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Increasing Culturally Competent Care of LGBTQ Patients by Providing Staff Education

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2020

Abstract

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The majority of health care professionals do not feel confident or competent to adequately care for a lesbian, gay, bisexual, transgender, and queer (LGBTQ) patient. Research has identified a link between poor preparedness of the provider/staff and poor patient outcomes. The purpose of this study was to evaluate the effectiveness of an in-person staff education module about providing culturally competent care to LGBTQ patients. The study focused on providers' attitudes, preparedness, and confidence in caring for a LGBTQ patient. The Iowa and Kirkpatrick models were utilized to ground and evaluate the study. This study was a one-group pre- and posttest intervention using a quasi-experimental design to evaluate the attitudes and confidence of providers regarding culturally competent care of the LGBTQ patient before and after completing an educational module on caring for the LGBTQ community. Participants were recruited through personal invitation. Participants comprised a convenience sample of 13 heterosexuals and 2 LGBTQ subjects. Participants were given a pre-and post-intervention Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS). A paired sample *t* test was used to analyze the data resulting in a 2-tailed *p*-value of 0.000. The results were a significant improvement in participant scores on the LGBT-DOCSS post intervention. Also, an increase in the mean score from pre- (52.6) to posttest (90.2) was noted. This effective educational module promotes positive social change by increasing confidence and competence in providers and staff when caring for a LGBTQ patient, thus increasing quality of care.

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Dedication

I dedicate this paper to my children Antonio, Marcus, and Carmello. Thank you for sharing me with the field of nursing. Thank you for helping each other with homework so that I could do mine. Thank you for your endless love. I want you guys to always remember that it does not matter what you are born but instead, what you become. There is no limit to what you can accomplish in your lifetime. To my parents who have always cheered me on and supported me no matter my choices. To my dear friend Connie Ash, thanks for all of your encouragement and support. Thanks for believing in me when I did not believe in myself. To my dear friend and Mentor Chimere Ashley, MD, thank you for allowing me to work alongside you and complete my education at the same time. Thanks for all the laughs, cries, defeats, and accomplishments. You are truly a wonderful soul. To my soon to be wife Jessica, thank you for believing in me. Thank you for pushing and dragging me across this finish line. Thank you for picking up my slack as a parent while I dedicated the majority of my time to this study. To J.K. Rowling, my favorite author, thanks for your commitment to the Harry Potter series. If it wasn't for me picking up that book in the 7th grade I do not believe I would have had the encouragement and dedication to be where I am today. To my friends Ny, Brittney, Sarah, Tiara, Cody, Emily, Kendra, Jennifer, Tabatha and everyone I didn't name, thank you for your support. Whether you are aware of it or not, your contributions to my life encourage me daily.

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I would like to send my sincere gratitude to my chair, Dr. Sipes. Thank you for putting up with me. Thank you for replying to countless emails, I am forever grateful for your guidance. To my committee member Dr. Everett, thank you for your guidance and encouragement. The input from you both provide me with the foundation and tools to complete this project.

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Introduction

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals face many negative health outcomes and health disparities. Over the lifespan, an LGBTQ individual is at an increased risk for suicide, sexually transmitted infection contraction, homelessness, disabilities, isolation, depression, tobacco use, and illicit drug use (Klein & Nakhai, 2016). Members of the LGBTQ community are less likely to seek health care in any form than their heterosexual counterparts (Lim, Brown, & Kim, 2014). Many of these disparities result in part from lack of health care staff's knowledge of the specific needs and gaps in care of the LGBTQ patient.

Despite continuing research that sheds light on the disparities for which this population is at risk for and ways to address the gap in practice such as health care staff education, there have not been any interventions adopted universally. These disparities must be thoroughly understood by the health care team to provide the best quality of patient care and mitigate the unfavorable health outcomes experienced by LGBTQ individuals.

Despite policy and lawmakers, health care stakeholders and authorities, physicians, psychiatrists, and health care staff from different areas of practice recognizing the need for LGBTQ cultural competencies to be implemented, there has been a lack of implementation of this recommendation (National Institutes of Health, 2017). To provide culturally competent care, the provider must have the ability to understand, communicate

with, and effectively interact with people across cultures (Beagan, Fredericks & Bryson, 2015).

Providers and other health care members should be willing to learn the culture of the LGBTQ community to effectively deliver health care services that meet the social, cultural and linguistic needs of LGBTQ patients.

As always, times are changing, and the need for culturally competent care for the LGBTQ community is at a critical stage. The nature of this Doctor of Nursing Practice (DNP) project was a staff education model to help increase culturally competent care for the LGBTQ population. Sociologists describe social change as advancement in human interactions and relationships to transform cultural and social institutions (Beagan et al., 2015). Social change is necessary for the advancement of quality patient care. The education module for culturally competent care of the LGBTQ patient could result in profound changes for this population, especially at the target site, a rural area in a Southern state.

Problem Statement

The LGBTQ community face unique health care disparities, in part due to a lack of access to health care. This lack of health care access is related to the absence of cultural competence in health care staff (Lim, Brown, & Kim, 2014). Members of this population are less likely to seek health care in any form than their heterosexual counterparts (U.S. Department of Health and Human Services [USDHHS], 2015). These disparities are determined by multiple components including an increased risk for suicide, drug use, mental health issues, and sexually transmitted infections inclusive of HIV. Until

1973, homosexuality was classified as a mental disorder (Beagan et al.,2015). Anti-LGBTQ bias is still an issue among providers and their staff. This causes LGBTQ patients to be less likely to seek health care services including preventative visits and screenings, continuing care visits, and acute illness visits. Members of this minority are also less likely to report their sexual orientation or gender identity to providers when they do seek care (Quinn et al., 2015). In the United States, the lack of culturally competent health care for the LGBTQ community is especially prominent (USDHHS, 2015). Rural communities where there tend to be fewer primary care clinics are notably affected by anti-LGBTQ bias (Kano, Silva-Banuelos, Sturm, & Willging, 2016). Many changes in health care result from evidenced based practice (EBP) typically performed by nurses or other care providers. Providing education and knowledge on the specific needs and the culture of the LGBTQ patient will help to increase the quality of care these patients receive. The need for providers to offer care that is respectful and attentive to the patient's values, preferences, and needs is termed patient-centered care, an idea that has gained national support (Institute of Medicine [IOM], 2011).

Purpose of the Project

The purpose of this DNP project was to address the gap in practice where there is a lack of knowledge in many providers of care to LGBTQ patients. Prior to the legalization of gay marriage and passage of antidiscrimination laws, very little education on how to provide culturally competent care to an LGBTQ patient was offered in educational settings. Even with recent changes, education is still lacking. According to the IOM (2015), poor cultural competence amongst providers and their staff may impact

the quality of care given to LGBTQ patients. Factors including the lack of culturally competent care from nurses, physicians, physician extenders, medical assistants and other staff contribute to preventable disparities (Quinn et al., 2015).

The practice-focused question (PFQ) for this project study was:

Will providing education on culturally competent care of the LGBTQ patient increase provider and staff confidence in caring for this population in a rural community in the Southern United States?

The USDHHS (2015) strongly recommends that new and existing human services programs include LGBTQ cultural competency as a required curriculum. While this is just a suggestion, a number of rural organizations do not implement this recommendation. The lack of culturally competent providers is a significant barrier to quality health care for LGBTQ patients (USDHHS, 2015). Many providers and staff will admit to being uncomfortable serving LGBTQ patients and feel they lack the knowledge to provide them with culturally competent care. The IOM (2016), updated their previously listed aims suggesting that health care should not only be safe, effective, timely, and efficient but also patient centered. The goal of the DNP staff education project was to broaden the knowledge of the culture of the LGBTQ community and educate participants on how to provide culturally competent care to LGBTQ patients.

Nature of the Project

Sources of evidence for the project included pre-and posteducation module questionnaires using the LGBT-Development of Clinical Skills Scale (LGBT-DOCSS) template. The questionnaires were aimed at evaluating the staff's thoughts and feelings

toward providing care to LGBTQ patients in addition to a self-assessment on their level of comfort when providing such care. The LGBT-DOCSS is a self-assessment clinical tool created by Bidell, (2017), that I as the project constructor/presenter printed and distributed at different times during the project process. The pre-education questionnaire or *pretest* was given and collected the day before the presentation with the posteducation questionnaire or *posttest* being given and collected after the presentation. To analyze results, scores from the pretest were compared to scores following the presentation. The favorable result was to see a significant increase in scores indicating that the staff had gained knowledge they can apply to practice. The purpose of the project was to increase staff knowledge and provide them with the education needed to provide culturally competent care to the target population. The expected results were that staff would feel they are more confident in their ability to provide culturally competent care to LGBTQ patients posteducation presentation, increasing culturally competent care to LGBTQ patients in the future. The goal of the project was to make the staff aware that they may not be providing culturally competent care to LGBTQ patients and to provide knowledge on remediating that lack, subsequently improving health care of the target population in the area.

Significance of the Project

Stakeholders included patients, physicians, nurses, providers, and other staff such as front desk clerks, billing consultants, and other ancillary staff members. Each mentioned stakeholder has no risk related to the educational presentation; all data was de-identified. All staff involved were asked to participate at their own free will and volunteer

their time for learning module as they would not be reimbursed for their time directly. The patient will benefit the most from the project as they may be more likely to seek care. Insurance companies are also a stakeholder and will benefit from the increase in health promoting behaviors that are likely to result from the educational presentation. Physicians and other providers such as nurse practitioners and physician assistants may see an increase in revenue and incentives as their "pay for performance" level will likely increase. Educational models such as this may be transferred and used with other minorities or groups. For example, finding a target population and educating staff and providers on how to provide culturally competent care will forever be beneficial. The advancement of the patient/provider and patient/staff interaction after this educational presentation is a direct image of social change.

Summary

Health disparities in the LGBTQ community are directly related to the lack of culturally competent care given by members of the health care team (Quinn et al., 2015). Many providers and their staff are unaware just how nonculturally competent they may be. Without being able to provide the best quality of care to the LGBTQ community, these patients will remain at a higher risk of health care disparities for conditions such as mental health issues, tobacco and illicit drug use, and sexually transmitted infection contraction. They will also continue to be less likely to have routine screenings such as mammograms and colonoscopies. One step to improve patient-centered quality of care to LGBTQ patients is to advance the cultural competence of providers and staff regarding the LGBTQ community. Providing staff with interactive straightforward education on

LGBTQ cultural competence will help staff be more comfortable, confident, and aware of how to treat and establish a trusting patient/provider/staff relationship with an LGBTQ patient. Utilizing the IOWA model to help establish the need for the education guided the construction of the education. For an evaluation method, the Kirkpatrick model was beneficial to evaluate if the staff education project had a positive impact on the target audience.

Section 2: Background and Context

Introduction

LGBTQ individuals in the United States are at a higher risk of a multitude of health disparities compared to other groups. A lack in health care provider and staff training and competence in LGBTQ specific needs and disparities plays a significant role in the poor health promotion seen in this community (Beagan et al. 2015). Studies have shown that a feeling of negativity and judgement from providers and staff have deterred the LGBTQ community from seeking or continuing care (Klein & Nakhai, 2016). Therefore, one option to improve health promoting behaviors as well as patient-centered high-quality care for the LGBTQ community is to increase cultural competence in providers and staff by providing educational materials and tools.

The practice focused question that this DNP project was designed to answer to resolve was:

Will providing education on culturally competent care of the LGBTQ patient increase provider and staff confidence in caring for this population in a rural community in the Southern United States?

In rural areas, there are fewer health care providers (Klein and Nakhai, 2016). This results from rural areas have a difficult time retaining providers. Typically, providers in the rural areas consist of small private practices with providers ages 40 and up (Kano et al., 2016). With the LGBTQ population growing, there is a need for more culturally competent providers as this group is at an increased risk of multiple health disparities. The purpose of this doctoral project was to provide clinicians and staff with an

educational experience that would successfully increase their confidence and cultural competence skills in treating the LGBTQ community. As a result, the LGBTQ population in the area may be more likely to access care, thus leading to a decrease in health disparities.

Concepts, Models, and Theories

The Iowa Model

The Iowa model for evidence-based practice (EBP) was used to drive this project. The Iowa model was developed at the University of Iowa Hospital and Clinics in the 1990s by Dr. M. Titler (Buckwalter et al., 2017). Since the construction of the model, it has been widely used by nurses to apply research findings to patient care to improve the quality of patient care. In this model, there are seven steps: (a) identifying the problem or trigger that is in need of a change, (b) forming a team or plan, (c) reviewing and critiquing literature relevant to the trigger, (c) grading research that supports the need for change, and (d) construction of a plan for change, (e) implementation of the plan, and (f) evaluation of the new EBP standard or change.

The PICOT Method

I used the PICOT method, an acronym for population, intervention, comparison, outcome, and time method to locate research. The PICOT method continues to be one of the best methods to help identify research to broaden knowledge about clinical interventions (Blanchard & Van Wissen, 2017). For the purpose of the project, the population (P) was providers and staff in primary care offices. The intervention (I) was providing culturally competent care for the LGBTQ community. The comparison (C) was

the same group prior to the educational intervention. The outcome (O) was that staff would benefit from the education. The time (T) was a 30-minute staff education presentation. By utilizing this framework, I performed a targeted literature search.

The Kirkpatrick Model

To evaluate the doctoral project, I used the Kirkpatrick model of evaluation. With this model, the investigator can evaluate their method of change. This model is made up of four sections: reaction, learning, behavior, and results. The Kirkpatrick model has been used to evaluate EBP changes in nursing as well as other areas where an assessment of an education method is needed.

Dorri, Akbari, and Sedeh, (2016) conducted a cross-sectional study using the Kirkpatrick model of evaluation to assess an in-service education module of cardiopulmonary resuscitation given to nurses. After the in-service, participants were provided with a researcher-made questionnaire. Dorri et al. (2016) found that the in-service had a favorable effect on all four levels of the Kirkpatrick model for all participants. The Kirkpatrick model was chosen for evaluation of this doctoral project because it provides a tried and true framework to evaluate teaching methods.

Provider Perceptions

In a qualitative study performed by Beagan et al. (2015), it was noted that most providers in the sample reported feeling under-prepared to provide care to a patient of the LGBTQ community. The aim of the study was to correlate poor health promotion in the target community with the decreased cultural competence of the providers. Interviews were conducted with 24 providers with mixed perceptions on how sexual/gender identity

can impact patient care and outcomes. Results derived from the study indicated that most of the providers were not confident in their ability to care for a member of the LGBTQ community, reinforcing is the notion of a direct link between poor provider cultural competence and inadequate health promotion in the target population. Even with recommendations from top medical education experts, education on LGBTQ patients is not widely incorporated in educational or provider settings (Beagan et al. 2015).

Clarification of Terms

Sexual identity: An individual's sense of self as a sexual being, including gender identity, gender role, sexual orientation, and sexual self-concept. Sexual identity may also refer to the language and labels people use to define themselves. Sexual self-concept refers to the individual's assessment of their sexual identity. Development of sexual identity is a critical part of adolescence (Konow, 2017).

Gender Identity: An individual's own sense of self as a woman, man, transgender, or none or other gender identities. Gender identity may or may not conform to an individual's biological sex (Konow, 2017).

Relevance to Nursing Practice

Previous research has pointed out the seriousness of health disparities in the LGBTQ community (Beagan et al. 2015) There have been a multitude of projects aiming to pinpoint gaps in practice regarding healthcare for LGBTQ patients. Overall, the literature revealed that a lack of culturally competent care continues to be a factor in the declining health promotion of the target population. Cultural competence education is a proven strategy to improve care outcomes in the LGBTQ patient population (USDHHS,

2015). With a renewed interest of LGBTQ health care, several organizations have established guidelines to help health care organizations and educational institutes implement LGBTQ cultural competence training. For example, the USDHHS (2015) issued a compilation of recommendations and actions to improve the health of LGBTQ patients. These recommendations were preceded and expanded from the IOM's (2011) identification of knowledge gaps, strategies, and guidelines for LGBTQ improvement of care.

State of Nursing

Despite the overwhelming evidence suggesting the correlation between poor cultural competence and poor patient outcomes in the LGBTQ community, health care has yet to mandate implementation of education to staff in the United States (IOM, 2011). This has been proven to be true in both the educational setting and the workplace setting (Alencar Albuquerque et al., 2016). According to the American Nurses' Association (2001), nurses should practice with compassion and respect for all patients without any prejudice. Notwithstanding, there is still a knowledge gap when providing culturally competent care to minority groups, particularly, the LGBTQ patient population. Rural communities are especially lacking in LGBTQ culturally competent providers and health care staff.

Patterson, Tree, and Kamen, (2019) performed a quantitative survey on provider attitudes and different areas related to the LGBTQ patient. A total of 85 providers (N = 85) participated in a self-report survey on LGBTQ cultural competence. Of the providers, only half (54.1%) felt competent when caring for an LGBTQ patient. These providers

also felt that while they would treat LGBTQ patients equally, they felt some level of discomfort when treating an LGBTQ patient (Patterson et al., 2019).

Strategies

Strategies used by researchers in the past included effective teaching such as lectures, presentations, case simulations, discussions, and mock encounters. In a qualitative study performed by Frick, Thompson, and Curtis, (2017), a total of 27 participants were assessed pre- and post-film intervention to explore if the LGBTQ related films influenced their perceptions of the LGBTQ community. Of the participants, 24 were women and 3 were men with a median age of 35. They were all graduate students with majors in counseling, social work, and psychology. Over half (n = 18) expressed that their perceptions of the LGBTQ community had changed, and they felt more knowledgeable about the culture of the LGBTQ community. After the films, 15 participants reported having an increased awareness and broader knowledge of experiences, prejudice, and disparities faced by the LGBTQ community (Frick et al., 2017).

The Gap

Identifying as an LGBTQ member is almost an automatic determinant for less than optimal patient care (Alencar Albuquerque et al., 2016). One method for increasing health promoting behavior in the LGBTQ community is to educate providers and staff on the prejudice and disparities faced by the LGBTQ community. There have been recommendations by a several of organizations to implement culturally competent care into core curriculum, but as of now, it is still optional (IOM, 2011). In addition, while

there are recommendations for general cultural competency, there are no specific recommendations for LGBTQ content. Therefore, providers and staff would benefit from a staff education module that is LGBTQ specific. Culturally competent providers and staff are more likely to create a trusting, quality bond with the patient, thereby decreasing the potential for disparities in the LGBTQ patient population.

Local Background and Context

In the United States, approximately 4.5% of adult Americans identify as LGBTQ (Gates, 2017). While this seems like a small percentage, there are still some of this minority who have chosen not to identify publicly as LGBTQ. In the area in which the DNP project was executed, the LGBTQ population makes up 3.3% of the state's population. As mentioned, there are likely several unaccounted-for LGBTQ members. The chosen area is also a rural sector of a Southern state. It is typical in these areas also known as "The Bible Belt" to see more instances of homophobia and other forms of prejudice in contrast to the Northern, Eastern, and Western states. The south lags behind other areas in in regard to practice limitations for advance practice registered nurses (American Association of Nurse Practitioners, 2018). Most providers in this rural setting are at least 40 years of age. Many have been in practice for over 10 years. The LGBTQ community recently gained media attention with the enactment of laws allowing same sex marriage and protection from discrimination. Since then, the number of persons identifying as LGBTQ has increased (Gates, 2017). However, many providers and staff have had little to no education on culturally competent care for the LGBTQ population. Research has shown that a lack of training in culturally competent care for providers and

staff may lead to less than ideal care (Alencar Albuquerque, et al., 2016). Because of this, a staff education module on culturally competent care in the LGBTQ patient was a priority.

Role of the Doctor of Nursing Practice Student

As a nurse practitioner, I have a commitment to be a patient advocate and to contribute to promoting social change. As a member of the LGBTQ community, I have an increased interest in this topic. Constructing a means to improve quality patient care for the LGBTQ community by helping to eliminate barriers is a personal goal of mine. Throughout my practicum experience, I have seen firsthand that there is a lack of culturally competent providers in the area. My role in the DNP project was to construct and implement a staff education module with expert panel input to aid in increasing cultural competence in providers and their staff. The module includes evaluative pre- and posttest responses of the providers who participate. The topic for my project was chosen because of the significance of being a member of the LGBTQ population while also being a provider. In my experience, nursing education did not provide much more than a paragraph or two dedicated to LGBTQ health.

One of my inspirations for this doctoral project occurred when I was starting out in primary care as a new nurse practitioner. I had a female patient who had recently tried to commit suicide because she was under a great deal of stress related to “coming out” to her grandparents. It was at that moment that I, as a lesbian, could not think of a culturally competent plan of care for this patient. I knew I identified as lesbian, but I was not aware of the prevalence of disparities faced by the LGBTQ community. I had no advice other

than the general psychiatric plan that I referenced in books. After scouring my nursing school texts, I moved on to my collaborating physician's books and, not surprisingly, found very little literature on the subject. I then made it a personal goal to help disseminate knowledge on how to provide culturally competent care to LGBTQ patients.

A potential bias could stem from the fact that I identify as a member of the LGBTQ community. To address this bias, I researched educational modules and participated as if I were an unknowing provider. As previously mentioned, I was unaware of the high occurrence of disparities experienced by the LGBTQ community. I am in good health, I have not suffered depression or anxiety related to being LGBTQ, I have had all of my screening exams when due. I strongly believe that if I was not a health care provider, I may have very well experienced some if not all of the disparities associated with being LGBTQ such as mental health disorder, obesity, sexually transmitted infections, and poor health promoting behavior.

Summary

Lack of provider education in culturally competent care of the LGBTQ has been linked to poor quality health care in the LGBTQ community. It is less likely that an LGBTQ patient will form a valuable bond with their chosen provider and staff if they sense feelings of judgement or homophobia. Even a minute amount of provider education on LGBTQ culture can have a positive impact on the care delivered to an LGBTQ patient (Alencar Albuquerque, et al., 2016).

The Iowa Model aligns with this doctoral project. Consisting of seven steps, the model takes the researcher through planning, implementation, and evaluation. I used the

Kirkpatrick model of evaluation with the staff education project. Reaction, learning, behavior, and results are the building blocks of this model. The need for education on the background, terminology, lifestyle, and disparities in the LGBTQ patient is imperative for health promotion in the target population. Therefore, this proposed to implement a staff education project as an EBP standard to educate providers and their staff on offering culturally competent care to the LGBTQ community to increase health promotion. The project was evaluated using the LGBTQ-DOCSS tool as pre- and posteducation questionnaires for the staff. Data were collected and analyzed using the quasi-experimental approach.

Section 3: Collection and Analysis of Evidence

Introduction

The purpose of this DNP project was to provide education to staff and providers on culturally competent care of the LGBTQ patient. There have been numerous research studies that directly link poor health care outcomes in the LGBTQ community to the lack of culturally competent care given by providers (IOM, 2011). Members of the LGBTQ community find it hard to establish a trusting relationship with health care staff due to the fear of homophobia and prejudice (Alencar Albuquerque et al., 2016). Educational curricula and onboarding employee orientation are not required to include culturally competent information on specific minority groups such as LGBTQ.

I designed this DNP project to increase provider and staff cultural competence with the LGBTQ patient through an educational lecture/presentation. With an increase in provider and staff knowledge, the LGBTQ patient will likely feel more comfortable with the provider and staff. Feeling comfortable and respected is imperative to creating a patient/provider/staff bond. The LGBTQ patient will be more likely to access care, which will decrease the likelihood of certain disparities.

Practice Focused Question

The practice focused question that this DNP project aims to resolve was:

Will providing education on culturally competent care of the LGBTQ patient increase provider and staff confidence in caring for this population in a rural community in the Southern United States?

The issue addressed by this project is a lack in LGBTQ cultural competence in health care amongst providers and their staff. This is often more prevalent in rural areas. Many organizations give a quick summary of cultural awareness in the onboarding of new hires, but there is no specific education on the LGBTQ community. The majority of schools for various professions also do not incorporate LGBTQ cultural competence in their curriculum. The LGBTQ population is at a higher risk for a magnitude of health care disparities such as obesity, diabetes, hypertension, and mental health issues. Research has noted that the poor health of the LGBTQ is caused in part by the lack of culturally competent care given by staff at providers (Klein, & Nakhai, 2016). The practice focused question was:

> Will providing education on culturally competent care of the LGBTQ patient increase provider and staff confidence in caring for this population in a rural community in the Sothern United States?

Operational Definitions

The gap in practice was that providers and staff in the target area had very little confidence when treating LGBTQ patients. This was a result of the lack of culturally competent education provided to staff and providers. Beagan et al. (2015), explained that over half of providers and staff do not feel confident in the ability to properly care for an LGBTQ patient. By educating providers on the background and disparities specific to the LGBTQ community, providers will be able to offer higher quality patient-centered care.

The purpose of this project was to educate providers and staff on cultural competence surrounding the LGBTQ population. By utilizing EBP guidelines and

research, I constructed an educational module and presented to staff and providers in the target area. The material was implemented in an easy to understand format with written narrative of important points. The results were then analyzed by collecting the scores pre- and posttest surveys and comparing them.

Most of the terms used in this DNP project are common verbiage. However, each term that makes up the acronym LGBTQ may need clarification. In addition, there are many different types of "staff" who are referenced to in this project.

Lesbian: A woman whose enduring physical, romantic, and/or emotional attraction is to other women (Lesbian, Gay, Bisexual & Transgender Community Center, 2014).

Gay: The adjective used to describe people whose enduring physical, romantic, and/or emotional attractions are to people of the same sex. Most widely used when referring to men (Lesbian, Gay, Bisexual & Transgender Community Center, 2014).

Bisexual: A person who has the capacity to form enduring physical, romantic, and/or emotional attractions to those of the same gender or to those of another gender (Lesbian, Gay, Bisexual & Transgender Community Center, 2014).

Transgender: An umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth (Konow, 2017).

Queer: An adjective used by some people, particularly younger people, whose sexual orientation is not exclusively heterosexual (Konow, 2017).

Registered nurse (RN): A graduate trained nurse who has been licensed by a state authority after qualifying for registration (American Nurses Association, 2001).

Licensed practical nurse (LPN): A person who has undergone training and obtained a license conferring authorization to provide routine care for the sick (American Nurses Association, 2001).

Medical assistants (MA): An allied health professional who supports the work of other health professionals (American Nurses Association, 2001).

Certified nursing assistant (CNA): An allied health care worker who helps patients or clients with health care needs under the supervision of an RN or LPN (American Nurses Association, 2001).

Physician: A medical doctor (MD) or doctor of osteopathy (DO); a person qualified to practice medicine (IOM, 2011).

Nurse practitioner (NP): An advanced practice registered nurse who is trained to assess patient needs, order and interpret diagnostic and laboratory tests, diagnose disease, and formulate and prescribe treatment plans (American Nurses Association, 2001).

Sources of Evidence

Published Outcomes and Research

To perform the literature review, I used the following databases and search engines: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, Google Scholar, Institute of Medicine (IOM), Walden University library, LGBT Life with Full text, and American Association of Nurse Practitioners database. A CINAHL search using the terms *cultural competence, homosexuality, LGBT, LGBTQ, bisexuality,*

transgender, and *provider competence* returned over 3,000 results. After narrowing the inclusion criteria to studies from 2014 to present with full-text only option, 2,019 results were returned. After sorting through magazine articles and questionnaires there were a total of approximately 174 references from academic journals related to the project.

With such a large number of results returned with a variety of different foci such as nursing specific education and patient perspectives, I conducted a narrower search in the same search engines and databases. Using only the terms *LGBTQ* and *cultural competence* and including the inclusion criteria, a total of 36 articles were returned. After eliminating over half of the articles related to duplication and irrelevance, a total of 10 articles were incorporated into this project.

Evidence Generated for the Doctoral Project

Participants

The sample was a convenience sample from voluntary participants who were members of the health care community in the county of the target area. Before beginning the project, I received approval from Walden University's Institutional Review Board. This projects approval number is 02-12-20-0420633. There was a total of six provider offices in the area. Of those six, two were obstetrics and gynecology offices while the remaining four were primary care clinics. The providers and staff at each of these offices consisted of MAs, CNAs, LPNs, RNs, MDs, DOs, NPs, and front office staff. Participants were selected based on their availability on the selected day and their willingness to participate. There were no financial incentives for participation. This notwithstanding, with approval of the provider, the participants will be paid for time as

the staff education was conducted during business hours. Inclusion criteria for this project were that staff would include members of the health care team who were directly involved in patient care. Participants must also have been able fill out the appropriate surveys. All data was de-identified.

Procedures

Education methods. The plan was to educate providers and staff on culturally competent training of the LGBTQ patient via PowerPoint presentation. The presentation was formatted to include important topics and key points from the research and literature review. A pre-and post-LGBT-DOCSS (see Appendix A) was used to assess participants attitudes toward LGBTQ patients and were filled out by the participant. All participants were de-identified and did not put their names on their surveys to keep all information confidential. Once the surveys were completed, the data was collected by me and a collaborating physician who served as an expert member. After collecting the data, pretests were compared to the post tests for comparison. I then summarized the de-identified data using Excel to be used later during the project. After data had been collected by either me or the collaborating physician, the paper copies were shredded. The educational module took place in an area in the provider office equipped for a projector and was presented by me with input from the expert member. Most offices worked from 9 am to 5 pm; therefore, the training was most beneficial to be provided at lunch time. The total time for the educational material and questionnaire participation was limited to 30 minutes.

At the end of the educational module but before the post-LGBTQ-DOCSS test was administered, a case study was given by the expert member that was open for discussion amongst the group. The case scenario consisted of proper pronouns and sexually transmitted infection workup of an LGBTQ patient.

Protections

Participants in this project were anonymous and all data was de-identified. There was no harm associated with participation, and participation was voluntary. Therefore, this project will fell under blanket approval of Walden University's Institutional Review Board. The project proposal was reviewed by chair members for preliminary approval. The strategy used as a method for recruitment was a personal invitation given by me to the staff. I traveled to each location and explained the purpose of the DNP project. As previously mentioned, participation was voluntary, and all names were de-identified. Participants who agreed to participate were informed of the specific date and time. The participant had the choice to terminate participation at any time.

Analysis and Synthesis

I used a quasi-experimental approach to analyze and evaluate the project pre- and post evaluation data using Statistical Package for Social Sciences (SPSS). A quasi-experimental approach is useful when trying to determine if an intervention was successful (Delucchi, 2019). The most useful information was the comparison of pre- and posttest scores indicating participant benefit from the education presentation. I used SPSS to formulate a visual to represent the data. Results of the project will be shared with the organization upon request. The data collection tool was the LGBT-DOCSS. A study

performed by Bidell (2017), showed that there is a strong internal validity when using this tool. Validity was tested by comparing relationships between scores on the LGBT-DOCSS with specific participant characteristics and with scores on established assessment scales. In that same study, reliability was assessed by using the LGBT-DOCSS two weeks later in the same group of participants. The results stayed the same as the first time the participants took the LGBT-DOCSS.

Summary

The project involved the implementation of a staff education presentation on culturally competent care with the LGBTQ community. LGBTQ patients require primary care providers and staff who can provide care that addresses their specific needs and disparities. Several disparities this population faces are a result of poor use of the health care. LGBTQ patients may feel that they may be discriminated against, or they may have had negative experiences in the past. The project was assessed by the LGBT-DOCSS questionnaire, which was given both before and after the staff education module. Quasi-experimental analysis was the method chosen to analyze the data of the scores. Sources of evidence were listed in this section. Methods to ensure protections of the human subjects were used throughout the project.

Findings from the staff education project was analyzed using SPSS. After the data was analyzed, strengths and limitations of the project were identified and addressed. A plan for dissemination will also be addressed to ensure that the project will be a positive contribution to social change and helpful to the nursing profession.

Section 4: Findings and Recommendations

Introduction

Identifying as LGBTQ member is a major hurdle when it comes to patient/provider relationships. Most members of this community feel providers and staff in the health care field are not up to date on caring for them without bias. This issue has been confirmed by multiple researchers and a link was made between provider competence and the availability and administration of education on LGBTQ cultural competence (Klein & Nakhai, 2016). The gap in practice was that most health care education organizations, employers, and clinical organizations have failed to offer adequate provider and staff education on culturally competent care for the LGBTQ community. Over half of all providers do not feel confident in their ability to provide culturally competent care to a LGBTQ patient (Beagan, et al., 2015). The practice focused question that this DNP project was designed to resolve was:

> Will providing education on culturally competent care of the LGBTQ patient increase provider and staff confidence in caring for this population in a rural community in the Southern United States?

The purpose of the doctoral project was to increase provider and staff confidence by educating providers in the target area on culturally competent care of the LGBTQ population.

To assess the confidence level of the participants, a pretest LGBT-DOCSS was administered by the expert panel. Next, a short PowerPoint presentation was delivered with case study questions to follow. Finally, a posttest LGBT-DOCSS was administered

and collected by the same expert panel. Each participant was assigned a number from 1-15 to use as an identifier. No names or other participant identifiers were used. The numbers were assigned to compare pre- and posttest scores for each participant. After all the screening tools were collected, the data was transferred to an Excel spreadsheet and then later analyzed using SPSS. A paired sample *t* test was used to analyze data to confirm the hypothesis that providers' scores relating to preparedness and confidence when caring for a LGBTQ patient would increase after the education presentation was completed.

Findings and Implications

A total of six offices responded to my request to have their providers and staff participate in the project's education module. Most offices had three participants each while one office had two participants and one office had one participant. There was a total of 15 ($N = 15$) participants. Of those 15, 40% (6 participants) were male and 60% (9) were female. Fifty-three-point three percent of participants were over the age of 25, the other 46.6% identified in the age range of 18-24. Of all the participants, only 2 (13.3%) identified as a member of the LGBTQ community. Scoring of the pretest resulted in the highest score being 61 points and the lowest being 39 points for a mean of 52.6. The posttest scores were much higher with the highest score being 95 points and the lowest being 84 points, resulting in a mean of 90.2. The greatest improvement in scores was an increase of 50 points. The 2-tailed *p*-value of 0.000 indicated that there was a significant difference in the two groups (pre- and posttest) and that the study was successful.

Unanticipated limitations related to the project included the small number of LGBTQ participants. I was initially hoping for a larger percentage. This limitation did not directly affect the findings of the study. In addition, the small sample size also served as a limitation. While the study showed that the education module was effective, a larger sample size would have made a larger impact.

Findings from the study implied that education on how to provide culturally competent care to the LGBTQ community is beneficial and increases provider and staff confidence to do so. On an individual level, most participants left feeling confident and prepared to care for an LGBTQ patient. Participants also felt as though their institution would benefit from the training and would be willing to adopt the education presentation to administer to current and future staff. If participants use the knowledge gained from the education module, the community may see a rise in health promotion, compliance, and wellness exams in the LGBTQ population in the target area,

As previously mentioned, social change is needed for the future of all populations. The LGBTQ community has a higher risk of health care disparities relating to the underuse of health care services. According to Alencar Albuquerque et al. (2016), providing staff an educational session on cultural competence will provide them with the skillset and knowledge to properly care for LGBTQ patients. The long-term effect of the study will ensure that participants feel prepared and confident to take care of an LGBTQ patient to the best of their ability. As a result, improvement of health promotion in the LGBTQ community will follow.

Recommendations

Education presentation, materials, and modules on culturally competent LGBTQ care can benefit providers and staff by increasing knowledge and confidence when caring for the target population. Ideally, institutions and employers will adopt the educational module or come up with something similar to ensure that all employees receive adequate education. A screening tool such as the LGBT-DOCSS (Appendix: A) can be used in the initial hire packet and repeated after education has been completed. A low score in both the pre-and post-LGBT-DOCSS could be a trigger for further education or may be indicative of a bias.

The educational information could be printed and provided to staff upon initial hire or during yearly competence training, A direct link to the educational PowerPoint would also be beneficial. The information can be updated as evidence-based practice continues to evolve.

Contribution of the Doctoral Project Team

The process of working with the expert panel was fairly effortless. The expert panel was composed of a collaborating physician with whom I have been collaborating for the past couple of years. The expert panel took the role of administering the LGBT-DOCSS and assisting in analyzing data. The expert panel's input was also taken into consideration when planning and relaying the educational content.

After analyzing data and seeing that the education was successful, recommendations for further dissemination were discussed. The expert panel member plans to adopt the DNP project education module into her practice. With the expert

panel's status in the community, the plan is to extend the educational material to other clinics in the area and encourage each clinic to use the material.

Strengths and Limitations of the Project

One strength of the DNP project has been the collaboration of multiple disciplines to increase the knowledge and confidence to provide culturally competent care to the LGBTQ patient. The educational material proved to be beneficial in preparing and educating providers on the best quality of patient care for the LGBTQ community. Additionally, the screening method was easy to use and can be used outside of the DNP project by employers.

A limitation of the project was the small sample size along with the small geographic area. With a sample size of 15 participants, success was clear. The evidence would hold more weight if the same results were found in a larger sample size in multiple geographic areas.

Future studies should be expanded to include all staff upon hire or during yearly competencies. Other topics that can be explored using LGBTQ culturally competent education materials include a patient satisfaction survey. This type of study can be triggered by patient data identifying the patient as a member of the LGBTQ community. If the patient reports that the provider and staff has provided culturally competent care, there is evidence that the education has a positive outcome.

Section 5: Dissemination Plan

To improve the quality of patient care provided to the LGBTQ community, it is essential to give providers and staff the education, knowledge, and tools to succeed. To date, there are few educational institutions and organizations that incorporate LGBTQ cultural competence training to students and employees. To disseminate the work to institutions, participants recorded the education module and printouts were provided. I plan to keep a recording of the project for future use by clinics. As unique as the LGTQ population is, education on how to provide culturally competent care to those patients will be beneficial for many years to come. With an increase in LGBTQ rights, the known population continues to grow. Increased knowledge of LGBTQ disparities and health care is an integral step in the improvement of health promotion with this population. Additionally, health care professionals will be better prepared to provide quality, evidenced-based, culturally competent care to LGBTQ patients.

Organizations such as hospitals, clinics, schools, social services, and mental health institutions would all be appropriate to use this project. More audiences than just health care professionals can benefit from education on culturally competent care in the LGBTQ community. Even retail stores can use the education as they come in contact with the LGBTQ population frequently.

Analysis of Self

As a Practitioner

A personal goal of mine has always been to be an advocate for the LGBTQ community. Identifying as a lesbian, I have seen firsthand the bias toward the poor

patient care provided to the LGBTQ community. As a nurse for the past 10 years, I did not always feel that our opinions toward patient care were appreciated and felt that once I obtained my master's degrees, would have a platform to improve the quality of patient care provided to the LGBTQ patient. After obtaining my master's in nursing and becoming a nurse practitioner six years ago, I was able to pinpoint a cause in the poor quality of patient care in the LGBTQ community. What I realized was that I had not been properly educated on how to care for this population, my own population. Education on culturally competent care is either lacking or nonexistent in most organizations. During the development of this project, I became more aware of the perception of patient care in this population from other provider and staff views. It was not that they did not want to provide quality patient care, it was that they really were not knowledgeable enough to be confident in their ability to provide culturally competent patient care to the LGBTQ population. I have grown to understand that there is not a one size fits all solution when it comes to educational materials. I also learned a great deal about and plan to improve the quality of patient care that I personally provide to the LGBTQ community.

As a Scholar

This project helped me to develop the skills to perform an in-depth literature review. The project has also helped me learn which resources are credible. I have also gained hands-on experience in the development of educational materials and presentations, and I am better equipped to present information in a clear and precise way. The project has given me the skillset I need to tackle gaps in practice and utilize evidenced-based research to formulate a plan.

As a Project Manager

As the project manager of the DNP project, I was responsible for the coordination and efficiency of the project able to develop a detailed project plan despite some obstacles, was able to successfully follow the plan. I recommended a solution and evaluation method relating to assessing the importance of education on culturally competent care for the LGBTQ community. As I monitored the project from start to finish and delegated tasks to the expert panel member found that the experience prepared me for future issues in health care. Now I am better prepared to perform quality research and carry out solutions to other gaps in practice.

Throughout the scholarly journey, my communication skills and confidence have greatly improved. I once felt as though my opinions would not amount to much in the eyes of other providers, particularly physicians or nursing veterans with more experience. After completing this journey, I have come to realize that it is not about a title or how many years' experience a person may have, but instead, more about the time and effort put into the solution and the credibility of the research and literature used. With the assistance of the expert panel member I was able to efficaciously complete this DNP project and provide participants with quality education that can be used for years to come.

Summary

The purpose of this project was to assess the effectiveness of an educational module on culturally competent care of the LGBTQ patient utilizing scores form a pre- and posttest screening tool. Improved scores after the education module was complete

demonstrated this project's effectiveness in providing cultural competence education to health professionals. LGBTQ cultural competence is not often discussed in education and employment settings. The evidence from this study shows that health professionals will benefit from education on how to provide culturally competent care to the LGBTQ community. As a result, an increase in health promotion with the LGBTQ population will likely follow.

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Appendix A: LGBT-Development of Clinical Skills Scale

Instructions: Items on this scale are intended to examine clinical preparedness, attitudes, and basic knowledge regarding lesbian, gay, bisexual, and transgender (LGBT) clients/patients. Please use the provided scale to rate your level of agreement or disagreement for each item. Please note, items on this scale primarily inquire about either sexual orientation (LGB = lesbian, gay, and bisexual) or gender identity (transgender). Two questions are inclusive and refer collectively to lesbian, gay, bisexual, and transgender (LGBT) clients/patients.

1. I am aware of institutional barriers that may inhibit transgender people from using health care services.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

2. I am aware of institutional barriers that may inhibit LGB people from using health services.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

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3. I think being transgender is a mental disorder.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

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4. I would feel unprepared talking with a LGBT client/patient about issues related to their sexual orientation or gender identity.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

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5. A same sex relationship between two men or two women is not as strong and committed as one between a man and a woman.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

6. I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

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7. LGB individuals must be discreet about their sexual orientation around children.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

8. I am aware of research indicating that transgender individuals experience disproportionate levels of health and mental health problems compared to cisgender individuals.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

9. When it comes to transgender individuals, I believe they are morally deviant.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

10. I have received adequate clinical training and supervision to work with transgender clients/patients.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

11. I have received adequate clinical training and supervision to work with lesbian, gay, and bisexual (LGB) clients/patients

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

12. The lifestyle of a LGB individual is unnatural or immoral.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

13. I have experience working with LGB clients/patients.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

14. I feel competent to assess a person who is LGB in a therapeutic setting.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

15. I feel competent to assess a person who is transgender in a therapeutic setting.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

16. I have experience working with transgender clients/patients.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

17. People who dress opposite to their biological sex have a perversion.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

18. I would be morally uncomfortable working with a LGBT client/patient.

Strongly Disagree Somewhat Agree/Disagree Strongly Agree

1 234 567

Scoring Instruction for the LGBT-DOCSS

1) Reverse score all 8 questions in parentheses: (3), (4), (5), (7), (9), (12), (17), and (18). Use the reverse scoring Likert scale (1 = 7, 2 = 6, 3 = 5, 4 = 4, 5 = 3, 6 = 2, 7 = 1).

2) Calculate total LGBT-DOCSS mean score: Add all test items (using the reverse score for items in parentheses) and divide by 18.

The total LGBT-DOCSS mean score is equal to: 1 + 2 + (3) + (4) + (5) + 6 + (7) + 8 + (9) + 10 + 11 + (12) + 13 + 14 + 15 + 16 + (17) + (18) = LGBT-DOCSS Total Raw Score. Divide by 18 to obtain mean score.

3) Calculate Subscale scores: For each subscale, add up the scores of the questions listed (using the reverse score for items in parentheses) and divide by the number of questions in each subscale.

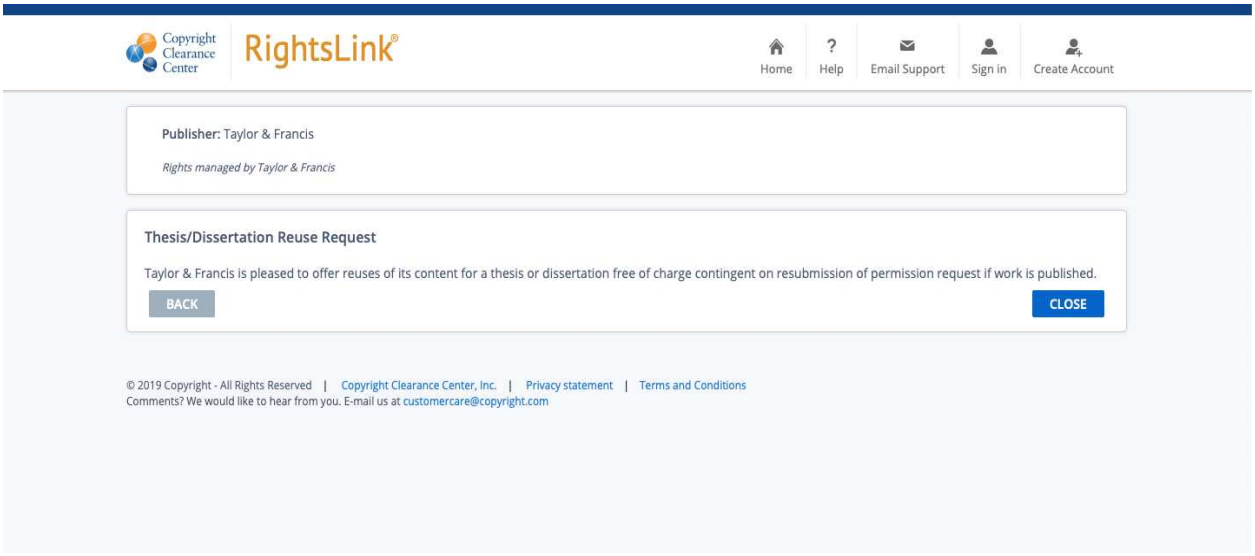
Clinical Preparedness subscale: (4) + 10 + 11 + 13 + 14 + 15 + 16 = LGBT-DOCSS Clinical Preparedness Subscale Total Raw Score. Divide by 7 to obtain mean score.

Attitudes subscale: (3) + (5) + (7) + (9) + (12) + (17) + (18) = LGBT-DOCSS Attitudes Subscale Total Raw Score. Divide by 7 to obtain mean score.

Knowledge: 1 + 2 + 6 + 8 = LGBT-DOCSS Knowledge Subscale Total Raw Score. Divide by 4 to obtain mean score.

4) Higher scores are indicative of higher levels of clinical preparedness and rudimentary knowledge and less prejudicial attitudinal awareness regarding LGBT clients/patients. Scoring instructions are not initially provided to potential respondents and typically not provided to research participants.

Appendix B: Permission to Use and Reprint LGBT-Development of Clinical Skills Scale



To ensure this was the correct permission to use on 3/31/2020 I contacted ProQuest, Copyright.gov, and RightsLink via phone.

Appendix C: Tables

Table C1

Demographic Characteristics

Variable	Parameter	Distribution
Sex (as identified by participant)	Male Female	40% 60%
Sexual Orientation	Heterosexual LGBTQ	86.7% 13.3%
Age	18-24 24 and up	46.6% 53.3%

Note. $N = 15$.

Table C2

Comparison of Scores

Participant	Pretest	Posttest	Difference +/-
1	59	91	+32
2	63	88	+25
3	46	90	+44
4	58	92	+34
5	39	84	+45
6	44	91	+47
7	46	88	+42
8	56	87	+31
9	59	93	+34
10	60	91	+31
11	61	94	+33
12	41	91	+50
13	46	88	+42
14	52	90	+38
15	59	95	+36