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Insight into Student Perceptions of LGBTQIA+ Content Inclusion in BSN Education

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Abstract

Previous research has indicated that LGBTQIA+ clients continue to receive discriminatory care from healthcare professionals. Undergraduate nursing students (n = 24) completed a survey inquiring about their perceptions of knowledge of this vulnerable population, their preparedness to provide care, and the education they received from their BSN program. Twenty-two students' responses, 91.67%, indicate a need for further education on the provision of care to LGBTQIA+ patients. These students demonstrated discrepancies in their perceptions and the application of their knowledge. As such, nursing programs should begin to consider providing more thorough education on this vulnerable population to prepare student nurses with practical skills to provide competent care to address care deficits affecting this community.

Insight into Student Perceptions of LGBTQIA+ Content Inclusion in BSN Education

The lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) community, is a historically marginalized population according to the Institute of Medicine (IOM) (2011). The community is often recognized as a singular entity despite the differences between romantic and sexual attraction and gender identity (IOM, 2011). In literature, this division between lesbian, gay, and bisexual (LGB) identities and transgender or gender non-conforming identities may be observed in nursing literature. Research within nursing, while limited, has focused largely on same-sex attraction orientations according to Walsh and Hendrickson (2015). Nursing literature has been examined by Eliason, Dibble, and DeJoseph (2010) regarding the limited quantity of research that has been conducted pertaining to these populations; the authors found that only eight of 5,000 articles published in the previous five years by the ten largest journals in nursing addressed lesbian, gay, bisexual, and transgender (LGBT) populations. In the same year, Lambda Legal (2010) produced a report stating the LGBT community and those living with human immunodeficiency virus infection [HIV], were continuing to experience discrimination in health care. In their survey, 56% of LGB and 70% of transgender respondents reported discriminatory behaviors by healthcare professionals; these behaviors included the refusal to touch or excessive utilization of precautions while providing care, the use of abusive language, or being physically abusive or rough during care. Further 7.7% of LGB and 26.7% of transgender patients were denied care because of their sexual orientation or gender identity (Lambda Legal, 2010, p. 10). The purpose of this research is to understand student nurses' perceptions of their knowledge pertaining to the care of this community and the preparatory education provided by their program such as to determine relationships indicating preparedness or need for further education.

Literature Review

Nursing students are incoming healthcare professionals. They may or may not have prior experience with client care. Additionally, nursing students may not be exposed to all populations that they may later serve. Nursing research has found that increased exposure to members of different cultural groups, such as the LGBTQIA+ communities, may decrease prejudice towards them (Brown, Keller, Brownfield, & Lee, 2017; Cornelius & Carrick, 2015). Brown, et al. (2017) concluded that students who received education and then developed confidence in their perception of their ability to provide care to diverse patient populations were more likely to develop competency in culturally appropriate care. Therefore, it may be presumed that the inverse, a lack of education regarding the LGBTQIA+ communities, can contribute to care deficits. Failure to educate nursing students on gender and sexual minority populations can contribute to the development of social stigma and prejudice that may impair students' ability to provide care (Walsh & Hendrickson, 2015). Surveyed nursing programs frequently report a limited number of hours spent on LGBTQIA+ content. Two studies in 2015 were published after surveying nursing faculty; one found that faculty only spent an average of 1.63 hours on LGBT community content, and the other study finding an average of 2.12 hours for the entire program (Walsh & Hendrickson, 2015; Lim, Johnson, & Eliason, 2015). This may be attributed to faculty and college staff as believing that LGBTQIA+ health care topics are inappropriate for discussion, unimportant to the students' education, or incompatible with the current design of curricula (Aaberg, 2016; Lim, Johnson, & Eliason, 2015; Walsh & Hendrickson, 2015; Echezona-Johnson, 2017). Nurse researchers have found that nursing students lack the appropriate understanding to provide adequate care to this population and have then argued that practicing nurses experience difficulty in providing care as well (Carabez, et al., "Nursing…," 2015; Carabez, et al.,

"Never…," 2015). Nurses in current practice may lack formal education on this patient population and have reported a discomfort treating LGBT patients. Nurse researchers have attributed this discomfort to uncertainty of how to provide culturally competent care or unaddressed bias towards this community (Carabez, et al., "Never…," 2015; Dorsen & Van Devanter, 2016). Practicing nurses have reported a need to learn how to provide competent care to the LGBT population specifically, which is in direct contrast with some peers who report that LGBT health education is inappropriate for organizational training (Carabez, et al., "Never…," 2015). This contrast is observed as a majority of professionals holding positive views regarding homosexuals, but results have demonstrated that a minority of professionals holding very negative views exists (Sirota, 2013). In addition to practicing nurses, nurse faculty may also lack the training necessary to educate nursing students on care for this population, with a majority unaware or having limited knowledge of health issues (Lim, Johnson, & Eliason, 2015; Sirota, 2013). This lack of knowledge by practicing nurses and faculty may perpetuate the provision of care that is not culturally competent.

Methods

Participants and Setting

The survey link was sent to 315 potential participants, of which only 24 consented and completed the survey for a 7.62% response rate. All participants were above the age of 18 and were enrolled in the same undergraduate BSN program at a Midwestern university. Students in a registered nurse (RN) to BSN or second-degree programs were excluded from the surveyed population due to increased likelihood of clinical practice experience with LGBTQIA+ community members. Regarding gender identity of the sample, 18 participants identified themselves as women (75%), five participants identified themselves as men (20.83%), one

participant identified as nonbinary and clarified that they identify as agender (4.17%). Regarding sexual orientation of the sample, 16 participants identified themselves as heterosexual (66.67%), four identified themselves as bisexual (16.67%), two identified themselves as homosexual (8.33%), one identified themselves as pansexual (4.17%), and one reported that they chose not to use an identifier but have “had sexual and romantic relationships with both men and women.” Both questions regarding gender identity and sexual orientation were designated to participants as “select all that apply” to enable those who use multiple identifiers to report them, only the single participant identifying as agender and nonbinary used this. In regards to religion among participants, 12 reported identifying themselves as Christians (50%), six identified themselves as atheists (25%), three identified themselves as agnostic (12.5%), one person identified themselves as spiritual (4.17%), one person reported as feeling unsure of their religious beliefs (4.17%), and one reported having no religious beliefs (4.17%). Regarding political ideology, seven identified themselves as very liberal (29.17%), five identified as slightly liberal (20.83%), seven identified as moderate (29.17%), and five identified as slightly conservative (20.83%).

Procedures

The 43-question survey was designed using the Qualtrics software for approval by the Midwestern university’s institutional review board. This survey did not use established instruments for development. The survey was composed of a brief demographic section. Following this, students answered seven-point Likert scales regarding their familiarity with the LGBTQIA+ community, health needs, disparities, and how to best communicate with identifying patients. The final question in this section was a seven-point Likert scale allowing participants to self-report their level of comfort providing care to LGBTQIA+ patients. If participants self-reported discomfort, they were given the option to self-report the origin of this discomfort. The

following section evaluated participants basic understanding of identities by asking for the participants definitions of identities such as cisgender, nonbinary, homosexual, and asexual. This section was followed by a series of six situational examples in which participants were asked about the provision of care to LGBTQIA+ community members and nonmembers. The final section of the survey asked students about their perception of the education they were receiving by their program and whether they felt this was sufficient. Permission for data collection was granted in early 2020. With permission granted, the student researcher coordinated with the BSN office of student services [OSS] to send emails containing information about the survey and the survey link. The OSS sent a total of three of these emails to potential participants. The data collection period was three weeks. The data was then analyzed using qualitative analysis in which the student researcher derived themes from participant responses and relationships between a participant's answers throughout the survey. This research is intended to identify and describe the relationship between students' perceptions of their knowledge and preparedness to provide care to this population, and the inclusion of education regarding this population in their program.

Results

Discrepancies in understanding

Identities. Student responses whilst defining LGBTQIA+ identifiers indicated a discrepancy in the students' understandings of sex and gender. In defining heterosexual and homosexual, 58.33% (n = 14) of students identified attraction as occurring between opposite or same sex partners. When defining heterosexual, 33.33% (n = 8) identified attraction as occurring between opposite gender partners; seven of those students then identified same gender attraction defining homosexual attraction, and one student submitted, "attracted to the same sex/gender."

When defining bisexual attraction, half of respondents used sex and a third used gender to indicate attraction. In one instance a participant defined bisexual as “those attracted to members of both the male and female genders." Regarding nonbinary persons, 54.17% of students (n = 13) defined this identity in gendered language such as, “an individual who does not identify with any gender or several genders.” Three students defined the identity using sexed language, and identified nonbinary as, “does not identify as male or female.” Four respondents used both sex and gender in defining this identity: “not identifying with either of the two ‘main’ genders male and female,” “someone who does not conform to the traditonal [sic] male-female binary gender system,” and “you do not identify with either male or female as a gender.”

Comfort providing care. Students responses to the Likert scale evaluating their comfort providing care to LGBTQIA+ clients can be viewed in Table 1. Half of the sample reported that they were moderately comfortable providing care, 45.83% of students (n = 11) reported that they were extremely comfortable in providing care, and one student reported feeling slightly uncomfortable providing care. Of the eleven students who reported themselves as extremely comfortable providing care to this population, 81.82% of respondents (n = 9) submitted errors in situational example questions. On average, these nine students submitted 2.94 erroneous responses to these survey questions, with the highest rate of errors being five responses of seven failing to meet target responses. The questions most frequently missed pertained to responding to a client’s self-disclosure of an unfamiliar identity (n = 6), identifying disparities experienced by the LGBTQIA+ community (n = 5), and identifying which clients to screen for substance use disorder (n = 5).

Discrepancies in knowledge

In their response submissions, students demonstrated discrepancies in their perceptions of having existing knowledge and the practical application of this knowledge. Student perceptions of their existing knowledge are displayed in Table 2.

Definitions. In their submissions of definitions for LGBTQIA+ identities students demonstrated these discrepancies. An example of this can be seen in the definition a participant provided of the identity cisgender: “not of the LGBTQ community.” This respondent self-reported that they agreed as having existing knowledge of the LGBTQIA+ community, which can be understood as also having knowledge of the identities outside of the community. These responses conflict with one another as cisgender persons may be homosexual, bisexual, pansexual, or identify along the asexual spectrum. Further, a respondent defined a transgender person as “an individual who identifies with the two socially known genders. male [sic] and female.” The identifier “transgender” is used broadly and as an umbrella term that includes gender nonconforming persons. This respondent had determined that they partially agreed to having existing knowledge of the LGBTQIA+ community. This student’s responses are therefore conflicting and demonstrating a discrepancy as their definition of transgender relies on binary identities. Regarding asexual identities, twenty students (83.33%) responded that asexual persons do not experience sexual attraction. Respondents wrote definitions such as: “lack of sexual attraction,” “not attracted to any sex,” and “without sexual feelings.” All twenty students agreed to having some existing knowledge of the LGBTQIA+ community, with 25% partially agreeing, 50% agreeing, and another 25% strongly agreeing. Only six respondents then clarified that asexual persons do not wholly lack sexual attraction, one student describing that asexual attraction is “more nuanced: doesn’t do so in a normative way and that the type that is

experienced may be less important to oneself than is typically experience [sic] by non-asexual people."

Situational Examples.

Safe sex education. The six situational examples began with surveying the nursing students on which clients should be asked about safe sex practices. A majority of students (n = 17), identified that all clients should have this need addressed. Seven students identified only some or one of the clients. Of these respondents, four did not identify the asexual person, one did not select the lesbian client who reports multiple partners, and two only selected the lesbian client. Those students who did not identify the asexual person had described asexual persons as lacking sexual attraction or the possibility of engaging in sex acts. All seven students had agreed and partially agreed to having existing knowledge of LGBTQIA+ health needs, but their determinations of who receives safe sex education directly conflicts this.

Scheduling a pap smear. The second situational example was focused on determining which clients were due to schedule a pap smear. Eleven students, 45.83%, identified the target response of cisgender women, nonbinary persons assigned female at birth (AFAB), and transgender men as candidates for this procedure. Seven students, 29.17%, did not identify at least these three populations. Six of these students identified cisgender women, AFAB nonbinary persons, and transgender women as candidates, and the remaining student identified only AFAB nonbinary persons and transgender women as candidates. The six students submitted appropriate definitions of transgender, and two partially agreed and three agreed to having existing knowledge about the health needs of the LGBTQIA+ community, which indicate a discrepancy in their selection of clients. The student who did not identify the cisgender woman reported lacking a definition for cisgender, which may explain why they did not select cisgender women;

however, this student partially agreed to having existing knowledge of health needs and submitted a definition that was partially aligned with the target response for transgender, indicating a conflict between responses.

Requesting pronouns. A majority of students, 79.17% (n = 19), submitted that all patients, regardless of gender identity, should be asked for which pronouns they use. Three students (12.5%) determined only the nonbinary person and transgender woman should be asked. One participant reported that only the nonbinary person's pronouns should be asked, and another determined that no patient should be asked. Of the five students who did not report a necessity to ask all clients, three reported themselves as extremely comfortable providing care to the LGBTQIA+ community. Their responses suggest a conflict between the provider's knowledge and their perception of their ability to provide care. One student disagreed, two partially agreed, and two students strongly agreed to having existing knowledge of how to communicate with LGBTQIA+ patients. Of the students who strongly agreed, one determined that only a nonbinary patient should be asked for their pronouns. Due to the nature of transgender persons identities, their identities or chosen name may not be input into their medical record which would require this student nurse to make assumptions about their clients and their needs.

Handling unknown identity disclosure. When surveyed on how the student nurse would respond to the disclosure of an unfamiliar identity, fourteen participants (58.33%) indicated that they would explain their lack of knowledge and request the client to educate them on their healthcare needs. Ten students (41.67%) reported that they would discuss the importance of the identity to the client and their wellbeing but would conduct research on their own to identify best practices. Of those who submitted that the client should provide medical advice about their own care, a majority rated some form of agreement to having existing knowledge of how to

communicate with LGBTQIA+ clients. Six respondents agreed and three respondents strongly agreed with having existing knowledge. Another three reported partial agreement with this statement. Only two students partially disagreed or disagreed with having existing knowledge of communicating with LGBTQIA+ clients. Those twelve students who agreed to having existing knowledge demonstrate a conflict of understanding the application of their knowledge with their selection in this situational example.

Health disparities. Regarding disparities experienced by the LGBTQIA+ community, 14 (58.33%) correctly identified that clients are at increased risk for mental health disorders, increased risk for substance use disorder, increased risk for body dysmorphia, and may experience lack of access to preventive care resources. Of the ten students who did not correctly identify these disparities, 60% submitted that LGBTQIA+ community members have increased utilization of healthcare, 20% reported that community members do not experience difficulty in accessing preventative resources, 20% did not identify an increased risk of body dysmorphia as a disparity, and 30% of these students reported that all transgender persons experience gender dysphoria requiring extensive transitioning. Of the ten students who did not submit the target disparities, only two self-reported that they did not or were unable to determine if they have existing knowledge on health disparities affecting the LGBTQIA+ community. Five participants reported that they partially agreed and three agreed to having existing knowledge of LGBTQIA+ health disparities. One participant who agreed to having existing knowledge made two errors in their selection of disparities. Eight students' perceptions of their knowledge were not reflected in the disparities that were selected.

HIV prevention education. When surveyed on who should receive HIV prevention education, 20 students (83.33%) determined that all clients should receive HIV prevention

education. The four clients the students were presented were: a heterosexual cisgender man; a homosexual cisgender man, a heterosexual cisgender woman, and a bisexual transgender woman. Four students submitted that they would not provide education to all clients. Two students determined that only LGBT patients should be educated on HIV prevention. Another two students determined that the only client that did not need education was the heterosexual cisgender man. Of those who did not submit all clients as needing HIV prevention education, all agreed or partially agreed to having existing knowledge of health needs for the LGBTQIA+ community. Only one student was in a semester of the program that had not yet covered HIV education. Additionally, of these four respondents, two had previously responded that asexual persons do not require safe sex education. These responses indicate a discrepancy in knowledge of health needs.

Substance use disorder screening. In regard to determining which clients should be screened for substance use disorder, thirteen students (54.17%) submitted all clients for screening. The clients included two LGBTQIA+ community members, one of which who was self-reporting use of illicit substances, and a heterosexual cisgender woman. Of the remaining students, ten (41.67%) determined that only the man who self-reported illicit substance use should be screened. One student determined that both LGBTQIA+ community members should be screened, but not the heterosexual cisgender woman. The target response included all clients. When student nurse responses for this situational example are compared against the corresponding existing knowledge areas, a majority of student's responses indicate discrepancies between student perceptions. The student who determined that only the LGBTQIA+ community members should be assessed for substance use disorder reported partially agreement with having existing knowledge of health disparities affecting the LGBTQIA+ community. Only one student

disagreed with having existing knowledge regarding health disparities, and their answer aligned with their response for this situational example. Excluding these respondents, the remaining participants demonstrate a discrepancy between their perceptions of existing knowledge of health disparities. These students agreed and partially agreed to having existing knowledge of the health needs of and the disparities affecting this community, but these ten students demonstrated otherwise when selecting only the self-reporting client.

Student perceptions of provided education

Of the 24 student nurses surveyed, only fifteen reported the inclusion of LGBTQIA+ content within their program. Fourteen of the respondents had completed their fourth semester in the program; the remaining student had completed their first semester. Eleven (73.33%) of the fifteen students reported education taking place in their theoretical education course. The remaining students submitted classes such as simulation, lab, and clinical placements. Ten of the fifteen students submitted responses when asked about their perceptions of the education provided. Five students described the education they received as inadequate: “it was brief and not very thorough,” “it was very limited,” “the education provided was surface level,” and “focused on disparities.” A second student submitted that the education was “brief, but helpful for practice.” Another student responded about the time provided responding that “not enough time given to present on the topic.” One student perceived that the education was “comprehensive but should have gone into more detail.” The final student found the education provided “thorough and adequate;” however, this student’s responses through the situational examples are contradictory to them providing knowledgeable and appropriate care. The students were then surveyed on the time spent on this education for each course applicable. The majority of respondents (n = 7) reported approximately 120 minutes were spent on the education, with the

minimum being 30 minutes and the maximum of 360 minutes. Students were asked if this was adequate time, and seven students submitted that it was inadequate, five submitted that the time they reported was adequate, two did not submit a decision, and one student did not submit a response. Students could then self-report what they would perceive to be adequate. Students who determined that their reported time was adequate either reported no change in the amount of time or lessened it to "directly for an hour, and briefly whenever necessary." Students who determined that their reported time was inadequate reported improvements of "more than two hours" when they reported "two hours total over the course of the four semesters in this program." Others requested substantially more time: one student indicated that six hours was necessary compared to the two they reported, and another indicated that eight hours was necessary compared to two hours. One student responded that "more than 10 hours per course would have been more appropriate" given the region. When surveyed whether this content was necessary for their education, 73.33% (n = 11) reported that it was definitely necessary, 13.33% (n = 2) reported that it was probably necessary, one student did not report a decision, and one student did not submit a response. When surveyed whether the students were comfortable applying this content and education to their practice, 80% (n = 12) of students identified that they were comfortable, 13.33% (n = 2) reported that they were not comfortable, and one student did not submit a response. Those students that reported themselves as not comfortable applying this education to clinical practice reported that the education was "not enough training" and the program "didn't have any practical strategies" and that the education left the student feeling "more comfortable doing my own research about this topic."

Discussion

Of the 24 completed surveys, only two sets of responses (8.33%) were submitted that matched the target responses. As such, 91.67% of the nursing students' responses indicate a need for further education on the provision of care to LGBTQIA+ patients. Only one student reported feeling uncomfortable providing care, and they elaborated, "I do not feel as though I have enough knowledge about the specific needs of the LGBTQ community to completely comfortably care for them."

Indications of bias

Some students' responses suggested a potential bias. One student defined transgender identity as, "someone who was born one gender but identifies as someone else." Transgender persons identify apart from the gender and sex society assigned them, but all other aspects of the person remain unchanged. Their internal characteristics are unchanged by this identity. Further, another student defined nonbinary as, "those who flaunt traditional binary distinctions." The tone of this response is inherently negative. Throughout this survey, students' responses were suggestive of making assumptions of clients. A student only selected the non-binary patient when determining who should be asked about their pronouns, but information on a given client's identity or a preferred name may not be added to their medical record; therefore, this student's response is suggestive of assuming the client's needs. The use of the correct pronouns is necessary for all patients. Avoidance of using a patient's correct pronouns may be regarded as a microaggression and endanger future access to necessary healthcare. Making assumptions regarding clients' cultures, beliefs, and needs is never appropriate. The LGBTQIA+ community has a broad culture and the various identities have their own needs and cultures. It is inappropriate to assume the client's identity and how to communicate with them effectively. As a

client may present in innumerable ways, it is up to the healthcare professionals to ask each client about their pronouns; this is supported by previous nursing research (Rounds, McGrath, & Walsh, 2013).

A call for education

Given that nursing research has demonstrated that education on cultural groups may decrease prejudice towards them, nursing literature directly calls for the development of educational content regarding the LGBTQ community for nursing curricula (Brown, et al., 2017; Cornelius & Carrick, 2015; Walsh & Hendrickson, 2015; Sirota, 2013; Lim, et al., 2015). Of these researchers, Walsh and Hendrickson (2015) and Cornelius et al (2015) had discussed that the lack of education regarding the LGBT community in nursing programs contributes to care deficits, which is observed in 91.67% of this sample's responses. Further, if health issues are taught in conjunction with highly stigmatized health issues such as HIV education, LGBT youth issues such as suicide and homelessness rates, and hate crimes, there is potential for the development of implicit bias. Lim, et al. (2015) identified that these discussions are often presented simultaneously. De Guzman, et al. (2018) identified that nursing textbooks that contain mention of LGBT identities discuss the community closely with topics such as substance use and sexually transmitted infections; further the analyzed textbooks did not supply content regarding the development of skill in providing competent care for this population, which one of the students expressed a need for. Respondents in Walsh and Hendrickson's (2015) study reported that their program would not include transgender health care in the curriculum unless it was incorporated into the NCLEX-RN blueprint or textbooks. Lim, et al. (2015) reported that their survey respondents also suggested that inclusion of LGBTQIA+ health issues within the NCLEX would increase the likelihood of these cultural groups being discussed in nursing curricula. The

lack of culturally appropriate education being necessary for accreditation means this content is often purposefully excluded as unnecessary for a program with limited time (Lim, et al, 2015). The students in this survey reported estimates of 120 minutes spent on LGBTQIA+ content in their program, which aligns with previous research. Several students then reported a need for additional time, supporting the findings of previous research (Lim, et al., 2015; Walsh & Hendrickson, 2015).

Limitations

There are several potential limitations in this study. Data was collected from one population of undergraduate BSN students at a single Midwestern university. Of a potential sample size of 315 potential participants, 24 students completed the survey. As such, the findings of this study cannot be generalized to other populations of undergraduate BSN students. Further, this study focused on those students obtaining their BSN for entry into practice, so the results are not generalizable to all BSN nursing programs, such as RN to BSN or second-degree programs. Additionally, the students opted to take the survey themselves which eliminated the opportunity for sampling protocol. Of 24 respondents, 8 identified themselves as LGBTQ. LGBTQ students may have been more likely to complete the survey than cisgender heterosexual peers. To prevent the student researcher from having access to private information of the studied population, such as names and contact information, the OSS was contacted to send the survey to the undergraduate BSN population. On assessment of the collected data, it was determined that a select all question regarding the course in which education was provided was designed as a multiple-choice question instead. This forced students to indicate only one course in which education was provided, rather than each course, thus limiting the data.

Conclusion

When education is introduced to nursing students, the presumption that students' external exposure is sufficient is proven false. Carabez, et al. (2015; "Nursing…") demonstrated through their study that nursing students, at all levels of education, lack the appropriate understanding to provide adequate care to this population. The results of this study concur with previous findings that nursing students are not prepared to provide care to LGBTQIA+ patients in a clinical setting. In conclusion, the student respondents demonstrated that despite being comfortable providing care, they do not possess the knowledge or understanding of the care and communication skills necessary. As such, nursing programs should begin to consider providing more thorough education on this vulnerable population to prepare student nurses with practical skills to provide competent care.

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Tables

Table 1

Student Nurse Perceptions of Comfortability in Providing Care

	Total (n = 24)	LGBTQIA+ (n = 8)	Non-Community (n = 16)
Extremely Uncomfortable	0	0	0
Moderately Uncomfortable	0	0	0
Slightly Uncomfortable	1	0	1
Prefer Not to Say	0	0	0
Slightly Comfortable	0	0	0
Moderately Comfortable	12	2	10
Extremely Comfortable	11	6	5

Table 2

Student Nurse Perceptions of Existing Knowledge

Focus	Strongly Disagree (percent)	Disagree (percent)	Partially Disagree (percent)	Undecided Prefer not to Say (percent)	Partially Agree (percent)	Agree (percent)	Strongly Agree (percent)
Community	0	0	0	0	25	54.17	20.83
Health Needs	0	12.5	8.33	0	33.33	41.67	4.17
Health Disparities	0	0	8.33	8.33	33.33	37.5	12.5
Communication	0	8.33	12.5	0	20.83	41.67	16.67