Improving Provider Confidence and Partnership With LGBT Patients Through Inclusivity and Education

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IMPROVING PROVIDER CONFIDENCE AND PARTNERSHIP WITH LGBT PATIENTS
THROUGH INCLUSIVITY AND EDUCATION

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A DNP project submitted in partial fulfillment of
Requirements for the degree of

Doctor of Nursing Practice

Seattle University

Spring, 2020

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Date: Jun 5, 2020
Abstract

The focus of this project utilizes patient recommendations for LGBT-inclusive intake practices to increase provider confidence in communication with LGBT patients using pre-and post-survey data comparing provider confidence before and after a 20-minute video education session. LGBT-inclusive provider education has been shown to be deficient if not nonexistent in most educational settings, yet, LGBT individuals have increased risk of negative health disparities, violence, and discrimination. Research examining the ability for small changes in provider education to enable positive health outcomes for this vulnerable and marginalized population is imperative for the quality of life of these communities. A quasi-experimental design utilized pre- and post-surveys to gather data on provider confidence before and after a recorded, LGBT-inclusive education session. Statistically significant increases in provider confidence were seen for 70% of the instrument items. This project highlights both the lack of LGBT-inclusive provider practice as well as LGBT patients’ awareness of the lack of provider education through their own experiences. Results in this project show that minimal changes to provider education can be made to increase the inclusivity of graduating providers practice and ultimately improve the quality of life for LGBT individuals.

*Keywords*: provider education, LGBT, inclusive
This DNP project aims to address crisis levels of unequal access to competent, inclusive and informed healthcare that the lesbian, gay bisexual, transgender, queer, plus (LGBTQ+ to be represented by LGBT) community faces in the clinical setting. The overwhelming prevalence of experienced and perceived discrimination, and fear of further discrimination in the healthcare field is perpetuated and magnified by ingrained and unexamined biases of educational institutions, creating healthcare providers (HCPs) that lack formal education focused on the specific healthcare needs of the vulnerable LGBT population.

The estimated 12 million LGBT Americans (Carabez et al., 2015) are a part of society that until the 1970s, considered their very existence a mental health problem. This community is further broken down into 8 million LGBT Americans who have experienced discrimination while seeking medical treatment from HCPs and institutions. Fifty six percent of LGBT individuals cite the absence of proper gender designation on intake forms or simple, blatant refusal to provide specific and necessary health services as experienced discriminatory acts (UCLA Williams Institute, 2016).

LGBT individuals are more likely than heterosexuals to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities (Lick et al., 2013). Gay and bisexual men (men who have sex with other men) represent only 2% of the U.S. population, but account for 61% of those living with Human Immunodeficiency Virus (HIV) and 70% of new HIV infections in the U.S (CDC, 2016). The rate of HIV is also disproportionately high among transgender women who constitute 0.6% of the U.S. population, but at a 22% prevalence within this community (Baral et al., 2013). LGBT communities are at risk for mental health conditions with researchers finding that there is a two and a half times increase in depression, anxiety and substance misuse (Lick et al., 2013).
Two thirds of LGBT adults have experienced some form of sexual orientation or gender identity discrimination including slurs, rejection by friends or family, receiving poor service at a place of business or being treated unfairly by an employer or being made to feel unwelcome in a place of worship and a full 30% have experienced physical threats or attacks (Pew Research Center, 2013). Rates of sexual violence are also higher amongst LGBT groups. 46% of bisexual women have been raped, compared to 17% of heterosexual and 13% of lesbian women. Additionally, 75% of bisexual women have experienced sexual coercion or harassment. 61% of bisexual women have experienced intimate partner violence (IPV) compared to 44% of lesbian and 35% of heterosexual women (CDC, 2013).

Just 16% of LGBT patients choose to inform their health care provider (HCP) of their sexual orientation due to HCPs simply not asking (Haider et al., 2017). A study of both patients and HCPs in the Journal of the American Medical Association (JAMA) found that nearly 80% of HCPs surveyed believed that patients would refuse to disclose their sexual orientation, when in fact only 10% of patients from a randomized, national sample of lesbian, gay, bisexual and heterosexual subjects said they would refuse (Haider et al., 2017). In 2015, 80% of first year medical students expressed implicit bias against gay and lesbian people and 50% expressed explicit bias (Tortelli, 2016). Such attitudes are reinforced as students’ progress through medical school programs, with most medical schools dedicating a mere 5 hours to LGBT-specific healthcare training (Chen, 2011).

Addressing the health inequalities faced by the LGBT community through increasing the inclusivity of the healthcare setting via improvement in HCP education, has the long-term opportunity to increase quality of life and decrease loss of productivity, disability and healthcare costs for this marginalized and vulnerable population. Badgett (2014) discusses health as a form
of human capital with critical implications for economic outcomes illuminating the link between exclusion, health and economic productivity. “Minority stress” as discussed by Mereish et al. (2014) focuses on the psychological impact of the LGBT community’s underprivileged and marginalized position in society on both macro (legal and economic situations) or micro (micro-aggressions and stigma experienced in everyday life). Through the marginalization of the LGBT community, we see clear disparities in almost all sections of everyday life from increased rates of poverty and violence to HIV transmission and unemployment (Kates et al., 2015).

Gaps in practice that contribute to poor LGBT health outcomes involve LGBT-exclusive systemic and interpersonal healthcare environments, lack of cultural and communicative competency in healthcare teams and deficits in LGBT-inclusive HCP education. The inclusivity of these aspects of both direct and indirect patient care has been endorsed by the Gay and Lesbian Medical Association (GLMA) with the intention of reducing health disparities and the sequelae that follow discrimination, stigma and poor health.

The clinical question this project intends to answer is: can patient recommendations for LGBT-inclusive intake practices increase HCP confidence in communication with LGBT patients using pre and post survey data comparing HCP confidence before and after a 20-minute video education session?

**Purpose of the Project**

The 3 aims of this project focus on understanding the current scope of inclusivity as seen in intake forms, revealing LGBT experiences in the healthcare setting and determining if simple educational improvements for providers can impact LGBT inclusivity in healthcare.
Aim I: Understand the current local level of inclusivity in intake processes as shown in publicly available patient intake forms. The literature suggests the utilization of LGBT-inclusive intake forms as a tool for building patient trust in the healthcare setting and for improving the healthcare environment to increase LGBT access of care. Phase I in this study was an informal, inclusivity analysis of intake forms sourced on the internet. Seven healthcare group intake forms from the Seattle area loosely representing intake forms from throughout the U.S. were informally analyzed for inclusivity in a quantitative manner in Spring 2019. This analysis found that 2 of 7 asked for a patient’s pronouns or gender identity, 5 of 7 had only “M/F” sex markers (which might be further conflated with gender identity), 1 of 7 asked sexual orientation and 4 of 7 asked for a preferred name.

Aim II: Understand both LGBT/ non-LGBT patient experiences and HCP interactions within the healthcare setting. Literature shows that LGBT patients are dissatisfied with current, general levels of inclusivity in the healthcare setting. Phase II (Intake Form Survey) focused on asking community members about their interactions with intake forms, their feelings about how inclusive they are and what people would and would not like to be asked on their intake forms or by their HCPs.

Aim III: Determine if additional HCP education creates a change in LGBT sexual healthcare confidence that is statistically significant. As we have seen in the work of Henry (2017), additional LGBT-inclusive education has had positive patient outcomes. Phase III (Education Session Survey) is the main study in this project as its success will be evaluated. Phase III (Education Session Survey) aims to determine if a 20-minute LGBT-inclusive education session increases HCP confidence in providing this care. A self-efficacy scale (SES) will be utilized to analyze any change in confidence between pre and post survey data.
Background and Significance

The Office for Disease Prevention and Health Promotion listed the improvement of the health, safety, and well-being of LGBT individuals as a Healthy People 2020 goal (Lesbian, Gay Bisexual & Transgender Health, 2017). There is a wealth of research which shows that this group faces disproportionate health disparities linked to social stigma, discrimination and denial of their civil and human rights associated with high rates of chronic conditions, psychiatric disorders, substance abuse, interpersonal and sexual violence and suicide. The reduction of health disparities for this population would include reductions in disease transmission and progression, increased physical and mental well-being, reduced healthcare costs as well as an increase in quality of life. Healthy People 2020 supports appropriately inquiring about and being supportive of a patient’s sexual orientation and gender identity to enhance the patient-provider interaction and regular use of care.

The importance of improving care for the LGBT population has been declared on a national level with US hospitals urged to create a more welcoming, safe and inclusive environment that promotes improved health care quality for LGBT patients and their families (Joint Commission, 2011). The Health Care Equality Index (HEI), created in 2007 by Human Rights Campaign is the national LGBT benchmarking tool that evaluating 1,600 healthcare facilities’ policies and practices related to the equity and inclusion of their LGBT patients, visitors and employees. The purpose is to ensure that LGBT Americans receive equitable, knowledgeable, sensitive, and welcoming health care, free from discrimination (Human Rights Campaign, 2014).
Literature Review

The 3 main themes that emerged from the literature focusing on LGBT health disparities were systemic and interpersonal environment, cultural competency, and the need for improved HCP education on LGBT health issues.

Systemic and Interpersonal Environment

Many health care spaces are oriented towards heteronormative patients, allowing them to feel at ease and comfortable in the environment but excluding LGBT individuals. This includes the physical environment as well as interactions with organizational systems and patient interactions with HCPs (Bolderson & Ralph, 2016). Multiple authors agree that the creation of a welcoming patient environment is a key step in decreasing barriers for LGBT individuals accessing care (Wilkerson et al., 2011; Kane-Lee & Bayer, 2012; Bolderson & Ralph, 2016; Carabez et al., 2015). This environment includes both systemic and interpersonal aspects including clinical mission statements and policies, HCP training needs, intake forms, verbal and nonverbal communication from staff members, resources offered to patients and the specific health issues addressed in the patient visit (Wilkerson, Rybicki, Barber & Smolenski, 2011; Kane-Lee & Bayer, 2012). These systemic and interpersonal factors all contribute to an environment that fosters trust and allows for honest discussion between patient and HCP that is crucial not only for competent care of this population but also to encourage future preventative and well visits.

In most initial health care encounters, there is an information gathering phase that includes form-filling often accompanied by an intake interview. Information on sexual orientation and trans status, alternative gender options, preferred name and pronouns, inclusive relationship status and partner gender/sex, sex assigned at birth and gender identity can be
gathered allowing for greater understanding of a patient’s health needs (Bolderson & Ralph, 2016; Carabez et al., 2015). Assumptions of heteronormativity can harm the provider-patient relationship and lead to decreased trust followed by the refusal of the patient to access health services from that HCP (and potentially others) in the future (Colpitts & Gahagan, 2016; Fish & Bewley, 2010). All staff in a healthcare setting from reception to medical assistants and nurses to HCPs must understand the importance of the addition of these identifiers for patient intake. Appropriate staff education needs to be addressed (HCP education will be more deeply discussed later in this paper) as well as electronic health record (EHR) adjustments to allow for the collection of this information into the patient’s chart as suggested by the Institute of Medicine in 2011 (Kane-Lee & Bayer, 2017).

Quinn et al. (2015) addressed healthcare barriers to LGBT patients including fear of disclosing sexual orientation or gender, due to perceived discrimination, lack of health care professional knowledge and/or negative views of LGBTQ persons, and lack of sufficient access to culturally sensitive health care resources and referrals. Inclusive language in intake procedures allows for comfort when self-disclosing sexual orientation or gender identity with the majority of gay men, lesbian women, and bisexual men and women reportedly looking for “significant other or domestic partner” on medical intake forms with 70% stating that the setting was then viewed as more inclusive (Quinn et al., 2015).

**Evolution from Competence to Safety**

In 2011 the Institute of Medicine released a report that recognized the lack of LGBT cultural competency as significant barrier to LGBT access to healthcare (Kane-Lee and Bayer, 2012). Rossi and Lopez (2017) define competence as multidimensional and fluid, covering a broad range of areas in which a person must be proficient in order to be identified as having
competence. Cultural competency in health care is the application of cultural knowledge and skills to meet the patients' health and social needs (Bolderson & Ralph, 2017). As such, authors argue for a shift in the definition of competent, from someone who is simply ready to practice to a qualified measure of someone’s ability within a certain context. Changing language to be inclusive of LGBT populations allows for communicative competency further breaking down barriers to healthcare access. Using the phrase “sexual orientation” rather than “sexual preference”, lesbian and gay male instead of “homosexual” and differentiation between sex and gender allows for culturally sensitive interviewing of sexual minorities (Rossi & Lopez, 2017). Rossman et al. (2017) show how microaggressions (both verbal and nonverbal) from HCPs after patient disclosure of sexuality are evidence for the argument of communicative competency with LGBT patients. One of Rossman et al. participants reported that their HCP stated, “Oh my god do you know you should get a HIV TEST [sic] its very good for you people.” (p. 8). Other participants reported HCPs assumption of heteronormativity and were then “surprised or did not believe the participant” (Rossman et al., 2017, p. 9) following LGBT disclosure. Non-verbal communicative competence is just as important, with participants reporting “bad looks of disapproval” or a “look of disgust” following LGBT disclosure in the care setting (Rossman et al., 2017, p. 9).

Intake forms in their current state often reflect various values and send non-inclusive messages to LGBT patients through the use of terms such as “marital status” instead of “relationship status”, “husband/wife” instead of “spouse/partner”, or asking for information about a “mother/father” rather than “parent/legal guardian”. The Supreme Court ruled to legalize same-sex marriage in June 2015, yet many intake forms have yet to reflect this in their language.
automatically sending the message that same-sex relationships are not equal in the eyes of healthcare organizations.

Wilkerson et al. (2011) state that dramatic changes are not required to create an inclusive and culturally competent healthcare environment for LGBT patients, that a simple rainbow sticker on the door and inclusive language used by staff and on forms is enough to show LGBT patients that they are respected, safe and seen. Quinn et al. (2015) agree with discussing how a Human Rights Campaign sticker or Safe Space designation giving a non-verbal cue that LGBT patients will be respected in this healthcare setting. Kane-Lee and Bayer (2012) state that cultural competence includes HCPs demonstrating an understanding of how community norms influence patient behavior. LGBT contextual historical and social understanding is needed, for example, to see the connection between higher alcohol and substance use with some LGBT populations and gay bars and clubs being some of the only safe spaces available for LGBT socialization. LGBT-specific patient education materials as well as LGBT friendly directories are another way that healthcare settings can increase LGBT visibility and access while engaging in a culturally competent manner (Kane-Lee & Bayer, 2012).

If the health care needs of lesbian, gay and bisexual patients are often poorly addressed; those of trans patients can be seriously mismanaged (Bolderson & Ralph, 2017). As well as normal health care needs, trans patients may access the health care system to align their physical appearance with their internal gender identity using hormones and/or surgeries. Providing culturally competent care to these patients often presents challenges to HCPs who aren't familiar with transgender health issues. Trans patients gender identity must be respected but they may need screening related to their natal gender (e.g. pap screening for cervical cancer for trans men or prostate screening for the population they care for to promote a sense of comfort; inclusion and
familiarity. LGBT patients often express a preference for LGBT staff who they feel may understand their perspectives. Organizational efforts that promote non-heteronormative health care environments can provide benefits for both patients and staff members. For staff, having LGBT role models who are visibly out and comfortable in the workplace is of importance. Role models can signal to existing and new staff and students that the organization is a safe place to be out, and that the workplace values diversity (Bolderson & Ralph, 2017).

While cultural competency has been the standard for addressing diversity and inequality for minority groups since its creation by Terry Cross in 1988 (Kirmayer, 2012), more recent and progressive models such as Irihapeti Ramsden’s model of Cultural Safety (created in the 1980s and endorsed by the Ministry of Education in New Zealand in 1990) should be used to inform LGBT inclusive communication in healthcare. Cultural safety was originally developed to respond to Maori dissatisfaction with medical care, attempting to evolve past the concept of “cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care” (National Aboriginal Health Organization, 2008, p. 3). Cultural safety examines how cultural factors seriously impact the relationship between patients and HCPs and how these potential differences affect care. The aim of cultural safety is to mitigate negative effects of these differences on the patient’s cultural identity (Parisa et al., 2016). In an LGBT inclusive context, cultural safety is an alternative, viable and appropriate framework for addressing sexual minority communities in the healthcare setting (Kellett & Fitton, 2017).

Evolution from cultural competence to cultural safety as a framework for care would involve teaching HCPs to recognize and understand cultural, personal, and professional power dynamics and how these impact patient-provider relationships (Henderson et al., 2018).
Progressing Provider Education

Eliminating barriers to care requires a skilled, culturally competent, sensitive and welcoming HCP community, however, HCPs may lack training to respectfully care for LGBT patients. In a recent UK study, 72% of patient-facing staff had never received training on the health needs and inclusive language and practices for the LGBT community. Most LGBT patients don't expect their HCPs to be experts on sexual orientation and gender identity, but they do expect to be treated with dignity, sensitivity and respect (Bolderson & Ralph, 2016).

Awareness training should start at the undergraduate level where LGBT health issues and culture should be included in HCP curricula. Assessment of medical schools revealed a median of only about 5 hours of LGBT-focused education over the course of the curriculum (Obedin-Maliver, 2011). A 2014 report from the Association of American Medical Colleges recommended strategies for change in medical institutions to improve care for LGBT patients that included a full curriculum revision, the addition of an elective LGBT health study or the addition of a required class (Hollenbach, Eckstrand & Dreger, 2014). Threading LGBT education and increasing visibility throughout medical school curriculae could also involve (for example) using case studies of LGBT people where the sexual orientation or gender identity of the patient is linked to the case study itself, or just incidental. LGBT standardized patients could also feature in communications skills training e.g. in objective structured clinical examinations.

Training and education should also continue during clinical practice with continuing professional development (Bolderson & Ralph, 2017).

Utamsingh et al. (2017) reviewed LGBT healthcare training in 13 U.S. medical schools between 2000 and 2016 via literature review and found that only eight programs included completely mandatory LGBT education components, two had some mandatory components and
3 were elective. Seven programs involved real or standardized patient, shadowing experience or a patient panel allowing for actual contact with LGBT patients. LGBT educational components were between 1-2 hours in length or included 1-2 lectures. Ten programs focused on LGBT health while only 3 focused specifically on trans health at all. These statistics show the potential glaring holes in LGBT-focused HCP education and appear to show that while LGBT health is identified as a national health focus, an LGBT-focus is not a strong component of HCP education. Kane-Lee and Bayer (2012) echo this by stating that policy changes are not enough to provide LGBT patients the care that they need but that HCPs must seek continuing education opportunities due to the lack of official LGBT education they receive to learn more about LGBT health disparities and how to provide care for these populations.

Nurse Practitioners (NPs) are as unlikely as physicians to receive adequate LGBT-inclusive health education. In a 2018 study by Manzer et al. focused on NP experiences of providing care to LGBT patients, 91% of their NP participants reported not remembering receiving any LGBT-specific content in their education program. Additionally, respondents noted that if there was LGBT-focused content it was only a few minutes to a few hours (Manzer et al., 2018). Paradiso and Lally (2018) echo Manzer et al., (2018) with a focus on transgender-focused NP education stating that there is no curriculum requirement to include transgender health nor to address transgender issues as diversity in general. Generally, nursing (both Registered Nurse and NP) education programs have yet to include transgender issues into their curriculum at all and when they are addressed, about 2 hours is spent on the topic (Paradiso & Lally, 2018). These authors state that in 2018, there was only one published article on the topic of LGBT content integration into an NP program and that there were no published studies on the
beliefs, educational needs or attitudes of NPs when providing transgender care to patients (Paradiso & Lally, 2018).

Lack of appropriate HCP education can directly affect the rate of access of care of certain LGBT groups. Lesbians are one of the groups with the lowest preventative care access with more than 75% of lesbian women not accessing necessary preventative care. Multiple factors enter this equation including the requirement of a pregnancy test by medical institutions and blanket questioning about birth control method during intake, particularly after disclosing their sexual orientation. These culturally inappropriate actions can feel like “a slap in the face” or can be taken as an indication the HCP isn’t listening to the patient or is collecting information without tailoring care to the patient’s needs (Quinn et al., 2015).

Carabez et al. (2015) found four themes in their interview responses from 268 nurses when asked about gender inclusive forms to assess the current state of LGBT-sensitive nursing practice. Theme one was related to answers that indicated participants did not understand the question being asked (85% of respondents), with many of the respondents appeared to have no idea what the question meant. Beyond merely not knowing whether their agencies had the forms; their answers indicated that they had no idea what gender inclusive meant. The second theme was characterized by confusion (44% of respondents). These nurses confused sex with gender identity while other respondents confused gender identity with sexual orientation and thought that gender inclusive meant asking about a patient’s sexual identity. The third theme represented nonverbal discomfort (exhibited by 8% of respondents). These respondents laughed at the question or provided other non-verbal responses such as rolling eyes or deep sighs. Some gave rambling, incoherent verbal responses that reinforced their nonverbal discomfort with the topic. Finally, the fourth theme was related to a belief in the lack of relevance of gender inclusive
forms (4% of respondents). These respondents indicated that their agencies did not have gender inclusive forms because “why would we ask that question, it doesn’t matter”. Some respondents indicated that they did not know if the agency had the question because it had never occurred to them to look for such questions implying that consideration of gender beyond male and female was irrelevant to their nursing practice (Carabez et al., 2015).

Similarly, Rossman et al. (2017) describe patient experiences where HCPs demonstrated a lack of understanding about LGBT issues and patients with nurses confused about patient sexual orientation and HCPs not knowing how to properly treat a trans patient. In 2014, Lim et al. identified 17 studies that found nurses had at least some aspects of negative attitudes toward LGBT population. Additionally, in 2009 a study by Rondahl found that 90% of studied nursing students were unable to correctly identify and discuss LGBT terms and concepts.

Henry (2017) studied the measured variables of 1) LGBT-inclusive HCP knowledge, attitude, and behavior and 2) LGBT self-disclosure to the HCP across an educational intervention with both measures increasing post intervention. It was found that HCPs had a 16% increase in knowledge, 1.24% increase in skills, 22% increase in attitudes, and a 63% increase in LGBT disclosure between pre and post measurements (Henry, 2017). Recommendations of formal training for staff on LGBT-related care and specific policies on nondiscrimination of LGBT patients and families (organizational leadership improvements), meaningful dissemination of findings from evidence-based practice and research for quick and positive impacts on nursing and patient outcomes (clinical scholarship evolution) and inclusive improvements to EHRs (information systems and technology progression) all equate to increased LGBT-visualization and inclusion, improving health outcomes for these communities.
LGBT input should be gathered to discern the lived experience of exclusive practices when accessing healthcare with a focus on what aspects should be improved to decrease healthcare disparities for this population. Initial, informal analysis of six Seattle based healthcare organization’s intake paperwork by this primary investigator show that 2/3 of sampled registration paperwork is not LGBT inclusive despite almost a decade of research and suggested improvements. Without inclusive intake practices in patient facing intake documents, it can be suggested that perhaps care teams are also practicing in LGBT-exclusive ways. The addition of inclusive discussion surrounding sexual orientation, gender identity, preferred name, abuse, trauma, pronouns, sex assigned at birth and relationship status and sex/ gender identity of partner have all been repeatedly suggested and highlighted as a systemically minimally invasive yet highly beneficial and effective inclusivity practice for LGBT patients.

Local research on the current condition of LGBT-inclusive HCP education and those HCP’s confidence in caring for LGBT patients in a culturally safe way would allow for greater understanding of present barriers to care that the LGBT community faces.

**Conceptual Framework**

The seminal work on cultural safety, by Irihapeti Ramsden, originated in the 1980s when nurses began to identify the need to address Maori health disparities through nursing and midwifery education and biculturalism in New Zealand. These cultural safety standards were named “Kawa Whakaruruhau” directly translating from Maori to English as “cultural safety”. These standards were implemented as requirements in nursing and midwifery state examinations by the Nursing Council of New Zealand in 1991 (Papps & Ramsden, 1996).

Ramsden defines “culture” as a particular way of living in the world, attitudes, behaviors, links and relationships with others, with culture not seen as ethno-specific, but including groups
within cultures (class, socialization, sexual orientation, age etc.) (Nursing Council of New Zealand, 1992). Ramsden additionally defines “safety” as “nursing or midwifery action to protect from danger and/or reduce risk to patient [client] community from hazards to health and wellbeing. It includes regard for the physical, mental, social, spiritual and cultural components of the patient/client and the environment" (Nursing Council of New Zealand, 1995). Unsafe practice is then defined as "any action or omission which endangers the wellbeing, demeans the person or disempowers the cultural identity of the patient/ client" (Nursing Council of New Zealand, 1995).

Education regarding cultural safety focuses on challenging learners to recognize other experiences of life and accompanying world views. When discussing “when one group far outweighs another, or has the power to impose its own norms and values upon another, a state of serious imbalance which threatens the identity, security and the ease of other cultural groups, thus creating a state of disease” (Nursing Council of New Zealand, 1992). Cultural safety intends for learners to 1) examine their own realities and attitudes they bring to each person they encounter in practice, 2) to be openminded and flexible in their attitudes towards those who are different from themselves, 3) not to blame the victims of historical and social processes for their current circumstances, 4) to produce a workforce of well-educated and self-aware nurses and midwives who are culturally safe to practice (Nursing Council of New Zealand, 1992).

Support for the use of the framework of cultural safety to be used in the education of all healthcare team members (not just nurses and midwives as originally discussed by Papps & Ramsden (1996) as a tool for LGBT-inclusivity is well established (Kellett & Fitton, 2017). Kellett & Fitton (2017) declare that most medical education programs deserve a failing grade with respect to supporting gender diversity and engaging in the safe and supportive care of
LGBT patients. When cultural safety is contextualized within today’s understanding of LGBT health disparities, just as it was created to understand Maori health disparities, it is able to be presented as a framework to address gender diversity within HCP education (Kellett & Fitton, 2017).

Cultural competency and cultural safety were created during the same decade; however, their depth of application is different when implemented in healthcare. Cultural safety asks HCPs as well as health organizations and systems to evaluate taken for granted power structures and be ready to challenge their own culture and cultural systems rather than prioritizing becoming ‘competent’ in the culture of others (Curtis et al., 2019). This argument built on the Aboriginal Nurses Association of Canada’s similar critique of the limitations of cultural competence suggesting that it reduces culture into a set of skills for which practitioners can gain knowledge with a focus on learning rather than action (Hart-Wasekeesikaw & Gregory, 2009).

Authors Darroch et al. (2017) describe cultural safety as a concept that encompasses elements of cultural awareness, cultural sensitivity, and cultural competence. Further understanding these concepts allows for the differences between them to emerge. Cultural awareness is the basic acknowledgment of differences between cultures where cultural sensitivity builds on cultural awareness’ acknowledgment of difference with the addition of the requirement of respecting other cultures (Baba, 2013). Cultural competence fuses both cultural awareness and cultural sensitivity (Appendix A) to include the behaviors, attitudes, and policies that support effective work with diverse populations (Baba, 2013). Cultural competence differs from cultural awareness and sensitivity by evolving beyond recognizing the “cultural other” and encouraging HCPs and researchers to examine their own position, values, power, and culture. Evolving these concepts even further, cultural safety advances reflection of economic, social and
Ramsden’s original cultural safety framework places an emphasis on adequate education for nurses and midwives as a foundation for safe patient care. This project suggests that Ramsden’s framework can be extended to additionally include culturally safe HCP education and is the foundation for the intervention of this project. The focus of education in the cultural safety framework mirrors this project’s focus on the importance of education in HCPs being able to care for their LGBT patients in a culturally safe manner. A quasi-experimental design focuses on HCP confidence in delivering LGBT-inclusive patient care in a pre-survey, implements a culturally safe education session centered on LGBT-inclusivity, then measures change across the intervention with a post-survey.

**Methodology**

This project focuses on HCPs (specifically NPs) caring for LGBT patients and utilizes LGBT patient suggestions to educate HCPs on gender identity, sexual orientation and sexual health history taking. This is a quasi-experimental study design that utilizes quantitative and qualitative data throughout its three phases. It culminates in a statistical analysis of Phase III (Education Session Survey) intervention data showing whether or not the education session of HCPs was effective in improving their confidence in providing LGBT inclusive healthcare.

This study was reviewed by Seattle University’s Institutional Review Board and determined the study to be exempt from IRB review in accordance with federal regulation criteria on 12/12/19. Due to Covid-19 and the need to change this project from an in-person to online intervention, further permission was requested from Seattle University’s Institutional
Review Board and the remote, online format was approved and determined to remain exempt from further IRB review on 4/1/20. Informed consent was obtained from each participant.

**Phase II – the Intake Form Survey**

Phase II surveyed participants on their experiences within the healthcare system and their perceptions of HCPs. Demographic information such as age, gender identity, sexual orientation and pronouns were also collected. Pre- and post-survey data was collected comparing HCP confidence before and after an LGBT-inclusive education session with the aim to increase HCP confidence in communication with and caring for their LGBT patients.

Phase II, Intake Form Survey of this project was conducted 2/6/20 until 2/16/2020. This survey was administered online in an outward snowball design through SurveyMonkey and was answered by 58 participants (27 self-reported LGBT and 31 self-reported non-LGBT). These participants were recruited via social media (Facebook) and word of mouth with interested parties forwarding the survey link onto other possible participants. Demographic information was collected from participants along with qualitative and qualitative data to better understand relationships between individuals answers and their lived experiences. The Phase II, Intake Form Survey, data set the foundation for the need of HCPs to have improved LGBT-inclusive education and was the basis for the implementation of Phase III, the Education Session Survey.

**Phase III - Education Session Survey**

Phase III of this project was conducted in 2020 from April 6 to April 12. The original design for Phase III, the Education Session Survey, was a matched, deidentified pre- and post-survey of healthcare team members in attendance of an LGBT Health education session. A convenience sample of healthcare team members able to attend the LGBT Healthcare
presentation would include front and back office personnel, administrators, and HCPs from the Everett Clinic in Lake Stevens WA.

Due to the complications of Covid-19, the education session was converted to a remote experience consisting of an online SurveyMonkey pre-survey, recorded, narrated PowerPoint presentation focused on LGBT healthcare followed by the online post-survey. This intervention was disseminated to the Everett Clinic by the primary investigator through email to the Site Preceptor. Due to the acute need for HCPs to be caring for patients at the Everett Clinic setting, the intervention was also sent to a convenience sample of other HCPs in the community who had expressed interest in this project. Information from the recorded education session is summarized below.

*Recorded LGBT-Inclusive Education Session Content*

The recorded LGBT-inclusive education session was entitled “Increasing LGBT Inclusivity in Healthcare through Improving Provider Education”. It was a narrated PowerPoint that was uploaded to YouTube with a private hyperlink embedded in the SurveyMonkey pre- and post-survey, so it was easily navigated to by participants. The recording was 20 minutes and 18 seconds long. After a brief introduction, the recording described this project focus as “increasing LGBT inclusivity in healthcare through improving HCP education”.

*Background*

Initial Phase II - Intake Form Survey findings (n=58) were described for participants so they had community-sourced background and significance for this project. “Fifty percent of LGBT patients feel intake forms are not inclusive or representative of their lived experience”, “sequelae of exclusivity: 65% of LGBT patients reported that they would feel unsafe if not represented on intake forms and 50% of LGBT patients reported that they would choose not to
return to this setting”. “Sixty nine percent of LGBT people have felt discriminated against in a healthcare setting”, “LGBT patients have stated that they want to be asked about their pronouns, preferred name, gender identity and sexual orientation”. LGBT patients feel that HCPs don’t know how to address conversations around sex (58%), sexuality (69%), identity (31%) or abuse/trauma (46%) at greater rates than heteronormative patients (42%, 32%, 16% and 26% respectively). Additionally, LGBT patients report HCPs as nervous, uncomfortable, anxious or disinterested in discussing sex (50%), sexuality (58%), identity (31%) and abuse or trauma (38%) at almost double the rate of heteronormative patients (35%, 32%, 13% and 23% respectively).

Intake

It was then stated that this data shows that “providers are not doing a great job discussing sex, sexuality, identity, abuse or trauma with anyone, but especially with LGBT patients. It was then stated that “this is easy to change” and that “excellent intake practices make this easy to accomplish” and that “language choices are crucial for inclusive intake practices”. First, “know what anatomy your patient has present (crucial for inclusivity with gender nonconforming, nonbinary and trans patients). “Providers should be focused on risk factors based on anatomy and behaviors due to their relevance to preventative screenings, testing, treatment and professional recommendations.

Discussing Sex

Discussing inclusive questions such as: “are you having sex with anybody? (not are you sexually active?)”, “when was your last STI screen?”, “have you had any new partners since your last STI screen?”, “do you have a monogamous agreement with your partner or partners?”, “do you use barriers? (never, sometimes, always?)?”, “are you having vaginal, oral or anal sex?
(as applicable), “is that oral/anal sex insertive or receptive?”. Crafting questions for patients in ways that give direct information on risk factors is crucial.

**Discussing Sexuality**

Asking patients, “do your sexual partners have penises, vaginas or both?”, allows for further individualized discussion on STI screening and possible birth control needs without assumptions about a patient’s needs. It is also important to “be ready for uncommon answers” so that patient responses do not create nonverbal cues of judgement or microaggression.

**Discussing Identity**

“Ideally, patients should be asked their pronouns and preferred name at intake”. This ensures patients are not misgendered or called by the incorrect name, increasing the possibility of feelings of discrimination and being unwelcome. HCPs should be ready to share their own pronouns for all patients) not just gender nonbinary, nonconforming or trans patients. HCPs should additionally “ensure they are ready to talk about transitional paperwork and/or therapy” and if transitional therapy is not something HCPs feel comfortable providing due to inadequate education, HCPs should ensure they have appropriate resources and referrals ready for patients who request or show interest in this care.

**Discussing Abuse or Trauma**

Questions to understand risk, “do you feel safe in all your interpersonal relationships?”, “do you have a history of sex work, incarceration, IV drug use?”, “have you ever had sex/been involved in sex that was non-consensual?”. Phrasing questions so HCPs can assess a patients current and historical physical and sexual risk factors causally relates to being able to recommend specific testing and further screening.
Concluding the recording were notes on gender affirming hormone care (transitional hormonal therapy) and HIV Preventative Prophylaxis (PreP) and the importance of HCPs being ready with community resources if these are care areas that require further education and/or referral. Finally, the recording offered the advice of “when in doubt… it’s OK to apologize, be transparent and refer out”. As these practice recommendations are often lacking in HCP education, HCPs must be gracious with themselves while developing these language practices to become more inclusive in their patient care.

**Study Design**

Phase II: an outward snowball design allowed for anonymous survey responses where both demographic information such as age, sexual orientation and gender identity were collected along with survey responses. The demographic information of sexual orientation and gender identity were used to separate the participant data into heteronormative and LGBT groups to identify themes within each group’s responses.

Phase III: In this quasi-experimental study, pre- and post-survey data was collected from HCPs on their confidence in providing LGBT inclusive healthcare. These pre- and post-surveys were collected before and after a recorded narrated PowerPoint presentation entitled: Increasing LGBT Inclusivity in Healthcare through Improving Provider Education. The pre- and post-surveys were then analyzed to see if a statistically significant increase in HCP confidence in providing LGBT-inclusive healthcare was seen.

**Sample and Setting**

Phase II: A total of 58 participants completed the 29-item survey on SurveyMonkey which included 26 survey items and 3 demographic questions. Participants found this survey on social media and was shared in an outward snowball design through word of mouth and sharing
on social media. Twenty seven of the participants self-identified as LGBT or non-cisgendered while 31 participants identified as heteronormative and cisgendered. On average, participants spent 17 minutes completing the online survey on a laptop, computer or smartphone.

Phase III: Participants found the survey by word of mouth from Everett Clinic staff and by expressing interest in participation in the data collection of Phase II (Intake Form Survey). A total of 10 HCPs (4 Family Nurse Practitioners, 2 Adult Gerontology Nurse Practitioners, 3 Psychiatric Nurse Practitioners and 1 Certified Nurse Midwife) completed the pre and post survey. Three Registered Nurses also completed the surveys, but their data was not included in the analysis because they did not meet inclusion criteria of being an HCP. On average participants had 5 years and 3 months experience as HCPs. On average HCPs reported 1 hour and 45 minutes of LGBT focused education in their professional schooling with zero hours of continuing education focused on LGBT health since graduation. The average age of participants was almost 47 years old. Six participants reported being cisgender, heterosexual females, 3 reported being cisgendered, bisexual females, 1 was a cisgendered, lesbian and 1 was a cisgendered, heterosexual male.

The survey and education session were completed entirely on the internet via either phone, computer, laptop, or tablet. Participants completed the 10-item pre survey on SurveyMonkey then clicked on an embedded hyperlink to the recorded LGBT education session video on YouTube. Once the video was finished, participants were directed back to the 10-item SurveyMonkey post-survey where they were asked the exact same questions as the pre-survey.
Instruments

The instrument used in Phase III of this study include pre-post-survey and a self-efficacy scale measuring HCP confidence in providing LGBT-inclusive healthcare using a Self-Efficacy Scale (SES).

**Data Collection Procedure:**

The pre- and post-survey were developed by the primary investigator based on Phase II, Intake Form Survey and data. These were exact copies of each other so that matched data before and after the intervention (recorded education session) could be paired. The first item on the pre-survey included consent with participant survey continuation understood as an informed consent process. The average time respondents spent completing the entire intervention session was 39 minutes. The statements and questions included in the survey were as follows:

“This pre survey aims to gather information on your confidence in providing inclusive healthcare to LGBT patients *right now* before the education video.

Think about your confidence and comfort in discussing the following topics surrounding LGBT sexual health topics. You will rate your confidence in discussing these topics with your patients *right now*, before the education session and rate your confidence between 0-100.

0= no confidence at all in discussing this topic with your patient *right now* and 100= absolute confidence in discussing this topic with your patient *right now*.”

The 10-item pre survey was then started by the participant. They were asked to rate their confidence using the SES about:

- Collecting a thorough sexual history
- Discussing sexual partners
• Discussing sexual orientation

• Asking a patient’s pronouns

• Asking about barrier use

• Asking about sexual practices (vaginal, oral, anal receptive or insertive sex)

• Giving your own pronouns

• Inquiring about anatomy present (ovaries/ cervix/ uterus, penis/ prostate/ testes, breasts)

• Asking if a patient has experience with sexual abuse or violence

• Your ability to find out what STI screening is most appropriate for your patient

After watching the recorded education session on YouTube, participants were then asked the same 10-item post-survey.

**Measured Variables:**

Confidence was measured with a modified Self-Efficacy Scale (SES) (Banduras, 2006), a self-administered 10-item, 11-point instrument (scale from 0-100 in increments of 10, with 0 = no confidence at all and 100 = absolute confidence) developed to measure HCP confidence in their ability to provide LGBT-inclusive healthcare. The possible scores range from 0 to 100 per item; higher scores indicate higher levels of confidence. Reliability and construct validity of this modified SES have not been analyzed due to its modifications from any previous SES before it.

**Data Analysis:**

IBM SPSS Statistics Subscription Trial (Classic) was used to analyze data in this study. Pre and post scores for each item and participant were entered into SPSS. A paired t-test was used to analyze any statistically significant change between pre and post survey data.
Results

Phase II – Intake Form Survey Results

LGBT respondents were 62% “content” with the intake form last presented to them, compared to non-LGBT respondents at 81%. Ninety-six percent of LGBT respondents had considered that intake forms might not be inclusive of all people’s lived experience, compared to 84% of non-LGBT respondents. LGBT respondents reported a 50% rate of intake forms representing their own lived experience, compared to 84% of non-LGBT respondents. Both groups strongly agreed that there was a possible issue with being asked to circle “M/F” on an intake form. LGBT respondents said that it was appropriate to be asked pronouns (94%), preferred name (99%), gender identity (90%) and sexual orientation (72%) on intake forms.

Quantitative data collected from LGBT respondents continued to support the themes of intake exclusivity and developed the theme of HCP discomfort, anxiety, disinterest and lack of LGBT-inclusive education. When asked “if an intake form didn’t represent your own lived experience, how would that make you feel?”, one respondent answered “the intake process is the introduction to care and if it appears limited to “norms”, and didn’t fit me, I would wonder if I would get what I need from that setting. Safety is paramount to mental and physical health settings in my opinion”. When asked if LGBT-respondents have ever felt discriminated against in a healthcare setting, a respondent answered “yes, doctors and medical professionals that don’t have a clue about how to deal with transgender persons, I often have to educate them”. LGBT-respondents also said “many providers have made comments about my gender before knowing it. As soon as this happens, having any real conversation about difficult topics just seems insurmountable” and “some providers don’t know how to address sexual trauma or don’t know how to respond once I have brought it up”.
Hypothesis

The null hypothesis was that there will be no significant difference between the pre- and post-surveys of HCPs in their confidence in LGBT-inclusive healthcare before and after a recorded education session. The alternative hypothesis was that there will be a significant difference between pre- and post-surveys of HCPs in their confidence in LGBT-inclusive healthcare before and after a recorded education session.

Statistical Analysis

Pre- and post-survey answers from the 10-item SES completed by 10 participants (Appendix B) were entered into IBM SPSS Statistics Subscription Trial (Classic) to be analyzed in a paired t-test to measure statistical significance with 95% confidence interval.

Table 1

Paired T-Test Significance for HCP Confidence and SES Items:

<table>
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<tr>
<th>Question Pair</th>
<th>Sig. (2-tailed)</th>
<th>SES Items</th>
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<tbody>
<tr>
<td>Pre1 - Post1</td>
<td>0.002000</td>
<td>Collecting a thorough sexual history</td>
</tr>
<tr>
<td>Pre2 - Post2</td>
<td>0.002000</td>
<td>Discussing sexual partners</td>
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<tr>
<td>Pre3 - Post3</td>
<td>0.012000</td>
<td>Discussing sexual orientation</td>
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<tr>
<td>Pre4 - Post4</td>
<td>0.153000</td>
<td>Asking a patient's pronouns</td>
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<tr>
<td>Pre5 - Post5</td>
<td>0.058000</td>
<td>Asking about barrier use</td>
</tr>
<tr>
<td>Pre6 - Post6</td>
<td>0.015000</td>
<td>Asking about sexual practices (vaginal, oral, anal, insertive or receptive sex)</td>
</tr>
<tr>
<td>Pre7 - Post7</td>
<td>0.176000</td>
<td>Giving your own pronouns</td>
</tr>
<tr>
<td>Pre8 - Post8</td>
<td>0.014000</td>
<td>Inquiring about anatomy present (ovaries/ uterus/ cervix/ vagina, testes/prostate/penis, breasts)</td>
</tr>
<tr>
<td>Pre9 - Post9</td>
<td>0.014000</td>
<td>Asking if a patient has experience with sexual abuse or violence</td>
</tr>
<tr>
<td>Pre10 - Post10</td>
<td>0.044000</td>
<td>Your ability to find out what STI screening is most appropriate for your patient</td>
</tr>
</tbody>
</table>

Seven of the ten SES items (items 1-3, 6, 8-10) showed statistically significant increases in pre/post-survey confidence (Appendix B) after the recorded education session rejecting the null hypothesis for these items (2-tailed significance: 0.002 – 0.04). These items favor the alternative hypothesis (Table 1). Three of the ten SES items (items 4, 5 and 7) did not show statistically significant increase in pre/post-survey confidence (Appendix B) after the recorded education session.
These data show that the recorded education session showed a statistically significant increase in HCP confidence in the following SES items:

- Collecting a thorough sexual history
- Discussing sexual partners
- Discussing sexual orientation
- Asking about sexual practices (vaginal, oral, anal, insertive or receptive sex)
- Inquiring about anatomy present (ovaries/uterus/cervix/vagina, testes/prostate/penis, breasts)
- Asking if a patient has experience with sexual abuse or violence
- Your ability to find out what STI screening is more appropriate for your patient

The items that did not show a statistically significant increase in HCP confidence are the following items:

- Asking a patient’s pronouns
- Asking about barrier use
- Giving your own pronouns

**Changes in Participant Confidence**

Across the 10 participants, pre-survey confidence ranged from 44 points to 89.5 points (Appendix E) across the 10 items.

The lowest pre-survey confidence item was SES Item 6: “asking about sexual practices (vaginal, oral, anal, insertive or receptive sex)” averaging a confidence score of 55.5 points. The highest pre-survey confidence items were SES Items 4 and 7, “asking a patient’s pronouns” and
“giving your own pronouns”, averaging confidence scores of 84.4 and 86 respectively (Appendix E). The pre-survey confidence across all participants and items was 69.44 (Appendix D).

Across the 10 participants, post-survey confidence ranged from 81.5 points to 95.5 points across the 10 items (Appendix F).

The lowest post-survey confidence item was SES Item 6: “asking about sexual practices (vaginal, oral, anal, insertive or receptive sex)” averaging a confidence score of 86 points. The highest post-survey confidence items were SES items 4 and 7, “asking a patient’s pronouns” and “giving your own pronouns”, averaging confidence scores of 96.6 and 97.8 respectively (Appendix F). The post-survey confidence across all participants and items was 89.74 (Appendix F).

The average pre-survey confidence across all items was 69.44 (Appendix E). The average post-survey confidence across all items was 89.74 (Appendix F). This is an average increase in confidence of 20.3 points between the pre- and post-survey.

On average every participant increased in confidence between the pre- and post-survey. This average increase in confidence ranged from 4.5 to 48.5 (Appendix D). The average difference in confidence between pre- and post-surveys per item was between 11.8 and 31.5 points (Appendix D). The items that participants increased more than 25 points on average were “collecting a thorough sexual history” (average 25.5 points increase), “asking about sexual practices (vaginal, oral, anal, insertive or receptive sex)” (average 31.5 points increase) and “inquiring about anatomy present (ovaries/ uterus/ cervix/ vagina, testes/ prostate/ penis, breasts)” (average 25 points increase) (Appendix D). Individual participant results are summarized in Appendix D.
Quantitative Data

A final question for participants after the post-survey was completed was “how do you feel that this presentation will impact your healthcare practice with your LGBT patients?”. The themes from participants responses included acquiring tools for increased LGBT inclusivity, improved inclusive language, increased confidence as presenting as an LGBT ally, improved communication skills, deeper understanding of the importance of LGBT-inclusivity in healthcare and appreciation of practical examples that can directly be used in practice.

Discussion

The clinical question this project intended to answer is: can patient recommendations for LGBT-inclusive intake practices increase healthcare HCP confidence in communication with LGBT patients using pre and post survey data comparing HCP confidence before and after a 20-minute video education session?

The data analysis showed that the recorded education session was successful overall at increasing HCP confidence in providing LGBT-inclusive care for seven of the ten SES items. This project has shown that increased time spent on education on LGBT-inclusive healthcare topics allows for HCPs to deepen their knowledge, develop skills, and increase their confidence in delivering inclusive healthcare to this vulnerable population.

This education session was pared down to just 20 minutes due to the health crisis caused by Covid-19 and the emphasis on patient care vs. continuing education at the time that this project was being launched. The original design was an hour education session. The statistically significant increase in HCP confidence after just 20 minutes, however, supports the idea that large scale curriculum changes are not needed for healthcare education to become more LGBT-inclusive.
The quantitative data collected during this project showed overwhelming HCP support for the importance of LGBT-inclusive healthcare education. One participant stated “I really enjoyed this presentation. I had little to no formal education around serving LGBT patients, and I think increasing exposure and practice is the only way to provide appropriate care”. This participant’s assertion that “increased exposure and practice” are the tools that aid LGBT-inclusive practice, support the importance of increasing the visibility of these topics in healthcare curriculum. Multiple participants discussed that they felt like they had acquired “tools” during the education session that would help them increase inclusivity within their practice and that the concrete examples of ways to inclusively ask questions would impact their discussions with all patients, but especially LGBT folks. The importance of language was discussed by several participants, including how there is sometimes a difference between the question you ask and the answer you want to receive. Open communication with patients without any underlying assumptions allows for trust and honesty between patients and HCPs, and while this is crucial for LGBT-inclusive education, multiple participants felt like they were lacking these skills.

For the two Psychiatric Mental Health Nurse Practitioner (PMHNP) participants whose confidence increased the most, a possible explanation of this is that since they also had averaged just a year of practice, perhaps they had the most to learn as they had not had the breadth of experience some of the other participants had, allowing for a greater increase in confidence with this exposure to new information. Additionally, confidence may have initially been low because PMHNP’s don’t typically provide reproductive health care or take sexual histories. Similarly, the two Family Nurse Practitioner (FNP) participants whose confidence increased the least, averaged nine years in practice and perhaps felt more confident starting the education session compared to those whose confidence increased the least.
**Barriers**

The main barriers for project implementation were initially that this project would require Everett Clinic healthcare team members to take time out of their schedule to attend the planned in-person education session. Communication with the site was complicated by busy schedules and at times, weeks could go by without returned emails or messages. This barrier was partially hurdled by the Covid-19 pandemic which barred all clinical projects from being implemented in-person at clinical sites. This project was then redesigned to be entirely remote so that participants could complete it anywhere they had internet access and a spare 40 minutes. This transition to a remote design necessitated the length of the education session to be shortened as it was thought that participants would be more likely to donate a total of 40 minutes of their schedule to a research project than they would if it included a pre/post-survey and an hour long education session as originally planned. A concern with the redesign was that 20 minutes would not be long enough to cover the breadth of information originally planned for the education session.

**Strengths and Weaknesses**

This project design shows the ability for uncomplicated changes in current healthcare education to have large impacts on the inclusivity of LGBT communities within the clinical setting. Inclusive language, concrete examples, and explanations of how to interview patients in inclusive ways should be focused on in healthcare education.

Two main weak points in this project have been identified. They focused on the lack of statistically significant increases in HCP confidence surrounding requesting and giving pronouns within the healthcare setting as well as discussing barrier use. Pronouns were reviewed in the education session as a crucial aspect of initial patient intake and the importance of normalizing sharing pronouns in practice was included. Discussing barrier use in an inclusive way was also
reviewed in the education session with suggestions on language and how to ask inclusive questions. The data shows that HCPs did not feel that this information was discussed in depth enough to show an increase in confidence and this may be due to the education session time constraint or that the information shared about pronouns within the education session was not of direct use to HCPs.

*Limitations and Generalizability*

This study had a large enough sample size to show statistical significance but would have had more power in its results with a larger sample of HCPs participating. Due to the limitations of implementing this project in a remote format vs. in-person, arguments can be made for both sides as to whether a larger sample would have been available with an in-person project on site at the Everett Clinic. The results gathered from this study are not widely generalizable at this time due to the small sample size, yet this project shows that improving HCP education is correlated with increased confidence in providing LGBT-inclusive care. These findings suggest the need for a larger scale project with a similar design to further support the changes necessary to make healthcare education inclusive of LGBT needs.

*Implications for Advanced Practice Nursing*

This project further illustrates the lack of LGBT-inclusive formal education that the research demonstrates. Educational institutions need to be implementing LGBT-inclusive education strategies so that the Advanced Practice Nurses that are being educated and entering practice have a clear, developed understanding of the depth of the need for LGBT-inclusive healthcare practices. These new HCPs will then be positioned to make a difference in healthcare settings implementing the inclusive practices that should be the foundation of care that is provided.
**Sustainability**

The original design of this project with its focus on diversity and inclusive practice lends itself to be used in future iterations as an official training for healthcare settings with the potential for it to be a mandatory iteration of a ‘diversity training’. This would allow for the in-person time constraints (in a post-Covid setting) to be lifted as many care settings require annual continuing education trainings focused on diversity in the care setting. If this project could be found to have reliability and validity in future designs with larger sample sizes, this project could be well positioned to be implemented in the clinical setting as a way of increasing LGBT-inclusivity on a larger scale.

Additionally, this project shows the importance of improving HCP education with a focus on LGBT-inclusivity and could sustainably influence curriculum changes. These curriculum changes would increase HCP confidence in providing LGBT-inclusive care from the start of an HCP’s career, allowing for them to start practice with the tools to create an inclusive care environment from the beginning vs. having to change their practice once habits and patterns have been established.

**Dissemination**

Upon its completion, this project will be reworked and formatted for submission to either the Women’s Healthcare Journal published by the professional organization Nurse Practitioners of Women’s Health (NPWH) or the Journal of Midwifery and Women’s Health, published by the American College of Nurse Midwives (ACNM). Midwives and NPWH are strategically positioned as HCPs exclusively for those in marginalized and vulnerable bodies which makes inclusive practice changes a foundational aspect of their care practice.
Conclusion

LGBT-individuals have expressed feelings of discrimination within the healthcare system, partially due to HCPs lack of education surrounding the culturally safe provision of LGBT healthcare. Focus on the improvement of HCPs education to include LGBT-based health curriculum would allow for a larger population of HCPs to be able to provide high quality, inclusive care to all their patients.

This project consisted of three aims: understand the current level of inclusivity shown on intake forms, understand the inclusivity of patient experiences with HCPs and determine if LGBT-inclusive education can increase HCPs confidence in caring for LGBT patients. Current intake forms and processes were shown to be overwhelmingly LGBT-exclusive through both quantitative and qualitative analysis in Phase I and II. Phase III showed that minimal continuing education significantly increased HCPs confidence in providing inclusive care to LGBT patients.

This project provides evidence to support the importance of HCPs receiving LGBT-inclusive education aiming to improve the LGBT community’s experience in accessing the healthcare system. This project design needs to be repeated with a larger sample to see if its results are replicable. It will then hold enough evidence to inform HCP education changes in the hopes that a more inclusive healthcare environment will eventually allow for the improvement of the quality of life for LGBT-individuals.
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IMPROVING LGBT PATIENT CARE THROUGH PROVIDER EDUCATION


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Appendix A: Evolution from Cultural Awareness to Cultural Safety, (Ramsden, 1996)

Cultural Safety

is an outcome of nursing and midwifery education that enables safe service to be defined by those who receive the service.

Cultural Sensitivity

alerts students to the legitimacy of difference and begins a process of self-exploration as the powerful bearers of their own life experience and realities and the impact this may have on others.

Cultural Awareness

is the beginning step toward understanding that there is a difference. Many people undergo courses designed to sensitise them to formal ritual and practice rather than the emotional, social, economic and political context in which people exist.
## Appendix B:

**Phase III (Education Session Survey) Pre- and Post-Survey Data on 10-item SES for SPSS**

### Analysis

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<th>Participant</th>
<th>Pre1</th>
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## Appendix C:
### Paired T-Test Analysis in SPSS for Pre/Post-Survey Questions

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Appendix D:
*Pre/Post-Survey Differences in Confidence per SES Item*

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Average Difference Between Pre/Post Confidence

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### Appendix E:
*Pre-Survey Item Confidence and Averages*

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| Pre Participant Answer Average = | 69.44 |
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