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Culturally Sensitive Emergency Care for Sexual and Gender Minority Youth

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Abstract

There is substantial evidence of disparities in access to healthcare and health outcomes affecting sexual and gender minority youth (SGMY). However, evidence surrounding SGMY cultural sensitivity training for pediatric emergency health professionals is limited. This quality improvement research project in an urban pediatric emergency department (PED) used a cross-sectional, pre-test post-test design to improve health professionals' knowledge, attitudinal awareness, and clinical preparedness in caring for this population. It was informed by the Institute for Healthcare Improvement's Model for Improvement and completed in four Plan-Do-Study-Act (PDSA) cycles. Evidence-based pedagogical strategies were utilized for a 60-minute staff training session, including introducing foundational terminology and health disparities, utilizing a content expert, and incorporating an experiential learning role-play. After the sessions, participants demonstrated an increase in LGBT-DOCSS scores with a statistically significant increase in the clinical preparedness subscale. The content was well-received by staff, and the intervention was made sustainable by integrating a web-based module into new nurse onboarding.

Keywords: sexual and gender minority youth, culturally sensitive care, health equity, continuing education, emergency care

Definitions

In a public health context, an individual's sexual orientation and gender identity drive a number of health-related behaviors, interventions and health promotion content. Recognizing that individuals' identities may be fluid or change over time is important to helping providers and health systems imagine and deliver care that reflects the unique risks and patient preferences that flow from identity. Additionally, the capacity to measure and monitor health disparities and the outcomes of quality improvement initiatives requires categorical variables that are less fluid than the identities they are constructed to represent. The acronym SGM has been created and adopted by public health agencies to include individuals who are attracted to or have sexual contact with people of the same gender and individuals whose gender identity or expression is different from their sex assigned at birth (The National Institutes for Health, 2020). The identities included in the umbrella term SGM can be both broad and distinct from one another or overlapping (e.g., lesbian, gay, transgender, non-binary, queer) and the authors have chosen SGM as the most inclusive term to acknowledge identity while also categorizing risk and focusing opportunity for improvement.

Introduction

Problem Description

Culturally sensitive care is an integral part of patient safety for sexual and gender minority-identifying youth (SGMY) presenting to the PED in a physical or mental health crisis. In the same way that call lights and bed rails prevent falls, culturally sensitive care is a critical safety measure that prevents diagnostic errors, missed screenings, harmful treatment interactions, and disruption of trust and a therapeutic alliance between patients and their healthcare providers (Brach et al., 2019, Fadus et al., 2020). Although most ED presentations are not directly related

to a patient's sexual orientation or gender identity (Janeway & Coli, 2020), culturally sensitive care, such as using a patient's preferred names and pronouns, are indispensable parts of patient safety for SGM patients.

Providers' implicit attitudes and stereotypes, believed to be caused by stress, stigmatization, homophobia, transphobia, and a lack of social support, unintentionally guide their behaviors and decision making (Apodaca et al., 2022; Ayhan et al., 2020). In a study of over 11,000 health care professionals' responses to implicit attitudes testing (IAT), nurses were found to have the strongest preference towards sexual and gender majority groups when compared to physicians, mental health providers, healthcare support workers, and other diagnosing and treating professionals (Howard, 2022). Although these attitudes are trending towards greater acceptance of minority groups (Howard, 2022), implicit biases contribute to discrimination of sexual and gender minority-identifying people in the health care system including an outright refusal of care (Center for American Progress, 2017). Evidence supports that implicit bias diminishes the quality of care by affecting treatment recommendations, prescriptions and tests ordered, and the number of questions asked of the patient (McDowell et al., 2020). On the other hand, providers' explicit biases contribute to overt discriminatory behavior, including the refusal to provide care.

These attitudes and behaviors, whether intentional or not, contribute to the host of negative experiences SGM patients report across the healthcare continuum. These experiences often precede avoidance or delayed engagement with routine, preventative, and emergency care due to expected or past discrimination (Hadland et al., 2016; Karakaya & Kutlu, 2021; Kruse et al., 2021; Simons & Voss, 2020). Healthcare avoidance during the critical period of childhood and adolescence results in missed opportunities for routine preventive health care that is

recommended for all children, but also a missed opportunity to tend to the unique mental and physical health problems that stem from minority stress.

Purpose

The purpose of this patient safety quality improvement project was to improve pediatric emergency nurses' awareness of the specialized needs of SGMY and to equip PED nurses to provide culturally sensitive emergency care using a patient safety rationale. The authors created and implemented an educational intervention on culturally sensitive care as continuing education for ED nurses at a large level 1 trauma center and pediatric hospital in the southeastern United States.

Available Knowledge

Gender identity and sexual orientation emerge and can each remain fluid through adolescence, as children grow and develop physically, socially and emotionally to meet the psychosocial crisis of establishing stable identity (Calzo & Blashill, 2018). Features of gender dysphoria, the emotional and mental distress that stems from an incongruence between one's gender identity and assigned sex at birth, have been appreciated in children as young as two years old (World Professional Association for Transgender Health, 2012; Simons & Voss, 2020). During this critical time of development, youth who are exploring either sexual or gender minority identities report overlapping and compounding experiences of abuse, rejection and discrimination within the home from their families, at school by their peers, and in a wide range of shared community spaces (Baams, 2018; Basile et al., 2020; Centers for Disease Control and Prevention, 2019; Hadland et al., 2016; Hafeez et al., 2017; Jackman et al., 2020; Johns et al., 2020; Jones et al., 2020; Ream, 2020; Salerno et al., 2020; The Trevor Project, 2021).

The self-stigma, prejudice, discrimination, and victimization that stem from a heteronormative, anti-LGBTQ culture directly influence the social determinants of health and are key drivers of mortality risk, health disparities and poor health outcomes including anxiety, depression, and suicidality (Fulginiti et al., 2020). Sexual and gender minority youth had 3 times the rate of suicidal ideation and were significantly more likely to have made a suicide plan, attempted suicide, and required medical treatment due to a suicide attempt compared to their sexual and gender majority-identifying peers (Ivey-Stephenson et al., 2020; Kruse et al., 2021; The Trevor Project, 2021). The mortality risk that exists for SGMY who seek care in psychological crisis and are met with a system that reflects the anti-LGBTQ culture that has contributed to the crisis, creates a patient safety emergency. Nurses are the largest proportion of healthcare providers (Smiley et al., 2018); preparing nurses to provide culturally sensitive care for this vulnerable population m can positively influence care-seeking motivation by expanding the network of affirming providers (Brach et al., 2019, Goldenberg et al., 2021; Hadland et al., 2016; Schultz et al., 2021).

Educational interventions targeting clinical staff have been associated with an improvement in cultural competence, including patient-centered knowledge and skill and in caring for SGMY in various clinical settings including emergency departments. However, research evaluating the impact of educational interventions on pediatric nurses is scarce. Defining best practices for delivering this material to nursing students and practicing nurses is a critical quality improvement opportunity for nurse educators.

Review of Evidence

Preparing Nurses

Foundational SGM content in the core curriculum of pre-licensure nursing programs has increased and improved in the past decade, yet significant opportunities for improvement remain to prepare nurses to meet the complex needs of this marginalized population. Eickhoff's (2021) study of 140 nursing schools demonstrated a slight increase in the number of SGM content hours from the average 2.12 hours reported in the Lim et al. (2015) study. However, most respondents reported teaching less than five hours with 18 schools (13.3%) excluding content entirely (Eickhoff, 2021).

Eickhoff (2021) also found that out of 38% of schools, faculty had the knowledge to adequately teach the content. They were reluctant to do so, however, because of time constraints and uncertainty of how and when to integrate content within the curricula (Bonvicini, 2017; Bosse et al., 2015; Cornelius et al., 2017; Lim et al., 2015). Sexual and gender minority invisibility in health assessment and anatomy and physiology textbooks further hindered faculty preparedness, knowledge, and comfort (De Guzman et al., 2018; King et al., 2021). Though faculty demonstrated positive attitudes related to exposing students to SGM content, low intent to teach the material contributed to incongruencies in curricula and nurses' preparedness in caring for this population (Marsh et al., 2022). The most frequently taught SGM health-related topics included HIV/STI risks, youth issues, and violence and hate crimes. In contrast, the least taught topics were obesity, inadequate access to health care and insurance, and high rates of drug, alcohol, and tobacco use (Hodges et al., 2021; Lim et al., 2015). Eickhoff (2021) found that nearly 25% of schools did not cover sexual and gender minority mental health disparities, leaving students without basic knowledge of a well-studied cause of morbidity and mortality among this population.

Limited exposure in the continuum of pre-licensure preparation affects student training in the clinical setting. A study of 172 baccalaureate nursing students found that nearly 95% of participants had never cared for a sexual or gender minority patient in their clinical experiences, while only 43% stated indicated that they ask a patient's sexual orientation in an impartial, non-threatening manner (Englund et al., 2019). The combination of limited clinical exposure and didactic training focused on stigmatized disparities may yield a consequence of provider bias (Howard, 2022). Many nurses are practicing or will soon practice without having ever covered this content and report feeling resistant, uncomfortable, and unprepared (Carabez et al., 2015; Eickhoff, 2021; Margolies & Brown, 2019). Therefore, educational interventions that seek to improve cultural competence must directly address provider bias and the unequal treatment and discrimination that SGM patients experience in healthcare in addition to content on basic knowledge and terminology, population health statistics and health disparities.

Pre-Licensure Educational Interventions. Compared to interventions among practicing nurses, pre-licensure interventions included the achievement of learning outcomes in addition to measured constructs. Constructs measured included knowledge of SGM identities and disparities, attitudes, cultural competence, and confidence in caring for SGM patients. There was significant variation among measurement tools. However, tools used in multiple studies included the Gay Affirmative Practice Scale, the Sexual Orientation Counselor Competency Scale (SOCCS) (McEwing, 2020), the Genderism and Transphobia scale (Tartavoulle & Landry, 2021), the Homonegativity scale (Tartavoulle & Landry, 2021), the Attitudes Towards Lesbian, Gay, Bisexual, and Transgender Patients (ATLGBTP) scale (Traister, 2020), the Knowledge of Lesbian, Gay, Bisexual, and Transgender People questionnaire (Traister, 2020), and the Ally Identity Measure Tool (Bristol et al., 2018; Kaiafas & Kennedy, 2021).

Pre-licensure nursing interventions demonstrated notable variability of teaching modalities including short films, lecture, PowerPoint, class discussions, and online modules compared to practicing nurses' interventions. The academic milieu is well-equipped to accommodate pre-class modules and reading assignments, which allow participants to scaffold knowledge with in-class experiences. High and low-fidelity simulation experiences provided the opportunity for students to have firsthand interactions with sexual and gender minority patients on a variety of levels and to develop recognition of health care disparities prior to entering the clinical setting (Carabez et al., 2015; Hickerson et al., 2018; Koch et al., 2021; McEwing, 2020; Ozkara, 2020; Pittiglio and Lidtke, 2021; Tillmann et al., 2016).

Pre-licensure students participating in these in interventions demonstrated an increase in post-test scores on the Gay Affirmative Practice scale (Englund et al., 2019; Maruca et al., 2018, Pittiglio & Lidtke, 2021), the Sexual Orientation Counselor Competency Scale (SOCCS) (McEwing et al., 2020), the Genderism and Transphobia scale (Tartavoulle & Landry, 2021), and the Homonegativity scale (Tartavoulle & Landry, 2021), each of which are positively associated with increased knowledge of the SGM population, affirming attitudes, cultural competence, and confidence in caring for SGM patients.

Educational Interventions for Practicing Nurses. All interventions among practicing nurses in the literature review consisted of lecture and dialogue interventions. Felenstein (2018) and Traister (2020) employed unique pedagogical strategies by utilizing SGM content experts to present didactic data, while Felenstein (2018) and Henry (2017) incorporated SGM community members into their discussion panels. However, few interventions in the literature were targeted towards pediatric nurses. House et al. (2019) presented SGM focused education for pediatric emergency staff at the Children's Hospital in Philadelphia (CHOP). Nurses were required to

complete asynchronous modules including specific scenarios identified by staff as challenging with SGM patients and families; however, no outcome measures were included (House et al., 2019). Walia et al. (2019) implemented a two-part lecture series for perioperative staff at Nationwide Children's Hospital. The series was presented by the director of the LGBTQIA+ Health Initiative and the lectures were recorded for staff who could not attend. Walia et al. (2019) found that staff initially demonstrated moderate to high baseline levels of knowledge and comfort on the 7-item questionnaire. After training, knowledge and comfort self-ratings did not improve, but the score on the objective knowledge test significantly increased to a median of 6 out of 7 possible points. Current literature demonstrates flexibility in pedagogical strategies in which to integrate SGM content in the academic and clinical settings and the positive outcomes it produces. However, it is evident that further research and quality improvement projects could provide additional guidance for those wishing to implement similar interventions, particularly in the pediatric setting.

Methods

Theoretical Model

The Institute for Healthcare Improvement's (IHI) Model for Improvement is a commonly used quality improvement framework. This model, as shown in Figure 1, aims to accelerate improvement by asking the following questions: "What are we trying to accomplish?", "How will we know that a change is an improvement?", and "What change can we make that will result in improvement?" (Institute for Healthcare Improvement, 2022). Small-scale changes can be tested using iterative Plan-Do-Study-Act (PDSA) cycles (Institute for Healthcare Improvement, 2022). "Plan" refers to developing a plan with identified tasks and assigning a task owner if applicable. This portion of the cycle highlights when, where, and how the plan will be

implemented and should include objectives and outcome predictions (Institute for Healthcare Improvement, 2022). Carrying out and documenting data related to the plan, including successes, problems, or unexpected outcomes, occurs in the “do” step. “Study” is the most crucial step in the cycle, in which data is reviewed and analyzed to determine if the plan is working, needs to be adapted, adjusted, or continued. Predicted and actual results are compared, and learning is discussed. Finally, the “act” step determines whether the intervention being tested is adopted, adapted, or abandoned based on findings from the previous step (Institute for Healthcare Improvement, 2022). The PDSA cycle is then repeated with new tasks until the project's overall aim is met (Institute for Healthcare Improvement, 2022).

Project Design

The IHI’s Model for Improvement was used to develop a cultural-sensitivity training module that was implemented tin the Pediatric Emergency Department (PED) at Monroe Carrell Jr. Children’s Hospital at Vanderbilt between August and December 2022. The module was informed by Josepha Campinha-Bacote’s model, “The Process of Cultural Competence in the Delivery of Healthcare Services” (2002) and aimed to improve staff awareness of the specialized needs of SGMY, equipping them to provide culturally sensitive emergency care. The module integrated content using a patient safety rationale. The concepts of clinical preparedness, basic knowledge, and attitudinal awareness were measured in a cross-sectional, non-experimental design before and after the intervention. This study was reviewed and verified as exempt by the institutional review boards at Belmont University and Vanderbilt University Medical Center.

Initial Pitch and Assembling the Project Team

The idea for the project stemmed from an incidence of overt discrimination between a transgender patient admitted for a suicide attempt and a PED staff member performing one-to-

one observation. The author and project leader recognized the urgent need for staff training related to caring for SGM patients with a focus on patient safety and reinforcement of ethical and professional caring obligations. Using the position of a DNP-prepared nurse with experience in research, advocacy, and leadership (Sherrod & Goda, 2016), the project leader described this experience and pitched the idea of an educational intervention for staff to an assistant nurse manager in the PED and faculty advisor through their academic institution. A literature review commenced for evidence-based pedagogical strategies of sexual and gender minority content integration among pre-licensure nursing programs (Goodall & Wofford, 2022) and interventions among practicing nurses with a similar focus. Verbal approval to initiate a project was granted in January 2022.

The PED is a 40-bed unit that employs 66 nurses. Nursing staff vary in years of practice from new graduate nurses to highly experienced nurses. The staff is divided into thirds; one-third works the day shift, one-third works overnight, and the final third works a mid-shift beginning between 12:00 P.M. and 3:00 P.M. The unit sees between approximately 120 and 220 patients daily with a steadily increasing number of patients presenting for mental health-related complaints (B. Aiello, personal communication, February 1, 2022). Prior to this project, no PED-specific training focused on SGM culturally sensitive care. The hospital-wide Nurse Residency Program discussed this concept approximately four times throughout the year-long program but highlighted marginalized populations beyond those who identify with a sexual or gender minority identity (S. Smith, personal communication, March 1, 2022).

Key stakeholders were identified for the project team, including bedside nurses, unit managers, and content experts from the Program for LGBTQ+ Health and Office for Diversity Affairs. The inclusion of a content expert in the project team with the intent to have them present

content was informed by Felenstein (2018) and Traister (2020). The project leader met with each member to describe the experience that inspired the project, presented results from the integrative review to make a case for timeliness and clinical impact and invited them to participate in the project team. All agreed except the bedside nurse due to scheduling difficulties. After these meetings, primary communication occurred via email and virtual team meetings were held bi-monthly via Microsoft Teams. The project leader and nurse faculty member reviewed the project team and adopted it into the first PDSA cycle.

PDSA Cycle 1: Planning the Educational Sessions

The major tasks of planning the educational sessions were determining the “where,” or how the sessions were going to be offered, and the “what,” or the content, structure, and pedagogical strategies. This cycle took place from March to August 2022. Mitigation strategies were reviewed for barriers of implementing medical and nursing continuing education (CE). The project leader performed ground-level outreach working as a bedside nurse in the PED, introducing a relevant, personal connection with the project and improving initial staff buy-in (Shahhosseini & Hamzehgardeshi, 2015). A Google Forms survey was distributed to PED staff by the assistant nurse manager using a unit-wide email address, demonstrating supervisors' support. The survey was used to determine the largest engagement for two dates each in August, September, and October 2022 to optimize scheduling and minimize staff time constraints (Shahhosseini & Hamzehgardeshi, 2015). These months were intentionally selected due to historically lower patient volumes and fewer staff out with paid time off (PTO). The survey offered times convenient for both day and night shift, and virtual or in-person modalities. All PED nurses were invited and encouraged to voluntarily attend at no cost to them. There were no restrictions on when participants could attend; they could participate on a day they were not

scheduled or choose to participate virtually while on the unit if another staff member covered their patients. Participants met criteria for inclusion for research if they were registered nurses employed by the PED at Vanderbilt. Frequent communication to staff demonstrated continued support as session dates and times were established (Shahhosseini & Hamzehgardeshi, 2015).

After the “where” was determined, the project leader focused on Campinha-Bacote’s model (2002) to further the translation from evidence into practice, using it to inform the development of PED-specific SGM educational content and learning activities. This model asserts that cultural competence is a process consisting of five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire and is shown in Figure 2. The project leader collaborated closely with faculty and content experts to curate high-quality evidence-based content and to design dynamic learning activities that targeted learner growth in each of the model’s five key constructs. See Figure 2 and Table 1 for more detail on how learning was mapped to each of the five constructs.

The LGBT-DOCSS scale was selected to measure program effectiveness through assessment of clinical preparedness, basic knowledge, and attitudinal awareness before and after the intervention (Bidell, 2017). The LGBT-DOCSS is a validated, 18-item tool that demonstrated internal consistency for all three subscales, test-retest reliability, and discriminant validity. Previous studies using this tool reported Cronbach alpha values greater than 0.80 (Bidell, 2017). The LGBT-DOCSS was selected for its consistency with the project aim and Campinha-Bacote’s model. The author approved the tool’s use for this quality improvement project on March 30, 2022 (M. Bidell, personal communication, March 30, 2022).

The inclusion of a pre-class module for participants to scaffold knowledge mimics a “flipped classroom” approach (Persky & McLaughlin, 2017) and was based on similar

interventions by Bristol et al. (2018), Felenstein (2018), McEwing (2020), and Pittiglio and Lidtke (2021). The Fenway Institute is an organization that provides educational resources and programs with the goal of optimizing care for sexual and gender minority people (The Fenway Institute, 2022). The module "Healthcare for LGBTQIA+ Youth" introduced content to participants and set the foundation for the sessions (The Fenway Institute, 2021). Links to access the module were included in recruitment emails to participants.

The project team planned recruitment strategies and predicted participation based on previous continuing education opportunities in the department. Distributing details about the opportunity by word of mouth, via the weekly unit newsletter, and direct email provided information about the program opportunity and demonstrated support from co-workers, managers, and program staff. Recruitment emails contained a link for session registration; this link was managed by the nurse manager to prevent a breach in confidentiality of survey responses. Emails were sent out one month, one week, and one day before each session.

PDSA Cycle 2: Assembling the Module

The project leader was responsible for building the didactic presentation used in the live sessions. Appendix C presents a lesson plan indicating the tools, main concepts, sequence, timing, and assigned presenters. The content expert and project leader collaborated to determine foundational content; most content was integrated from previous courses within the institution's Department of LGBTQ+ Health curriculum. The explanation of internal and external stressors and resulting health disparities was derived from the project leader's research. This information was strategically selected as it is easily transferrable to any pediatric practice setting and centralizes patient safety. Information on SGM mental health disparities bridged the transition from foundational content to PED-specific practices. The nurse manager assisted in creating

PED-specific information including opportunities to provide culturally sensitive care in triage, assessment, treatment, and documentation. Finally, the project leader reached out to a parent of a transgender child to provide a video describing their experiences seeking health care with their child and things they wished their child's providers knew. The video was incorporated into the conclusion of the presentation to increase authenticity and provide a parent's perspective.

Experiential learning interventions place participants in a highly active role in the learning experience and encourage meaningful learning (Lisko and O'Dell, 2010). The project leader followed examples by Englund et al. (2019) and McEwing (2020) to build a role play scenario between a triage nurse and a transgender patient presenting for suicidal ideation. The script was a fictional adaptation of the project leader's actual experiences. The same scenario was played twice, the first being through the lens of universal care and the second being culturally sensitive care. Group discussion questions were included after each scenario and provided participants an opportunity to demonstrate learning and identify what the triage nurse could have done differently. The role-play script can be found in Appendix B.

The project leader built the pre-session and post-session questionnaires using Qualtrics software. The two questionnaires were linked using a unique identifier consisting of the abbreviation of participants' birth month followed by the first three letters of their mother's maiden name, making responses confidential. The pre-session questionnaire included the following demographic information: sex assigned at birth, gender, age, highest level of education, years of RN experience, shift worked, and average hours of previous SGM content. The LGBT-DOCSS was included in both the pre-session and post-session questionnaires. The QR codes for the pre-session and post-session questionnaires were embedded in the first and last slides of the presentation, respectively.

Cultural encounters and cultural desire (Campinha-Bacote, 2002) were addressed in the post-session questionnaire in a series of four questions that assessed behavioral intention on a 7-point Likert scale. Course evaluation questions were also included in the post-session questionnaire and used the same Likert scale format. Participants had the opportunity to share comments related to the course. See Appendix C for the post-session questionnaire. The session materials were presented to the full project team, where they were unanimously approved and adopted into the next PDSA cycle. Textual and color revisions were made to the presentation for clarity and visibility.

PDSA Cycle 3: Session Implementation

A convenience sample of participants was accrued using recruitment strategies outlined in PDSA Cycle 1. A pilot session and six subsequent sessions were planned between August and October 2022. Four sessions were offered in a web-based virtual format via Zoom and two sessions were scheduled for in-person learning. The pilot session was presented solely to PED nurse managers. Each session lasted approximately 60 minutes. The August 16 and October 5 sessions were in-person, while August 30, September 6, October 11, and November 9 were held virtually via Zoom.

The project leader convened virtual full-team meetings to study preliminary results from the first two sessions. The project leader reviewed post-session Qualtrics data and disseminated it to the project team for decision-making. At this time, the comparison of pre- and post LGBT-DOCSS had not yet been completed; the fourteen post-session questionnaires had positive qualitative responses and all participants either agreed or strongly agreed that they were more likely to ask a patient’s chosen name and pronouns, they were more likely to correct another staff member misgendering a patient, they believed that staff could benefit from additional sessions,

they would recommend this course to others, and this course should be a requirement for onboarding in the PED.

After the pilot session, the nurse director of emergency services suggested reaching out to other staff members including social work, child life specialists, physicians, and expanding beyond the PED and making the sessions an interprofessional education opportunity. She was then tasked with sending recruitment emails to each respective group. Emails were also sent to previous participants encouraging them to encourage their peers to attend. See Appendix E for the additional recruitment email template. The demographic questions in the pre-session questionnaire were updated to reflect multiple roles.

The most significant adaptations within the implementation cycle related to the timing of the presentation. The initial session lasted nearly 90 minutes. Presenters were asked to be more cognizant of their timing, and the room reservations for in-person sessions were extended to two hours to accommodate for any extra time and prevent rushing towards the end of the session. The team elected to forgo in-person sessions in favor of a virtual format to maintain accessibility for staff. An additional live session was held virtually on December 15th based on staff request.

PDSA Cycle 4: Achieving Sustainability

The final project team meeting occurred after conclusion of the live sessions. During this meeting, a summative evaluation was conducted through a strengths, weaknesses, opportunities, and threats(SWOT) analysis (van Wijngaarden et al., 2012). Each team member’s input was informed by differing expertise: the project leader focused on the integrity of the research and dissemination, the nurse was guided by informal staff feedback, and the content expert excelled in teaching the information. The program’s identified strengths included the virtual format, which was favored by staff, the layout of the content was thoughtful and logical, and the parent

perspective video tied the content together and provided an alternate perspective. Conversely, the program lacked consistency in technology used to track registration and attendance, leaving no accountability for participants who registered but did not attend. Threats to the program included staffs' limited capacity to attend continuing education classes outside of work hours and a potential trickle-down effect of the institution's pause on gender-affirming surgeries for transgender adolescents.

The project team felt the greatest opportunity for the program rested in maintaining staff accessibility to the content. This would be accomplished by creating a voiceover e-learning module and placing a sexual and gender minority resource packet on the unit. The assistant nurse manager printed the "rainbow packet" including coloring pages, crisis lines, and resources in an easily accessible place within the PED to distribute to appropriate patients and families. See Image 1. The voiceover module would be integrated as a mandatory part of unit onboarding and placed in the e-learning platform to be accessed by current staff. The project leader transitioned the in-person session presentation to a voiceover presentation with video of the presenters to increase learner engagement. The creation of the e-learning module will ensure that all staff receives the content to improve SGMY patient safety in the PED, and could easily be replicated or adapted to expand the network of affirming providers and increase SGMY health-seeking behaviors.

Results

A total of 25 health professionals attended the sessions. Of these, 25 completed the pre-program survey, including demographic data, while 22 completed the post-program survey. Within the post-program survey, there were 19 course evaluation responses, as three participants failed to complete this portion. Sessions ranged from three to nine participants.

Participants' average age was 36 (*SD* = 10.69). All participants identified as cisgender. Most participants were female (*n* = 24, 96%). A range of qualifications and roles were represented: six participants held associate's degrees (24%), 13 had bachelor's degrees (52%), one held a master's degree (4%), and five held doctoral degrees (20%). Participants' roles included physicians (*n* = 4, 16%), nursing administration (*n* = 3, 12%), social work (*n* = 1, 4%), staff nurses (*n* = 11, 44%), and nursing assistants (*n* = 6, 24%). Most worked day shift (*n* = 11, 44%), while the remainder worked mid-shift (*n* = 8, 32%) or night shift (*n* = 6, 24%). Participants had a median of seven years of experience in their field. The number of previous SGM content hours ranged from zero to 40, with a median of 3.5 hours and nine participants reporting zero hours. One participant completed the pre-class Fenway Institute module, while two others intended to complete it after the session. Details on the demographics of the participants can be found in Table 2.

An independent samples t-test was completed using the 47 total pre-session and post-session questionnaires. With a maximum score of 7, pre-session LGBT-DOCSS scores averaged 5.787. Baseline attitudinal awareness scores were the highest with a mean of 6.554 (*SD* = .563), followed by knowledge (*M* = 5.880, *SD* = .963), and clinical preparedness (*M* = 4.177, *SD* = .719). Clinical preparedness was the lowest baseline subscale with an average score of 4.177 (*SD* = 1.040). After the session, participants' mean LGBT-DOCSS scores increased by 0.310 to a mean of 6.097. However, this increase was not statistically significant ($t = -1.901$, $p = .064$, $d = .558$). The subscale analysis showed a statistically significant increase in clinical preparedness after the program ($t = -5.602$, $p < .001$, $d = .892$). Participants demonstrated an increase in knowledge ($t = -1.462$, $p = .151$, $d = .983$) and a decrease in attitudes ($t = .319$, $p = .751$, $d = .832$). Findings are summarized in Table 3.

Course evaluation feedback was largely positive. All participants either agreed (n = 1, 5.3%), slightly agreed (n = 2, 10.5%), or strongly agreed (n = 16, 84.2%) that they would recommend the course to others. Behavioral intention responses were positive in that staff agreed they were more likely to ask a patient's chosen name and pronouns, correct another staff member who misgenders a patient, and provide SGM resources to patients. Furthermore, participants overall agreed that additional sessions covering this content would be beneficial for staff, and this content should be required for onboarding at the institution. Finally, participants wished for additional resources for SGM content and wanted to become more knowledgeable and skillful in caring for this population. Participants also had the option to provide comments on the strengths of the course and suggestions for improvement. All but one response was positive. Participants found the terminology, role play, and statistics beneficial to learning. One participant, however, stated, "I feel like I am being asked to judge a person by the questions asked in the pre- and post-survey. I was taught and continue to practice the best compassionate, personalized care I can to ALL patients whether they look/act the same or different than myself." Behavioral intention results and participant comments can be found in Table 4.

Discussion

In this pilot quality improvement program, health professionals in a large urban pediatric hospital demonstrated a statistically significant increase in clinical preparedness after the program. The increase in LGBT-DOCSS and knowledge subscale further exhibit that staff are more aware of appropriate terminology and health disparities related to those identifying with a sexual or gender minority. These results align with the program's aim of increasing awareness of these topics and better equipping staff in providing culturally sensitive care to this marginalized population in the pediatric setting. The program's findings are consistent with similar studies in

that dedicated staff education can improve knowledge, behavioral intention, and preparedness in caring for sexual and gender minority-identifying individuals (Traister, 2020; Singer et al., 2019; Kaifas & Kennedy, 2021; Bristol et al., 2018; Felenstein, 2018; Henry, 2017).

Staff Participation

Voluntary participation by a variety of health professionals in the PED was encouraging. Prior to the sessions, the project team established a goal of at least 30 participants (45% of total nursing staff) and fell short of that goal (n=25). The decision to make the sessions an opportunity for interprofessional education increased outreach to various roles. However, the less-than-expected nursing attendance was particularly surprising. The sessions were planned from August to November based on past patient census and PTO trends. During this planned time, a sharp uptick in respiratory virus activity increased both patient census and acuity, stressing the institutional site of the project and the potential participants (B. Aiello, personal communication, January 2023; Centers for Disease Control and Prevention, 2022). The physical and mental toll of the increased workload may have limited nurses' capacity for CE (Shahhosseini & Hamzehgardeshi, 2015). The smaller number of participants, however, works well as a pilot QI program and provides an opportunity to assess potential adaptations before scaling the program to clinical areas beyond the PED.

In the context of voluntary participation, the baseline high levels of attitudes and knowledge and the relatively small change post-session are not surprising. The pre-session questionnaire demonstrated high baseline attitudes while the post-session questionnaire had a decline of .08 with several notable low-scoring outliers. This inherent cultural desire might manifest as higher baseline attitudes. Findings related to the attitude subscale are reflective of Howard's (2022) study in that although health professionals' overall attitudes towards sexual and

gender minority people are improving, they are not free of bias. However, empowering staff who come with knowledge and attitudes with clinical best practices represents a meaningful, clinically significant advance toward improved patient safety. This was evident in the statistically significant increase in clinical preparedness. Making this training mandatory for staff could include those with lower baseline knowledge and attitudes, thereby promoting greater increases in knowledge, attitudes, and clinical preparedness thus improving unit culture and sexual and gender minority patient safety in the pediatric emergency setting. Standardizing evidence-based, culturally sensitive training among staff is essential to improving SGM patient safety outcomes, but empowering natural champions with skills and best practices through voluntary participation is a great start.

Program Format and Content

Providing accessible, up-to-date, and relevant content demonstrated meaningful learning in both the cognitive and affective domains for participants as evidenced by formal staff feedback in the post-session questionnaire and informal feedback discussed in the SWOT analysis. Evidence-based pedagogical strategies including didactic content and experiential learning opportunities were carefully selected and sequenced to optimize flow of the sessions. The project leader's anecdotes being integrated into the role-play provided a realistic triage experience and patient and family responses, increasing its authenticity (Walshe et al., 2022). Furthermore, this relevant scenario can be adapted to a different clinical space such as adult emergency departments, medical surgical units, or the outpatient setting. Participants' comments supported the benefits of integrating terminology and experiential learning. For example, when asked about specific things about the course or instructor that especially helped to support student learning, one participant responded, "Learning terms and what is hurtful and helpful!"

while another said, “I thought that going over definitions of terms at the beginning was very helpful.” Other participants stated that the clinical scenarios and inclusion of a mother’s perspective “hits home.”

Flexible learning platforms alleviated some personal barriers, increased accessibility, equity, convenience, and sustainability for future sessions (Santiago et al., 2021; Shahosseini & Hamzegardeshi, 2015). The virtual format of the live sessions was well-received by staff, demonstrated greater numbers of participants, and relinquished the need to reserve space at the project site. Only one to three participants attended in-person sessions, while virtual sessions saw up to 12. Flexible learning mitigates some difficulty in recruiting participants for a program that is not required. After conclusion of the pilot program, the unit manager and content expert could present additional live virtual sessions using the same presentation document.

Lawson et al. (2018) discussed factors affecting sustainability of quality improvement initiatives and reported that sustainability is often an afterthought after program initiation. That is the case with this program. However, the creation of the e-learning module in the final PDSA cycle builds capacity for continuation (Lawson et al., 2018). Results from this program suggest that a virtual format that combines foundational content and experiential learning addresses both knowledge deficits and continuing education barriers. Increased staff engagement and subsequent improved patient safety could be achieved by implementing both live sessions and sustainable e-learning modules.

Institutional Support

Institutional stakeholders’ lack of political will impacts education on “sensitive topics” and was identified as a structural barrier limiting participation. Project site leadership was hesitant to make attendance required or include it after a unit-wide staff meeting during the first

PDSA cycle. Not only was the project site in a traditionally conservative area of the Southeast, but, in September 2022, the transgender clinic within the institution halted its gender-affirming surgeries after receiving criticism from the state's GOP representatives and governor (Gluck, 2022). Gender-affirming surgery and hormone therapy falls under the umbrella of culturally sensitive care for SGM people (Reisner et al., 2016). Although neither of these topics were explicitly discussed in the program, the "culturally sensitive care" verbiage of marketing materials may have misled staff to believe that more invasive measures were being discussed and dissuaded them from attending. Furthermore, an opportunity to present the program to emergency medicine physicians was cancelled and changed to a discussion of the side effects of hormone therapy (B. Roach, personal communication, September, 2022).

The state's rejection of sexual and gender minority support is evidenced by numerous anti-trans bills (American Civil Liberties Union, 2023), and this lack of political will may have implicitly impacted program stakeholders through their hesitancy to require attendance and expand the program. Without this essential component of political will, program success and longevity are constrained (Lezine & Reed, 2007). While shifting culture can often happen from grassroots organizing and effort, institutional support and endorsement is ultimately critical to any patient safety initiative. The level of institutional support is far-reaching and affects funding, policies, quality and safety surveillance and monitoring, disciplinary action, and more.

Similar programs may have higher participation rates and greater impacts in less traditionally conservative geographic areas or institutions that already have a training in place to improve or modify. Future projects could dedicate time to assessing, strategizing, and acting toward the political will of the stakeholders and institution prior to implementing the project and would benefit greatly from including a DNP prepared nurse in the project team. The DNP's

skillset of research, process development, evaluation, change management, leadership, and advocacy uniquely position them to not only build capacity among peers, but also to advocate for change at a systems level (Sherrod & Gota, 2016).

Limitations

Limitations of the research within this QI project surround threats to internal validity including the potential for selection and response bias as well as imprecision in the statistical analysis. The LGBT-DOCSS attitude subscale questions address "sensitive topics," or beliefs of the participants related to the mental state and morals of sexual and gender minorities (Bidell, 2017). Participants' responses may not reflect their true attitudes, but rather mimic a more socially desirable answer (Charles & Dattalo, 2018). The voluntary sample may contribute to selection bias; they had a greater interest in improving their quality of care for this population as evidenced by high baseline knowledge and attitudinal awareness. A paired t-test would strengthen the evidence of the increase in LGBT-DOCSS scores (de Winter, 2013). However, this statistical choice was made due to a missing unique identifier question in the pre-session questionnaire for the first two sessions. This limited the number of paired tests available, influencing the decision to instead employ an independent t-test. Response bias was mitigated by confidentiality that was clearly explicated in the consent required to submit before proceeding with the pre-session questionnaire. Despite the limitations discussed, the positive staff feedback is reassuring for the practical and clinical significance of this training to improve SGMY patient safety outcomes.

Conclusion

This quality improvement project implemented a low-cost, effective intervention to improve pediatric emergency nurses' awareness of the specialized needs of SGM youth and to

equip them to provide culturally sensitive emergency care. Staff demonstrated an overall increase in combined knowledge, attitudes, and clinical preparedness to care for this vulnerable population, although the increase was not statistically significant. There was a statistically significant increase in clinical preparedness among participants. The use of evidence-based pedagogical strategies facilitated meaningful learning, covered foundational information missing from pre-licensure programs, and provided a safe space to simulate a culturally sensitive interaction. The didactic content and role play can be easily adapted to any clinical or educational setting or institution. This project also supports research gaps of staff training among pediatric institutions.

This intervention was especially timely as sexual and gender minority-identifying youth continue to experience overt discrimination and victimization from various sources, resulting in both physical and mental health crises for which they may seek care in a pediatric emergency room (The Trevor Project, 2021). Aspects of this program to adopt into subsequent PDSA cycles or translate to future programs include the flexible learning format, content sequence, and experiential learning. Conversely, the project team and future researchers should consider requiring staff attendance and performing an assessment of the local political climate surrounding SGM care. Making these changes may limit program threat and facilitate greater improvements in knowledge, attitudes, and clinical preparedness. Doing so translates to culture change and increased sexual and gender minority youth safety. Even one more affirming provider can notably improve care seeking motivation which increases adherence to preventative care and decreases complications of illness or injury.

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Figure 1

The Institute for Healthcare Improvement's Model for Improvement

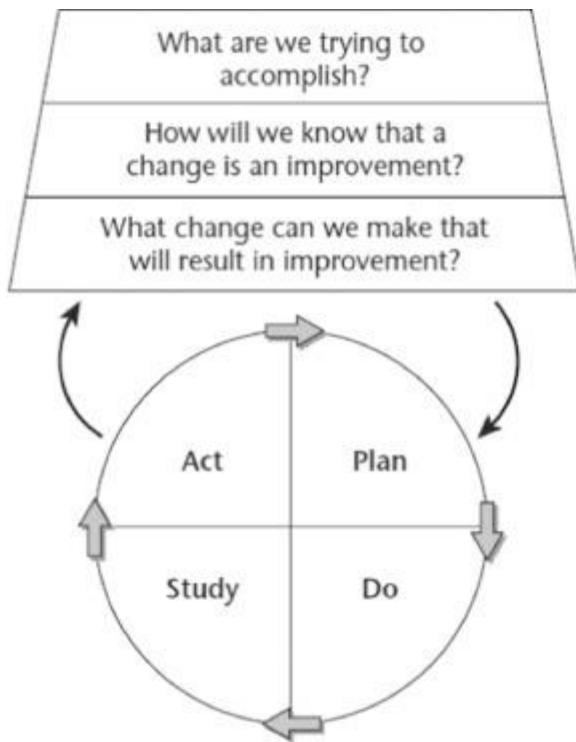

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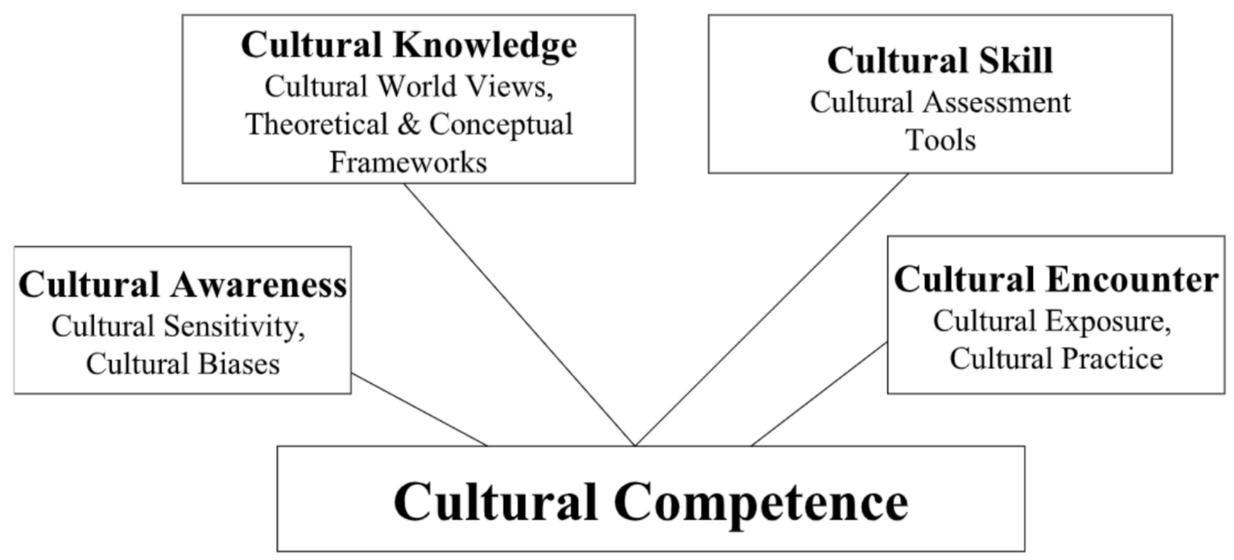
Figure 2

The Process of Cultural Competence in the Delivery of Healthcare Services



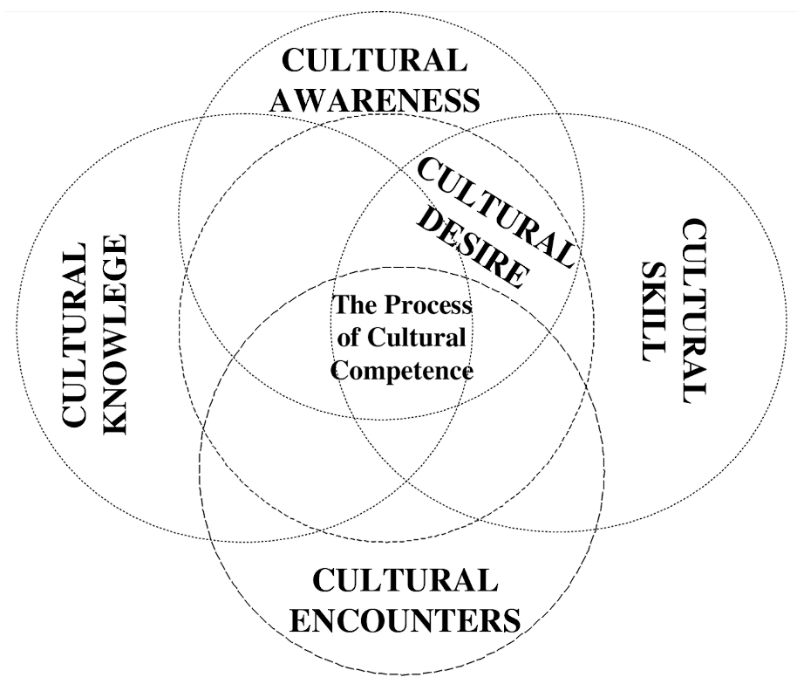


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Table 1

The Process of Cultural Competence in the Delivery of Healthcare Services in the Pediatric Emergency Department

Model Construct	**Example in Pediatric Emergency Department and How it is Addressed in Quality Improvement Project**
Cultural Knowledge	• Presentation of terminology and health disparities affecting this population
Cultural Awareness	• Discussion of the presence of bias and the feeling of discomfort among non-sexual or gender minority providers
Cultural Skill	• Instruction on how to provide culturally sensitive care in triage, during assessments, and in direct patient care
Cultural Encounters	• Participation in role-play scenario of a triage nurse interaction with a transgender patient and their mother
Cultural Desire	• Discussion questions and reflection of content presented and experiential learning role may instill a want, rather than a need, to learn more

Table 2

Participant Demographics

Characteristic	*n*	%	*M* ± *SD*	Median
Age			36 ± 10.69	34
Gender				
Female	24	96.0%		
Male	1	4.0%		
Cisgender	25	100%		
Transgender	0	0%		
Degree				
Associate’s	6	24.0%		
Bachelor’s	13	52%		
Master’s	1	4.0%		
Doctoral	5	20.0%		
Role				
Physician	4	16.0%		
Staff Nurse	11	44.0%		
Nursing Administration	3	12.0%		
Nursing Assistant	6	24.0%		
Social Work	1	4.0%		
Years of Practice	7	28.0%		
Shift Worked				
Day Shift	11	44.0%		
Mid Shift	8	32.0%		
Night Shift	6	24.0%		
Full-time Equivalent			0.92 ± 0.15	0.95
LGBTQIA+ Content Hours			5.79 ± 9.61	3.5
Completion of Fenway Institute Pre-Module				
Yes	1	4.0%		
No	21	84.0%		
No, but I plan to complete it after the session	3	12.0%		

Note. N = 25.

Table 3

Pre-session and Post-session Questionnaire Data (n=47)

Scale	Pre-Session (n=25)		Post-Session (n=22)				
	M	*SD*	*M*	*SD*	*t*(45)	*p*	*d*
Total LGBT-DOCSS	5.787	.554	6.097	.563	-1.901	.064	.558
Knowledge Subscale	5.880	.963	6.300	1.005	-1.462	.151	.983
Attitudes Subscale	6.554	.719	6.477	.944	.319	.751	.831
Clinical Preparedness Subscale	4.177	1.040	5.600	.685	-5.602	<.001	.892

*$p < .001$

Table 4

Post-Session Questionnaire Course Evaluation

Question	*n*			
Behavioral Intention Questions				
	Neutral	Slightly Agree	Agree	Strongly Agree
After this course, I am more likely to ask a patient's preferred name and pronouns during their care.	0	0	2	9
After this course, I am more likely to correct another staff member who misgenders a patient.	0	0	2	9
After this course, I am able to provide local resources for LGBTQIA+ youth.	0	1	6	4
After this course, I want to, rather than have to, engage in becoming more knowledgeable and skillful in caring for this population.	0	0	2	9
Outreach Questions				
I would recommend this course to others.	0	0	1	10
I believe additional sessions like this would be beneficial for staff.	0	0	0	11
I believe this content should be required for onboarding in the PED.	0	1	1	9
Course Strengths Selected Quotes				
"I appreciated the conversation about using the patient's last name and then asking about preferred name and pronouns. I appreciate the information about Estar changes within the system to account for preferred names and pronouns." "It was really helpful to have the course taught by people who are bedside and have real-time experience in these situations. This allows the verbiage used to be realistic and directly translatable." "Learning terms and what is hurtful and helpful! Giving examples that draw parallels so that I have a clearer understanding! Explaining that while I may have had good intentions in apologizing it's not the pt responsibility to make me feel better (take care of me) about my mistake! Make it sincere and move on." "Opportunity to maintain safe environment for pts especially during triage and initial opportunity to build rapport with a pt."				

Note. N = 11

Image 1

Placement of the "Rainbow "Packet" in the PED

Appendix A

Initial Recruitment Email Template

Team,

I wanted to let you all know of some exciting new training coming down the pipeline, Culturally Sensitive Emergency Care for Sexual and Gender Minority Youth! We will be putting on a learning session featuring Del Ray Zimmerman, the Director of the Program for LGBTQ Health and Office of Diversity Affairs. This session will last approximately 60 minutes and will cover topics such as terminology related to this population, LGBTQIA+ youth health disparities, and ways to implement culturally sensitive care in the PED. Although this is important for every visit, culturally sensitive care is of particular importance for our patients in mental health crises. The CDC recently released data that showed 1 in 4 LGBTQ teenagers attempted suicide in the first half of 2021, while a study of over 35,000 LGBTQ youth found that this population had 3 times the rate of suicidal ideation compared to their non-LGBTQIA+ peers.

This training is NOT required and is part of my DNP project for Belmont University. The sessions will be held the following dates and times:

8/16 7:30AM in-person
8/30 5:00PM virtual
9/6 7:30AM virtual
9/20 5:00PM in-person
10/5 7:30AM in-person
10/11 5:00PM virtual

Please sign up for which session you'll be attending. You don't have to put your name to maintain confidentiality of your pre- and post- tests, I would just like a count for how many people we can expect. You can sign up at this link: https://forms.gle/5jPiJu7FqAqroiYn8

To make the most out the session, please complete The Fenway Institute's module "Health Care for LGBTQ Youth" found here: https://www.lgbtqiahealtheducation.org/courses/healthcare-for-lgbtqia-youth/

A pre- and post-test will be given to establish baseline data for my research and evaluate the effectiveness of the intervention.

Hope to see you all there!

Sincerely,
Kaysi Goodall BSN, RN, CPN

Appendix B

Role-Play Script

Universal Care

Clinical Scenario: You are the triage nurse working on the unit. You look at the trackboard to determine your next patient. You call back 14-year-old Sarah Smith. Sarah is dressed in oversized black clothing and has a shaved head.

Triage Nurse: Hi Sarah, I'm the triage nurse today. We're going to get some vital signs, go over your basic information, and talk about what's bringing you in today.

Sarah's mother answers "She says she wants to kill herself, and I caught her cutting herself yesterday." You go over all the basic information, get the patient's vitals, and ask the mother to step out of the room so you can discuss the Columbia Suicide Screening Questions.

Sarah: Actually, I go by Max and use the pronouns they/them. My family refuses to acknowledge that because they don't want to "condone my behavior." I just feel like I'd be better off dead.

Triage Nurse: Oh, that makes sense since you're dressed more like a boy. I'm sorry you feel that way. Let's go get you back to a room.

You escort the patient and mother back to U-5. You forget to tell the primary nurse what the patient told you about their preferred name and pronouns. You overhear the provider and primary nurse walk into the room and address the patient as Sarah.

Discussion Questions:

1. As a provider, have you experienced a scenario similar to this?
2. How does this make you feel?

3. How do you think the patient feels?
4. What could the triage nurse have done differently?

So now we are going to go through the same scenario again. The triage nurse has taken this training and knows how to implement culturally sensitive care for our patients.

Culturally Sensitive Care

When calling the patient from the waiting room, you call their last name instead of their first.

Triage Nurse: Hi, I'm the triage nurse today. What name do you like to be called?

Max: Well, my legal name is Sarah but I like to go by Max.

Triage Nurse: Cool, hi Max. Can you step on the scale so we can get your weight? We're going to go over your basic information, get a set of vital signs, and talk about what's bringing you in today. When people refer to me, they use she/her pronouns. How would you like us to address you today?

Max: Wow, no health care provider has ever asked me this before. I use they/them pronouns.

Triage Nurse: What's bringing you in today?

The mother answers "She says she wants to kill herself, and I caught her cutting herself yesterday." You go over all the basic information, get the patient's vitals, and ask the mother to step out of the room so you can discuss the Columbia Suicide Screening Questions.

Max: My family refuses to acknowledge that I'm transgender and won't call me Max or use they/them pronouns because they don't want to "condone my behavior." I just feel like I'd be better off dead.

Triage Nurse: Thanks for sharing this with me, It sounds like you're not feeling supported by your family which is really hard. I want to let you know that our number one priority is to keep you safe. Would you like us to use your preferred name and pronouns in front of your family?

Max: Yes please.

You escort the patient and mother back to U-5. You forget to tell the primary nurse what the patient told you about their preferred name and pronouns. You overhear the provider and primary nurse walk into the room and address the patient as Sarah. Before going back up to triage you go into U-5.

Triage Nurse: Hey team! Sorry Max. I forgot to mention, the patient prefers to be called Max and uses they/them pronouns. I'll add it to my triage note when I get back up front.

Discussion Questions:

1. How do you feel after hearing the second scenario?
2. How do you think the patient feels?
3. Can you identify any barriers that you may have implementing this type of care?

Appendix C

Live Session Lesson Plan

Culturally Sensitive Emergency Care for SGMY

August-December 2022

Overview

This will focus on increasing participants' awareness of health disparities affecting sexual and gender minority-identifying youth, emphasizing our professional and ethical obligation to provide high-quality, safe care, and providing the tools to implement this care at Monroe Carrell Jr. Children's Hospital at Vanderbilt.

Materials

Google Slide Presentation

Role Play Word Document

Objectives

- Deliver brief, coherent summary of foundational information related to sexual orientation and gender identity to a community of health professionals
- Describe health disparities disproportionately affecting sexual and gender minority-identifying youth
- Introduce the idea of culturally sensitive care and providing examples of implementing this care into pediatric medicine
- Perform experiential learning role-play and engage in discussion with participants

Activities

- Prior to participants' arrival: Kaysi will have presentation pulled up with pre-test QR code
- 5:00-5:05: Kaysi will introduce program and presenters (slides 1-4)
- 5:05-5:30: Del Ray will discuss appropriate terminology including sex, gender identity, gender expression, sexual orientation, trans vs. cisgender, the gender binary and a more inclusive

gender binary model. Inappropriate terminology will also be covered (slides 5-15)

- 5:30-5:40: Kaysi will cover health disparities including family, peer, and partner victimization. A greater amount of time will be spent covering mental health disparities, specifically suicidal ideation and suicide attempts. Slide 20 focuses on negative experiences across the health care continuum (slides 16-20)
- 5:40-5:45: Del Ray will cover how to talk to and about transgender people. The importance of mirroring patient's language will remain a central idea (slides 21-25)
- 5:45-5:50: Brittney will discuss the implementation of culturally sensitive care for sexual and gender minority youth at Monroe Carell Jr. Children's Hospital at Vanderbilt during triage, report, assessment, and treatment. Appropriate documentation and resources for patients and families will be included in discussion (slides 26-35)
- 5:50-6:00: Brittney, Del Ray, and Kaysi will perform role play scenario and complete discussion questions with staff. Parent's perspective video will be shown (slides 36-39)
- 6:00-6:10: Participants will have the opportunity to complete the post-test and ask any final questions

Evaluation

- Feedback from post-test in course evaluation section
- Change in total LGBT-DOCSS scores and knowledge and clinical preparedness subscale scores

Appendix D

Post-Session Questionnaire

LGBT-DOCSS

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

3. I think being transgender is a mental disorder.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

Course Evaluation & Behavioral Intention

1. I would recommend this course to others.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

2. The course materials helped me understand the content.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

3. After this course, I am more likely to ask a patient's preferred name and pronouns during their care.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

4. After this course, I am more likely to correct another staff member who misgenders a patient.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

5. After this course, I am able to provide local resources for LGBTQIA+ youth.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

6. After this course, I want to, rather than have to, engage in becoming more knowledgeable and skillful in caring for this population.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

7. I would like additional resources for LGBTQIA+ content.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

8. I believe additional sessions like this would be beneficial for staff.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

9. I believe this content should be required for onboarding in the PED.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

10. What are one to three specific things about the course or instructor that especially helped to support student learning? (Short Answer)

11. What are the strengths of this course?

12. Do you have any specific recommendations for improving this course?

Appendix E

Further Recruitment Email Template

Hello,

Thank you for attending Culturally Sensitive Emergency Care for Sexual and Gender Minority Youth! We are thankful for your role in improving care for this vulnerable population. The feedback we have received for the program has been positive so far, and would like your help in recruiting additional participants. If you found this program helpful, please recommend it to your peers and encourage them to attend.

The remaining sessions are as follows:
10/5 7:30AM in-person @ VCH 2104
10/11 5:00PM via zoom @ https://belmontu.zoom.us/j/4034189836

Again, we thank you for your participation in this program and further recruitment and collaboration efforts.

In Service,
Kaysi Goodall BSN, RN, CPN, DNP-FNP Student
Brittney Aiello BSN, RN, CPEN
Del Ray Zimmerman, Director of the Office for LGBTQ Health and Diversity Affairs