored mental health outcomes of transgender and gender non-conforming populations found mental health outcomes such as, depressive symptoms, suicidality, interpersonal trauma exposure, substance use disorders, anxiety, and general distress, all consistent with the minority stress model (Valentine & Shipherd, 2018). Minority stress is focused in on mental health is can be extended to consider the impact on physical health (Baptiste-Roberts, Oranuba, Werts & Edwards, 2017).

Roberts and Fantz (2014) conducted a systematic review of transgender studies and found barriers to care included: (a) reluctance to disclose their identity, also known as gender

dysphoria, (b) lack of provider experience or resources, (c) structural barriers to include lack of gender-neutral bathrooms and binary collection of gender within EHR, (d) financial barriers due to high rates of trans population unemployment which is twice the national average, insurance barriers, and high cost of surgery.

Studies on sexual minority women pregnancy and necessary screening are lacking and proper screening of sexual orientation can promote better outcomes for this group as they may be at higher risk for postpartum depression and can be at risk for sexually transmitted infections, including HIV have been found in the literature (Baptiste et al., 2017). In two independent studies, both researchers found contrary to the minority stress hypothesis which predicts greater stress leads to higher rates of mental disorders of lesbian, gay and bisexual intersection with race and found people of color had more stress and more resilience compared to white lesbian, gay and bisexual individuals (Meyer, 2010) and insignificant changes in mental health prevalence amongst LGBTQ people of color when faced with increase stress of discrimination (Cyprus, 2017).

Qureshi et al. (2018) explored health issues and perceived barriers to healthcare, and health utilization among LGBTQ populations in New Jersey and found the major health issues by sexual orientation included HIV, acute infections, sexually transmitted diseases, gastric problems and hypertension. Perceived barriers to care and health utilization, access to care was hindered due to being uninsured (transgender individuals lacked insurance in greater numbers), poor transportation, lack of adequate housing, lack of mental health services, 53% lack of trained health care providers competent to deliver health care, 80% (*n*=347) underutilized healthcare, 54% (*n*=238) did not disclose their SO/GI information due to fear of being treated differently by

the health professionals (Qureshi et al. 2018). In addition, the study found Asian LGBTQ participants experienced more barriers to health care relating to refusal of care and stigma (*n*=78), an example of intersectionality of race contributing to minority stress (Qureshi et al., 2018).

Gender Differences in Attitudes Toward Homosexuality

Gender role beliefs are ideals on how men and women should behave and those who do not follow these gender norms will often be reacted to negatively, typically these are linked at a country-level view relating to laws on gender equality however, transgender beliefs about gender norms are at the individual level (Henry & Wetherell, 2017). Women were found more accepting of homosexuality compared to men (Barringer & Lynxwiler, 2013) but gender-based discrimination impacts women statistically significantly greater than men and is correlated to mental health disparities affecting women greater than men (Bostwick et al., 2014). McCrary (2014) found women social worker students more accepting, tolerant, and supportive of gay and lesbian adoption compared to men.

In a meta-analysis review of instruments that measured homophobia, gender differences were found; men scored higher on homophobia compared to women (Grey et al., 2013). Harbarugh & Lindsey (2015) found individuals who held stronger masculine gender role identity scored higher on the measures of homophobia and heteronormativity, and has less favorable attitudes toward gay rights, regardless of gender. Negative attitudes can also be driven by sexual identity violations which may also affect gender role violations, for example if is someone is feminine gay or a masculine lesbian woman or the male nurse suggesting both social perception and stereotypes contribute to prejudice (White & Garcia, 2018).

Healthcare Job Roles

Research on attitudes toward LGBTQ patients was focused on specific job roles but research is lacking to include other job roles and specialty areas within the healthcare sector. Educational intervention improved attitudes and supported the need for LGBTQ specific training in the nursing curriculum (Strong & Folse, 2015). Carabez et al. (2015) found 40% of nursing students felt unprepared to provide nursing care to LGBTQ patients before education intervention and 74% reporting the educational assignment made them more aware of LGBTQ issues. In another study involving the nursing role, researchers found a significant relationship of knowledge of LGBTQ healthcare issues and the nurse's willingness to provide care (Cornelius & Carrick, 2015).

Stigma and discrimination towards HIV-positive individual face continuous barriers to consistent quality of care due to healthcare clinician's attitudes (Nyblade, Stangl, Weiss & Ashburn, 2009). In a study of LGBTQ healthcare professionals, 88% heard disparaging remarks about LGBTQ patients and 50% witnessed poor care of LGBTQ patients (Eliason et al., 2018). Another study surveyed LGBTQ physicians whereas participants reported witnessing inequitable care of LGBTQ patients and disrespect to LGBTQ patient's partner (Eliason, et al., 2011).

Schabath et al. (2019) found oncology provider's had gaps in knowledge about LGBTQ specific cancer needs with high interest in education and were in high agreement of knowing gender identity of patients (65.8%) and found sexual orientation less important (39%). The lack of healthcare LGBTQ oncology specific knowledge was also found in among 1253 healthcare providers where only 50% of the participants correctly answered all 7 knowledge items and about half answered 3 out of 7 correctly (Banerjee, Walters, Staley, Alexander & Parker, 2018).

LGBTQ cultural training had a positive impact on attitudes and knowledge to the specific needs of the population in a pre/post survey conducted on an emergency health care team which also included areas of openness and support, and awareness of oppression regarding the LGBTQ community (Bristol et al., 2018).

Other studies suggest the need for formal training for medical school students on LGBTQ primary care issues (Abdessamad et al., 2013; Eliason et al., ; 2011) and LGBTQ cultural competency training of health care staff (Donaldson & Vacha-Haase, 2016; Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers, 2010; Quinn et al., 2015; Radix & Maingi, 2018; Seelman et al., 2018; Shetty et al., 2016; Thornton; 2018).

Religiosity

In a meta-analysis of scales that measure attitudes toward male homosexuals, Grey and colleagues (2013) found increased religiosity, defined by the frequency of religious service attendance or strict religious views, were associated with higher scores on homophobia instruments in heterosexual individuals. According to Smith (2017) the higher the religiosity, the higher the anti-gay bigotry with groups who took the word of the Bible literally, such as Evangelical Protestants and Muslims and Catholics. Buddhist, Eastern Orthodox, and Hindus are in the middle.

In a study of medical students in Paraguay, discriminatory attitudes were found by the majority the sample 71.4 % who were catholic (Torales, et al., 2018). In Turkey where homosexuality is considered a disease, religious beliefs were found to have negative attitudes towards homosexuality among nursing students (Bostanci, 2015). Nurse practitioner participants were found to have conflicted attitudes in a qualitative study working with LGB patients due to

religious or cultural beliefs (Dorsen & Devanter, 2016). Carabez et al. (2015) found more than one in 10 nursing students had religious values that might interfere with providing health care to LGBTQ patients. Contrary to most studies found in the literature, religion was not significantly related to knowledge and attitudes (Cornelius & Carrick, 2015)

Healthcare Setting and Workplace Culture

Chassin and Loeb (2013) inform healthcare workers are exposed excessive amounts of intimidation behavior that silences their reporting of safety problems. In studies that investigated psychosocial safety climate (PSC) amongst healthcare workers found adverse events were attributed to poor patient safety climate and increased cognitive demands in the emergency department (Rasmussen, Pedersen, Pape, Nielsen, Mikkelse & Madsen, 2014), health utilization increases when psychological complaints had physical consequences (Bronkhorst & Vermeeren 2016), emotional exhaustion was the strongest predictor of injuries going underreported (Zadow, Dollard, Mclinton, Lawrence & Tuckey, 2017). Workplace violence-related injuries in healthcare accounted for nearly as many injuries as all other industries combined between 2011-2013 (OSHA, 2015).

The emergency department (ED) is an important access point for the health care systems and in providing care to LGBTQ Patients. Two different studies compared the perspectives of both clinician and patient regarding data collection of SO and GI with similar findings. In the study of emergency department clinicians 80% felt patients would be offended to disclose SO and GI information (Schbath et al., 2017) and of LGBTQ emergency room patients reported greater comfort and improved communication when SOGI was collected via non-verbal self-report methods in the ED (Haideret al., 2018).

Nicol, Chapman, Watkins, Young and Shields (2013) explored the health professional's knowledge, attitudes and beliefs towards LGBTQ parents seeking healthcare for their children which revealed similarities in the knowledge, attitude, and beliefs of staff working in pediatric tertiary hospitals compared with those in secondary-level settings towards LGBTQ parents. Nicol et al. (2013) suggest "this a significant finding with regard to comparisons in family-centered policies and guidelines and the amount of exposure the staff working in these facilities have to diverse and nontraditional families". Greifinger, Batcherlor and Fair (2013) inform when youths transition out of pediatric or adolescent care setting into adult care, the system is not prepared to meet their needs, especially LGBTQ youth who are HIV positive. The LGBTQ youth are an at-risk population and the primary care provider relationship must supportive and confidential to be able collect sexual history to better address their healthcare needs (Chaplic & Allen, 2013).

In a study in Colorado of twenty-two staff members from three facilities, the core theme that emerged from the qualitative study was "staff sensitivity to minority sexual orientation and gender identity of residents" suggesting the need for staff awareness of asking SOGI information due to the lifelong experiences of discrimination which may hinder LGBTQ residents being willing to disclose SOGI (Donaldson & Vacha-Haase, 2016). In a review of lesbian, gay and bisexual adults ages 40-65 compared to heterosexual adults in long-term care expectations, lesbian, gay and bisexual adults were found less likely to expect care from family and more likely to expect to use institutional care such as nursing homes and assisted living facilities in old age (Henning-Smith, Gonzales & Shippee, 2015). Lesbian and bisexual woman were found to

be less financially prepared for end-of-life (Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers, 2010).

From the lens of LGBTQ healthcare worker, the complexities of minority stress working or training in the healthcare setting is evident in the literature. A recent study focused on stress coping strategies of LGBTQ healthcare professionals found 34% were verbally harassed, 37% socially ostracized in the workplace (Eliason et al., 2018). In another study, LGBTQ employees reported being bullied repeatedly at work, experienced health issues because of bullying at work, left a job because they were bullied, and 72% of LGBT workers do not report their bullying to human resources (Career Builder, 2017). Verbal bullying can often escalate to physical violence (OSHA, 2015).

Eliason et al. (2011) surveyed LGBTQ physicians who reported discrimination from colleagues from being harassed, socially ostracized, and overheard derogatory comments. In a cross-sectional study exploring 388 surgical resident respondent's attitudes and perceptions of the influence of sexual orientation on the training experience, 30% did not reveal sexual orientation, 43 identified as LGBTQ (Lee et al., 2014). Of those LGBTQ surgical residents 21% reported targeted homophobic remarks from fellow residents, 12 % from surgical attending physicians, none of the surgical residents reported the event to the supervisors (Lee et al., 2014). In a Croatian study, 1004 participant's attitudes towards LGB physician found discrimination was significant bringing attention to the idea that patients may refuse care from an LGBTQ provider, nurse or clinician (Grabovac, Mustajbegovic & Milosevic, 2016).

A mixed method study was conducted to gain knowledge about the discrimination and exclusion in the workplace by nursing education or professional nursing organizations, 261

LGBTQ nurses were sampled and the researchers found workplaces that lacked policies and procedures impacted how safe LGBTQ nurses felt and that many coworkers, supervisors, and patients had exhibited discriminatory behaviors or verbal harassment which has significant consequences for the LGBTQ workers (Eliason et al., 2015) evaluated awareness of workplace and professional policies regarding LGBTQ discrimination and found a significant association between policy awareness and LGBTQ inclusivity and confidence in reporting anti-gay harassment.

High Reliability Organizations

The healthcare environment is an area for both advocacy and health promotion for the LGBTQ population. The issues of patient prejudice against LGBTQ healthcare professionals also have a negative influence on the healthcare environment and promote ineffective delivery of care, conflict, and stress (Lim, 2016).

One of the target initiatives of High-Reliability Organizations (HROs) in healthcare is a safety culture (Joint Commission's Center for Transforming Healthcare, n.d.). The promotion of safety cultures and practices to high-reliability organizations is related to the promotion and adoption of EHRs (Ford, Silvera, Kazley & Huerta, 2016) and evidenced-based practices (Frankel et al., 2006). HROs are defined by their exceptional performance over extended periods of time with continuous oversight for enhanced performance, fostering on-going education, and by creating a culture that both motivates (respectful interaction) and allows opportunity for participation (mindful organization) with focus on the goal of reducing errors and enhancing reliability (Vogus & Iacobucci, 2016). HROs leader characteristics and behaviors that establish reliability as an organizational priority can transform and change (Vogus & Singer, 2016). A

just organizational culture can be achieved by creating a healthcare environment wherein caregivers feel they can have a voice while feeling safe and supported (Frankel et al., 2006). Organizational climate, specifically psychosocial safety climate, contribute to underlying risks factors which may increase or decrease physical health and safety (Baily et al., 2015; Spector et al., 2015). The Joint Commission's Center for Transforming Healthcare (n.d.) defines high reliability in health care improves organizational culture, effectiveness, efficiency, compliance, documentation and customer services. Chassin and Loeb (2013) concluded three major changes can help a healthcare organization's progress toward high reliability: (1) leadership commitment to goal of zero patient harm, (2) incorporate all the principals and practices of a safety culture throughout the organization, and (3) adoption of process improvement tools and methods across the system. Safety culture should include efforts to enhance the atmosphere for both LGBTQ patients and their families and LGBTQ employees.

ACO's can translate best practices from HROs with the use of systematic thinking and mindful organizing which has a positive effect on ways to achieve the triple aim in the promotion of population health (Vogus & Singer, 2016). As ACOs work with partners for patients to coordinate transition-related risks, understanding LGBTQ patients must navigate those challenges with historical discrimination, the importance of trusting relationships during the continuity of care and effective communication between providers and teams across settings is critical for quality of care outcomes (Cloyes, Hull & Davis, 2018).

A system's approach to the advancement of learning from all employees across all job roles and healthcare settings within the healthcare industry provides knowledge from all perspectives which can help or hinder mission goals (Meyer, 2003). The identification of sexual

prejudice is also important because LGBTQ stigma can manifest into workplace violence which impacts the healthcare industry four times more than private industry and adversely impacts organizational performance (OSHA, 2015).

Equitable and Inclusive Care

The Health Equality Index (HEI) (2018) evaluates healthcare facilities in the promotion of equitable and inclusive care for LGBTQ patients, families and employees. The survey to scored and divided into five sections: (1) non-discriminating and staff training, (2) patient services and support, (3) employee benefits and policies, (4) patient and community engagement and (5) responsible citizenship (HEI, 2018). Forty-eight percent of HEI 2018 participants use EPIC as their EHR but only 65% collect GI data and 50% collect SO data and only 10% on have turned on the SOGI functionality (HEI, 2018). In New Jersey, sixteen hospitals have received LGBTQ Healthcare Equality Leader designation (HEI, 2018) and have demonstrated protections in place for patients, visitors, and support and policies of LGBTQ staff and cultural competency training on LGBTQ inclusion (HEI, 2018).

Summary

The theoretical framework of this dissertation is a system's approach to the healthcare system's addressing the work environment as it pertains to the LGBTQ patient and employees. System thinking helps us to understand the influences of cause and effect and the relationships and connections they have within the system. In health care systems, addressing safety concerns through mapping is a best practice to identify the root cause. Implementing the collection of SOGI data can support access to care for LGBTQ populations and allow providers to monitor risk behaviors and support better health outcomes (Bosse et al., 2018). The collection of gender

identity was found of high important with oncology providers over sexual orientation (Schabath et al., 2019). The literature review indicated trends of discrimination and stigma of LGBTQ healthcare workers, it is likely their access in compromised to the healthcare system where they most likely would have to go for services to remain in-network or risk higher out of pocket deductible.

The conceptual framework of minority stress hypothesizes stigma, discrimination, and violence from societal, political environment, and structural levels, which cause stress for LGBTQ persons lead to health disparities (Meyer, 2003; Meyer, 2016). There were many gaps found in the literature for LGBTQ health intervention studies, effectiveness of provider health literacy training and/or cultural competency training within various healthcare settings, understanding of attitudes both patients and healthcare workers towards LGBTQ persons and specific focus on health issues/interventions of separate populations within the LGBTQ population and lack of intersectional review of dual minority status research. Research is lacking on downstream consequences of intersectionality due to experiences of multiple minority stress and mental health disparities (Bostwick et al., 2014; Cyprus, 2017).

Healthcare systems can lead social change for health improvement of the LGBTQ population with the understanding LGBTQ health disparities exist and can be reduced if providers know which of their patients are LGBTQ (Callahan et al., 2015). Consistent review of processes in both the collection of SOGI data and the delivery of care to LGBTQ patients across various settings to provide quality health outcomes while providing continuous education to increase awareness and acceptance are best practices (Ng, Yee, Subramaniam, Loh & Moreira, 2015). German et al. (2016) argue the emergency department is the first impression of the

hospital culture and whatever the impression this can be generalized across other healthcare system providers and facilities. The importance of sensitive, inclusive, and respective data collection of SO/GI and patient-centered competent care of LGBTQ patients across their life-course can be achieved with understanding healthcare worker's homosexuality cultural attitudes empowering education.

This study aims to promote social change by advancing LGBTQ health research with the knowledge of the needs of cultural training of health care workers in the state of New Jersey. The findings from this research may also inform interventional research focusing on those areas, if any, identified by job role or facility where implementation of cultural competency would address negative attitudes and aim to change behavior to have a positive influence on the lives of both LGBTQ patients and employees.

According to Callaghan et al. (2015), "to make changes in health care delivery, individuals and organizations need to make a long-term commitment to change, beginning with the individual recognition of unconscious bias and the decision to change behavior despite that bias."

Table 1

Literature Review of LGBTQ Healthcare Worker Research

Citation	Aim	Participants	Data collection methods	Key findings
Lee, Ketz, Dube & Morris (2014)	Explored surgical residents' attitudes and perceptions of the influence of sexual orientation on	*n*=388 surgical residents	Cross-sectional online study	More than half the respondents witnessed homophobic remarks by nurses, residents and

	the training experience.			surgical attending physicians. LGBT residents reported experiencing targeted homophobic remarks by fellow residents and by surgical attending physicians and none reported the event to their supervisors.
Phlemn, Lucas, Ridgeway & Taylor (2014)	To determine whether medical school curriculum, role modeling, diversity climate, and contact with sexual minorities predict bias among graduating students against gay and lesbian people.	*n*=4732 first year medical students	Prospective cohort study	Lower explicit bias against gay men and lesbian women was associated with more favorable contact with LGBT faculty, (*table continues*) residents, students, patients and perceived skill and preparedness for provide care to LGBT patients.

Ewton & Lingas (2015)	To assess current workplace culture and attitudes, and to evaluate awareness of workplace and professional policies regarding LGBT discrimination	n=163 Physician assistants	Cross-sectional survey	Respondents had an overall positive attitude toward LGBT providers, (>60%) was not aware of relevant policy statements. A significant association existed between policy awareness and LGBT inclusivity (P < .025) and confidence reporting anti-gay harassment (P = 017).
Donaldson & Vacha-Haase (2016)	To assess the LGBT cultural competency of staff working in LTC facilities in Colorado, identify their current training needs, and develop a framework for understanding LGBT cultural competency among LTC staff and providers	*n*=22	Qualitative focus groups	The core category that emerged through data analysis was labeled "staff sensitivity to minority sexual orientation and gender identity (*table continues*) (SOGI) of residents," which explained the process of culturally competent knowledge, attitudes, and

				behavior of LTC staff when working with LGBT residents. Small sample.
Grabovac, Mustajbegovic & Milosevic (2016)	Patient's attitudes towards having a LGB family physician in Croatia	*n*=1004	Cross-sectional online survey	Prevalence of discrimination was found significant towards attitudes of having a family physician who identified as LGB.
Shetty et al. (2016)	To assess knowledge, attitudes, and practice behaviors of oncology providers regarding LGBT health.	*n*=108 Oncology physicians	Cross-sectional web-based survey	<50% answered knowledge questions correctly. 94% stated they were comfortable treating this population. 26% actively inquired about a patient's sexual orientation when taking a (*table continues*) history. 36% felt the need for mandatory education on LGBT cultural competency at the institution.

				Results from the open comments section identified multiple mis-conceptions and gaps in LGBT health knowledge.
Bristol, Kostelec & MacDonald (2018)	Aggregate ED health care team member's knowledge and attitudes toward lesbian, gay, bisexual, and transgender people pre- and post-cultural competency training education.	*n*=134 participants	Pre/post quantitative Survey (included SOGI data collection)	LGBT cultural training had a positive impact on attitudes and knowledge.
Eliason, Streed & Henne (2018)	Researchers studied stress and coping strategies of LGBTQ healthcare professionals relating harassment and discrimination experiences	*n*=277 LGBTQ healthcare professionals	Mixed methods	Minority stress contributes to already stressful conditions of work in health care and is compounded by heavy workloads across many disciplines and roles. Coping was that of becoming an advocate and/or educator about LGBTQ+ issues in the workplace.

Schabath et al. (2019)	To identify potential gaps in attitudes, knowledge, and institutional practices toward lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) patients	*n*=149	Mixed methods	65.8% were in high agreement of knowing GI of patients; 39% low importance of SO. Overall, high interest in LGBTQ patient unique needs education and limited knowledge about LGBTQ health and cancer needs

Chapter 3: Research Method

In this chapter, I present an overview of the study, including a description of the research design, methodology, population, sampling, instrumentation, data management, and formulation of the research hypotheses.

Purpose of the Study

The purpose of this study was to take a systems approach to understanding healthcare workers' attitudes toward homosexuality by job role, gender identity, sexual orientation, race/ethnicity, and by various healthcare settings within the state of New Jersey. Identification of attitudes toward homosexuality is important because LGBTQ stigma and discrimination can manifest into workplace violence, which impacts the healthcare industry four times more than private industry and adversely impacts organization performance (OSHA, 2015).

Healthcare systems service issues present barriers to LGBTQ patients in addition to discriminatory care, which is associated with mental health disorders (Marcus, 2014), lack of provider knowledge on specific LGBTQ care issues (Abdessamad et al., 2013; Quinn et al., 2015), and other lack of service options, deterring healthcare access (Lisy et al., 2018; Romanelli & Hudson, 2017). Identification of access points and roles where significant homophobia exists provides important information for healthcare leaders and highlights the need for future research on the influence of educational awareness intervention.

Research Design and Rationale

This quantitative study was a cross-sectional design using data collection methods via an Internet survey. An Internet study is low cost and allows for access to the targeted population, while providing timely turnaround benefits to data collection (Creswell, 2018). Quantitative data

analysis using inferential statistics test was applied to explore the relationships between the dependent variable, attitudes toward homosexuality, and the demographic independent variables (gender, job role, religiosity, and healthcare setting) to answer the research questions.

Methodology

The study population included 227 participants who work in the healthcare sector in the state of New Jersey. According to New Jersey Department of Labor and Workforce Development (2018), there are approximately 471,000+ healthcare workers in the state of New Jersey. To determine sample size, Creswell (2014) suggested the following steps: (a) determine the margin of error= +/- 5%, (b) choose confidence level=95%, and (c) estimate the percentage of your sample that will respond in a given way=50%. Based on these steps, the sample size needed for this study was 384. Using the same methods, estimating slightly more than 50% of the 471,000+ New Jersey health care worker population size, 95% confidence level with a =/-5% margin of error (see Krejcie & Morgan, 1970), the same sample size was revealed. Cohen (2016) suggested f=0.40 for large effect for behavioral science when using the statistical test one-way ANOVA for many comparative groups, power set at .80, meaning the statistical test would have an 80% chance of finding the effect based on the sample sizes, then using the table to determine effect size, alpha; and based on the number of groups and the effect size is the standard deviation of the g population means divided by the common within-population standard deviation (see Cohen, 2016). For example, RQ-1 had five groups, based on power =.80, large effect = .040, and a=.05, the sample size is 18; thus, the total sample size needed was 18x5=90 (see Cohen,

2016). The application of this method was applied to each research question based on the independent variable number of groups based on Cohen's table.

Participants (n=227) were recruited using purposeful and snowball sampling via the professional LinkedIn network. A LinkedIn post was created inviting participants to take the survey along with a flyer attached (see Appendix A). The flyer survey replicated as the informed consent, which included identification of the type of participants sought, voluntary participation, participants received no financial compensation, benefits of the study, potential risks to taking the survey, procedures to confidentiality, and contact information for further information. LinkedIn members were also invited to share the post to increase survey exposure with LinkedIn members out of my network who may have met the criteria.

Data Collection Process

The survey was comprised of two parts: (a) a demographic questionnaire and (b) the Homosexuality Attitude Scale (HAS), included in Appendices B and C, respectively. The survey design was created in SurveyMonkey and included a custom design. For example, anonymous responses were selected, custom disqualifications were set to ensure survey criterion were met, secure socket layer (SSL) encryption was used to ensure information being transmitted through the survey was encrypted, and there was a custom thank you page at the end of the survey. All responses remained anonymous and the link was securely sent over an SSL encrypted connection. SurveyMonkey allows for SSL encryption to be turned on for a survey, which creates a secure connection between the client and server while encrypting sensitive information being transmitted through the web page. The link to the survey implemented hypertext transfer protocol (HTTPS). According to Rodriguez (2018) "HTTPS is implemented at the beginning of

the link which will validate data integrity as HTTPS encrypts the chain of traffic, end to end and between surveys preventing third party vendors from malicious intent" (p.131).

Instrumentation and Operationalization of Variables

Demographic Questionnaire

The demographic questionnaire was designed to capture information about different subgroups within the healthcare industry (see Appendix B). Inclusion of the top 20 occupations in the health care industry that make up more than two-thirds of all the employment in the state, as were the facilities that make up the top three main healthcare sectors components (New Jersey Department of Labor and Workforce Development, 2018).

The Homosexuality Attitude Scale

The HAS assesses stereotypes, misconceptions, and anxieties toward homosexual people unidimensional (favorable or unfavorable) using a 5-point Likert scale (Kite & Deaux, 1986). The HAS scale has good test-retest reliability (r=.71) and excellent internal consistency (alpha >.92; Kite & Deaux, 1986). The HAS tool has been used by researchers in other studies to collect attitudes of healthcare workers toward homosexual individuals in the healthcare setting to understand the influence of religiosity on acceptance of homosexuality (Abdessamad et al., 2013; Ng, et al., 2015; Ng, Yee et al., 2015).

Data Analysis Plan

The survey data results were exported into a SAV file and then downloaded onto an external hard drive. SPSS 25 was used for statistical analysis. Any missing data due to a respondent who did not answer or missed a question were excluded in the analysis. For example,

because a respondent missed providing their job role, this participants' survey was excluded to answer the research question regarding attitudes toward homosexuality and job role.

Operationalization of Variables

The independent variables were categorical and included the following (a) gender, (b) job role, (c) religiosity, and (d) healthcare setting. Gender had five groups: male, female, transgender (transman and transwomen were combined), genderqueer, and something else. They were coded as male=1, female =2, transgender=3, genderqueer=4 and something else=5. For the variable job role, three groups were created, and variables were formatted as follows: healthcare practitioner, health care support, and office and administrative (see Table 2). Three new groups were created, and variables were formatted as follows: healthcare practitioners =1, healthcare support=2, and receptionist and information clerks=3. All job roles were recoded to match how they are listed in Table 2. For example, medical assistants were coded to reflect the new value 2. Similarly, healthcare facilities were grouped into three new groups: hospitals, nursing and residential care facilities, and ambulatory health care services (see Table 3).

Table 2

Independent Variable: Job Role Grouping

Healthcare practitioner	Healthcare support	Office and administrative
Register nurses	Nursing assistants	Receptionist and information Clerks
Licensed practical and licensed vocational nurses	Home health aides	Medical secretaries
Physicians and surgeons	Medical assistants	Billing and posting clerks and machine operators
Clinical laboratory technologist and technicians	Dental hygienist/assistants	Supervisors of administrative support workers

Physical therapists	Medical and health service managers	Social and human service assistants
Radiologic technologist and technicians		

Note. New Jersey Department of Labor and Workforce Development (2018). [PowerPoint slides]. Retrieved from https://nj.gov/labor/lpa/pub/empecon/healthcare.pdf

Table 3

Independent Variable: Healthcare Facility Grouping

Ambulatory healthcare services	Hospitals	Nursing care facilities
Office of physicians	General medical and surgical hospitals	Residential intellectual and developmental disabilities facilities
Office of mental health physicians and practitioners	Psychiatric and substance abuse hospitals	Continuing care retirement communities
Office of dentists	Other hospitals	Homes for the elderly
Office of optometrists		
Office of specialty therapist		
Office of podiatrists		
Office of miscellaneous health practitioners		
Family planning centers		
Outpatient mental health centers		
Health maintenance organization medical centers		
Kidney dialysis centers		
Freestanding emergency medical centers/urgent care		
Medical laboratories		
Diagnostic imaging centers		
Home healthcare services		
Ambulance services		
Blood and organ banks		

Note: New Jersey Department of Labor and Workforce Development (2018). [PowerPoint slides]. Retrieved from https://nj.gov/labor/lpa/pub/empecon/healthcare.pdf

The last variable regarding whether someone considers themselves religious or not or doesn't know, will be recoded and relabeled as: 1=considers themselves religious, 2= doesn't consider themselves religious, 3=doesn't know if they consider themselves religious or not.

The dependent variable was taken from the HAS Likert scale that measures attitudes toward homosexuality. Before running any statistical analysis, items 1, 2, 6, 8, 13, 14, 15, 18, 19, 20 and 21 were reversed scored, therefore, all negative items needed to be changed to create consistency among the items (Kite & Deaux, 1986). For example, answers within the items listed about will be changes accordingly, 1s's are changed to 5's, 2's are changed to 4's, 3's remain 3's, 4s are changed 2's and 5's are changed 1's.

Research Questions and Hypotheses

RQ1: What is the relationship between healthcare workers' attitudes towards homosexuality and healthcare workers' gender?

(Ho): There is no statistically significant relationship between healthcare workers' gender.

(HA): There is a statistically significant relationship between healthcare workers' attitudes toward homosexuality and healthcare workers' gender.

RQ2: What is the relationship between healthcare workers' attitudes towards homosexuality and their job role?

(Ho): There is no statistically significant relationship between healthcare workers' attitudes toward homosexuality by job role.

(HA): There is a statistically significant relationship between healthcare workers' attitudes toward homosexuality by job role.

RQ3: What is the relationship between healthcare workers' attitudes towards homosexuality and healthcare workers' religiosity?

(Ho): There is a no statistically significant relationship between attitudes toward homosexuality and healthcare workers' religiosity.

(HA): There is a statistically significant relationship between attitudes toward homosexuality and healthcare workers' religiosity.

RQ4: What is the relationship between healthcare workers' attitudes towards homosexuality and the type of facility in which the healthcare worker is employed?

(Ho): There is a no statistically significant relationship between attitudes toward homosexuality and the type of facility in which the healthcare worker is employed.

(HA): There is a statistically significant relationship between attitudes toward homosexuality and the type of facility in which the healthcare worker is employed.

Statistical Analysis

One-way ANOVA was used to determine whether statistically significant differences exist between attitudes toward homosexuality as the dependent variable and the independent variables. Cohen (2016) suggests f=0.40 for large effect for behavioral science when using the statistical test one-way ANOVA for many comparative groups, Power is set at .80, meaning the statistical test will have an 80% chance of finding the effect based on the sample sizes with the effect size (Cohen, 2016). Alpha or a=.05, the probability of making a Type 1 error in hypothesis testing of attitudes toward homosexuality had a relationship with any of the dependent variable found. According to Cohen's (2016), sample sizes needed for are based on number of groups, for example based on three groups a large effect .04 and a=.0.1 the sample

size is 30, the total sample size would be 30 x 3 =90 (Cohen, 2016). The sample size of 90 will be need for RQ2, RQ3, and RQ4 because the independent variable had three groups. RQ-1 has four groups, based on power =.80, and large effect = .040 and a=.05 the sample size is 18 thus, the total sample size needed would be 18x 5=90 (Cohen, 2016).

The *F* distribution and *F* statistic are used to test the difference between groups to within groups using an alpha level set at .05 to determine if there is a relationship between variables or not, and if we should reject or accept the null hypothesis (Frankfort-Nachmias & Leon-Guerrero, 2015). If we reject the null hypothesis, we are saying there is a significant variance within the group and at least one of the group's means is significantly differently from the other and our F obtained is greater than F critical (Frankfort-Nachmias & Leon-Guerrero, 2015). The homogeneity of variances or Levene's Test informs of equal variances and if we should reject the null based on the significance level below alpha =.05. If this is the case, we assume variances are not equal and we would reject the null hypothesis. Post hoc tests, such as Games-Howell are used when we assume unequal variances and provides an output comparison of the groups to determine if the mean difference is significant based on alpha=.05.

Threats to Validity

Threats to external validity may result in selection of participants in various different roles could be missed due to not having access to LinkedIn or not accessing the social network during the time of the study. The current study was focused on healthcare workers within the state of New Jersey and the research findings may not be generalized to all healthcare workers within the United States. Response bias may also be a factor with survey research as participants may provide answers they think is expected or desired by the researcher (Creswell. 2014).

Construct validity could result in the variables not being grouped or labeled correctly during the data cleaning process. The HAS instrumentation used has good test-retest reliability (r=.71) and excellent internal consistency (alpha >.92) (Kite & Deaux, 1986).

Ethical Considerations

The recruitment flyer (Appendix A), was used for recruitment of participants and serve as informed consent to include information about the study, voluntary participation, potential risks, information to elicit more information, study procedures to protect anonymity and confidentiality. Participants remained anonymous and surveys were protected on encrypted connections. The potential of collecting data from vulnerable groups is an ethical consideration but remained unknown due to some of the protected groups may have been included in the subpopulation demographic of healthcare workers, i.e. pregnant women. The raw data is stored on an external hard drive and will be kept in a safe deposit box in Wells Fargo Bank in Flanders, NJ for five years only accessible by this researcher minimizing any risk related to confidentiality. Data collection commenced upon permission and approval from the Internal Review Board (IRB) at Walden University.

Summary

In this chapter, we have reviewed the study research design, how we determined the sample size of the population to be studied, the instrumentation used to collect the data, operationalization of variables, data analysis procedures and the statistics used to test any significant relationships between the variables. A survey complied of both a demographic questionnaire and the HAS were used for data collection in the cross-sectional quantitative study. The survey was created using SurveyMonkey and was posted through the LinkedIn professional

network. Data analysis was completed in SPSS using inferential statistics tests to understand significant relationships of New Jersey healthcare worker's attitudes toward homosexuality and the dependent variables. The fourth and fifth chapters will include the study results, discussion of the findings and recommendations.

Chapter 4: Results

This chapter includes a discussion of the data collection method, data cleaning, deviations from the original data collection plan discussed in Chapter 3, impact of assumptions, descriptive statics used for analysis, and the results. The purpose of this quantitative study was to investigate attitudes toward homosexuality (dependent variable) of healthcare workers in the New Jersey healthcare sector to determine correlations with gender, job role, religiosity, and healthcare setting (independent variables).

Data Collection

A SurveyMonkey hyperlink was posted on LinkedIn, with a cover letter, to recruit New Jersey healthcare sector employees to participate in the study. After accepting the survey consent, the survey opened. The survey consisted of two parts: demographic information and the questions for the HAS. Participants answered the 21 questions for the HAS using a 5-point Likert scale to assess stereotypes, misconceptions, and anxieties toward homosexual people. The HAS tool has a test-retest reliability (r=.71) and excellent internal consistency (alpha >.92) (Kite & Deaux, 1986).

The survey remained open for 12 weeks, until 285 participants answered the required questions to complete the survey. Within the first three days, 641 people viewed the link, but only 28 participated in the survey. The survey was reposted four times and re-shared seven times by other LinkedIn users. Resharing was a suggestion in each of the four reposts as an approach to increase respondent-driven sampling during the timeframe the survey was opened. Data collection remained open longer than planned in the proposal to ensure a representative sample of the population.

Demographic Characteristics of New Jersey Healthcare Worker Respondents

Tables 4 illustrates the demographic characteristics of the sample after data cleaning. The New Jersey healthcare worker sample consisted mostly of females (78%) compared to males (22%), no respondents identified as transgender. The majority identified as heterosexual (93.4%) and 3.5 % identified as lesbian, gay, or homosexual, 1.8% bisexual, and the remaining respondents identifying as "something else" or "unsure." The predominant race of the sample was White or Caucasian (76.7%), with 4.4% being Black or African American, 8.4% being Hispanic or Latino, 7.9% being Asian or Asian American, and 2.2% identifying with multiple races. The majority of the respondents were married (67.4%), 1.8 % were widowed, 8.8% were divorced, 0.9% were separated, 2.2% were in a domestic partnership or civil union, 6.2% were single but cohabiting with a significant other, and 12.8% were single and never married.

Table 4

Demographic Characteristics of New Jersey Healthcare Worker Respondents

		Frequency	Percent	Cumulative Percent
Gender of respondent	Male	50	22.0	22.0
	Female	177	78.0	100.0
	Total	227	100.0	

		Frequency	Percent	Cumulative Percent
Sexual orientation	Straight or heterosexual	212	93.4	93.8
	Lesbian, gay or homosexual	8	3.5	97.3
	Bisexual	4	1.8	99.1
	Something else	1	0.4	99.6
	Don't know	1	0.4	100.0
	Total	226	99.6	
Missing	System	1	0.4	
Total		227	100.0	

		Frequency	Percent	Cumulative Percent
Race	White or Caucasian	174	76.7	77.0
	Black or African American	10	4.4	81.4
	Hispanic or Latino	19	8.4	89.8
	Asian or Asian American	18	7.9	97.8
	Identify with multiple races	5	2.2	100.0
	Total	226	99.6	
Missing	System	1	0.4	
Total		227	100.0	

		Frequency	Percent	Cumulative Percent
Relationship status	Married	153	67.4	67.4
	Widowed	4	1.8	69.2
	Divorced	20	8.8	78.0
	Separated	2	0.9	78.9
	In a domestic partnership or civil union	5	2.2	81.1
	Single, but cohabiting with a significant other	14	6.2	87.2
	Single, never married	29	12.8	100.0
	Total	227	100.0	

Notes: Tables 5-7 provide information on three of the independent variables. Religiosity was high with 62.2 % of the respondents reporting that they were religious, 30.3% did not believe they were religious, and 7.7% did not know if they were religious or not (see Table 5).

Table 5

Demographic Characteristics of Independent Variable: Religiosity

		Frequency	Percent	Cumulative Percent
Religiosity	Yes	137	60.4	60.4
	No	71	31.3	91.6
	Don't know	19	8.4	100.0
	Total	227	100.0	

The majority of the job roles fell within the healthcare practitioner group (46.5%) with registered nurses being most representative within the group (30.4%); 36.2% were in the healthcare support job roles with medical and health service managers/administrators (35.1%) being most representative within the group; and 16.2% office and group with supervisors of administrative support being most representative of the group (5.4%), see Table 6.

Table 6

Demographic Characteristics of Independent Variable: Job Role

		Frequency	Percent	Cumulative Percent
Job role	Physicians and surgeon	11	4.8	4.8
	Allied professional	19	8.4	13.2
	Registered nurse	69	30.4	43.6
	Licensed practical and licensed vocational nurse	1	0.4	44.1
	Medical assistant	3	1.3	45.4
	Emergency medical technician and paramedics	6	2.6	48
	Billing and posting clerks and machine operators	5	2.2	50.2
	Medical secretaries	4	1.8	52
	Receptionists, registrars and information clerks	11	4.8	56.8
	Medical and health service managers/administrators	77	33.9	90.7
	Supervisors of administrative support workers	14	6.2	96.9
	Social and human service assistants	5	2.2	99.1
	Therapist	1	0.4	99.6
	Radiological technologists and technicians	1	0.4	100
	Total	227	100	

The majority of respondents worked in the hospital group (74.6%), 21.1 % worked in ambulatory health care services, and 3.2% worked in nursing and residential care services (see Table 7).

Table 7

Demographic Characteristics of Independent Variable: Healthcare Facility

		Frequency	Percent	Cumulative Percent
Healthcare facility	Hospital or hospital system	171	75.3	75.3
	Psychiatric and substance abuse hospital	3	1.3	76.7
	Critical care hospital or other hospital	2	0.9	77.5
	Resident intellectual and developmental disabilities facilities	1	0.4	78
	Urgent care or freestanding emergency medical center	3	1.3	79.3
	Medical group, physician practice or clinic	21	9.3	88.5
	Ambulatory services	6	2.6	91.2
	Nursing home (Independent/assisted living/post-acute care)	5	2.2	93.4
	Orthopedic and other rehabilitation center (physical therapy, occupation therapy, and speech therapy)	1	0.4	93.8
	Mental health and addiction treatment centers	3	1.3	95.2
	Homecare and hospice	5	2.2	97.4
	Health insurance	2	0.9	98.2
	Pharmaceutical organization	2	0.9	99.1
	Healthcare advocacy organization	2	0.9	100
	Total	227	100	

The sample shared similar characteristics of the broader New Jersey healthcare worker population. According to the New Jersey Department of Labor and Workforce Development (2018), 75% of the healthcare workers are female, compared 25% being male. The majority of the New Jersey healthcare workforce is White (60%) and the remaining are more diverse than average among the Black and Asian populations (New Jersey Department of Labor and Workforce Development, 2018). Regarding job roles, healthcare practitioner roles have the majority of the workers in the health care industry (36%), followed by healthcare support (27%), and office and administrative (20%; New Jersey Department of Labor and Workforce Development, 2018). Healthcare facilities also had similarities to the sample, especially with the majority working in hospitals (33%), 19 % employed in ambulatory care services, and 19% in nursing and residential care services (New Jersey Department of Labor and Workforce Development, 2018).

Operationalization of the Variables

As discussed previously, surveys where all questions were not completed were not used in the data analysis; this was the cleaning process. If a respondent answered all survey questions but omitted a demographic variable the HAS survey data was included in the survey analysis but not included when running statistical tests. For example, a respondent omitted healthcare facility in their survey response, so this survey was omitted in correlation analysis to determine a relationship between attitudes toward homosexuality and healthcare facility. This information will be noted and discussed for each research question.

The gender variable was coded into two groups rather than five groups, a deviation from the original plan due to zero respondents identifying as transgender in this study. The new

gender group included male (n=50) and female (n=177). The healthcare facility variable was combined into three types of healthcare facilities. Participants are represented as follows: Hospitals (n=156), Ambulatory Healthcare Services (n=44), and Nursing and Residential Care Services (n=6). The healthcare job role was combined into three job categories. Respondents were represented as followed: Healthcare Practitioners (n=95), Healthcare Support (n=74), and Office and Administrative Support (n=37).

The HAS scale measuring attitudes toward homosexuality needed to be reversed scored, meaning, all negative items needed to be changed to create consistency among the items. Items 1, 2, 6, 8, 13, 14, 15, 18. 19. 20, and 21 were changed according: 1's = 5's, 2's = 4's, 3's remained 3's, 4's = 2's and 1's = 5's. All scores were added together for the 21 items to create the homosexuality attitude variable. The total possible score of the HAS was 105 which represented the highest level of positive attitude toward homosexuality. Figure 1 shows the distribution of the scale. The mean value was 95.37 with a standard deviation of 10.293. The distribution is negatively skewed due to the scores of the participants falling on the higher side with minimal

low scores from the majority of the participants.

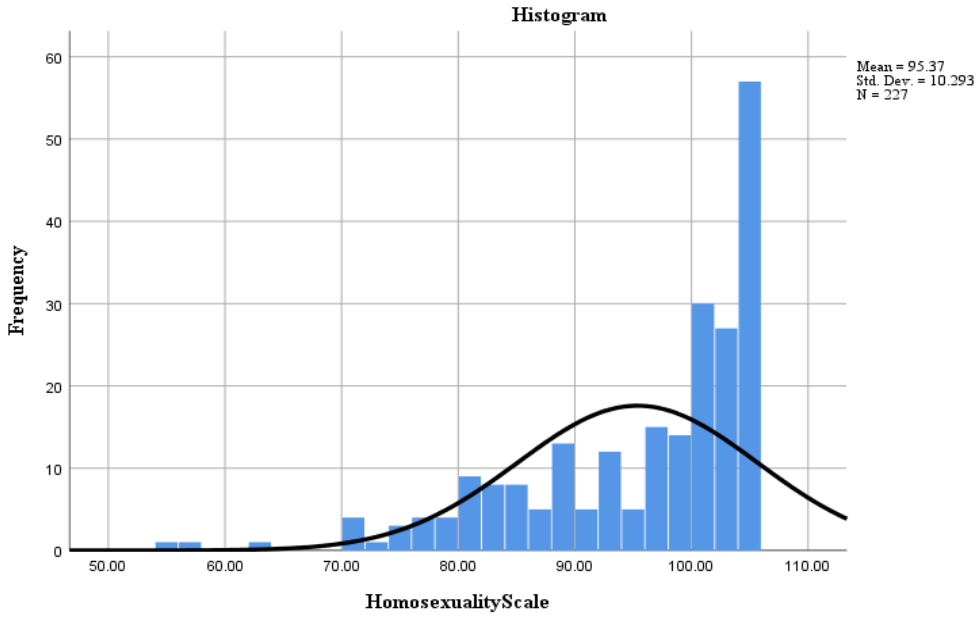

Figure 1. Distribution of the Homosexuality Attitude Scale (HAS). Approval to use the scale in this research was provide in Appendix D.

Results

There are three assumptions for the One-Way ANOVA: the assumption of independence, assumption of normality, and assumption of homogeneity of variances which was tested for each of the questions (Field, 2013). The assumption of independence is related to the research design which states all observations are random and independent from the population being sampled, this assumption has been met for all research questions. In Figure 1, the data distribution of the HAS scale are not normally distributed, therefore, non-parametric tests should be used in place of One-way ANOVA to answer the research questions. The Kruskal-Wallis test is the non-parametric method used when comparing two or more independent samples of equal or different

sample sizes and does not assume the data is normally distributed and Welch's t-test is used when variances are equal (Field, 2013).

Research Question One

What is the relationship between healthcare workers' attitudes towards homosexuality and healthcare workers' gender?

(Ho): There is no statistically significant relationship between healthcare workers' attitudes toward homosexuality and healthcare workers' gender.

(HA): There is a statistically significant relationship between healthcare workers' attitudes toward homosexuality and healthcare workers' gender.

Non-parametric tests and effect size. A Kruskal-Wallis was conducted to examine the difference between gender and attitudes toward homosexuality; no survey responses were omitted. The Kruskal-Wallis H test showed no statistically significant differences $\chi 2(2) = .296$, $p=0.587$, $df= 1$ were found in the two categories of participants with mean rank homosexuality attitude scores of 109.56 for males and 115.25 for females (see Table 8). The researcher does not reject the null hypothesis as no statistically significant difference between a healthcare worker's attitudes toward homosexuality and healthcare worker's gender was identified. To determine effect size, a crosstabulation test was run to obtain eta squared $\eta 2 = 0.00144$ which informs us that .1% of attitudes toward homosexuality can be accounted for by gender indicating there is no effect (Cohen, 2016).

Table 8

Kruskal-Wallis Test: Attitudes toward homosexuality and Gender

	N	Mean Rank
Male	50	109.56
Female	177	115.25

Total	227
Kruskal-Wallis H	0.296
df	1
Asymp. Sig.	0.587

Research Question Two

What is the relationship between the healthcare workers' attitudes towards homosexuality and their job role?

(Ho): There is no statistically significant relationship between healthcare workers' attitudes toward homosexuality by job role.

(HA): There is a statistically significant relationship between healthcare workers' attitudes toward homosexuality by job role.

Non-parametric tests and effect size. A Kruskal-Wallis was conducted to examine the difference between job role and attitudes toward homosexuality; one survey was omitted in data analysis. The Kruskal-Wallis H test showed no statistically significant differences $\chi 2(2)=.064$, $p=0.968$, $df= 2$ were found in the three categories of participants with mean rank homosexuality attitude scores of 113.38 for healthcare practitioners, 114.66 for healthcare support and 111.45 for office and administrative support, see Table 9. The researcher did not reject the null hypothesis as no statistically significant difference between a healthcare worker's attitudes toward homosexuality and healthcare worker's job role were identified. To determine effect size, a crosstabulation test was run to obtain eta squared $\eta 2= 0.00073$ which informs us that attitudes toward homosexuality can be accounted for .07% by healthcare role indicating there is no effect

(Cohen, 2016).

Table 9

Kruskal-Wallis Test: Attitudes Toward Homosexuality and Job Role

N		Mean
Healthcare practitioner	107	113.38
Healthcare support	80	114.66
Office and administrative support	39	111.45
Total.	226	
Kruskal-Wallis H	0.064	
Df	2	
Asymp. Sig.	0.968	

Research Question Three

What is the relationship between healthcare workers' attitudes towards homosexuality and healthcare workers' religiosity?

(Ho): There is no statistically significant relationship between attitudes toward homosexuality and healthcare workers' religiosity.

(HA): There is a statistically significant relationship between attitudes toward homosexuality and healthcare workers' religiosity.

Non-parametric tests and effect size. A Kruskal-Wallis H was conducted to examine the difference between religiosity and attitudes toward homosexuality; no survey responses were omitted. The Kruskal-Wallis H test showed there are statistically significant differences $\chi 2(2)$

=.7.344, p=0.025, df= 2 with mean rank homosexuality attitude scores of 105.55 for yes, 131.33 for no and. 110.33 for don't know, see Table 9. The researcher rejects the null hypothesis because a statistically significant difference between a healthcare worker's attitudes toward homosexuality and healthcare worker's religiosity is evident. A Games-Howell post hoc test was run to review multiple comparisons between groups to determine a significant value for each subset and what groups in subsets have non-significant means. In Table 11, we can see the first subset of participants answered yes, they considered themselves religious compare to the second subset of participants who answered no, they did not consider themselves religious had a significantly different means p=.005. To determine effect size, a crosstabulation test was run to obtain eta squared $\eta 2$= 0.03562 which informs us that 3.6% of attitudes toward homosexuality can be accounted for by religiosity which is a small effect (Cohen, 2016).

Table 10

Kruskal-Wallis Test: Attitudes toward homosexuality and Religiosity

	N	Mean
Yes	137	105.55
No	71	131.33
Don't know	19	110.13
Total	227	
Kruskal-Wallis H	7.344	
Df	2	
Asymp. Sig.	0.025	

Table 11

Games-Howell Multiple Comparisons: Attitudes toward homosexuality and Religiosity

					95% Confidence Interval	
(I) Religiosity	(J) Religiosity	Mean Difference (I-J)	Std. Error	Sig.	Lower Bound	Upper Bound
Yes	No	-4.27018*	1.33603	.005	-7.4264	-1.1139
	Don't know	-1.33615	2.41673	.846	-7.3526	4.6803
No	Yes	4.27018*	1.33603	.005	1.1139	7.4264
	Don't know	2.93403	2.40635	.453	-3.0642	8.9323
Don't know	Yes	1.33615	2.41673	.846	-4.6803	7.3526
	No	-2.93403	2.40635	.453	-8.9323	3.0642

Note: *The mean difference is significant at the 0.05 level.

Research Question Four

What is the relationship between healthcare workers' attitudes towards homosexual and the type of facility in which the healthcare worker is employed?

(Ho): There is a no statistically significant relationship between attitudes toward homosexuality and the type of facility in which the healthcare worker is employed.

(HA): There is a statistically significant relationship between attitudes toward homosexuality and the type of facility in which the healthcare worker is employed.

Non-parametric tests and effect size. A Kruskal-Wallis H was conducted to examine the difference between attitudes toward homosexuality and healthcare facilities; one survey was omitted in data analysis. The Kruskal-Wallis H test was not statistically significant $\chi 2(2) = .0711$, $p = .0701$ with mean rank homosexuality attitude scores of 115.44 for hospitals, 106.34

for ambulatory healthcare services, and 110.58 for nursing and residential care services, see Table 12. The researcher did not reject the null hypothesis as no statistically significant difference between a healthcare worker's attitudes toward homosexuality and the healthcare facility was not identified. To determine effect size, a crosstabulation test was run to obtain eta squared $\eta 2 = 0.00884$ which informs us that .8% of attitudes toward homosexuality can be accounted for by healthcare facility indicating there is no effect (Cohen, 2016).

Table 12

Kruskal-Wallis H Test: Attitudes toward homosexuality and Healthcare Facility

	N	Mean
Hospitals	175	115.44
Ambulatory healthcare services	45	106.34
Nursing and residential care services	6	110.58
Total	226	
Kruskal-Wallis H	0.711	
Df	2	
Asymp. Sig.	0.701	

Summary

This chapter presented the results of data collection, data cleaning and descriptive statistical tests to explore the correlations of attitudes toward homosexuality and healthcare worker's gender, religiosity, job role, and the healthcare facility in which they are employed. *Kruskal-Wallis H test was conducted* using SPSS to compare means between the independent variable groups and attitudes toward homosexuality to correct for violations to normality. The

null hypothesis stated there would be no correlation between the independent variables and attitudes toward homosexuality, as measured using HAS.

There were no statistically significant correlations with attitudes toward homosexuality and healthcare worker gender, job role, or the healthcare facility in which they were employed and no effect size. The results did show statistical significance between attitudes toward homosexuality and religiosity amongst the respondents the responded, yes, they considered themselves religious compared to those respondents who answered no, they did not consider themselves religious. The effect size was small. The significance of this finding will be further discussed in Chapter 5 along with conclusions and recommendations.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to investigate attitudes toward homosexuality (dependent variable) of healthcare workers in the New Jersey health sector to determine a correlation, if any, with gender, job role, healthcare facility and religiosity (independent variables). The research supported the hypothesis of a correlation between attitudes toward homosexuality and religiosity. The hypotheses regarding attitudes toward homosexuality and gender, job role, and healthcare setting did not have statistically significant relationships.

The research questions were as follows:

- What is the relationship between healthcare workers' attitudes towards homosexuality and healthcare workers' gender?
- What is the relationship between the healthcare workers' attitudes towards homosexuality and their job role?
- What is the relationship between the healthcare workers' attitudes towards homosexuality and healthcare worker religiosity?
- What is the relationship between healthcare workers' attitudes towards homosexuality and the type of facility in which the healthcare worker is employed?

Interpretation of Findings

The first hypothesis explored healthcare workers' attitudes toward homosexuality and healthcare workers' gender. Although the research suggests females are more accepting of homosexuality compared to males (see Barringer & Lynzwiler, 2013; Grey et al., 2013), this

research did not find a statistical difference with gender. It is noteworthy that the New Jersey health sector females outnumber males 3-1 and there is no information found regarding the number of transgender healthcare workers employed in the New Jersey health sector (New Jersey Department of Labor and Workforce Development, 2018). Other studies support negative attitudes are stronger related to gender role attitudes than to gender (see Harbarugh & Lindsey, 2015; White & Garcia, 2018).

The second hypothesis explored healthcare workers' attitudes toward homosexuality and the healthcare workers; job role. Research on attitudes toward homosexuality and healthcare workers' job roles is lacking, with most studies focusing on healthcare providers and nurses. In the current study, 47% of respondents were in the healthcare practitioner group, but there was not a statistically significant relationship with attitudes toward homosexuality. Other studies found nurses' unwillingness to provide care to LGBTQ patients (see Cornelius & Carrick, 2015) and inconsistent delivery of care of clinicians towards HIV-positive individuals due to stigma and discrimination (see Nyblade et al., 2009). In a study conducted in New Jersey, 78 Asian LGBTQ participants reported they experienced stigma and were refused care (Qureshi et al., 2018).

The third hypothesis explored healthcare workers' attitudes toward homosexuality and healthcare worker religiosity. In the current study, pairwise comparison of groups showed the statistically significant result was within the group of those respondents that considered themselves religious compared to those who did not consider themselves religious. The present findings align with negative attitudes towards homosexuality the higher religiosity (see Grey et al., 2013; Janssen & Scheepers, 2019; Smith, 2017).

The fourth hypothesis explored healthcare workers' attitudes toward homosexuality and the facility in which the healthcare worker is employed. The results between a healthcare worker's attitude toward homosexuality and the healthcare facility in which a healthcare worker was employed was not a significant finding. The majority of the healthcare workers were employed in the hospital setting (n=173). Out of those hospitals, 83 respondents answered they were employed at one of the 25 hospitals in the state of New Jersey that was a designated LGBTQ Healthcare Equity leader. In 2019, hospitals had to additionally demonstrate they offered transgender-inclusive healthcare benefits to their employees to reflect their commitment to LGBTQ-inclusive policies and practices (HEI, 2019). This could explain the findings in the results.

The healthcare system is complex and has many different areas a patient needs to navigate to receive care. The approaches to care delivery need to be non-judgmental at every access point to effectively address care variation and organizational culture. For example, different approaches to data collection of SO and GI has been shown to better address the healthcare needs of LGBTQ youth. The preferred method of data collection was non-verbal, as discovered in two emergency room studies, which increased LGBTQ patient comfort levels during intake (see Chaplic & Allen, 2013; Haider et al., 2018; Schbath et. al., 2017).

Limitations and Future Research

Several limitations in this study should be considered when evaluating and making conclusions. First, findings are based on self-reported information and acquiescence response bias (respondents tend to agree with agree-disagree questions), impacting external validity (see Kuru & Pasek, 2016). Participation bias is a phenomenon in which consideration for

participation in sensitive topics, such as attitudes toward homosexuality, has been found to have increased participation bias due to concerns with privacy and confidentiality and stigma (Zapien, 2017). Although this survey provided anonymous responses and collected no personal information, participation was less than expected. For example, in monitoring survey responses within the first three days, there were 640 views of the survey but only 28 respondents completed the survey. The survey remained open for an additional five weeks. A noteworthy finding was that no respondents identified themselves as transgender who participated in the survey.

The data analysis was conducted and validated; however, the results are limited by the sample size. The sample size is a primary limitation to the generalization of these results, which also reduces the power of the outcome. Although the sample size is representative of the New Jersey health sector, the results should be considered preliminary and offer contributions to future studies.

Future research studies should consider hospital system-specific or facility-specific pre and post studies to access attitudes toward homosexuality and the LGBTQ patient experience with interventional cultural competency to help address systematic barriers of LGBTQ patients, families, and employees in order to promote improved health outcomes and reduce care variation. This study is limited to the religiosity variable. Future studies should include religious denomination to determine which religious affiliation might have a relationship with attitudes toward homosexuality by job roles and across healthcare settings.

Social Change Implications

The current study revealed a relationship with religiosity and attitudes toward homosexuality. More specifically, the higher a healthcare worker's religiosity, the more negative

the healthcare worker's attitude toward homosexuality. By replacing LGBTQ healthcare barriers of discrimination, ignorance, and fear with the empowerment of education at the institutional and hospital system levels, and by providing tools and resources that promote cultural competency, the better care LGBTQ patients will receive. At the institutional level, LGBTQ specific training can better prepare providers, nurses, and other clinical support roles of LGBTQ patient needs and support better health outcomes through clinical practice and research. The hospital system can aim to address LGBTQ health disparities with proper data collection to monitor the LGBTQ population within the community they serve. Cultural competencies training should be part of the mandatory annual training hospitals institute and may help address the some of the underreporting of incidents that result in workplace violence and employee turnover. The importance of sensitive, inclusive, and respective data collection of SO and GI and patient-centered competent care of LGBTQ patients across their life course may be achieved by proactively addressing potential religious barriers by healthcare providers at the institutional level and in all healthcare settings.

Positive social change may occur through the commitment of healthcare administrative leadership to continuous review approaches to care delivery and monitoring organizational culture into one of inclusion, acceptance, and willingness to care for LGBTQ patients. Additionally, this transformation of culture could benefit the LGBTQ employees working in the healthcare system.

Conclusions

The theoretical framework of this dissertation is a system's approach to the healthcare system's addressing the work environment as it pertains to the LGBTQ patient and LGBTQ

employees. System thinking helps us to understand the influences of cause and effect and the relationships and connections they have within the system.

This research highlights the need for the development of training infrastructure in medical schools, nursing programs and in other clinical training environments on specific LGBTQ patient care. Additionally, the research supports the need for resources and tools to impact the clinical management of patient care throughout the care continuum and aid in the creation of supportive networks and the development of cultural competency training. The application of systems-centered theory is a practical approach to use when there are differences or conflict within a group or sub-groups. The information may provide insight into future research to determine after detection of current cultural environment results in negative attitudes toward homosexuality within a healthcare system. The consequences of discrimination may impact employee performance and wellbeing. Identifying potential risk areas can guide positive interventions to protect human capital, reduce financial and legal liability while closing the gap on LGBTQ health disparities (Department of Labor, n.d.; Frankel et al., 2006; Meneghel et al., 2016; OSHA, 2015).

Healthcare leaders should routinely review organizational policy changes to address LGBTQ health disparities and improve LGBTQ employee's job satisfaction at the system level. A non-judgment care environment needs to consist of the transfer of empathy, support, and availability of other resources to connect with the LGBTQ community to promote health outcomes, increase job satisfaction, and develop work resilience (Meneghel et al., 2016).

Healthcare systems have the ability to transform their culture by measuring and monitoring employee feedback and understanding if any negative attitudes toward

homosexuality exist. The advancement of learning from all employees across all roles within the healthcare system provides knowledge from all perspectives which can help or hinder the steering of strategy and mission goals towards diversity and inclusion goals and becoming a high reliability organization (Meyer, 2003; Studer, 2013). Identification of bias within a healthcare system is important because LGBTQ stigma can manifest in workplace violence which impacts the healthcare industry four times more than private industry (OSHA, 2015).

By removing the barriers of discrimination, ignorance, and fear and replacing with empowerment of education through culturally competency, attitudes can be transformed into a culture of acceptance and willingness to care for LGBTQ patients. Healthcare organizations can lead in advancing LGBTQ patients health and wellness and make the healthcare sector a better place for LGBTQ employees to work.

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Appendix A: Recruitment Flyer

You are invited to participate in a web-based online survey on health care system's approach to addressing LGBTQ disparities. This research project is being conducted by Mary Egan a student at Walden University. It should take approximately 10 minutes to complete.

PARTICIPATION
Your participation in this survey is voluntary. You may refuse to take part in the research or exit the survey at any time without penalty. You are free to decline to answer any particular question you do not wish to answer for any reason. There is no compensation for your participation.

BENEFITS
You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about attitudes towards homosexuality towards LGBTQ individuals.

RISKS
The possible risks or discomforts of the study are minimal. You may feel a little uncomfortable answering some survey questions.

CONFIDENTIALITY
Your survey answers will be sent to a link at SurveyMonkey.com where data will be stored in a password protected electronic format. Survey Monkey does not collect identifying information such as your name, email address, or IP address. Therefore, your responses will remain anonymous. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study.

CONTACT
If you have questions at any time about the study or the procedures, you may contact my research supervisor.

You can download this form and save it to your computer or print it for your record.

Thank you for your participation.

Sincerely,
Mary Egan

Appendix B: Demographic Questionnaire

1. Do you think of yourself as?
    - Male
    - Female
    - Female to Male/Transgender male/Trans man
    - Male to Female/Transgender female/Trans woman
    - Genderqueer (neither exclusively male nor female
    - Something else
    - Declined to answer
2. What sex were you assigned at birth, on your original birth certificate?
    - Male
    - Female
    - Decline to answer
3. Do you think of yourself?
    - Straight or heterosexual
    - Lesbian, gay, or homosexual
    - Bisexual
    - Something else
    - Don't Know
    - Choose not to disclose
4. How would you describe yourself?
    - American Indian or Alaska Native
    - Asian
    - Black or African American
    - Native Hawaiian or Other Pacific Islander
    - White
    - Identify with Multiple Races
5. What is your marital status?
    - Single (never married)
    - Married or in a domestic partnership
    - Widowed
    - Divorced
    - Separated
6. Do you consider yourself religious?
    - Yes
    - No
    - Don't know
7. What type of healthcare organization or facility do you work at as your primary location?
    - Hospital or Hospital System
    - Psychiatric and Substance Abuse Hospital
    - Critical Care Hospital or Other Hospital
    - Resident Intellectual and Developmental Disabilities Facilities
    - Urgent Care or Freestanding Emergency Medical Center

- Medical Group, Physician Practice or Clinic
- Ambulatory Services
- Nursing Home (Independent/assisted living/post-acute care)
- Orthopedic and other Rehabilitation Center (physical therapy,
- Occupational therapy and speech therapy; (short- and long-term care)
- Kidney Dialysis Center
- Mental Health and Addiction Treatment Centers
- Homecare and Hospice
- Health Insurance
- Pharmaceutical Organization
- Healthcare Advocacy Organization
- Family Planning Services
- Blood and Organ Banks

8. If you answered, Hospital or Hospital System, are you a designated LGBTQ Healthcare Equality Leader?
   - Yes
   - No
   - Don't know
9. What type of role do you perform in your workplace?
   - Physicians and Surgeons
   - Allied Professional
   - Registered Nurses
   - Nursing Assistants
   - Licensed Practical and Licensed Vocational Nurses
   - Home Health Aides
   - Medical Assistants
   - Emergency Medical Technician and Paramedics
   - Dental Hygienist or Assistants
   - Billing and Posting Clerks and Machine Operators
   - Medical Secretaries
   - Receptionists, Registration and information clerks
   - Medical and Health Service Managers
   - Supervisors of Administrative Support Workers
   - Environmental Services (Maids and Housekeeping)
   - Social and Human Services Assistants
   - Risk Manager/Claims Investigator/Underwriter/Broker/Agent
   - Food servers, non-restaurants
   - Therapist (Physical, Occupational, Speech and Language)
   - Radiologic Technologist and Technicians

Appendix C: Homosexuality Attitude Scale (HAS)

Please indicate your level of agreement with the items below using the following scale:

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

1. I would not mind having a homosexual friend.

2. Finding out that an artist was gay would have no effect on my appreciation of his/her work.

3. I won't associate with known homosexuals if I can help it.

4. I would look for a new place to live if I found out my roommate was gay.

5. Homosexuality is a mental illness.

6. I would not be afraid for my child to have a homosexual teacher.

7. Gays dislike members of the opposite sex.

8. I do not really find the thought of homosexual acts disgusting.

9. Homosexuals are more likely to commit deviant sexual acts, such as child molestation, rape, and voyeurism (Peeping Toms), than are heterosexuals.

10. Homosexuals should be kept separate from the rest of society (i.e., separate housing, restricted employment).

11. Two individual of the same sex holding hands or displaying affection in public is revolting.

12. The love between two males or two females is quite different from the love between two persons of the opposite sex.

13. I see the gay movement as a positive thing.

14. Homosexuality, as far as I'm concerned, is not sinful.

15. I would not mind being employed by a homosexual.

16. Homosexuals should be forced to have psychological treatment.

17. The increasing acceptance of homosexuality in our society is aiding in the deterioration of morals.

18. I would not decline membership in an organization just because it had homosexual members.

19. I would vote for a homosexual in an election for public office.

20. If I knew someone were gay, I would still go ahead and form a friendship with that individual.

21. If I were a parent, I could accept my son or daughter being gay.

Appendix D: Permission to Use Instrument

RE: Permission to use the Homosexuality Attitudes Scale

Kite, Mary <mkite@bsu.edu>

Tue 1/15/2019 12:11 PM

To:Mary Egan <mary.egan@waldenu.edu>;

Hi Mary:
You have permission to use my scale. Best of luck with your dissertation.
Mary Kite

From: Mary Egan <mary.egan@waldenu.edu>
Sent: Monday, January 14, 2019 6:04 PM
To: Kite, Mary <mkite@bsu.edu>
Subject: Permission to use the Homosexuality Attitudes Scale

Greetings Dr. Kite,

I would like to use your Homosexuality Attitude Scale in my research related to me completing my dissertation at Walden University. I was hoping that you would grant me permission to use this scale in my study of healthcare workers in the state of New Jersey.

Kindly email me back if you approve of me using your scale in my dissertation. I look forward to your response.

Thank you for your time and anticipated consideration.

Sincerely,
Mary Egan, MHA