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Improving Sexual Orientation and Gender Identity Knowledge in Convenient Care Clinics: A Toolkit and Competency Training for Caregivers

Elizabeth M. Gallagher

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Doctor of Nursing Project

Improving Sexual Orientation and Gender Identity Knowledge in Convenient Care Clinics:

A Toolkit and Competency Training for Caregivers

Elizabeth M. Gallagher, MSN, ARNP, FNP-BC

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Approved by: Bonnie H. Bowie Date: 6/14/2019
Bonnie H. Bowie, PhD, MBA, RN

Chairperson: Kumhee Ro Date: 6/14/2019
Kumhee Ro, DNP, ARNP, FNP-BC

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Abstract

It is well documented that transgender individuals experience higher rates of discrimination than non-transgender, also known as cis-gender, individuals (Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017). This discrimination extends into the healthcare system, a place where all individuals should be treated with dignity and respect (Bauer, Scheim, Deutsch, & Massarella, 2014). Over the last few decades, cultural humility has been promoted in health care professional training (Fisher-Borne, Cain, & Martin, 2015; Tervalon & Murray-Garcia, 1998). However, transgender care is rarely included. This lack of training can lead to a decreased confidence in providing care to transgender individuals and poor experiences for transgender patients when accessing health care. The purpose of this project is to design and implement a toolkit to be used by a system of convenient care clinics in order to improve caregiver knowledge and confidence in providing care to transgender individuals. Through organizational, research, and community input, a toolkit was developed and disseminated to the caregivers through an in-person training. A pretest, posttest and follow up survey were developed to measure increase in knowledge, caregiver confidence, and practice change of providers during interactions with transgender individuals. These were analyzed and demonstrated statistically significant change in knowledge. Participants also noted increased confidence and practice changes.

Keywords: Transgender; transgender; cultural competency; patient satisfaction; discrimination; training

Introduction

Gender dysphoria is defined by the American Psychological Association (APA) as “a conflict between a person's physical or assigned gender and the gender with which he/she/they identify” (2016). The APA further clarifies that this discordance can often lead to significant distress. It is well documented that transgender individuals experience increased rates of discrimination including in health care (Bauer et al., 2014; Scandurra et al., 2017).

Bauer et al. (2014) found that 21% of transgender individuals surveyed avoided seeking emergency care, when it was needed, due to fear of discrimination (95% CI, 14% to 25%). The same study showed that for those who accessed care, often the healthcare provider required education from the patient on transgender care. In 2015, Lim, Johnson, and Eliason surveyed 1, 231 undergraduate nursing faculty regarding Lesbian, Gay, Bisexual, and Transgender (LGBT) education. The researchers found that about half of the participants admitted to knowledge deficits regarding LGBT care and an average of only 2.12 hours was spent educating future nurses on these issues during undergraduate education. Similarly, a study of a physician emergency medicine residency found that only 33% of programs surveyed included LGBT content in their curriculum (Moll et al., 2014). From these studies one could conclude that health care professionals do not receive adequate training to care for this vulnerable population.

In addition to inadequate health care services, transgender individuals experience depression and anxiety at higher rates than the general population (Bouman et al., 2017; Budge, Adelson, & Howard, 2013; Dawson, Wymbs, Gidycz, Pride, & Figueroa, 2017; Reisner et al., 2016, Rotondi et al., 2011; Scandurra,

Amodeo, Valerio, Bochicchio, & Frost, 2017). The American Foundation for Suicide Prevention and the Williams Institute's National Transgender Discrimination Survey found that 46% of trans men and 42% of trans women surveyed had attempted suicide during their lifetimes compared with 4.6% of the general population (Haas, Rogers, & Herman, 2014). These alarmingly high rates of discrimination, depression, anxiety, and suicide attempts indicate the critical need for increased training for health care professionals about the specific health care needs of this population in order to decrease transgender health disparities.

As individuals of LGBTQ experience often face discrimination leading to avoidance in the healthcare setting, it is important that facilities that serve as an entry point to health care are welcoming. Convenient care clinics are one such facility. These clinics, often located within pharmacies, are intended to provide increased access to care with extended hours and convenient locations. Many of these convenient care clinics are operated by larger health system and provide an opportunity for the system to demonstrate its values. These convenient care clinics offer access to all populations, including those who are often not connected with stable health care. It is critical that all patients, especially historically disenfranchised, are treated by providers with knowledge and respect so that they will feel welcome by the system. In order to promote an accepting environment that delivers transgender competent care for illnesses and injuries, more training is needed for providers.

Purposes of the Project

Does implementation of a transgender health toolkit and competency training improve caregiver knowledge, confidence, and sensitivity in delivering care to the transgender population? Furthermore, does it change caregivers' practice behaviors? The purposes of the project are to: 1) develop a transgender health toolkit for caregivers; 2)

develop and implement competency training to improve caregiver knowledge, increase confidence, and sensitivity in delivering care to the transgender population; and 3) assess any change in care giver practices related to transgender health care.

Background and Significance

Prior to describing the project, relevant background is provided on the history of transgender medicine and the prevalence of transgender individuals. A review of discrimination and health disparities, including mental health disorders is also outlined. Gender affirming treatment options are discussed. Finally, there is review of health care providers' training in LGBTQ care.

History of Recent Transgender Experience

Transgender awareness in the United States has gained recognition and acceptance over the past decade. However, the recognition of gender dysphoria (previous called gender identity disorder by the APA) and treatment have been occurring for over a half a century. The World Professional Organization for Transgender Health (WPATH) first officially incorporated in 1979 and published guidelines on transgender care (Devor, 2012). Since then, the organization has revised and updated the guidelines over the years as well as hosted biannual symposiums (Devor, 2012).

WPATH has taken steps to move away from viewing gender dysphoria as a pathology to recognizing it as diversity. Their May 2010 position states:

The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative. The psychopathologization of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination

more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalization and exclusion, and increasing risks to mental and physical well-being.

A similar successful campaign for the depathogenization of homosexuality has occurred with the removal of “homosexuality” from the Diagnostic and Statistical Manual (DSM) in 1973 (Drescher, 2015). The removal of this term signified a shift in medicine from *how can we cure it?* to *how can we support the individual?* Drescher claims this shift, along with social progression, advances the acceptance and rights of homosexuals. A removal of a clinical diagnosis of gender dysphoria may promote social change but may also lead to unintended consequences such as lack of insurance coverage for gender affirmative care. The American medical system is based on payment for treating disorders and if the diagnostic code is removed, there may no longer be incentive for insurance companies to cover care. Overall, there is a movement shift viewing the transgender experience as a pathology to a point on the spectrum of the human experience.

Prevalence of Transgender Individuals

The prevalence of transgender individuals is not well established as there are no formal epidemiologic studies. In the 2011 Standards of Care, WPATH notes:

Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one’s gender identity – is actually occurring in a population (p. 6).

However, utilizing the data that is available, which comes from mostly western cultures and samples of patients presenting for gender transition, the predicted prevalence ranges from as high as 1:11,900 to as low as 1:45,000 for male-to-female individuals (MTF) and as high as 1:30,400 to as low as 1:200,000 for female-to-male (FTM) individuals (WPATH, 2011). It is noted that these estimates are likely very low as it is a difficult population to sample due to discrimination after disclosure.

Discrimination

It is well documented in the literature that transgender individuals face higher rates of discrimination than cis-gender individuals, both in the community and when seeking health care. Reisner et al. (2014b) completed a survey of 452 transgender individuals in Massachusetts in 2013 regarding discrimination and health. They found that while 86% of their respondents had some college education or more, their incomes were less than Massachusetts residents on average. According to the study, “sixteen percent reported an annual income of less than \$10,000; this was more than twice the percentage of Massachusetts residents overall who reported earning less than \$10,000, and comparable to what was observed among transgender individuals on the national level” (p. 12). Transgender individuals’ lower income, despite higher levels of education, can be a sign of job discrimination. They found that a staggering 65% of their respondents had experienced discrimination in at least one public accommodation setting in the past year, with 24% of those occurring in a health care setting. Unfortunately, 19% of respondents did not seek medical care when sick or injured in the past year because of mistreatment related to their transgender status.

A similar finding of avoiding health care because of discrimination was published by Bauer et al. (2014). The researchers analyzed a subset of data from the Trans PULSE survey in Canada (N= 433) and found that while approximately one-third of the transgender population in Ontario reported need for emergency medical care, only 71% (95% CI; 40%-91%) were able to receive care. Comparable to the rate found by Reisner et al, Bauer et al. (2014) found 21% (95% CI; 14%-25%) of respondents reported ever avoiding emergency medical care because of beliefs that being trans would negatively affect the visit. For those who did access care, 52% (95% CI, 34% to 72%) reported negative experiences including hurtful language and/or statements by the healthcare professional that they did not know enough to provide care. They found “approximately 54% reported having to educate their providers “some” or “a lot” about trans issues” (p. 717). This lack of knowledge regarding care of the transgender patient leaves transgender individuals at risk for receiving sub-optimal health care as well as feeling discriminated against.

Scandurra et al. conducted a survey of 149 transgender individuals in Italy. They found 71.8% of respondents had suffered verbal abuse ($p= 0.2678$) (2017). Furthermore, there were high rates of prejudice including difficulty finding a job, troubles in accessing health care, and eviction. High rates of discrimination, even outside of the health care, increase risk for poor health outcomes.

Health Disparities

Prevalence of mental health disorders.

Adults.

In 2016, Reisner et al. conducted a literature review of 116 studies of addressing the disease burden for transgender patients (2016). They included studies from thirty countries,

although the majority were from the United States, conducted between 2008 and 2014. Overall, mental health was the most commonly studied area of transgender health and while the methods varied greatly, there was agreement across the studies that transgender individuals experience high rates of mental health disorders including depression (Reisner, 2016). However, it is unclear if these symptoms are part of gender dysphoria or related to the discrimination often faced by those of LGBTQ experience.

Bauman et al. (2017) compared survey data for 913 transgender individuals to the responses of 3,816 non-trans individuals. The surveys were collected over a three-year period, subjects were recruited from a transgender clinic, then matched to data from a cis-gender population. Bauman et al., found transgender individuals are almost three times more likely to have anxiety (p. 22). Dawson et al. (2017) conducted a large online survey with the objectives of determining the prevalence of transgender individuals among United States residents, as well as the prevalence of mental health disorders. The online survey of 6, 287 people found 0.8% of participants self-identified as transgender. Identifying as transgender increased the likelihood of Attention Deficit Hyperactivity Disorder (ADHD), depression, and anxiety. The likelihood of depression is four times higher for those identified as transgender. Furthermore, 44.5% of transgender individuals reported more than one of the above diagnoses versus only 21.2% of the cis-gender respondents (p. 299). Budge, Adelson, and Howard (2013) also found depression and anxiety at higher rates than the general populations in their survey of 351 transgender individuals. These disparities outline the need for health care professionals to decrease barriers

to care so that transgender individuals feel welcome, supported, and receive appropriate care.

Children and adolescents.

Reisner et al. (2014a) studied 180 transgender patients age twelve to nineteen, of which 106 were female-to-male and 74 male-to-female, who were matched on gender identity, age, visit date, and race/ethnicity to cisgender controls. In a retrospective review of electronic health records, the authors found trans-youth had higher rates of anxiety and depression compared to cis-youth. Depression rates among trans youth were 50.6% versus 20.6% for cisgender youth (N=360; RR, 3.95; 95% CI, 2.60-5.99) and anxiety rates were 26.7% for transgender youth versus 10% for cisgender youth (N=360; RR, 3.27; 95% CI, 1.80-5.95). Of grave concern is that they also found higher rates of suicidal ideation with 31.1% of transgender youth experiencing ideation versus 11.1% of cis-gender controls (RR 3.61, CI 95%, 2.17-6.03). An alarming 17.2% of the trans-youth with a suicide attempt versus 6.1% of cis-gender (RR 3.20, CI 95%, 1.53-6.7) was also reported. These high rates of mental illness in pediatric patients warrant concern.

Human immunodeficiency virus.

In addition to suffering disproportionately high rates of mental health disorders, transgender individuals also suffer from higher rates of human immunodeficiency virus (HIV). In 2013, Baral et al. conducted a meta-analysis of studies that looked at HIV rates in transgender women from 2000-2011. They found across the fifteen countries in which there was data, for transgender women HIV prevalence was 19.1% (95% CI 17.4–20.7). Across all 15 countries, the odd ratio for infection with HIV for transgender women as compared with all adults of reproductive age was 48.8 (95% CI 21.2–76.3). This is a

significant burden for a group which already suffers from increased risk of mental illness and discrimination.

Social Determinants of Health

There is increasing understanding in the medical community of the impact social determinants of health (food, housing, safety, poverty) have on health outcomes. In their study examining the demographic and psychosocial features associated with distress and resilience Bariola et al. (2015) surveyed 169 transgender men and women age ten through seventy-seven. The researchers surveyed individuals regarding family support, frequency of contact with the LGBT community, victimization, as well as both distress and resilience scales. Forty six percent of the sample reported high psychological distress, which was greater in the younger and less educated population. Those who did not turn to family for support and had infrequent contact with LGBT friends experienced more victimization and reported higher distress. Those who identified as heterosexual, had a university education, were currently working, had higher incomes, family support, and LGBT friends, had greater resilience. This study suggests that financial stability and social support are protective factors against distress. Budge, Adelson, and Howard (2013) also found through their survey of 351 transgender individuals, that the greater the social support reported, the lower the anxiety and depression rates. Owens-Smith et al. (2017), conducted a study via an online survey of 399 participants and discovered that those who have had two episodes of abuse or discrimination have increased risk of depression. In regard to social support, Testa, Jiminez, and Rankin (2014) found decreased fearfulness, less suicidality, and more comfort if the transgender individual knew another transgender individual. These studies reaffirm

the importance of decreasing discrimination in order to improve transgender individuals' health.

Kauth, Barrera, Denton, and Latini (2017) studied 252 urban, suburban, and rural lesbian, gay, and transgender veterans via a survey to determine differences in anxiety, depression, tobacco use, and body mass index. Greater distances to primary care provider was correlated with higher depression scores (PHQ-9) and anxiety scores among the participants (OASIS)($R= 0.26$ and $R= 0.21$, $P=0.01$). This finding underlines the importance of accessible culturally appropriate care.

Standards of Care

The Endocrine Society, the University of California San Francisco's Center of Excellence for Transgender Health, and WPATH have published treatment guidelines for care of the transgender patient. The WPATH guidelines state "with appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians" (2011, p.41). They go on to add the importance of training primary care providers in transgender care to increase patient access to appropriate care. The APA has published their own guidelines to complement and provide additional clarification so that psychologists can provide culturally appropriate care. Overall, these guidelines encourage clinicians to work with transgender individuals to find a method of gender expression that works best for them. Treatments include any combination of hormone therapy, surgery, psychotherapy, and change in gender expression and role (APA, 2015, Hambree et al., 2017; WPATH, 2011; Deutsch, 2016).

Gender affirming treatment.

Gender dysphoria is defined by the distress it causes the individual due to the discordance between gender assigned at birth and perceived gender. To date, four studies

have found that gender affirming hormone therapy can lead to improved mental health. Bauman et al. (2017) found hormonal gender affirmation therapy was positively correlated with decreased anxiety, particularly for MTF transgender. Similarly, in Davis and Colton Meier's study of 208 trans-women, those treated with testosterone had decreased depression, anxiety, and anger. Davis and Colton also found that chest reconstruction surgery was correlated with higher body satisfaction. Rotandi et al. analyzed data from 205 FTM participants and found the rate of depression is 2.8 times greater for FTMs not currently using hormones compared with those who are (2011). For those who are planning surgery or hormone therapy but have not started, there is a five times greater likelihood of depression. In Gorin-Lazard et al.'s study of 67 trans men and women found hormonal therapy is an independent risk factor in greater self-esteem, less severe depression symptoms, higher self-care, and psychological well-being; after controlling for age, gender identity, sexual orientation, partner status, and children (2013). Owens-Smith et al.'s (2017) study of 399 trans-individuals also found depression to be higher among those wanting but not receiving hormone replacement therapy. Demonstrating that access to gender affirming care (i.e. hormone therapy and gender confirmation surgery) can have a positive effect on the mental health of transgender individuals.

Education of Health Care Professionals

In their review article, Safer et al. cite lack of provider knowledge and cultural competence as barriers to access to care for transgender individuals (2016). The hospital accrediting body, the Joint Commission, also recognized healthcare systems lack of knowledge as a barrier. In 2011, they published a field guide to promote advancing

knowledge and care of the LGBT community. Their guide includes recommendations for systems at four levels: leadership, provision of care, workforce, and community engagement. The provision of care level focuses on preparing the staff and organization to provide high quality care. In the medical field, this training can be presented via continuing education.

In their study of seventy-six participants at a cultural competency training for those caring for aging LGBT community, Porter and Krinsky demonstrated positive changes associated with the training (2014). Their study compared pre and post test data and found a statistically significant increase in awareness of resources for transgender individuals among the care providers (N, 76; $T=8.39$; $P=0.00$). They also showed an increase in participants' willingness to challenge a homophobic or transphobic remark (N, 76; $T=3.559$; $P = .000$). Similarly, Felenstein studied a hybrid computer module and panel discussion training to increase LGBT cultural competence in a clinic setting (2018). Felenstein found that 72% of the eleven individuals who participated in the intervention felt more prepared to care for LGBT patients than before the intervention. While these studies are small, they show positive effects on increasing knowledge of this population.

Hasseman, Morrison, and Russian conducted a study on the effectiveness of three transgender and gender non-conforming health care professional trainings utilizing both qualitative and quantitative means (2007). They conducted a posttest with both quantitative and qualitative analysis of the attendees' perceptions. They found statistically significant increases in provider knowledge in the quantitative analysis. However, the qualitative analysis revealed weaknesses of the training such as failure to convey diversity among those within the transgender community. The authors of the study created recommendations for training modules based on their findings. These include creating

specific objectives for training programs, being sure to offer resources to providers that can be used by the professionals to learn more, as well as materials that can be distributed to patients. Furthermore, the study discussed the importance of including members of the trans community in development of the intervention to ensure both future connections for caregivers and patients as well as the quality of the content delivered.

Mansouri and Lockyer performed a meta-analysis of the literature addressing outcomes in continuing medical education (2007). In their analysis of 61 studies, they found active and mixed methods had medium effect sizes on learning ($r = 0.33$; CI, 0.13–0.50 and $r = 0.33$; CI, 0.24–0.43; respectively). Whereas passive methods of learning only produced a small effect ($r = 0.20$; CI 0.15- 0.26). This data shows the importance of designing interventions that actively involve participants.

Limitations in the Data

There are several limitations across published studies examining the transgender population. Importantly, none of the studies in this literature review were randomized controlled trials, which is considered the gold standard of research. Furthermore, many of the studies utilized on line surveys which limits respondents to those who have both access to the internet as well as the computer skills necessary to complete the study. The majority of the participants across all studies were white, limiting the data on racially diverse populations which have historically experienced higher rates of marginalization. There is also a lack of funding for transgender research contributing to the lower volume of research in this area. Lastly, this population is very difficult to fully engage as evidenced by the lack of data regarding the prevalence of transgender people, which in itself leads to difficult data collection.

Conceptual Framework

The conceptual framework for this project is based on cultural humility. Cultural humility was first introduced by Tervalon and Garcia as an alternative to cultural competence (1998). The concept of cultural humility offers a continual growth perspective on culture as opposed to a subject to be mastered. Tervalon and Garcia state:

Cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial non-paternalistic partnerships with communities on behalf of individuals and defined populations. (p. 123)

Cultural humility allows the practitioner to first recognize one's own background before approaching patients. The practitioner must examine their position of power as well as the privileges accessed in one's lifetime. Fisher-Borne, Montana Cain, and Martin's work with cultural humility outlines "three core elements: institutional and individual accountability; lifelong learning and critical reflection; and mitigating power imbalances" (2015, p. 174). Their work outlines the importance of considering the institution's role in working towards a more egalitarian space. Fisher-Borne et al. offer a check list of individual and organizational questions to assess cultural humility. They are questions about getting to know one's personal beliefs better such as "What are my initial reactions to clients, specifically those who are culturally different from me?" (p. 176). Or examining institutional culture "Does our organization's culture encourage respectful, substantive discussions about difference, oppression, and inclusion?" (p.176.). As well as questions about the organization's actions such as "What training and professional development opportunities do we offer that address inequalities and encourage active self-reflection

about power and privilege?” (p.176). Throughout the development of this toolkit and training, the underlying spirit of this DNP project will follow the concept of cultural humility, seeking to be aware and accountable to personal and organizational beliefs and working towards a culture of equality for all.

Methodology

Institutional Review Board

The Swedish Medical Group’s institutional review board (IRB) representative determined the project “Not Research. The Seattle University’s IRB determined the project “Not Human Subjects Research”.

Intervention Description

Practice Setting. This intervention takes place in the convenient care clinic division of a primary care group that is owned by a large network of hospitals and clinics within the Seattle area. The clinics offer same day services for acute illnesses, minor injuries, sports physicals, and screenings for sexually transmitted diseases. There are eleven individual locations throughout the greater Seattle area located within a large national chain pharmacy, each staffed by one provider (mostly advanced practice clinicians) and a medical assistant. They offer extended hours, open twelve hours each day, 365 days a year, for increased access. The service line is open to all patients, accepting the majority of insurance plans including Medicaid and Medicare as well as offering a self-pay option. The office space consists of two exam rooms which also serve as the area for patient registration; there is no front office. Patients are able to schedule appointments online, by calling a toll-free number, or by walking in. After the visit, if patients are

in need of a primary care provider, clinic staff attempt to connect patients to a provider.

Intervention. An informal needs assessment of the clinics' transgender care readiness was conducted through policy analysis, reviewing the electronic medical record capabilities, consultation with the primary care division's Sexual Orientation and Gender Identification (SOGI) work group, and conversations with leadership and staff.

Community stakeholders including local transgender advocates were consulted. It was determined that patients have expressed dissatisfaction with the care received within the health care system related to being mis-gendered. Furthermore, leadership reported deficiency in knowledge in caring for transgender patients which have led to suboptimal care.

From the assessment, a list of program goals and objectives were developed. The staff training curriculum (Appendix A) was adapted from SOGI training that had been developed for primary care medical assistants and front office. The curriculum was then refined utilizing principles outlined in The National LGBTQ Cancer Network's "Best Practices in Creating and Delivering LGBTQ Cultural Competency Trainings for Health and Social Service Agencies" (Margolies, Joo, & McDavid, n.d.) and the National Organization of Nurse Practitioner Faculties' "Patient-Centered Transgender Health: A Toolkit for Nurse Practitioner Faculties and Clinicians" (Selix & Waryold, 2018).

The educational workshop took place at a mandatory in-person staff meeting. There were 40 participants including administration, clinicians, and medical assistants. The trainers included author and the organization's primary care division SOGI trainer. The teaching methodology included lecture with power point, a question and answer session, and role playing. Active participation was highly encouraged. See appendix A for curriculum, appendix B for presentation slides. The toolkit the author created (Appendix F)

along with the organization's previously established LGBTQ workflows were printed and given to participants as well as placed on the clinic's intranet sharing site.

Sample and Recruitment

Participants in the training were the employees of the eleven greater Seattle area convenient care clinics. The participants were medical assistants (MAs), physician assistants (PAs), advanced registered nurse practitioners, (ARNPs), a medical doctor (MD), and clinic administration. While participation in the staff meeting at which the intervention was held was mandatory, participation in the surveys was voluntary. The participants were emailed the surveys. A written informed consent was in the body of the email of the pre/posttest and follow up survey.

Measurement

The pretest, posttest, and follow up survey were designed with input from "Best Practices in Creating and Delivering LGBTQ Cultural Competency Trainings for Health and Social Service Agencies" (Margolies, Joo, & McDavid, n.d.). They were reviewed for face validity by Seattle University professors within the College of Nursing well versed in survey development as well as those who are experts in LGBTQ care. The pretest (Appendix C) has nine questions- one true/false, 6 multiple choice, and two demographic questions. The posttest (Appendix D) included the same nine questions from the pretest with the addition of three questions reviewing the content and quality of the in person intervention. The true/false question assesses comfort with caring for gender non-conforming patients. The six multiple choice questions measured knowledge. For example, "What is the

best way to determine which STI testing is necessary?”. The demographic questions included role at the clinic (i.e. MA, PA, ARNP, MD, or administration) and years in practice (i.e. 0-5, 6-10, 11-15, and 16 plus).

The follow up survey (Appendix E) included eight questions- three yes/no, three open ended, and the same two demographic questions as the pre/posttest. The yes/no questions asked if the respondent had cared for a gender non-conforming individual since the training, if they felt more comfortable in caring for the transgender individual since the training, and if they utilized the toolkit. The open ended questions included space for noting any practice changes, recommendations for increasing inclusivity and suggestions for further learning opportunities.

Data Collection Procedures

The pre training assessment, post training assessment, and follow up survey were distributed through Qualtrics, an online survey tool, to the administration, clinicians, and medical assistants via work email. All participants employed by the service line were included in the distribution but participation in the survey was voluntary. The pretest (Appendix C) was distributed two weeks before the in-person workshop and the posttest (Appendix D) was distributed the day of the in-person intervention. Reminder emails were sent one week after the initial pre/posttest mailing. The program evaluation survey (Appendix E) was distributed via Qualtrics one month after the in-person training. All surveys were de-identified including IP addresses. The three assessments were not linked.

Results

Data Analysis

Data were analyzed both through reports available through Qualtrics as well as through exporting data from Qualtrics into Microsoft Excel. Descriptive statistics were used to analyze perception of the training. The scores for the matched knowledge base questions on the pre/posttest were then analyzed for statistical difference utilizing a one-way t-test of different variance via Microsoft Excel. Increased confidence was measured through the pre/posttest question asking if participants felt comfortable caring for gender non-conforming individuals. The responses were analyzed using a one-way t-test via Microsoft Excel. Furthermore, descriptive statistics were used to analyze the follow up survey question “Do you feel the training increased your confidence in providing care to the transgender individuals?”. Increased sensitivity and practice change were measured with narrative responses which were analyzed by hand for themes.

Review of Training Session

The pre-test had 26 responses, the post-test had 13 responses, and the program evaluation had ten responses, however, only 6 responses were completed in full. In the one month period following the educational session six out of ten respondents (60%) cared for a transgender individual. In evaluation of the in person training environment, 12 of the 13 respondents (92%) found the inclusive. Furthermore, 11 of the 13 respondents (84%) found the presenters “very knowledgeable”. The respondents found each of the topics either “Very Useful” or “Useful” with terminology being ranked the most useful by 100% of the respondents. In the follow up survey 12.5% (N=8) of respondents utilized the toolkit.

Knowledge

The six knowledge assessment questions on the pre and posttest were graded for correct answers. The mean score for the 26 respondents of the pre-test was 62.2% (SD= 13.8) The mean score for the 13 respondents of the post-test was 84.6% (SD= 14.4).

Despite a small sample size, there was a significant difference between the pretest and post test scores; $t(23) = 1.7, p < 0.001$.

Confidence

Increased confidence was measured by asking participants during both the pre and posttest, "I feel comfortable providing care for gender non-conforming patients." In the pretest, there were 26 respondents, 84.6% stated they felt comfortable. In the post test, there were 13 respondents and 84.6% stated they felt comfortable. Of the respondents in the pretest (n=4) and the posttest (n=2) that did not feel comfortable, 83.3% had been in practice for more than 6 years. In the follow up survey, 83.3% (N=6) of the respondents stated the training increased their confidence in caring for gender non-conforming patients. Two of the trainees sent text messages to the researcher remarking on a positive experience they had with a transgender patient after the training. They both thanked the trainer for providing tools to increase confidence in delivering care.

Practice Change

In the month after the training and the follow up survey, 60% (N=10) of respondents had the opportunity to care for a gender non-conforming patient in the clinic. Two respondents commented on the question asking if there were any recommendations for improving care for transgender individuals in the clinic. One stated, "treat them like a normal person." The other respondent recommended "displaying the caregiver's personal pronouns". In analyzing the open ended question aimed at practice change, four themes

were identified. Themes included increased awareness, increased desire to determine patients' preferences, increased confidence, and increased knowledge of the tools. One respondent noted they have implemented the practice change of "looking at their preference before starting a conversation." This demonstrates both awareness of the need to look as well as knowledge of where to do so. Increased confidence was demonstrated through the comment that the respondent is "more confident about asking sexual practice details."

Discussion

Overall, this quality improvement project, found favorable outcomes in regard to knowledge development and confidence of the clinical staff. With regard to the training itself, overall caregivers found the environment inclusive and the trainers knowledgeable. However, after one month of the training, only one of the eight respondents had utilized the toolkit. This could be due to limited respondents or the nature of the clinics which provide same day services for acute illnesses and therefore needs for further resources were limited.

Despite a small sample size, there was a statistically significant improvement in participant knowledge of transgender care ($t(23) = 1.7, p < 0.001$). This indicates the training is effective in disseminating important information about the transgender populations and ways to improve care. The training was in person and utilized active learning. It would be interesting to compare knowledge increase after the in person training versus an online training that is available on the health care systems website.

In regard to confidence, there was no change, with 84.6% reporting feeling confident between the pre-test and post-test. However, in the follow up survey, 83% of the respondents stated the training did increase their confidence. The

former finding may be limited as the pre-test had more respondents than the posttest and the responses were not linked. Of note, of the individuals after the training who did not feel comfortable caring for gender non-conforming individuals, all had been in practice between 11-15 years, the highest number of years for the cohort. This may be because clinical education greater than ten years ago did not include any education on LGBTQ care or this may be related to generational comfort with LGBTQ issues. Two personal messages received by the author expressed increased confidence and improved satisfaction with patient visits after the training. These messages also noted the patient expressed gratitude for LGBTQ friendliness of the clinic and noted that this was an improved health care experience from previous encounters. This indicates that the training is not only increasing caregiver knowledge and confidence but assisted in reaching the ultimate goal of decreasing health disparities and discrimination for transgender individuals.

Increased sensitivity and practice change are evident through narrative responses on the follow up survey in which individuals came up with ideas for increasing clinic inclusivity. Furthermore, one participant emailed the author and stated he incorporated asking the gender of patient's sexual partners into his practice. He noted that he was pleased to have asked as his patient responded she was in a same-sex relationship. Another participant noted they "feel more confident about asking sexual practice details." Respondents also noted they are using gender neutral language, looking at patient pronouns and asking the patient how they would like to be addressed. Another respondent noted increased knowledge of the utilizing the electronic medical record's SOGI options. One respondent simply noted they are "more aware". This awareness correlates to the theoretical basis of the project. Awareness is a main tenant of cultural humility and the

foundation for approaching patients. If caregivers are aware of themselves and that their background is unique, it can help them in navigating their relationships with all patients.

Limitations

A main limitation of the analysis of this quality improvement project was that the pre-test, post-test, and follow up survey were not linked. This limited the ability to determine if the same individual increased understanding. Further limitations include sample size. The small sample size made it difficult to determine statistical significance.

For future quality improvement projects, the survey questions should be modified. In the post test, the participants should be asked if they found the training useful. Also, a question should be included to ask participants what further information they would have liked. There should also be an open comment section so that participants have the opportunity to share other thoughts and opinions. Furthermore, the survey only had face-validity. In the future a more rigorous validation of the surveys is recommended.

Conclusions and Implications for Practice

The transgender community suffers from increased rates of discrimination and health disparities. Access to culturally sensitive care can improve health care outcomes as well as patient experience. Medical training programs offer limited education on LGBTQ issues. Convenient care clinics offer an accessible portal to health care systems. By developing welcoming clinics that provide competent care, transgender individuals will have decreased health care avoidance and discrimination.

The SOGI training in the convenient care clinic increased caregiver knowledge of transgender care. The participants showed improved sensitivity to LGBTQ patients and noted increased confidence in specific aspects of care. A few trainees noted improved patient experiences since the training. This educational session should be included in new hire orientation for all clinic staff in order to reduce health disparities for this vulnerable population. The clinics should also continue to work on being inclusive when creating new documents and marketing.

Future Plans

A written analysis and discussion of the data will be distributed to the organization's leadership along with all of the participants. The educational session has been delivered to another service line within the organization. The author is working with the SOGI coordinator to implement more trainings throughout the organization. The author also plans to advocate for the incorporation of more LGBTQ content into nursing education.

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Appendix A

Curriculum and Teaching Methodology

1. Introduction
 - a. Introductions
 - b. Objectives
 - c. Review of the organization's mission, vision and values
 - d. Review of cultural humility
 - i. Teaching methodology: power point slide at workshop
 1. 10 minutes
2. Increase caregivers' knowledge of LGBTQ community
 - a. Outline the definitions and concepts of the gender identity, gender expression, and sexual orientation and those definitions associated with these concepts
 - b. Review gendered language
 - i. Teaching methodology: power point slide at workshop
 1. 10 minutes
 - c. Have participants utilize the "Genderbread person" to reflect on self and apply terminology to self
 - i. Teaching methodology: worksheet
 1. 2 minutes
3. Increase understanding of the health disparities among the LGBTQ populations
 - a. Review increased rates of discrimination in the trans community including within the health care setting
 - i. Teaching methodology: video from transgender patients

1. 6 minutes
 - b. Review high rates of mental health disorders including suicide
 - c. Review social determinants of health and their effect on health outcomes
 - d. Review intersectionality and role in discrimination
 - i. Teaching methodology: power point slide at workshop
1. 5 minutes
4. Review Gender Affirming Therapy
 - a. Review WPATH's and UCSF's standards of care
 - i. Teaching methodology: power point slide at workshop
1. 5 minutes
5. To Review Sexual Health
 - a. Review incidence of HIV
 - b. Review terminology for discussing sexual activity
 - c. Review appropriate screening tools for STIs
 - d. Review PREP
 - i. Teaching methodology: power point slide at workshop
1. 10 minutes
6. Review strategies for inclusion in the clinic
 - a. Review scripted language recommendations
 - b. Review EMR options for SOGI
 - i. Teaching methodology: power point slide at workshop
1. 5 minutes
- c. Have participants brainstorm strategies of inclusion
7. Review resources


- a. Review printed packet papers
 - i. Teaching methodology: Review
 - 1. 5 minutes
- 8. Allowing for clarification
 - a. Take questions about above material
 - i. Teaching methodology: open forum questions/ written anonymous questions
 - 1. 5 minutes
- 9. Practice utilizing transgender sensitive skills
 - a. Role playing scenarios
 - i. Teaching methodology: role playing
 - 1. 10 minutes
- 10. Debriefing
 - a. Discuss difficulties and successes with role playing
 - i. Teaching methodology: Discussion
 - 1. 10 minutes

Appendix B

Training Slide Deck and Handouts


Sexual Orientation and Gender Identity Training

Swedish Express Care
Elizabeth Gallagher, MSN, ARNP, FNP-BC
Alex Kuller
February 8, 2019



Objectives

- To review cultural humility as a framework for caregiving
- To review concepts related to Sexual Orientation and Gender Identity (SOGI)
- To increase understanding of health disparities among the LGBTQ populations
- To review gender affirming therapy
- To review best practices in sexual health
- To brainstorm strategies for inclusion within the clinic
- To review documentation guidelines
- To preview resource toolkit
- To practice with case scenarios
- To answer participants' questions



Swedish Mission, Vision, and Values

- **Mission**
 - To improve the health and well-being of each person we serve.
- **Vision**
 - Health for a better world.
- **Values**
 - Compassion
 - Justice
 - Excellence
 - Dignity
 - Integrity
 - Safety






Image Source: Swedish Values Worksheet





Cultural Humility

- **Continual growth** as opposed to mastery of facts about a culture (Tervalon & Garcia, 1998)
- Must recognize one's **own background** (Tervalon & Garcia, 1998)
- Institutional and individual **accountability** (Fisher-Borne, Cain, & Martin, 2015)
- Lifelong **learning** and critical **reflection** (Fisher-Borne, Cain, & Martin, 2015)
- Mitigating power **imbalances** (Fisher-Borne, Cain, & Martin, 2015)




Terminology

Terminology

- **Gender Identity:** a person's internal sense of being male, female, some combination of male and female, or neither male nor female
- **Transgender:** of, relating to, or being a person whose gender identity differs from the sex the person had or was identified as having at birth
- **Cisgender:** of, relating to, or being a person whose gender identity corresponds with the sex the person had or was identified as having at birth
- **Nonbinary:** relating to or being a person who identifies with or expresses a gender identity that is neither entirely male nor entirely female
- **Genderqueer:** of, relating to, or being a person whose gender identity cannot be categorized as solely male or female (Merriam-Webster)



Terminology

Trans woman/ Male to Female/ MTF




Image Source: <https://www.kkkk.org/about-us/press-releases/mtf-transgender-panel/>

Trans man/ Female to Male/ FTM




Image Source: <https://www.cnn.com/2013/06/22/health/ftm-transgender-panel/index.html>

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Pronouns

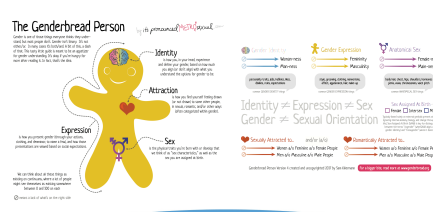
Subject/object/possessive/possessive pronoun/reflexive

- **She/her/hers/herself**
 - She has an 11:00 am appointment today.
- **He/him/his/hisself**
 - His temperature is 102F.
- **They/them/theirs/themself**
 - They are here for a sports physical.
 - I asked them to wait in the lobby until the room was available.
 - Their blood pressure is 120/80.
- **Zo/hir/hirs/hirself**
 - Zo is filling out the new patient form.
 - Hir pulse ox is 98%.
 - This urine sample is hers.
- **Name only**
 - Lynn has an appointment at 12:40 pm today.
- **Less common**
 - Per, ve, xe

(University of Wisconsin-Milwaukee, 2019)

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The Genderbread Person



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Health Disparities



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Health Disparities

- **21% of transgender individuals surveyed avoided seeking emergency care due to fear of discrimination** (Bauer, Scheim, Deutsch, & Masercola, 2014).
- For those who accessed care, often the healthcare provider **required education from the patient on transgender care** (Bauer et al., 2014).
- **High rates of prejudice** including difficulty finding a job, accessing health care, and eviction (Sardone et al., 2017).
- The likelihood of **depression is four times higher** for those identified as transgender (Dawson et al., 2017).

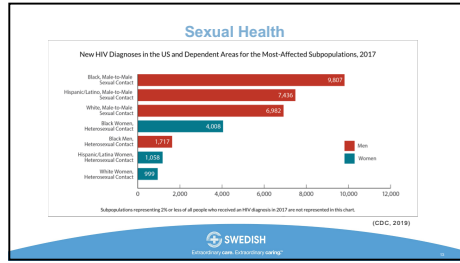
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Gender Affirming Care

- **At this time the diagnosis is Gender Dysphoria, there is a push to remove Non-hormone/non-surgical therapy**
 - Breast binding, hair removal, voice training, clothing
- **Hormone therapy**
 - Masculinizing: Testosterone
 - Feminizing: Estrogen, Anti-androgen, Progesterone (ie. spironolactone)
- **Surgical**
 - Masculinizing: Hysterectomy, Mastectomy, Phalloplasty and Metoidioplasty
 - Feminizing: Vaginoplasty, Breast augmentation

(World Professional Association of Transgender Health, 2011; World Professional Association of Transgender Health, 2012; USCF Center for Excellence of Transgender Health, 2016)

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- ### Sexual Health
- **Determining risk**
 - "Who do you partner with?" or "Do you have sex with individuals who have penises, vaginas, or both?"
 - "Which body parts do you use when you have sex or a sexual encounter?" or "Which parts of your body and a partner's body are part of sex for you?"
 - **CDC 2015 Guidelines for STI screening** (CDC, 2015)
 - **Pre-Exposure Prophylaxis (PREP)**
 - Use of Truvada (tenofovir and emtricitabine) to prevent transmission of HIV
 - Reduces the risk of getting HIV from sex > 90%. Reduces risk from IV/IDU by >70% (CDC, 2018)
 - For HIV negative high risk individuals (ongoing HIV+ partner, IV drug use, high risk sexual behavior)
 - Discuss risk reduction, HIV testing every 3 months, pregnancy testing ever 3 months, bacterial STI check every 6 months (CDC, 2014, CDC, 2018)
- SWEDISH
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- ### Sexual Health
- **Gonorrhea and Chlamydia**
 - Use the Aptima swabs for vaginal, cervical, urethral, pharyngeal, and rectal specimens
 - Dirty urine, no void 1 hour prior to specimen collection (LABcorp, 2019)
 - Treatment for Gonorrhea: Azithromycin with Ceftriaxone. If not available, use oral Cefixime, however increasing rates of resistance. If pharyngeal and using Cefixime, test of cure in one week. (Seymour, Smith, & Cohen, 2018)
 - Expedited Partner Therapy (EPT). Not recommended for MSM.
 - **Syphilis**
 - Blood draw
 - Treatment: primary care clinic, Harborview STI walk in clinic
 - **HIV**
 - Blood draw
 - Treatment: Primary care, County Doctor, Madison clinic, Harborview STI clinic
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- ### Strategies for Inclusion
- **Use gender neutral scripting**
 - "The patient is ready to be seen"
 - "What name would you like me to use?"
 - "Who did you bring with you today?"
 - **Use patient's pronouns in the chart**
 - Do not be overly curious in the patients gender identity
 - Keep chart notes relevant
 - "Non-binary assigned female at birth presents..."
 - **Updated the chart with the correct gender**
 - If you make a mistake, apologize and move on
 - **When taking every patient to the bathroom, show them both the male and female bathrooms**
 - No gossiping about patients
 - Remember the historical trauma patients have faced.
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Registration

- Under **Registration**, there is a **Sexual Identity and Gender Identity** tab
- It is **important to document name and pronouns correctly**
 - For patient comfort
 - To ensure team member understanding
- **Only use for name and pronouns**

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- ### Additional Resources
- **Handouts in your packet**
 - Respecting Patient's Sexual Orientation and Gender Identity
 - Sexual Orientation and Gender Identity Definitions & Scripting
 - Sexual Orientation and Gender Identification Workflow
 - CDC's 2015 STD guidelines
 - **LGBTQ Caregiver Resources**
 - **LGBTQ Patient Resources**
 - **Swedish Intranet LGBTQ page**
 - **Health Stream Module: PSJH: ICP SOGI Education**
 - **Third Annual LGBTQ+ Health Symposium: Health Disparities in Marginalized LGBTQ+ Populations**, Swedish First Hill, April 12, 2019
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Questions







Practice Scenarios


- Assign roles
 - Patient
 - Medical Assistant
 - Provider
 - Time Keeper
- Act out scenarios in each group
- Talk through the questions in the scenario
- Each case should take about 3 minutes





Reflection





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Who Am I?

Cultural humility calls us to reflect on who we are and our beliefs so that we better understand the lens with which we view the world.

The Genderbread Person^{v4}

⊗ means a lack of wheels on the right side

Gender Identity Gender Expression Anatomical Sex

Sexually Attracted to... Romantically Attracted to...

Educational Level _____ Race/Ethnicity _____

Socioeconomic status _____ Religious beliefs _____

(Graphic by Sam Killerman/The Safezone Project)

Practice Scenarios

Case 1:

Background: You are registering a new walk-in patient for an appointment at [the clinic]. The driver's license states the patient's gender is Male. On the registration form, the patient notes the pronoun as "She/Hers".

Instructions: Assign a patient and a caregiver. Walk through the registration. As a caregiver, do you need to ask the patient any clarifying questions? Which pronoun will you use to describe the patient in the note?

Case 2:

Background: A Male to Female (MTF) transgender patient presents for STI testing. The patient is established, the gender listed in the chart is listed as Female. There are no notes regarding hormone status or surgical status. However, a previous ED note states the patient is MTF.

Instructions: Assign roles of a patient, a MA, and a clinician. Walk through the visit. What language will you use to determine what testing is needed? How much detail will you ask the patient to share? What testing will be performed? How will you document the rationale for which testing was completed in the chart?

Case 3:

Background: A MTF patient present for URI symptoms. The last time they were seen at the organization was 5 years ago and their chart lists Male as the gender. The ID lists the gender as Female. The patient presents as female. If asked, the patient uses they/them pronouns.

Instructions: Assign roles of a patient, a MA and a clinician. Start with registration of the patient. How will you proceed? Will you change the gender? Will you ask the patient about changing the gender? How will you determine which pronouns to use? Then as the clinician, practice the visit with the patient utilizing they/them pronouns. Go through the visit (asking HPI, etc) to practice using they/them pronouns.

Appendix C

Transgender Cultural Humility Training Pre Test

1. I feel comfortable providing care for gender non-conforming patients.
 - a. True
 - b. False
2. Which best described the term transgender?
 - a. Someone who prefers to wear clothing of the opposite sex.
 - b. Someone who is attracted to a member of their biological sex.
 - c. A person whose gender identity differed from their assigned sex assigned at birth.
 - d. A person whose born with a combination of male and female biological characteristics, such as chromosomes or genitalia.
3. A MTF (male to female) patient present to clinic. The gender on the ID is listed as male, the patient presents as female, and on the registration form the pronouns are listed as they/their. When documenting in the chart, which of the following statements should the caregiver write?
 - a. She presents to clinic complaining of a sore throat. She states the pain started yesterday afternoon.
 - b. They presents to clinic complaining of a sore throat. They states the pain started yesterday afternoon.
 - c. He presents to clinic complaining of a sore throat. He states the pain started yesterday afternoon.
 - d. They present to clinic complaining of a sore throat. They state the pain started yesterday afternoon.

4. What percentage of transgender individuals avoid medical care due to fear of discrimination?
 - a. 21%
 - b. 6%
 - c. 54%
 - d. 13%
5. What is the best way to determine which STI testing is necessary?
 - a. Allow the patient to tell you his/her sexual preference.
 - b. Screen every patient for oral, genital, and anal STIs.
 - c. Ask patients if they have sex with men, women, or both.
 - d. Ask if they engage in sex with individuals with penises, vaginas, or both.
6. A new patient comes into the clinic. The state ID lists the gender as male but a note on the registration form states the pronoun the patient uses is female. How do you proceed?
 - a. You register them as male as that is congruent with their state ID.
 - b. You register them as female as that is congruent with the gender pronoun the patient uses.
 - c. You register them as male, but you put the gender pronoun the patient uses in a sticky note in Epic.
 - d. You register the patient as male, but you put the gender pronoun the patient uses under the preferred pronoun tab.
7. A transgender patient presents for flu like symptoms. Is it necessary to determine hormone therapy status or surgical status?

- a. Yes
 - b. No
8. What is your role at Express Care?
- a. Medical Assistant
 - b. PA
 - c. ARNP
 - d. MD/DO
 - e. Administration
9. What are your years in practice?
- a. 0-5
 - b. 6-10
 - c. 11-15
 - d. 16+

Appendix D

Transgender Cultural Humility Training Post Test

1. Did you feel the environment of the training was inclusive and welcoming of questions?
 - a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree

2. Did the trainers seem knowledgeable about the topic?
 - a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree

3. Please rate the following parts of the training.

Topic	Very useful	Somewhat useful	Not useful	Not covered
Cultural humility				
Terminology				
Health disparities				

Gender affirming treatment				
Resources				
Role playing exercises				

4. I feel comfortable providing care for gender non-conforming patients.
 - a. True
 - b. False

5. Which best described the term transgender?
 - a. Someone who prefers to wear clothing of the opposite sex.
 - b. Someone who is attracted to a member of their biological sex.
 - c. A person whose gender identity differed from their assigned sex assigned at birth.
 - d. A person whose born with a combination of male and female biological characteristics, such as chromosomes or genitalia.

6. A MTF (male to female) patient present to clinic. The gender on the ID is listed as male, the patient presents as female, and on the registration form the pronouns are listed as they/their. When documenting in the chart, which of the following statements should the caregiver write?
 - a. She presents to clinic complaining of a sore throat. She states the pain started yesterday afternoon.

- b. They presents to clinic complaining of a sore throat. They states the pain started yesterday afternoon.
 - c. He presents to clinic complaining of a sore throat. He states the pain started yesterday afternoon.
 - d. They present to clinic complaining of a sore throat. They state the pain started yesterday afternoon.
7. What percentage of transgender individuals avoid medical care due to fear of discrimination?
- a. 21%
 - b. 6%
 - c. 54%
 - d. 13%
8. What is the best way to determine which STI testing is necessary?
- a. Allow the patient to tell you his/her sexual preference.
 - b. Screen every patient for oral, genital, and anal STIs.
 - c. Ask patients if they have sex with men, women, or both.
 - d. Ask if they engage in sex with individuals with penises, vaginas, or both.
9. A new patient comes into the clinic. The state ID lists the gender as male but a note on the registration form states the pronoun the patient uses is female. How do you proceed?
- a. You register them as male as that is congruent with their state ID.
 - b. You register them as female as that is congruent with the gender pronoun the patient uses.

- c. You register them as male, but you put the gender pronoun the patient uses in a sticky note in Epic.
 - d. You register the patient as male, but you put the gender pronoun the patient uses under the preferred pronoun tab.
10. A transgender patient presents for flu like symptoms. Is it necessary to determine hormone therapy status or surgical status?
- a. Yes
 - b. No
11. What is your role at Express Care?
- a. Medical Assistant
 - b. PA
 - c. ARNP
 - d. MD/DO
 - e. Administration
12. What are your years in practice?
- a. 0-5
 - b. 6-10
 - c. 11-15
 - d. 16+

Appendix E

Program Evaluation Survey

1. Since the in person training, have you cared for a gender non-conforming patient in the Express Care setting?
 - a. Yes
 - b. No
2. Do you feel the training increased your confidence in providing care to the transgender individuals?
 - a. Yes
 - b. No
3. Explain any practice changes you have implemented since the training.
4. Have you utilized the resources in the toolkit?
 - a. Yes. Which resources?
 - b. No
5. Are there any other resources you wished you had?
6. Any recommendations for enhancing the patient experience of LGBTQ patients at Express Care?
7. What is your role at Express Care?
 - a. Medical Assistant
 - b. PA
 - c. ARNP
 - d. MD/DO
 - e. Administration
8. What are your years in practice?

- a. 0-5
- b. 6-10
- c. 11-15
- d. 16+

Appendix F

Toolkit

LGBTQ Resources for Caregivers**World Professional Association for Transgender Health (WPATH)**

- “To promote evidence based care, education, research, advocacy, public policy, and respect in transgender health.”
- Professional organization. Published the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People
- Website: <https://www.wpath.org/>

UCSF Center of Excellence for Transgender Health

- “Increasing access to comprehensive, effective, and affirming healthcare services for trans communities.”
- Guidelines for primary and gender-affirming care for health care providers
- Website: <http://transhealth.ucsf.edu/trans?page=guidelines-home>

The Fenway Institute

- “The mission of Fenway Health is to enhance the wellbeing of the lesbian, gay, bisexual and transgender community and all people in our neighborhoods and beyond through access to the highest quality health care, education, research and advocacy.”
- National LGBTQ Training Center has publications and training materials on LGBTQ health
- Website: <https://fenwayhealth.org/the-fenway-institute/>

The Safezone Project

- “Our mission is to create and provide free online resources to make your Safe Zone trainings (and all of your LGBTQ+ educational opportunities) effective, fun, dynamic, and impactful.”
- Free, downloadable training program
- Website: <https://thesafezoneproject.com/>

CDC STD Treatment Guidelines 2015

- Screening and treatment guidelines for STI
- Website: <https://www.cdc.gov/std/tg2015/default.htm>

Health Stream Module

- PSJH: ICP SOGI Education

LGBTQ Resources for Patients



Ingersoll Gender Center

- "An organization for and by transgender and gender non-conforming people. Providing mutual support through peer led support groups, advocating in navigating resources, community organizing, and education- all in the pursuit of our collective self-determination".
- Can email Ingersoll for help in accessing health care providers
- Website: <https://ingersollgendercenter.org/>
- Phone: (206) 849-7859
- Location: 911 E Pike St Suite #221 Seattle, WA 98122

Gay City

- "Promoting wellness in LGBTQ Communities by providing health services, connecting people to resources, fostering arts, and building community."
- Offer donation-based HIV/STI testing services for asymptomatic men who have sex with men, transgender men and women, gender non-conforming and non-binary people. Rapid HIV testing for all at Out of the Closet. They also have a prep clinic. Can also help with finding insurance.
- Website: <https://www.gaycity.org/>
- Phone: (206) 860-6969
- Location: 2 locations in Capitol Hill, Seattle.

Entre Hermanos

- "To promote the health and well-being of the Latino Gay, Lesbian, Bisexual, Transgender, and questioning community in a culturally appropriate environment through disease prevention, education, support services, advocacy and community building."
- Free Spanish bilingual HIV testing on Mondays, case management and support for HIV+ individuals, immigration assistance
- Website: <https://entrehermanos.org/>
- Phone: (206) 322-7700
- Location: 1621 N Jackson Street Suite # 202 Seattle, WA 98144

**PFLAG**

- “Our mission is to provide support, education, and advocacy. To that end, we offer a multitude of resources and services.”
- For LGBTQ individuals, their families, and allies
- Seattle Chapter website: <https://www.pflagseattle.org/>
- Bellevue/Eastside Chapter <https://www.pflagseattle.org/>

Seattle Children’s Gender Clinic Reading List

- Booklist for parents, friends, and children
- <https://www.seattlechildrens.org/globalassets/documents/clinics/pe2634.pdf>

Lambert House

- “Lambert House empowers lesbian, gay, bisexual, transgender, and questioning youth through the development of leadership, social, and life skills.”
- Youth programming including a drop in center M-F 4-9:30
- Website: <http://www.lamberthouse.org/>
- Phone: 206-322-2515
- Location: 1818 15th Ave on Capitol Hill in Seattle (between E Howell & E Denny Way).