# Increasing LGBTQ Cultural Competence in Primary Care Providers

Jessica M. Milford

College of Nursing, East Carolina University

Doctor of Nursing Practice

Dr. Janet Tillman

April 26, 2021

## Notes from the Author

### Acknowledgements

Mom and dad; thank you for your endless supply of love and encouragement, for being and raising my tribe, and for instilling in me determination and perseverance. We did it! Amy; thank you for your listening ear, talking me down off many ledges (figuratively), making me continuously belly-laugh, and exemplifying the kind of nurse practitioner I hope to become. Jeff; your love, support, and personal insights guided me to study this worthy cause. Thank you for being a light. Traci; you kept me calm, cheered me on, and answered my many questions; thank you for being a great friend, classmate, and coworker. Lastly, Nick, Lleyton, and Leo; you are my world, you have made this dream of mine possible; all the mac-n-cheese and PB&J dinners, the nightly bath and bedtime books with dad, the playing outside because mom is doing homework inside, the hugs and snuggles, and the sheer exhaustion you all have endured these past four years, please know your sacrifices have not gone unnoticed. Thank you for picking up the slack and then some, for being my people, and for being the rock I needed to finish this race. We did it!

### Dedication

For the marginalized, the disenfranchised, and the voiceless; this project is for you. It has been an honor and a privilege to have the opportunity to add to the body of knowledge that will help transform healthcare and lives. My sincerest hope is that we may take steps together, as allies, in the direction of love and acceptance.

**Abstract**

The lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) community experiences healthcare disparities disproportionate to their cisgender and heterosexual counterparts. The etiology of these inequalities is multifactorial, and contribute to poor health outcomes for members of the LGBTQ community. The aim of this DNP quality improvement project was to create a systems-thinking solution to combat barriers this vulnerable population endures when receiving healthcare, by creating an educational program for primary care providers aimed at increasing LGBTQ cultural competence. 120+ providers were present for a live webinar providing education on LGBTQ cultural competence, population-specific primary care considerations, and patient case scenarios. For those unable to attend the live session, a self-paced online module was created through a large healthcare organization's online learning management portal. Based on post-presentation survey results, most providers have some experience with LGBTQ patients, are somewhat comfortable identifying common health problems specific to this population, and are willing to incorporate best practice guidelines from the presentation into their own clinical practice.

*Keywords:* LGBTQ, cultural competence, healthcare disparity, primary care provider, healthcare barriers

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## Section I. Introduction

### Background

The lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) population experiences health care disparities disproportionate to the heterosexual and cisgender population. Health care access, quality of care, and health-related outcomes are consistently lacking in this group who account for 2-3% of the total population in the United States (Aleshire et al., 2018; Gahagan & Subirana-Malaret, 2018). Systemic explanations for these barriers in health care outcomes includes lower rates of health insurance, lower incomes, inadequate numbers of culturally competent healthcare providers, stigmatization, and absent or vague nondiscriminatory policies in healthcare organizations. Additionally, LGBTQ-specific education for medical students is entirely inadequate, amounting to an average of zero to five hours of education spanning an entire medical program, despite continued emphasis on its importance by The Joint Commission, the American College of Physicians, and the Association of American Medical Colleges (Nowaskie & Sowinski, 2019).

Primary care providers are poised to meet the primary care needs of the LGBTQ community, but appropriate education concerning cultural competence and sensitivity must lead this endeavor to ensure sustainability of this best practice (Gahagan & Subirana-Malaret, 2018).

### Organizational Needs Statement

A large health system located in central North Carolina is a non-profit organization serving the citizens of Guilford, Alamance, Forsyth, Rockingham, and Caswell. This organization consists of six hospitals, three ambulatory care centers, three outpatient surgery centers, four urgent care centers, a retirement community, and over 100 provider practices. Its mission is to care for patients, each other, and our communities. This mission is actualized by

providing exceptional quality and compassionate care in a safe environment, appreciating each other through open and honest communication and respect, and engaging our communities with integrity and transparency (Cone Health, 2020).

This healthcare organization has identified a need for educating and identifying culturally-sensitive and competent primary care practitioners in their employ. This need is consistent with this healthcare organization's purpose in meeting the Triple Aim, as it will fulfill the objective of promoting the health of populations, lowering healthcare costs, and improving patient experiences (Institute for Healthcare Improvement [IHI], 2020). In 2019, the Human Rights Campaign's Healthcare Quality Index designated all six hospitals in this healthcare organization as leaders in healthcare equality. Leader status is based on LGBTQ patient-centered care, support services, employee benefits and policies, and community engagement (Cone Health, 2019). While this designation was well-received by the LGBTQ community in central North Carolina, this recognition is not offered to the smaller outpatient facilities, such as primary care offices, within this system (L.Vail, personal communication, February 5, 2020). This is the impetus for expanding the LGBTQ-specific services encompassing educating and identifying culturally-sensitive and competent primary care practitioners in this large health care organization.

National and state benchmarks currently exist to illustrate on-going efforts to identify areas of opportunity for improving the health care of the LGBTQ population. Healthy People 2020 aims to increase the number of states which include standardized sets of questions that identify LGBTQ populations on state-level surveys and data systems. Additionally, Healthy People 2020 intends to increase the number of cervical and breast cancer screenings per guidelines, increase the proportion of people who have health insurance, and reduce suicide

rates, all of which are disproportionally represented in the LGBTQ community (Office of Disease Prevention and Health Promotion [ODPHP], 2019). Healthy North Carolina 2030's objectives include reducing the suicide rate and the number of HIV infections in North Carolina. New HIV diagnoses in men who have sex with men (MSM) were 155 times greater than their heterosexual and cisgender counterparts in 2018, and the suicide rate for LGBTQ youth is 4.5 times higher than that of heterosexual and cisgender youth (North Carolina Institute of Medicine [NCIOM], 2020). The Centers for Medicare and Medicaid Services is working to ensure this specific population receives quality health insurance and health care information to prevent widening the healthcare disparity gap (Centers for Medicare & Medicaid Services [CMS], 2020).

**Problem Statement**

A large healthcare organization in central North Carolina has identified a need for more primary care providers who can sensitively and competently provide excellent evidence-based care to the LGBTQ community in the primary care setting.

**Purpose Statement**

The purpose of this project is to provide educational opportunities to primary care providers at a large healthcare organization in central North Carolina, to increase their LGBTQ cultural competence in a way that will empower them to sensitively and competently provide excellent and evidence-based primary care to the LGBTQ community.

## Section II. Evidence

### Literature Review

The literature review was conducted to evaluate the current available knowledge related to the proposed project plan. This search strategy was conducted using Medline via PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Google Scholar, and One Search. The medical subject headings (MESH) terms used in the literature search were LGBTQ, barriers to primary care, primary care providers, cultural competence, and education. The initial search yielded 539 journal articles from the aforementioned databases. Articles were further narrowed by full-text availability, peer-reviewed, published within the last five years, and available in English. Exclusion criteria for this literature search included articles lacking necessary levels of evidence, those containing duplicate information, or not directly related to the proposed project plan. The levels of evidence required for a thorough, well-developed, and legitimate literature review necessitate levels I through III for qualitative articles and levels I through VI for quantitative journal articles. After applying inclusion and exclusion criteria to the 539 articles, 16 articles were carefully reviewed for eligibility.

#### *Current State of Knowledge*

The LGBTQ population experiences healthcare disparities disproportionate to their heterosexual and cisgender counterparts. Examples of LGBTQ-specific health inequities are:

- LGBTQ persons are 1.5 times more likely to suffer from anxiety and depressive disorders.
- Lesbian women are three times more likely to experience alcohol and substance abuse disorders.
- 40% of transgender adults have attempted suicide.

- Lesbian women have higher Body Mass Indices (BMI) than heterosexual women.
- Gay and bisexual men have higher cardiovascular stress markers and illicit drug use (Nowaskie & Sowinski, 2019; Whitehead et al., 2016).

LGBTQ youth are also similarly affected by poorer health outcomes. They are overrepresented in the homeless population, accounting for 35% of homeless youth. Family rejection, adverse mental health outcomes related to bullying and harassment at school, and physical and sexual victimization in sexual minorities contribute to the healthcare disparity exhibited in this population (Hunt, Vennat, & Waters, 2018). These inequalities are further perpetuated by societal stigma, implicit and explicit bias held by healthcare providers, as well as microaggresisons in the healthcare setting (Dean, Victor, & Grimes, 2016).

Current guidelines, expectations and best-practice recommendations for LGBTQ health screening and prevention are readily available. An appropriate screening includes obtaining an organ inventory to assess potential for breast, cervical, endometrial, prostate and testicular cancers. Human Immunodeficiency Virus (HIV) prevention and Pre-Exposure Prophylaxis (PrEP) recommendations are accessible for the transsexual patient, and the CDC has up-to-date recommendations for vaccines applicable to those who engage in high-risk sexual behavior. Cardiovascular risk reduction and osteoporosis screening in the patient receiving hormone-replacement therapy is another aspect of health screening and prevention pertinent to the care of the LGBTQ patient (Whitlock et al., 2019). Sexually transmitted infection (STI) screening, anal pap testing, breast and pelvic examination of the transgender patient, and modifying interview and examination techniques for the non-binary patient are other unique aspects to LGBTQ patient care which necessitate holistic care by a provider possessing sensitivity and competence (Nisly et al., 2018).

Primary care providers are uniquely poised to meet the distinctive health care needs of the LGBTQ community. However, many primary care providers lack the knowledge, security or cultural-sensitivity required to safely and effectively provide this population with evidence-based care (Gahagan & Subirana-Malaret, 2018). The most evidence-based and successful solution to bridging the gap in primary care provider knowledge on LGBTQ healthcare delivery includes addressing implicit and explicit bias awareness, understanding correct terminology, addressing barriers and access to care, establishing empathy and adjusting primary care practitioners' own heteronormative value systems (Klein & Najhai, 2016; Law et al., 2015).

### *Current Approaches to Solving Population Problem*

Several approaches are appropriate for solving the problem of primary care providers' lack of cultural competence in providing care to the LGBTQ community. Enhancing medical and advanced practice provider educational curricula to include the recommendations made by the Association of American Medical Colleges, the Joint Commission, and the American College of Physicians concerning LGBTQ-specific education is one solution in addressing the lack of cultural competence in primary care providers (Daniel & Butkus, 2015; the Joint Commission, 2011; Nowaskie & Sowinski, 2019; Streed et al, 2020). Providing primary care providers with an opportunity to participate in a computer-based competency module is another avenue explored by current research. This educational opportunity supported the progression of the cause by addressing factors at the micro and macro systems levels. Providers participated in an online learning module to increase LGBTQ cultural competence, while addressing personal awareness and values of the individual practitioner (Gahagan & Subirana-Malaret, 2018). The latter approach is most appropriate for the proposed project with the partnering organization. Time, the cost-effectiveness of reaching a large group of primary care providers with very little required

monetary contribution, feasibility, and accessibility of all primary care practitioners employed by a large healthcare organization in central North Carolina were all factors contributing to the decision of using a computer-based, online learning module to increase LGBTQ cultural competence for primary care practitioners.

### *Evidence to Support the Intervention*

Creating a computer-based, online learning module, available to all primary care providers employed by a large health organization in central North Carolina is the most feasible evidence-based ways to increase primary care providers' LGBTQ cultural competence. Diversity training allows providers to identify and confront their own biases, and this provider-centered training emphasizes the topics of microaggressions, personal responsibility, and structural heteronormativity (Dean et al., 2016). Schweiger-Whalen et al. (2019) concluded through their study that diversity training involving space for self-reflection provides awareness into personal clinical behavior, and further strategies should be utilized to build trust and safety within the learning environment. The practitioner participating in continuing education using the Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS), can also expect this self-assessment tool to aid them in the ever-evolving journey of becoming LGBTQ culturally competent (Bidell, 2017).

## Evidence-Based Practice Framework

### *Identification of the Framework*

The successful execution of this proposed project was aided by the Iowa Model of Evidence-Based Practice (Iowa Model) as a conceptual framework, and viewed through the lens of Meyer's Stress Minority Theory. The Iowa Model was created with the specific goal to help nurses blend research and evidence-based practice, yielding better patient outcomes. Roger's

Diffusion of Innovation theory served as a foundation for this model, and the Quality Assurance Model Using Research (QAMUR) was a precursor (Iowa Model, 2017). This model consists of seven specific steps necessary for successful implementation. The selection of a topic is the principal step, as it guides the researcher in addressing the significance of the problem and determining if it is a priority in the organization. A team is then developed who is responsible for the development, implementation, and evaluation of the project. This step involves a bottom-up approach, and consists of stakeholders and other team members who can provide practical recommendations for the project and financial support. Retrieving and grading the evidence comprise the next steps, and function to add quality, strength, and credibility to the project. This crucial step determines whether existing research supports a practice change. After careful review of the literature, the development of an evidence-based practice standard or protocol can be actualized that is patient-centered and individualized. Implementing the evidence-based practice occurs through the conduit for which the project was intended; such examples include policy, procedures, or guidelines for practice. The final step in the Iowa Model is the evaluation. The process of auditing and promoting feedback is critical to determine if the evidence-based change contributed to the benefit of the patient (Doody & Doody, 2011).

Meyer's Stress Minority Theory focuses on the concept of the psychological stress that results from being a minority. He specifically studied mental health in gay men as it related to being a minority, and concluded internalized homophobia, stigma, and prejudice predict psychological distress in this population (Meyer, 1995). Meyer further expounded on this notion to infer members of the LGBTQ community are exposed to these unique, chronic, and socially-based stressors, which accrue over a lifetime, in hostile and homophobic environments. The chronic stress related to stigmatization leads to poor health outcomes (Meyer, 2003). These

conceptual and theoretical frameworks provided foundational support and guided the direction of the proposed project.

**Ethical Consideration & Protection of Human Subjects**

Ethical considerations must be acknowledged for this project because primary care providers have a duty to their LGBTQ patients in recognizing them as members of a vulnerable population. This recognition signals to the patient that the provider understands the nuances, context, and disparities surrounding healthcare for vulnerable populations. Cultural, religious, or political beliefs may prevent some primary care providers from adequately addressing health issues specific to this population. If providers are not comfortable delivering healthcare to persons identifying as LGBTQ because of personal beliefs, they should respectfully and swiftly refer patients to an inclusive and accepting provider.

The intervention in this project was equal and equitous to everyone in the target population. All primary care providers employed in this large healthcare organization had the opportunity to participate in the online learning module. There was no potential harm or possibility for anyone in the target population to be taken advantage of during the project implementation. The formal approval process for the project initially began with procuring a project site partner, a site champion, and a project navigator. The project navigator's role was facilitating the process of obtaining necessary documents to ensure compliance with the organization's Institutional Review Board (IRB) and the Nursing Research Council, both being prerequisites to implementing the project at this site. The completion of the Collaborative Institutional Training Initiative (CITI) modules was required to meet this healthcare organization's requirements for a quality improvement study. Upon approval by the Nursing

Research Council and completion of the organization's IRB application, the project received permission to commence.

## Section III. Project Design

### Project Site and Population

The quality improvement DNP project occurred within a large, non-profit healthcare system located in central North Carolina. This health system employs over 1,800 healthcare providers delivering care in over 150 locations, spanning five counties (Cone Health, 2020). The project site has an established Office of Diversity, Equity, and Inclusion that enhanced facilitation of the project. Potential barriers considered that could threaten the project's trajectory included the timeframe of implementation, the continuing state and organizational policy changes related to the current COVID-19 pandemic, and overall responsiveness of providers to engage in voluntary online education related to the project topic.

#### *Description of the Setting*

The online learning module was available through the organization's intra-web learning system. Healthstream is an electronic learning system that provides e-learning opportunities, continuing medical education credits, maintains licensure information, and houses mandatory workplace education and competencies available to all employees (Healthstream, 2020).

#### *Description of the Population*

The DNP project's population consisted of all outpatient primary care providers employed by a large, not-for-profit health system. These providers consisted of medical doctors, doctors of osteopathic medicine, physician assistants, and nurse practitioners.

### Project Team

The project team consisted of one DNP student, a Clinical Nurse Specialist serving as the site champion, a learning management systems administrator, the Director of Health Equity, and the Director and Chief Inclusion Officer of the organization's Diversity and Inclusion

Department. The members of the diversity and inclusion office coordinated and facilitated interdisciplinary discussions related to the project topic, thus enhancing the project's reach within the health care organization.

## Project Goals and Outcome Measures

The goal of this quality improvement DNP project was to increase primary care providers' LGBTQ cultural competence, enhance education surrounding LGBTQ-specific primary care health issues, thus continuing the process of cultivating culturally sensitive providers. IRB approval was requested from the project site's review board and from East Carolina University's IRB. The methods involved in attaining the project goals included a live online presentation on LGBTQ cultural competence and primary care considerations, administering an online learning module, providing a short survey at the completion of the module, analyzing the data via Qualtrics software, and making recommendations for future educational opportunities for the organization. These project steps assisted in actualizing the Iowa Model, and the outcome measures were revealed upon data analysis.

### *Description of the Methods and Measurement*

A post-implementation survey consisting of open-ended, yes/no, and Likert-type scale questions were available to participants at the completion on the online learning module or the live presentation (Appendix A). The data was assimilated by the learning management systems administrator and evaluated by the project leader.

### *Discussion of the Data Collection Process*

The data collection process occurred in coordination with the learning management systems administrator, who compiled the reports of participants who have completed the module, along with the data associated with the post-education survey. The data was collected

electronically via the organization's secure e-mail, was free from any identifying information, and was stored within the system's two-factor authentication protected webmail space.

**Implementation Plan**

The implementation plan was accomplished through the utilization of the Situation-Background-Assessment-Recommendation (SBAR) technique (Institute for Healthcare Improvement, 2020), accompanied by steps based on the Iowa model. The initial implementation step involved alerting the primary care providers to the presence of the online learning module and the date of the live presentation, via e-mail. E-mails sent to providers' work addresses supported recruitment of adequate numbers of participants. A six-week time frame gave providers an opportunity to either plan to attend the live presentation or to self-assign this module and complete the survey. The providers received a certificate of completion in Healthstream, for which they could obtain up to twenty-one days after completion of the survey.

**Timeline**

The proposed DNP project launched on Tuesday, October 20, 2020 and continued through Tuesday, January 19, 2021, thus allowing for a total of 13 weeks for participants to complete the online learning module. The live online presentation portion of the project occurred on Wednesday, October 21, 2020.

## Section IV. Results and Findings

### Results

The goal of this project was to increase primary care providers' LGBTQ cultural competence and empower them in the delivery of evidence-based and culturally sensitive care. I measured primary care providers' self-reported LGBTQ cultural competence at the completion of a self-paced learning module and live online presentation focused on LGBTQ cultural competency and primary care guidelines. Original expectations consisted of having 30% of primary care providers within the healthcare organization participate in the online learning module or live presentation, and complete the survey. Upon closure of the survey, a total of 14 participants completed the Qualtrics survey, two by way of the self-paced online module through Healthstream. Three participants' responses were removed due to these participants not being medical doctors, physician assistants, or a nurse practitioners, thus totaling eleven participants.

#### *Outcomes Data*

Outcomes data consisted of number of participants, years in practice, ethnicity, and provider role. Subjective data collected included:

- experience caring for LGBTQ patients
- comfortability caring for LGBTQ patients and asking preferred patient pronouns
- likelihood of recommending preventative screening practices for LGBTQ patients
- number of participants who referred LGBTQ patients elsewhere for care due to lack of competence or comfort in providing their care
- likelihood of incorporating aspects of educational module on LGBTQ patient into own practice (Appendix A).

Provider ethnicity, provider role, and number of years in practice were identified in questions one, two, and three, for the purpose of describing the project participants. A Likert-type scale was used to quantify providers' experience with LGBTQ patients, comfortability with identifying and treating population-specific health concerns and best practices, comfort asking patients for preferred pronouns, and likelihood of incorporating information into current practice.

**Discussion of Major Findings**

The gaps between original expectations versus actual results included the small number of primary care providers who completed the survey, the two conduits for which the survey was available, and the relatively high scores the participants yielded for general comfortability when caring for LGBTQ patients (Appendix B). Although the sample size was small, the organizational need indicated a large provider knowledge gap surrounding LGBTQ healthcare and cultural competence. The original educational piece did not offer education delivery in-person to providers and high-ranking levels of the organization's leadership team due to COVID-19 social distancing considerations, but the fluidity of the project allowed for this avenue to be actuated.

## Section V. Interpretation and Implications

### Cost Benefit Analysis

The project would cost the organization minimal dollars, time, and resources. The hourly salary of the person, or people, responsible for the project would include compensation for the time to research the topic, imbed the information into a software program compatible with the organization's online learning system, create a PowerPoint to allow for easy accessibility via live WebEx, and communicate with key members of the healthcare organization's team to disseminate to primary care providers. Monetary costs for this project would depend on the title and paygrade of the person, or people, who comprise this team. The average salary of a Clinical Nurse Educator in North Carolina is $79,000, which averages to $37.98/hour (Clinical nurse educator, 2021). The time dedicated to the research, creation, and implementation of the project averaged 40 hours, resulting in a cost of $1,569.20, if this were to be completed by a Clinical Nurse Educator. Upon participant feedback, the overall presentation and modality by which it was implemented would not require additional costs should small changes to materials or project content be warranted. The software cost of the Healthstream program is null because the project site has already purchased software rights and uses this platform for system-wide mandatory competencies. Negligible costs could be attributed to the creation of a flyer to be displayed on the various campuses of the organization for purposes of notifying primary care providers of the learning opportunity.

The benefits the organization would receive with the incorporation of this project align with the Triple Aim goal of promoting the health of populations, reducing healthcare costs, and improving patient experiences (Institute for Healthcare Improvement [IHI], 2020). These objectives have the potential to increase the number of LGBTQ patients who actively seek

outpatient care with this healthcare organization, thus creating the possibility of more revenue and reimbursement for the organization. Providers will continue to deliver the organization's mission of providing exceptional quality and compassionate care in a safe environment, appreciating each other through open and honest communication and respect, and engaging our communities with integrity and transparency (Cone Health, 2020). The potential for such an overwhelmingly positive return on a small and low-risk investment makes this project feasible, sustainable, and necessary.

**Resource Management**

The organization's most impactful resources responsible for successful outcomes were the primary care providers and leadership teams in recognizing the need for enhancing primary care providers' cultural competence in caring for individuals who identify as LGBTQ. Barriers to a more successful outcome in participation were attributed to lack of provider awareness regarding the educational opportunity availability. Personal outreach was used in January and February of 2021 to solicit more participants, and these participants asynchronously viewed the presentation material and completed the survey. The organization could have used Continuing Education Credits (CEUs) to incentivize providers to complete the learning modules. However, this avenue was explored during the project development phase, and was determined that the benefit of obtaining only one CEU did not warrant the costs and time associated with creating the CEU. It is feasible that the organization could reallocate resources to add to successful outcomes; the reallocation of resources would need to be specific and demonstrate a measurable enhancement to the project's design to ensure an adequate return on its investment.

## Implications of the Findings

Survey results suggested providers feel comfortable providing care to LGBTQ patients, but may not be aware of the nuance this entails as it relates to emerging guideline recommendations. Open-ended feedback at the end of the survey indicated the need for more time for discussion and questions at the conclusion of the presentation. The project was a cost-effective, timely, and well-received way to disseminate information to providers.

### *Implications for Patients*

The purpose of this project was closely aligned with DNP Essential VI: Interprofessional collaboration for improving patient and population health outcomes (AACN, 2006). LGBTQ patients served in this area of North Carolina will have access to culturally-competent and sensitive providers, who are well-versed in the nuances of primary care guidelines for this specific population. The delivery of this care will positively impact LGBTQ healthcare consumers' concept of their care. Delivering care to vulnerable populations in a considerate, evidence-based manner ensures patients' holistic health.

### *Implications for Nursing Practice*

This project fundamentally reduced barriers primary care providers face when delivering care to vulnerable populations. Increasing providers' ability to elicit patients' preferred pronouns, correctly utilizing appropriate sexual health screening practices, and using inclusive verbal and nonverbal communication techniques to strengthen the patient-provider relationship, will shatter barriers and create space for a trusting relationship to develop. Through the creation of an educational program aimed at providing a more focused, population-specific learning opportunity, the advanced practice nurse critically thinks, evaluates outcomes, and demonstrates leadership, thus actualizing DNP Essential VIII (AACN, 2006). Aligning with the fundamental

tenets of nursing practice, coupled with the increasing complexity of healthcare needs of individuals and healthcare systems, implications for nursing practice are salient.

### *Impact for Healthcare System(s)*

The project initiative publicly illustrated this organization's commitment to advocating for, and delivering care to all members of the community in which they serve. Nurse practitioners are primed to lead this change initiative by advocating for policy change at local, state, and federal levels, leading workplace quality improvement projects, spear-heading project development, and facilitating nurse practitioner-driven research to educate providers and advocate for improvements in healthcare systems. The opportunity allows the nurse practitioner to uphold the lofty standard of delivering quality patient care and affecting sustainable change in healthcare systems.

## Sustainability

The healthcare organization plans to keep the online learning module open for one year. There are no additional costs associated with keeping this module live for the allotted timeframe. Organizational buy-in and retaining personnel competent in sustaining the module are the only factors that would affect the project's sustainability long-term. Clinical Nurse Educators are well-equipped to analyze and retrieve new data and report to the Diversity, Equity and Inclusion leadership team at the organization. This team could then evaluate the outcomes and decide on necessary changes to the program content or delivery to ensure continued alignment with the organization's vision and current best practices.

## Dissemination Plan

Inclusion of this project in the organization's monthly wellness newsletter, during Pride Month in 2021, along with a poster submission for the Research, Evidence-Based Practice, and

Quality Symposium presented with Greensboro AHEC in 2021, would ensure optimal organizational dissemination. The project was presented at East Carolina University's College of Nursing poster presentation on April 6, 2021. It was then formally submitted to ECU's "The Scholarship" repository for doctoral projects.

## Section VI. Conclusion

### Limitations

Participants were genuinely interested in this topic, but limitations were apparent by the challenge to create a time for all primary care providers to attend a live presentation, allocate adequate time to give the presentation, and identify one central person who could email PCPs in order to notify them of the presentation. Notifying the providers in the organization proved taxing as several mass emails sent to PCPs largely went unanswered, leading to nonresponse bias in the project. Planning limitations included a constrained timeframe for the project implementation portion and the live presentation was restructured to comply with necessary pandemic safety measures.

### Recommendations for Others

Primary care providers' awareness of the project was perhaps the largest barrier in completing this project. Designing a similar project might be more successful if more resources and time were spent creating awareness and increasing the number of presentations available to providers. Due to the small number of participants who completed the self-assigned online module, considerations for more live information sessions may prove more successful. The extra steps necessary to navigate the organization's online educational system and self-assign learning modules, may be seen as a barrier to participation. Assigning the module to all PCPs eliminates this barrier and could prove beneficial in increasing participants, leading to better patient care. This module could be mandatory training in the onboarding process and orientation for new providers within the system, which may create a less burdensome atmosphere and increase the likelihood of participation. Lastly, the survey should have fewer demographic questions and the

addition of a dedicated question asking preferred learning modality, so the program can capture more participants and be adjusted to be more representative of the organization.

**Recommendations Further Study**

Further research should examine how to engage busy PCPs and what learning modalities are most successful in this population. Examining if a twenty-minute speech is captivating enough to deliver information without over-saturating providers would prove helpful in identifying participants' level of engagement. Identifying provider preference regarding mode of delivery via pamphlet, e-mail, or an informal educational session over a catered meal could yield valuable information for further study. Future studies could explore how measurable change could be defined for the targeted patient population. How many providers does this project need to reach in order to affect measurable change in the vulnerable population? Current studies indicate cultural competence training for healthcare workers is associated with higher patient satisfaction (Govere, L. & Govere, E., 2016), but are positive patient satisfaction scores a reliable indicator of change? Answers to these questions will benefit future projects aimed at increasing LGBTQ cultural competence in primary care providers.

In summary, this project actualized the goal to increase LGBTQ cultural competence in primary care providers. Through outcomes measures and data analysis of participant survey results and feedback, the live presentation and availability of the self-paced learning module revealed most providers are comfortable with common primary care health concerns in the LGBTQ population. However, some participants did not have experience providing care to this population, felt uncomfortable recommending preventative screening practices, or in asking patients their pronouns. It is in this gap where more education is needed to affect change and influence necessary health outcomes for the LGBTQ community.

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Appendix A

**Post Presentation Survey**

1.) What is your ethnicity? *Please fill in the blank* _____

2.) How many years have you been in practice?

☐ Less than 1 year ☐ 1-5 years

☐ 6-10 years ☐ Greater than 10 years

3.) What is your provider role?

☐ Medical Doctor (MD) ☐ Doctor of Osteopathic Medicine (DO)

☐ Nurse Practitioner (NP) ☐ Physician Assistant (PA)

4.) How much experience do you have with caring for LGBTQ patients?

1 No experience

2 Some experience

3 Neutral

4 Experienced

5 Extremely experienced

5.) How comfortable are you identifying common health issues specific to the LGBTQ community?

1 Completely uncomfortable

2 Uncomfortable

3 Neutral

4 Comfortable

5 Extremely comfortable

6.) How comfortable are you recommending preventative screening practices specific to LGBTQ health?

1 Completely uncomfortable

2 Uncomfortable

3 Neutral

4 Comfortable

5 Extremely comfortable

7.) How comfortable are you in asking a patient which pronouns they prefer?

1 Completely uncomfortable

2 Uncomfortable

3 Neither comfortable nor uncomfortable

4 Comfortable

5 Extremely comfortable

8.) Have you referred LGBTQ patients to another provider because you did not feel *competent* providing their care?

☐ Yes ☐ No

9.) Have you referred LGBTQ patients to another provider because you did not feel *comfortable* providing their care?

☐ Yes ☐ No

10.) Please indicate how likely you are to incorporate what you have learned from this module into your own practice.

☐ Unlikely

☐ Maybe

☐ Neutral

☐ Likely

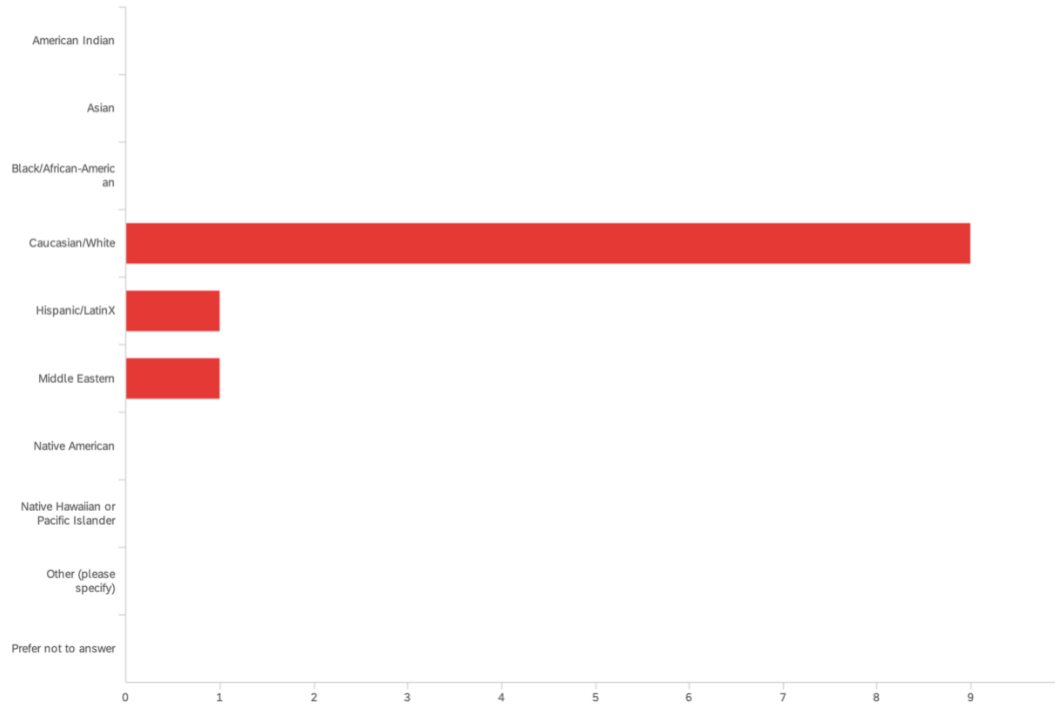
☐ Extremely likely

11.) Suggestions or recommendations for improvement of module content or delivery *(Free Text)*

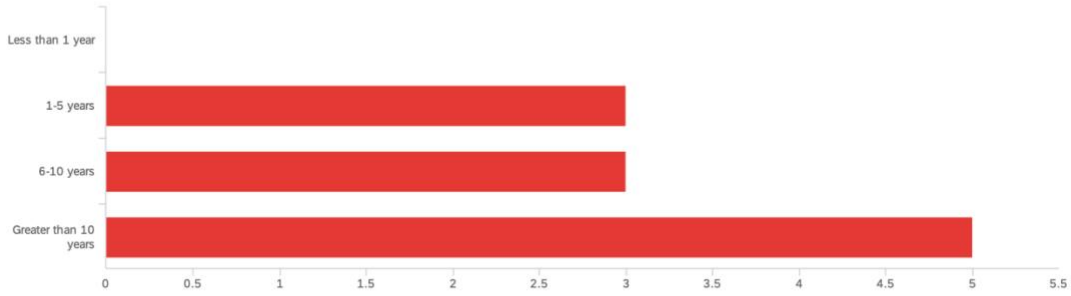
Appendix B:

**Qualtrics Data**

Q1 - What is your ethnicity?

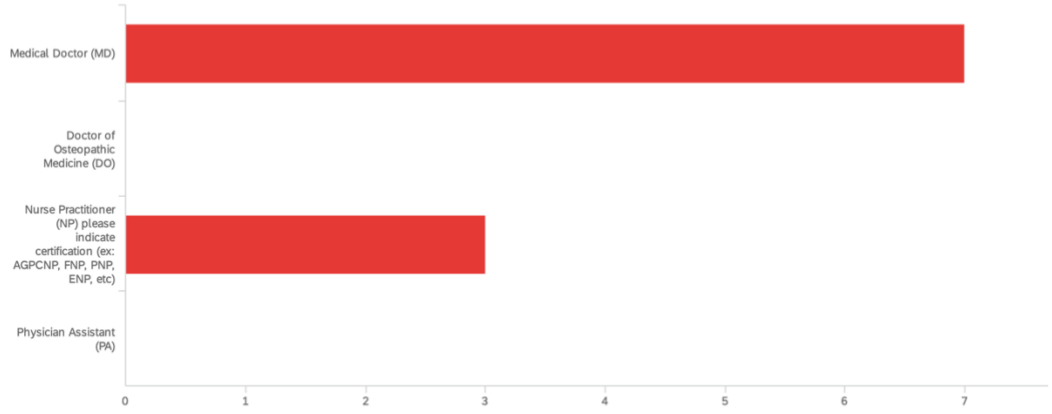



Q2 - How many years have you been practice?



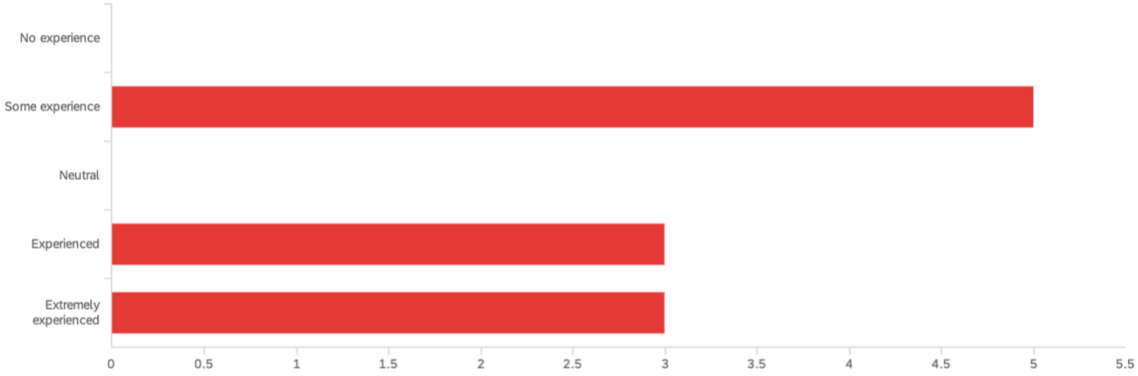

| # | Field | Minimum | Maximum | Mean | Std Deviation | Variance | Count |
|---|---|---|---|---|---|---|---|
| 1 | How many years have you been practice? | 2.00 | 4.00 | 3.18 | 0.83 | 0.69 | 11 |

## Q3 - What is your provider role?



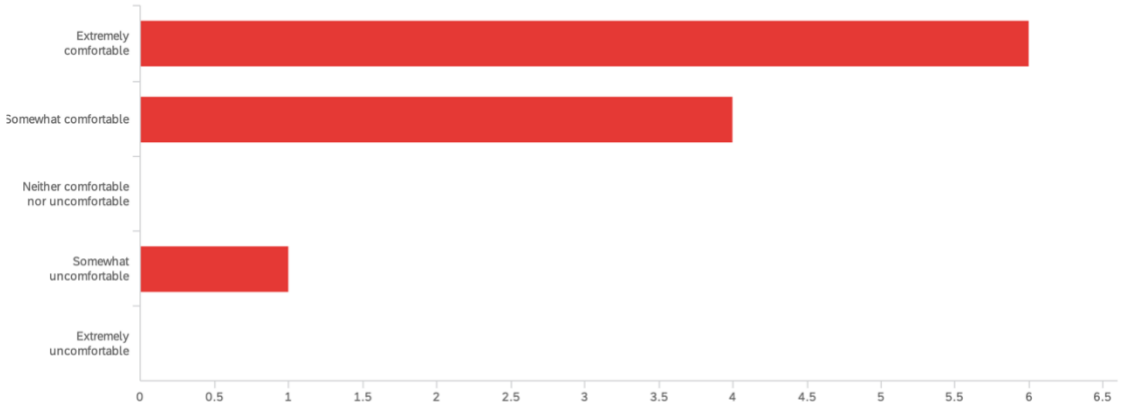

| # | Field | Minimum | Maximum | Mean | Std Deviation | Variance | Count |
|---|---|---|---|---|---|---|---|
| 1 | What is your provider role? - Selected Choice | 1.00 | 3.00 | 1.60 | 0.92 | 0.84 | 10 |

## Q4 - 1.) How much experience do you have with caring for LGBTQ patients?

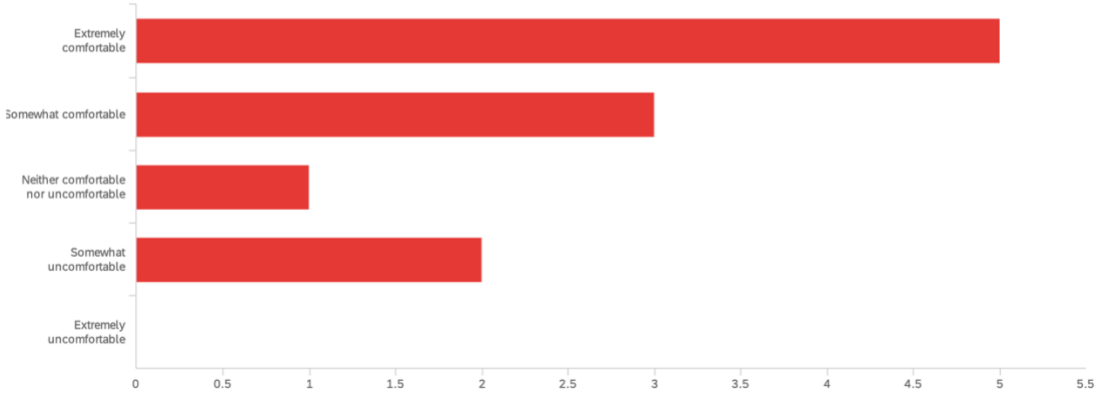



| # | Field | Minimum | Maximum | Mean | Std Deviation | Variance | Count |
|---|---|---|---|---|---|---|---|
| 1 | 1.) How much experience do you have with caring for LGBTQ patients? | 2.00 | 5.00 | 3.36 | 1.30 | 1.69 | 11 |

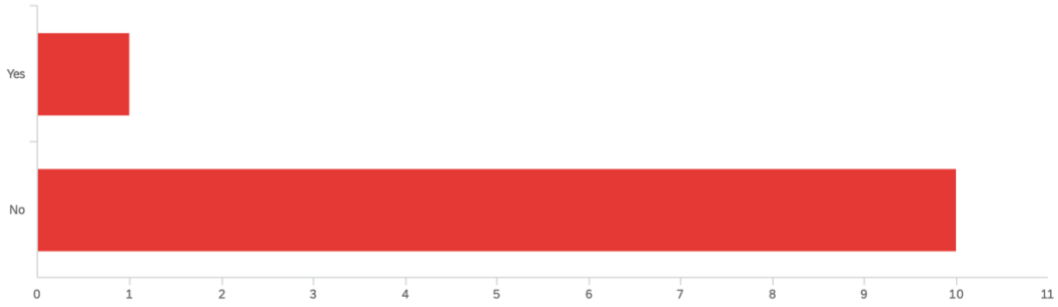
Q5 - 1.) How comfortable are you identifying common health issues specific to the LGBTQ community?



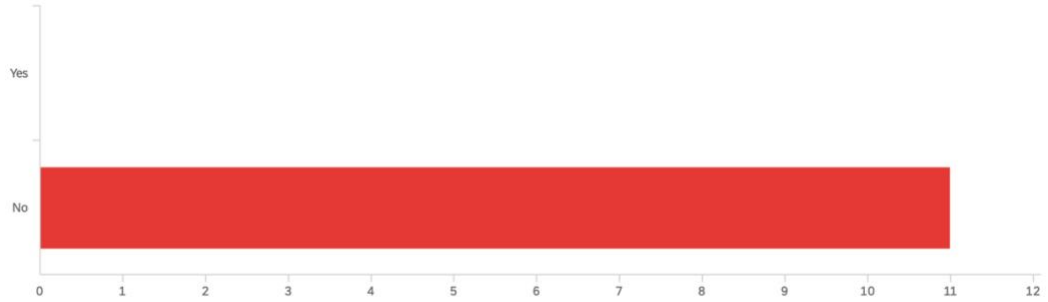

Q6 - 1.) How comfortable are you recommending preventative screening practices specific to LGBTQ health?



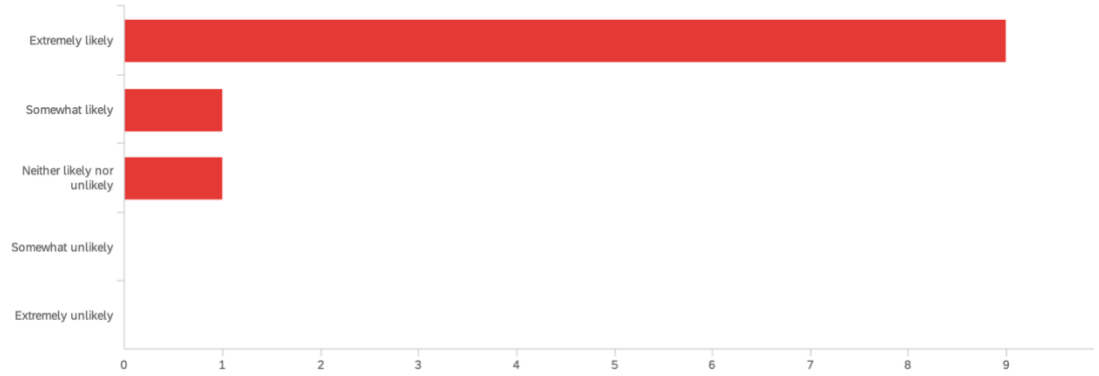
Q7 - 1.) Have you referred LGBTQ patients to another provider because you did not feel competent providing their care?



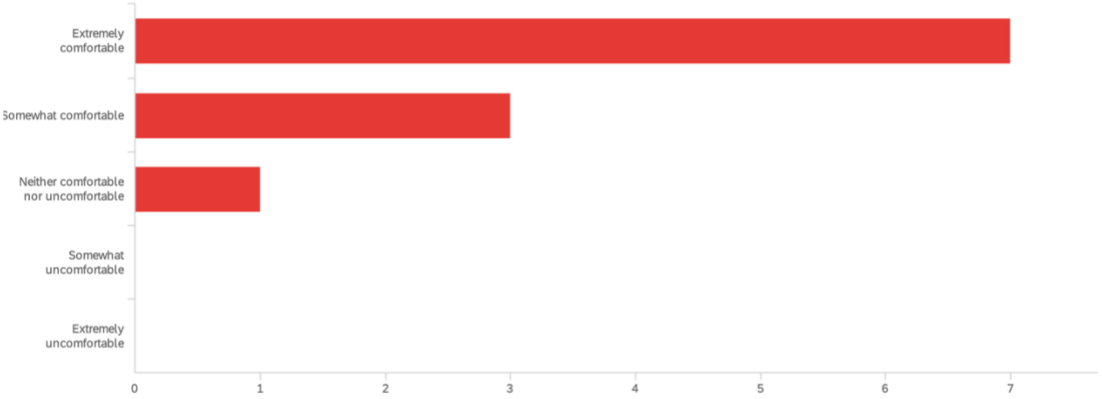

Q8 - 1.) Have you referred LGBTQ patients to another provider because you did not feel comfortable providing their care?



Q9 - Please indicate how likely you are to incorporate what you have learned from this module into your own practice.




Q11 - 1.) How comfortable are you in asking a patient which pronouns they prefer?




| # | Field | Minimum | Maximum | Mean | Std Deviation | Variance | Count |
|---|---|---|---|---|---|---|---|
| 1 | 1.) How comfortable are you in asking a patient which pronouns they prefer? | 1.00 | 3.00 | 1.45 | 0.66 | 0.43 | 11 |

Appendix C

**Project Budget**

| Line Item | Unit Cost | Quantity | Total |
|---|---|---|---|
| **Personnel**<br><br>(Clinical Nurse Educator) | $37.98/hr | 40 hours | $1,519.20 |
| **Software**<br><br>(Healthstream) | --- | --- | $0 |
| **Technology Cost**<br><br>(IT support staff to input & retrieve data from software) | $25/hr | 2 hours | $50 |
| **Total** | | | $1,569.20 |

Appendix D

## DNP Essentials

| | Description | Demonstration of Knowledge |
|---|---|---|
| Essential I ***Scientific Underpinning for Practice*** | **Competency** – Analyzes and uses information to develop practice<br>**Competency** -Integrates knowledge from humanities and science into context of nursing<br>**Competency** -Translates research to improve practice<br>**Competency** -Integrates research, theory, and practice to develop new approaches toward improved practice and outcomes | -Understanding at-risk populations and researching effective treatment methodology, while using Meyer's Stress Minority Theory, to create a culture change in the delivery of care. |
| Essential II ***Organizational & Systems Leadership for Quality Improvement & Systems Thinking*** | **Competency** –Develops and evaluates practice based on science and integrates policy and humanities<br>**Competency** –Assumes and ensures accountability for quality care and patient safety<br>**Competency** -Demonstrates critical and reflective thinking<br>**Competency** -Advocates for improved quality, access, and cost of health care; monitors costs and budgets<br>**Competency** -Develops and implements innovations incorporating principles of change<br>**Competency** - Effectively communicates practice knowledge in writing and orally to improve quality<br>**Competency** - Develops and evaluates strategies to manage ethical dilemmas in patient care and within health care delivery systems | -Assembled and lead a project development team with frequent meetings to discuss project goals<br><br>-Utilized project implementation plans and project timelines to communicate with members of the team |
| Essential III ***Clinical Scholarship & Analytical Methods for Evidence-Based Practice*** | **Competency** - Critically analyzes literature to determine best practices<br>**Competency** - Implements evaluation processes to measure process and patient outcomes<br>**Competency** - Designs and implements quality improvement strategies to promote safety, efficiency, and equitable quality care for patients<br>**Competency** - Applies knowledge to develop practice guidelines<br>**Competency** - Uses informatics to identify, analyze, and predict best practice and patient outcomes<br>**Competency** - Collaborate in research and disseminate findings | -Researched population-specific healthcare disparity in LGBTQ community<br><br>-Identified current state vs future state & added to best practice guidelines<br><br>-Collaborated with project site and ECU to disseminate findings |
| Essential IV ***Information Systems – Technology & Patient Care Technology for the Improvement & Transformation of Health Care*** | **Competency** - Design/select and utilize software to analyze practice and consumer information systems that can improve the delivery & quality of care<br>**Competency** - Analyze and operationalize patient care technologies<br>**Competency** - Evaluate technology regarding ethics, efficiency and accuracy<br>**Competency** - Evaluates systems of care using health information technologies | -Utilized online modules, WebEx meetings, and email technological modalities to improve delivery of information<br><br>-Qualtrics and Excel were used in data analysis |

| | | |
|---|---|---|
| | **Description** | **Demonstration of Knowledge** |
| Essential V ***Health Care Policy of Advocacy in Health Care*** | **Competency**- Analyzes health policy from the perspective of patients, nursing and other stakeholders<br>**Competency** – Provides leadership in developing and implementing health policy<br>**Competency** –Influences policymakers, formally and informally, in local and global settings<br>**Competency** – Educates stakeholders regarding policy<br>**Competency** – Advocates for nursing within the policy arena<br>**Competency**- Participates in policy agendas that assist with finance, regulation and health care delivery<br>**Competency** – Advocates for equitable and ethical health care | -Current literature review on vulnerable population policy<br><br>-Meetings with Diversity & Inclusion team at project site to advocate for the inclusion of this project in the pursuit of equitable and ethical healthcare |
| Essential VI ***Interprofessional Collaboration for Improving Patient & Population Health Outcomes*** | **Competency**- Uses effective collaboration and communication to develop and implement practice, policy, standards of care, and scholarship<br>**Competency** – Provide leadership to interprofessional care teams<br>**Competency** – Consult intraprofessionally and interprofessionally to develop systems of care in complex settings | -Continued outreach during project development and implementation with all members of the project team, project site, and providers |
| Essential VII ***Clinical Prevention & Population Health for Improving the Nation's Health*** | **Competency**- Integrates epidemiology, biostatistics, and data to facilitate individual and population health care delivery<br>**Competency** – Synthesizes information & cultural competency to develop & use health promotion/disease prevention strategies to address gaps in care<br>**Competency** – Evaluates and implements change strategies of models of health care delivery to improve quality and address diversity | -Completed detailed literature search on cultural competency, health promotion, gaps in care, and models to improve healthcare delivery and address diversity<br><br>-Utilized public health data specific to project's target population |
| Essential VIII ***Advanced Nursing Practice*** | **Competency**- Melds diversity & cultural sensitivity to conduct systematic assessment of health parameters in varied settings<br>**Competency** – Design, implement & evaluate nursing interventions to promote quality<br>**Competency** – Develop & maintain patient relationships<br>**Competency** –Demonstrate advanced clinical judgment and systematic thoughts to improve patient outcomes<br>**Competency** – Mentor and support fellow nurses<br>**Competency**- Provide support for individuals and systems experiencing change and transitions<br>**Competency** –Use systems analysis to evaluate practice efficiency, care delivery, fiscal responsibility, ethical responsibility, and quality outcomes measures | -Designed, implemented, and evaluated a project aimed on cultural competence<br><br>-Utilized Meyers' Minority Stress Theory, along with systems level thinking, to analyze outcomes and support the efficient, ethical, fiscal, and holistic delivery of patient-centered healthcare |

Appendix E

# Project Timeline

| MY TASKS | START DATE | DUE DATE | % COMPLETE | NOTES |
|---|---|---|---|---|
| **Meeting with Site Champion** | 8/3/20 | Date | 100% | Discuss Project Implementation Tool, Tracking Tool, & Timelines |
| **Meeting with Chris (Staff Ed) about HLC** | 8/24/20 | 8/24/20 | 100% | Make edits to my presentation, he will compile files & work on transitions & user interface |
| **Phone Engagement call w/ Constance Speight** | 8/24/20 | 8/24/20 | 100% | Email members of CHMG leadership about best way to get word out to PCPs about my project. |
| **Engagement meetings with Constance & Chris** | 9/1/20 | 9/1/20 | 100% | Update team on project timeline, Chris is behind out set timeline due to mandatory JAHCO work for the system |
| **Engagement meetings with Dr. Kossari, Debbie Grant & Sally Hammond** | 9/10/20 | 9/10/20 | 100% | Will go ahead with live WebEx, will have 40 minutes to present. Will need to make a memo to send out beforehand |
| **HLC complete** | 10/1/20 | 10/1/20 | 100% | Confirm with Chris Norwood that HLC is complete, small edits needed |
| **Complete WebEx ppt & Qualtrics Survey** | 9/14/20-10/1/20 | 10/1/20 | 100% | Make sure ppt is compataible with WebEx & can embed Qualtrics survey |
| **Project Implementation Beings** | 10/5/20 | 10/5/20 | 100% | Go-Live for Module |
| **Confirm with Dr. Tillman best way to get word out to PCPs** | 10/12/20 | 10/12/20 | 100% | Flyer has been sent to PCPs about live WebEx, maybe email about HLC? |
| **Live WebEx with CHMG** | 10/21/20 | 10/21/20 | 100% | Live WebEx with CHMG PCPs |
| **SBAR (beginning of implementation)** | 10/21/20 | 10/21/20 | 100% | Upload initial SBAR to Canvas if I have any participants at this time |
| **Friendly E-mail reminder** | 11/2/20 | 11/2/20 | 100% | Send out reminder, via Dr. Kossari, to PCPs to invite them to take the module and complete the survey |
| **SBAR (mid-cycle)** | 11/16/20 | 11/16/20 | 100% | Send out friendly reminder email and a thank you to providers who have completed HLC and survey; engagement to touch base with team; upload mid-cylce SBAR to Canvas |
| **SBAR (end of implementation** | 11/30/20 | 11/30/20 | 100% | May consider contigency plan if participation is less than 30% (leave module open longer); engagement to touch base with team; upload last SBAR to Canvas |

Appendix F

# Literature Matrix

| Authors | Year Pub | Article Title | Theory | Journal | Purpose and take home message | Design/Analysis/Level of Evidence | IV DV or Themes concepts and categories | Instr. Used | Sample Size | Sample method | Subject Charac. | Comments/critique of the article/methods GAPS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ashford, K., Fallin-Bennett, A. & Hatcher, J. | | Related to LGBTQ People: A Narrative Literature Review | efficacy | *Practice* | people | Systematic Reviews of descriptive & qualitative studies | | Rosenberg self-esteem scale | met eligibility criteria | convenience samples (7) & snowball sample (1) | negative attitudes varied slightly; some associations between | use grey literature or additional databases other than PubMed & CINAHL).<br><br>Usefulness: addresses implications for practice and well as implications for education<br><br>Synthesis: More research is needed and more education |
| Gahagan, J. & Subrina-Malaret, M. | 2018 | Improving pathways to primary health care among LGBTQ populations and health care proviers: Key findings from Nova Scotia, Canada | Theory of self-efficacy | *International Journal for Equity in Health* | More LGBTQ-specific training & support services for health care providers needed. | Level VI Evidence from a single descriptive or qualitative study | Cultural Competence | closed-ended online survey | 392 | Survey | 283-LGBTQ 109-healthcare providers | Limitations: questions based on self-perceptions & subject to interpretation<br><br>Usefulness: ideas to improve pathways to LGBTQ primary care<br><br>Synthesis: Intersectional & health equity approach; address issues at micro levels & macro (systems) level |
| Nowaskie, D. & Sowinski, J. | 2019 | Primary Care Providers' Attitudes, Practices, and Knowledge in Treating LGBTQ Communities | Theory of self-efficacy | *Journal of Homosexuality* | Providers acknowlege their need for more LGBTQ health-related education | Level VI Evidence from a single descriptive or qualitative study | IV: LGBTQ Survey<br>DV: PCP's attitudes, practices & knowledge (cultural competency) | LGBTQ-specific survey for PCPs, self-reporting, anonymous, addresses demographics, measures and exp. Questions (using a 5-pt Likert scale) | 127 | Survey using Likert Scale | Fam Med: 40.2%, IM: 21.3%, OBGYN: 16.5%, other:22% | Limitations: Sample size, don't care about practitioners who are not primary care.<br><br>Usefulness: Highlights disparities between providers' attitiudes and clinical practices<br><br>Synthesis: Most (70%) did not feel well-informed of LGBTQ-specific health needs or on referring patients |
| Nisly, N., Imborek, K., Miller, M., Dole, N., Priest, J., Sandler, L., Krasowski, M. & Hightower, M. | 2018 | Developing an inclusive and welcoming LGBTQ clinic | | *Clinical Obstetrics & Gynecology* | "how-to" guide of program development for LGBTQ inclusive clinic spaec | Level II: conceptual studies based on a single theoretical framework | Address institutional barriers to heath care and reduce health disparities for LGBTQ community | LGBTQ healthcare model | | | | Limitations: size (1 clinic in Iowa)<br><br>Usefulness: Highlights barriers and identifies people needed on the team<br><br>Synthesis: Addresses barriers and solutions on how to develop an inclusive & welcoming LGBTQ clinic |
| Rimes, K., Broadbent, M., Holden, R., Rahman, Q., Hambrook, D., Hatch, S. & Wingrove, J. | 2017 | Comparison of treatment outcomes between lesbian, gay, bisexual and heterosexual individuals receiving a primary care psychological intervention | Intersectionality theory | *Behavioural and Cognitive Psychotherapy* | Lesbian and bisexual women have poorer outcomes after treatment than hetero women | Level IV: case control & cohort studies | IV: psych outcomes as evidenced by scores on GAD/PHQ/WSAS<br>DV: psych intervention in primary care | PHQ-9, GAD-7, Work & Social Adjustment Scale (WSAS) | 10, 791 | adults attending Improving Access to Psychological Therapies in South London; patients included if they received at least 2 sessions | lesbian: 188, bisexual women: 222, hetero women: 6637, gay men: 645, bisex men: 75, hetero men: 3024 | Limitations: performed in UK, IAPT (Improving Access to Psych Therapies)<br>Usefulness: Implications to improve bisexual women's response to treatment and success to recover from anxiety/depression<br><br>Synthesis: Lesbian and bisexual women have poorer outcomes than hetero women after psych interventions; more research needed as to why. Possible explanations include more trauma, stigma from mental health providers |
| Ruben, M. & Fullerton, M. | 2018 | Proportion of patients who disclose their sexual orientation to healthcare providers and its relationship to patient outcomes: A meta-analysis & review | Minority Stress Theory | *Patient Education and Counseling* | person-centered approach is needed to collect sexual orientation information from patients | Level V Evidence from Systematic Reviews of descriptive & qualitative studie | patient characteristics, provider characteristics, location characteristics and disclosure characteristics | | | | | Limitations:<br><br>Usefulness: Helpful info for development/creation of module for DNP project<br><br>Synthesis: Highlights various reasons it is important for LGBTQ patients to verbally disclose sexual orientation to providers |
| Felsenstein, D. | 2018 | Enhancing lesbian, gay, bisexual, and transgender cultural competence in a Midwestern primary care clinic setting | Lippitt's Change Theory | *Journal for Nurses in Profesional Development* | "how to" guideon how to make a primary care clinic meet Joint Commission's LGBT cultural competencies & why this is important | Level III: Descriptive Study | IV: primary care staff cultural competence for LGBTQ clinic patients<br>DV: panel discussion & online learning module | 3 LGBT cultural competities from the Joint Commission, the JC's Field Guide Checklist & used PDSA | 11 | panel discussion, individual meetings-->used a pre-test and a post-test | clinic staff in a primary care office in the Midwest | Limitations: small sample size, patient population was small due to clinic being new<br><br>Usefulness: From a DNP and speaks to PDSA model, QI projects, and computer-based learning modules<br><br>Synthesis: Enhancing clinic cultural competence for LGBT population by panel discussion and online learning module. |

| Authors | Year Pub | Article Title | Theory | Journal | Purpose and take home message | Design/Analysis/Level of Evidence | IV DV or Themes concepts and categories | Instr. Used | Sample Size | Sample method | Subject Charac. | Comments/critique of the article/methods GAPS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dean, M., Victor, E. & Grimes, L. | 2016 | Inhospitable healthcare spaces: Why diersity training on | | *Bioethical Inquiry* | Expounds on microaggressions and the impact on LGBTQ patients; highlights the subtle interactions that lead to LGBTQ | Level II: conceptual studies based on a single | heteronormative microaggressions, systemic microaggressions & | | | | | Limitations: Vague recommendations<br><br>Usefulness: Describe microaggressions and the barriers they cause & offer recommendations to supplement |
| Bidell, M. | 2017 | The lesbian, gay, bisexual, and transgender development of clinical skills scale (LGBT-DOCSS): Establishing a new interdisciplinary self-assessment for health providers | | *Journal of Homosexuality* | 3 studies illustrate how the LGBT-DOCSS tool supports reliability and validity of tool; stresses this is a dynamic tool that should be used to further the lifelong pursuit of advancing this clinical muscle | | | Study 1: Item development and factor analysis Study 2: reliability estimates and test-retest reliability Study 3: construct validity | study 1: 312 study 2: 27 study 3: 564 | study 1: survey questions study 2: informational sheet, informed consent & demographic survey study 3: survey | study 1: 10 experts on LGBT health care from US, UK & EU study 2: undergrad counseling /psych/med stdents in UK (19-27 yrs) study 3: US/UK, undergrad/grad students/practitioners/educators from psych/counseling/primary care & psychotherapy | Limitations: over-represented mental health students and clinicians, relies only on self-reported responses, and addresses only explicit biases, not implicit ones<br><br>Usefulness: Notes this one test will help with lifelong development of this clinical skill, not just for a one time pass/fail. Cultural humility versus cultural competence<br><br>Synthesis: 3 studies illustrate how LGBT-DOCSS support reliability and validity of tool; stresses this is a dynamic tool that should be used to further the lifelong pursuit of advancing this clinical muscle |
| Institute for Healthcare Improvement | 2020 | The IHI Triple Aim | | *Institute for Healthcare Improvement [Website]* | Information on triple aim | | | | | | | Usefullness: info on triple aim http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx |
| NCIOM | 2020 | Healthy North Carolina 2030 | | *North Carolina Institute of Medicine [Website]* | Healthy NC 2030 goals | | | | | | | Limitations: Not a whole lot of info on LGBTQ goals Synthesis: NC-specific information for LGBTQ population |
| US Centers for Medicare & Medicaid Services | 2020 | LGBT partners | | *US Centers for Medicare & Medicaid [Website]* | Information on how CMS is addressing LGBTQ-specific health care needs | | | | | | | Top-down, federal information on LGBTQ-healthcare |
| US Dept of Health & Human Services, Office of Disease Prevention | 2019 | Healthy People 2020 | | *US Dept of HHS, Office of Disease Prevention [Website]* | Healthy People 2020 goals, benchmarks, info for geographic regions | | | | | | | Good information on national benchmarks, statistics, and areas for improvement for LGBTQ healthcare |
| Meyer, I. | 1995 | Minority stress and mental health in gay men | Minority Stress Theory | *Journal of Health and Social Behavior* | Minority status & economic status affect stress and distress & oppressive stigmatizing environment is the causative | Level II: conceptual studies based on a single | IV: internalized homophobia, stigma and prejudice DV: psych distress | Internalized Homophobia Scale, Stigma was measured using an 11-item scale, and prejudice was scored using 1 for anyone who | 741 | stratified random sample & snowball technique | Gay men in NYC in 1985 | Usefullness: Hallmark study for theoretical framework for project |

| Authors | Year Pub | Article Title | Theory | Journal | Purpose and take home message | Design/Analysis/Level of Evidence | IV DV or Themes concepts and categories | Instr. Used | Sample Size | Sample method | Subject Charac. | Comments/critique of the article/methods GAPS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Whitehead, J., Shaver, J. & Stephenson, R. | 2016 | Outness, stigma, and primary health care utilization among rural LGBT populations | Minority Stress Theory | *PLoS ONE* | Highlight impact of stigma on rural LGBT populations, assuming they have less access to culturall sensitive and quality healthcare | Level III: Descriptive Study | Determine if higher levels of stimga/lower levels of outness correlate with less PCP access for rural LGBT population | online survey | 946 | online survey via banner ads on Facebook | 18+, LGBT-related interests, lived in rural zip codes, cisgender man: 451, cis women: 340, trans/non-binary: 155 | Limitations: highlights the need for more intervention-based, evidence-supported interventions and evaluations for education for practitioners.<br><br>Usefulness: Mentions HRC, medical/nursing school cirriula from 2003 to 2011<br><br>Synthesis: Clinical assessment and treatment of LGBTQ patients by providers continues to lack, despite an explosion of research on the topic. Article looks at current status of medical and nursing education and gaps present. |
| Bonvicini, K. | 2017 | LGBT healthcare disparities: What progress have we made? | | *Patient Education and Counseling* | Reviews changes from article published in 2003, acknowledging importance of direct/indirect bias, evidence is unclear as to the best format to deliver LGBTQ training to providers | | Current status of medical and nursing edication/training specific programs | | | | | Limitations: correlation does not mean causation, poor racial/ethinic diversity in sample, used FaceBook which could skew sample of people who are more "out"<br><br>Usefulness: A lot of statistics on health disparities in groups and between groups & good primary care utilization information for this sample<br><br>Synthesis: Stigma and outness influence rural LGBT people's utilization of health care (removes other variables such as insurance status and geographic |
| Schweiger-Whalen, L., Noe, S., Lynch, S., Summers, L. & Adams, E. | 2019 | Converging cultures: Partnering in affirmative and inclusive health care for members of the lesbian, gay, bisexual, and transgender community | Minority Stress Theory, Campinha-Bactote's Theory/Model of Cultural Competence | *Journal of the American Psychiatric Nurses Association* | Even when not obviously negative or stigmatizing, heterosexual assumptions among providers can lead to communication difficulties and aspects of invisibility. Discussed therapeutic neutrality, heterosexual assumptions, | Level II: conceptual studies based on a single theoretical framework | IV: 4 hour workshop on cultural competence DV: PCPs cultural competence | GAP (Gay Affirmative Practice Scale), open-ended post-test questions aimed at self-reflection, & knowledge quiz | 130 | pre-test/post-test, | hospital employees and nursing students (undergraduate) | Limitations: quasi-experimental with no control group, participants in a Democratic-heavy location of Southwestern US, limited number of African American/Asian/Hispanic participants.<br><br>Usefulness: Expounds on Minority Stress Theory in this population & details Campinha-Bacote's Theory<br><br>Synthesis: Heterosexual assumptions, therapeutic neutrality, and lack of education perpetuate LGBTQ health care disparities by providers. Cultural Competence framework involves cultural awareness, culturalknowledge, cultural skill, cultural encounters, and cultural desire. |
| Klein, E. & Nakhai, M. | 2016 | Caring for LGBTQ patients: Methods for improving physicinn cultural competence | Cultural Competence Theory | *The International Journal of Psychiatry in Medicine* | Info needed to teach fam med residents about LGBTQ patients needs. Discusses implicit/explicit bias, appropriate terminology, patient-centered treatment plans | | Description of one curriculum used to teach family med residents about LGBTQ-inclusive care | | | | | Limitations: Family Medicine residency program<br><br>Usefulness: Defines curriculum, Genderbread Person, addresses barriers to care, appropriate terminology, health disparities, & establishing empathy.<br><br>Synthesis: Outlines specific components of one medical curriculum for fam med residents to provide culturally-sensitive and evidence-based care to LGBTQ patients. Areas addressed are bias awareness, terminology, barriers to care, health disparities, and establishing |
| Law, M., Mathai, A., Veinot, P, Webster, F., & Mylopoulos, M. | 2015 | Exploring lesbian, gay, bisexual, and queer (LGBQ) people's experiences with disclosure of sexual identity to primary care physicians: A qualitative study | Minority Stress Theory | *BMC Family Practice* | Highlighted importance of the PCP's relationship with the patient over lifespan, and that many PCPs have heteronormative assumptions; Nonverbal communication impacted participants as much as verbal | Level III: qualitative, desriptive study | | telephone interviews using a semi-structured interview guide. Nvivo qualitative data analysis software used | 12 | telephone interviews, 1-on-1 | Canadian citizens, 18+, English-speaking, identified as LGBTQ, had been to PCP or HCP within 5 years | Limitations: small smaple size, did not interview patient's PCP's to evaluate how they experienced the LGBTQ patient's care<br><br>Usefulness: Specifics to how LGBTQ patients perceive care when disclosing sexual identity to PCPs<br><br>Synthesis: PCP and patient relationship is one of the more important as it encompasses the lifespan. PCPs would do well to recognize their own heteronormative value systems and make neessary adjustments to allow better care for LGBTQ patients. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Meyer, I. | 2003 | Prejudice, social stress, and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence | Minority Stress Theory | *Psychological Bulletin* | Using this stress model to apply full spectrum of interventions aimed at ameloriating issue facing LGBTQ population | Level II: conceptual studies based on a single theoretical framework | | | | | | Limitations: presents LGBTQ group has a homogenous group, which they are not; ignores generational and cohort effects in minority stress<br>Usefullness: will serve as theoretical framework for my project; expounds on author's previous theory to include more LGBTQ<br>Synthesis: uses conceptural framework to discuss higher prevalence of mental health disorders in LGBTQ population is due to minority stress model/theory |
| Doody, C. & Doody, O. | 2011 | Introducing evidence into nursing practice: using the IOWA model | | *British Journal of Nursing* | 7 steps of IOWA model and explanations for each | | Iowa Model | | | | | Conceptual framework for paper/project |
| Iowa Model Collaborative | 2017 | Iowa model of evidence-based practice: Revisions and validation | | *Worldviews on Evidence-Based Nursing* | | | Iowa Model | | | | | Background of development of model and why it is used, as well as revisions. |