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Delivering Culturally Competent Care to the Lesbian, Gay, Bisexual, and Transgender (LGBT) Population

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Delivering Culturally Competent Care to the Lesbian, Gay, Bisexual, and Transgender (LGBT)

Population

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Abstract

Purpose: To this day, the lesbian, gay, bisexual, and transgender (LGBT) communities still experience negative health outcomes due to social stigma and discrimination. Additionally, nursing has lagged behind other health professions in the promotion of culturally competent care to members of this minority group. Several national authorities on LGBT health have proposed guidelines for providing such care to the LGBT population; however, many nursing schools are not integrating these recommendations into their curricula. *Methods:* Using these national guidelines, an educational program was developed for BSN students at a large south Florida university to improve competency in providing care for LGBT individuals. The goal was to improve nursing providers' attitudes, knowledge and skills in the care of the LGBT community. 120 BSN students completed online modules regarding LGBT health disparities and a disaster simulation requiring the placement of a transgender individual in proper emergency housing. Participants were surveyed pre- and post- intervention as well as one month after to assess if any changes observed had persisted. *Results:* Overall cultural competence scores increased significantly from baseline to post-test and did not decline significantly at one month follow-up. Notable improvements in the instrument sub-scales (knowledge, skills, and awareness) were also noted. Finally, both the presenter and the program received positive ratings regarding the usefulness of the program and its applicability to nursing practice. *Conclusion:* Educational content focused on providing culturally competent care for LGBT individuals may lead to improvements in providers' awareness, skills, and knowledge about the unique needs of the LGBT population.

Keywords: Lesbian, gay, bisexual, transgender, LGBT, cultural competence, nursing education, BSN

Introduction and Background

Across the lifespan, the lesbian, gay, bisexual, and transgender (LGBT) community in the United States is at risk for numerous deleterious health outcomes compared to other groups (Institute of Medicine [IOM], 2011; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012); Ward, Dahlhamer, Galinsky, & Joestl, 2014). These disparities are indicated by several factors, including increased risk for suicide, higher rates of HIV and sexually transmitted infections (STI), and mental health issues, which result, in part, from a lack of healthcare provider education on LGBT-specific needs and health disparities. Although many of these disparities are present across the lifespan, there are certain developmental periods of life where LGBT people are especially vulnerable. For example, LGBT youth (ages 13- 24) have an increased risk for homelessness (IOM, 2011; Saewyc, 2011), which is associated with a number of negative consequences and health outcomes, such as using sex as a means of survival, heightened substance use, depression and suicidality, and violent experiences both on the street and in homeless shelters (Coker, Austin, & Schuster, 2010). Older LGBT individuals (ages 50+) are at increased risk for disability, feelings of isolation, poorer mental health, tobacco use, and excessive drinking compared to their heterosexual peers (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Foglia, M.; & Fredriksen-Goldsen, 2014). Clearly, these disparities must be well understood by healthcare providers in order to deliver optimal care and reduce the negative health outcomes among LGBT individuals.

Despite ongoing research (IOM, 2011; SAMHSA, 2012, Ward, Dahlhamer, Galinsky, & Joestl, 2014) that illuminates these disparities in health outcomes for LGBT individuals, strategies to reduce them, such as healthcare provider training, have not yet been implemented systematically. Although recent efforts (Ard & Makadon, 2012; IOM, 2011; Gay and Lesbian

Medical Association [GLMA], 2006; Healthy People 2020, 2016; Joint Commission, 2011) by federal policymakers, leading health authorities, and nursing educators themselves acknowledge the need for LGBT-specific cultural competencies, schools of nursing have lagged behind other healthcare disciplines in educating nurses on these topics (Sirota, 2013; Lim, Johnson, & Eliason, 2015). Recent research literature (Sirota, 2013; Lim, Johnson, & Eliason, 2015) has revealed that despite decreases in homophobic attitudes on the part of nursing educators and a perceived need to include LGBT-related content into nursing programming, nurse educators do not feel equipped to perform this education, due to the fact that nurse educators do not have adequate exposure to LGBT individuals and therefore are unsure how on what to teach about LGBT health. Given that the recent Federal *Healthy People 2020* (2016) initiative explicitly lists LGBT health as a priority objective, it is imperative that nursing professionals, as front-line agents, develop competence in the care of the LGBT population (Sirota, 2013; Lim, Johnson, & Eliason, 2015).

Problem Statement

Across the lifespan, the lesbian, gay, bisexual, and transgender (LGBT) community in the United States is at risk for numerous negative health outcomes. These disparities are indicated by several factors, including an increased risk for suicide, higher rates of HIV and STI infection, and mental health issues, which result, in part, from a lack of healthcare provider education on LGBT-specific needs and health disparities. Currently, although schools of nursing acknowledge the need for LGBT-specific competency training, many nurse educators do not feel equipped to teach this content (Sirota, 2013; Lim, Johnson, & Eliason, 2015).

Review of Literature

Appraisal of Evidence

A selected literature search for LGBT education for nurses was performed in the following databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Academic Search Premier, and LGBT Life with Full Text. A CINAHL search using the terms *homosexuality, male or homosexuality, female or bisexuality or transgendered person*, and *nursing* returned 1,109 results. By narrowing inclusion criteria to studies from 2010 to present with a full-text only limiter, 271 results were returned. Of these, nine were magazine articles; one was a continuing education unit post-exam, leaving 262 references from academic journals.

Given the large number of results returned and the varying foci of the articles, such as nursing interventions aimed at health issues in the LGBT population, a narrower search was performed in the same databases, using the terms *LGBT* and *nursing* and *education*. This search returned 171 results; by narrowing the inclusion criteria to English-only full-text articles in academic journals from 2010 to present, 59 results were returned. Of the 59, six were duplicates, one was from a travel journal, one was a short news article, and seven were nursing intervention articles for dealing with specific LGBT health issues. After eliminating those 15 articles, 44 remained for examination. Articles that covered leading policy statements and research documenting the current climate of nursing education on LGBT topics were incorporated in this discussion.

According to the Johns Hopkins Nursing Evidence Based Practice (JHNEBP) rating scale, the quality of scientific literature may be classified as high, good, or poor quality. First, high quality refers to evidence that is of adequate sample size, is reproducible, has consistent results, and utilizes well-defined, rigorous, and valid methods. Second, good quality indicates

reasonably consistent results, fairly definitive conclusions, and reasonably consistent, and well-defined methods. Finally, low quality denotes inconsistent results, insufficient sample size, lack of clear conclusions, and/or poorly defined methods (Johns Hopkins Medicine, n.d.). In addition to the quality of research, the strength of studies may be classified on a one-to-five scale according to JHNEBP, with one representing the strongest evidence and five representing the weakest. Meta-analyses and experimental randomized controlled trials (RCTs) remain the strongest evidence and are assigned a Johns Hopkins Nursing Evidence Based Practice (JHNEBP) level of “I.” The next level of evidence is comprised of quasi-experimental studies, which are assigned a JHNEBP level of “II.” Finally, level “III” evidence consists of non-experimental studies or systematic reviews of a combination of RCTs, quasi-experimental studies, and non-experimental research.

In the search performed, however, no articles meeting criteria for a strength of I or II were found. All the research studies included in this discussion are categorized as JHNEBP III, due to the use of meta-syntheses, systematic reviews, and non-experimental research designs. Additionally, each study was deemed to be of high quality, except for two which were deemed to be good quality (Carabez, Pellegrini, Mankovitz, Eliason, & Dariotis, 2015; Rounds, McGrath, & Walsh, 2013) due to their small sample size, which diminished the studies’ generalizability. Notably, recent research has begun to examine LGBT health data as a whole at the population-level, but of the majority of the existing evidence base is comprised of studies that compare the LGBT community to their heterosexual peers. The strength of population data is its generalizability versus individual data that is less generalizable to the general populous. Despite the clear rationale for population-level data, only one study examined for this review incorporated this level of data (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013).

The remaining studies categorized as JHNEBP III, despite their recentness, still rely upon individual-level, or convenience sample, data. Of note, most state and national survey studies do not incorporate measures of LGBT status, which at least partially explains the dearth of population-level studies.

Synthesis of Evidence. In recent years, there has been a renewed focus on the health of the LGBT population and on their unique health challenges and disparities (Healthy People 2020, 2016; IOM, 2011; SAMHSA, 2012). Researchers posit that LGBT health disparities may result from prejudice, stigma, and victimization due to belonging to a minority group, a concept known as minority stress (Foglia & Fredriksen-Goldsen, 2014; IOM, 2011; Lim, Brown, & Jones, 2013; Lim, Brown, & Kim, 2014). Furthermore, health disparities that may initially appear in the adolescent LGBT population may persist across the lifespan (Foglia & Fredriksen-Goldsen, 2014; IOM, 2011; Lim, Brown, & Jones, 2013; Lim, Brown, & Kim, 2014; SAMHSA, 2012; Saewyc, 2011).

Beginning in adolescence, the LGBT population experiences adverse health outcomes such as higher rates of suicidality and depression, substance abuse, and high-risk sexual behaviors (IOM, 2011; Saewyc, 2011). These behaviors result in very high rates of sexually transmitted infections (STIs) and HIV/AIDS (IOM, 2011; Saewyc, 2011). Finally, young LGBT individuals, particularly transgender teenagers, have high rates of homelessness; in turn, these youth often must resort to survival sex, often increasing rates of STIs and HIV (IOM, 2011; Saewyc, 2011). These disparities continue into adulthood and may cause a wide array of health complications later in life. For example, rates of cardiac disease and breast cancer are higher, particularly among lesbian and bisexual women, due to obesity, alcohol, and tobacco use (IOM, 2011; Lim, Brown, & Jones, 2013; Lim, Brown, & Kim, 2014; SAMHSA, 2012). In addition,

LGBT individuals have higher rates of intimate partner violence (IPV) than their heterosexual counterparts (IOM, 2011; Lim, Brown, & Jones, 2013; Lim, Brown, & Kim, 2014; SAMHSA, 2012).

Regarding other subgroups within this minority, further health issues have been identified. In particular, older LGBT individuals are disproportionately affected by serious illness and disability, which can be worsened by ageism, discrimination, and healthcare providers' implicit biases (Foglia & Fredriksen-Goldsen, 2014; IOM, 2011; Lim, Brown, & Jones, 2013; Lim, Brown, & Kim, 2014; SAMHSA, 2012). In light of these findings, healthcare providers must be educated in order to address the unique needs of this population.

In the past several decades, research on LGBT health and documented policy statements have increased exponentially (Eliason, Dibble, & DeJoseph, 2010; Snyder, 2011). In fact, a trend analysis of publications on LGBT issues from 1950 to 2007 by Snyder (2011) noted that LGBT-specific research literature increased by about 300 publications between 2001 and 2007 alone. In addition to LGBT research, the majority of the health disciplines, including medicine and psychology, have published policy statements regarding the importance of LGBT inclusivity in the healthcare environment. These policy documents detail necessary curricular changes to healthcare provider education in order to meet the pressing health needs of the LGBT population.

Nursing Education. Despite the increasing focus on LGBT health, the nursing literature has remained relatively silent on LGBT-specific issues. Eliason, Dibble, and DeJoseph (2010) noted that among the top ten nursing journals, between 2005 and 2009, only eight articles focused on LGBT themes, a paltry 0.16% of all articles in the journals. Furthermore, while the American Nurses Association (ANA) (2017) provides links to LGBT resources, they do not have a position statement on LGBT health nor have they mandated explicit inclusion of LGBT

sensitivity content in nursing curricula. Perhaps unsurprisingly, a 2011 study by Chapman, Watkins, Zappia, Nicol, and Shields revealed that nursing students' overall knowledge of LGBT-related issues was poorer than that of medical students.

Although nursing has not kept pace with other disciplines' curricular revisions for LGBT competency, the need for this type of education within nursing has been documented. In a nationwide survey of 1,282 nursing educators, Sirota (2013) found that 78.6% of the sample felt that teaching about homosexuality in nursing curricula was very or extremely important; however, only 28.1% of those nurse educators felt that they were equipped to teach about LGBT issues. More recent research by Lim, Johnson, and Eliason (2015) corroborated Sirota's results, demonstrating that LGBT health topics were missing or barely included in courses taught by 75% of the nurse educators surveyed. This lack of competence in LGBT-specific issues illustrates the need for the integration of additional training and content in nursing curricula.

Several studies have been conducted recently regarding integration of LGBT cultural competence in nursing education in various capacities. Although singular assignments related to LGBT issues in a public health nursing class have proven beneficial to students (Carabez, Pellegrini, Mankovitz, Eliason, & Dariotis, 2015), several studies advocate integrating LGBT issues across the nursing curriculum (Bosse, Nesteby, & Randall, 2015; Lim & Bernstein, 2012; Lim, Brown, & Jones, 2013; Strong & Folse, 2015). Specifically, Bosse et al. (2015) noted that the health assessment course is an ideal opportunity to educate students in culturally sensitive LGBT history taking. Lim, Brown, and Jones (2013) specified numerous opportunities for LGBT educational inclusiveness, namely in simulations, case studies, nursing care plans, and affiliations with LGBT health agencies. More broadly, it is imperative that issues pertinent to LGBT health disparities be systematically interwoven throughout the nursing curriculum with a

focus on life stages (Lim & Bernstein, 2012; Lim, Brown, & Jones, 2013). Of equal importance is addressing provider attitudes toward LGBT individuals and improving provider capacity to care for this population (Rounds, McGrath, & Walsh, 2013; Strong & Folsie, 2015).

A review of the research has clearly revealed the need for the inclusion of LGBT-specific content in healthcare provider curricula. Specifically, nursing curricula must include sensitivity training in order to change providers' attitudes and incorporate a focus on LGBT health disparities, with an ultimate goal of reducing these distinct disparities. Nurses, who are front-line agents in the healthcare system, play a critical role in making LGBT patients feel safe and welcome by their providers. Still, existing nursing curricula do not provide adequate training on LGBT cultural competence, despite an expressed need to educate nurses on this topic.

LGBT competency guidelines. Similar to the JHNEBP rating scale for research studies, Johns Hopkins Nursing has put forth guidelines for assessing the strength and quality of clinical practice guidelines. Each of the guidelines included in this review has been assigned a JHNEBP level of IV, meaning that each of the recommendations is based on research and put forth by national experts. Although expert opinion is considered one of the lowest levels of evidence because it is the least generalizable type, the policy and practice guidelines included in this review are based on systematically reviewed evidence, which is synthesized into policy recommendations by leading national authorities, as described below.

In recent years, leading authorities have published several guidelines, which detail critical steps to increase provider competence in caring for LGBT patients. The seminal Institute of Medicine (IOM) (2011) report on the health of the LGBT population, LGBT care recommendations set forth by the Gay and Lesbian Medical Association (GLMA) (2006), the LGBT cultural competence field guide proposed by the Joint Commission (2011), and the recent

Healthy People 2020 initiative (2016) have highlighted the stigmatization of LGBT individuals and the need for research and training specific to this population. Despite the clear recommendations for provider education in LGBT sensitivity contained in these policy documents, nursing providers lack the cultural competence to engage their LGBT patients effectively.

Singularly, the Fenway Institute, a frontline leader in LGBT healthcare, has put forth recommendations to promote awareness among healthcare providers, build inclusive environments, and tailor care to the LGBT population (Ard & Makadon, 2012). The Fenway Institute, as well as several other policy groups (IOM, 2011; GLMA, 2006; Healthy People 2020, 2016; Joint Commission, 2011), advocate for provider education on salient LGBT health topics. One of the primary areas for providers to understand is the extent and severity of LGBT health disparities and how these disparities occur across the lifespan. Special attention should be paid to health disparities developing in adolescence and those that occur in the aging LGBT population (Ard & Makadon, 2012; Hardacker, Rubinstein, Hotton, & Houlberg, 2014). Notably, LGBT health disparities stem from several sources, including structural barriers, discrimination, and lack of provider sensitivity training (Ark & Makadon, 2012; IOM, 2011; GLMA, 2006; Healthy People 2020, 2016; Joint Commission, 2011). These disparities include: difficulty accessing care, lower rates of health insurance, fewer preventive health visits, higher rates of HIV and sexually transmitted infections (STIs), higher rates of mental health issues and suicidality, and substance use, among others (Ark & Makadon, 2012; IOM, 2011; GLMA, 2006; Healthy People 2020, 2016; Joint Commission, 2011).

Summary. In keeping with these provider education recommendations, nursing curricula must include content that enables nurses to provide culturally competent care to members of the

LGBT community. Namely, this content should include discussions of LGBT health disparities across the lifespan, enhance provider self-awareness and attitudes towards LGBT patients, and pinpoint strategies to make LGBT individuals feel at ease and welcome in the healthcare environment. This capstone project strove to provide the kind of training for health care providers that would equip them to deal effectually with the LGBT community, a population that continues to struggle disproportionately with health disparities, social discrimination, and victimization.

Theoretical Framework

The American Association of Colleges of Nursing (AACN) (2008) advances culturally competent nursing practice as one of the foundational elements of baccalaureate nursing education. Although several theoretical frameworks exist to describe and explicate the concept of cultural competence, one preeminent model selected for this capstone project was developed by Sue, Arredondo, and McDavis in 1992 and was most recently refined and updated by Sue and Sue in 2008 (Kumas-Tan, Beagan, Loppie, Macleod, & Frank, 2007).

Originally developed for counseling psychology, this model is referred to as the “tripartite framework” and encompasses three critical domains for healthcare providers to focus on: attitudes, knowledge, and skills. The attitude domain refers to a practitioner’s beliefs and attitudes about minority populations, developing awareness of any pre-existing biases on the part of the practitioner, and fostering a positive stance on multiculturalism (Sue, Arrendondo & McDavis, 1992). The knowledge domain reflects the practitioner’s awareness of the needs and struggles of minority populations with whom they work, as well as the social determinants of health disparities in minority populations. Lastly, the skills domain refers to the methods a provider utilizes in caring for minority populations as well as their own perceived ability (self-

efficacy) to incorporate these techniques effectively in their practice (Sue, Arrendondo, & Davis, 1992). As previously noted, healthcare practitioners' personal attitudes, knowledge of the unique needs and disparities faced by the LGBT population, and the ability to provide competent assessments and develop appropriate interventions can help mediate LGBT health disparities.

Conversely, homophobic attitudes, lack of LGBT-specific knowledge, and the inability to perform critical culturally appropriate assessments may contribute to health disparities (Ark & Makadon, 2012; IOM, 2011; GLMA, 2006; Healthy People 2020, 2016; Joint Commission, 2011). Therefore, a framework that addresses the affective (attitudes), intellectual (knowledge), and technical (skills) domains was ideally suited for the development of a nursing provider intervention aimed at improving LGBT cultural competence. The capstone project described below aimed to target all three domains of the tripartite framework. Attitudes and knowledge were primarily addressed through a didactic online learning module that included both factual content and self-reflective questions designed to promote self-inquiry regarding attitudes toward LGBT individuals. The affective domain was further explored, as was the skills domain, through the use of a clinical simulation exercise that allowed nursing students to practice and apply the principles learned in the didactic module. A debriefing session after the simulation afforded students the opportunity to further explore their own attitudes towards LGBT people as well as receive feedback on the skills for providing culturally competent care and to reflect on their self-efficacy.

In order to target attitudes, knowledge, and skills among nursing providers, an educational intervention was developed based on the recommendations set forth by leading health authorities such as the Institute of Medicine, Fenway Institute, GLMA, and Joint Commission. In keeping with the tripartite framework described above, the educational

intervention was rooted in social-emotional learning (SEL) theory. According to the Collaborative for Academic, Social and Emotional Learning (CASEL) (2015), SEL is the process by which students “acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions” (para. 1). As healthcare providers, nurses must examine their own attitudes toward working with LGBT individuals, assess their level of understanding of issues facing the LGBT community, and develop their ability to interact effectively with LGBT patients and plan for their needs. Social emotional learning has been studied in the context of nursing and has been shown to be an integral part of the nursing process as well as a means of understanding and relating to patients in an informed and genuine manner (Gerardi, 2015; McQueen, 2004; Reyes, Andrusyszyn, Iwasiw, Forchuk, & Babenko-Mould, 2015). As such, SEL was an ideal framework through which to develop a LGBT cultural competence training for nursing students.

Project Design and Methods

This DNP capstone project consisted of an educational program for undergraduate nursing students using an evaluation design including pre-post-test and repeated measures of analysis of providers’ sense of cultural competency in working with the LGBT community after the program. Descriptive statistics were used to evaluate the results once the intervention had been implemented. To assess the effectiveness of the educational session, a pre-test post-test design was used. This design involved a pre-test of skills, attitudes, and behaviors related to the care of LGBT individuals (Appendix A). Participants were then exposed to information on how to effectively provide care to LGBT individuals, and then tested again.

The existing scale termed the Sexual Orientation Counselor Competency Scale (SOCCS) developed by an LGBT counseling psychology professor based at Hunter College (Bidell, 2015) (Appendix A) was used. Recently, the SOCCS has been adapted by Dr. Bidell (2015) to include assessment of clinical competency in broader healthcare fields, such as nursing and has added a measure to assess clinical competency in working with the transgender population. Importantly, the scale is grounded in the tripartite framework, and is broken into subscales focusing on skills, awareness, and knowledge. The scale, having undergone substantial testing in the counseling psychology realm is noted to be a “psychometrically valid and reliable self-assessment” (Bidell, 2015, p. 1). Two versions of the scale – one focused on lesbian, gay, and bisexual cultural competence (Version 2) and the other for transgender cultural competence (Version 3) – were used in this project as part of the pre-post test measures for comparison. Each of the two scales consisted of 29 items that were averaged to arrive at an overall cultural competence score. Each of the items on the scale are measured in terms of agreement. A response of “1” indicates “Not at all true”; “4” is “somewhat true” and “7” indicates “Totally true”. As mentioned, the SOCCS instrument has three sub-scales: knowledge, consisting of eight items; awareness, consisting of 10 items; and skills, consisting of 11 items. The scale is free to use and was utilized as a pre- and post-intervention measure as well as at one-month post-intervention (Bidell, n.d.). The instruments’ survey questions were programmed into Qualtrics® data-management system and students completed the measures before, immediately after, and at one-month post-intervention.

Project success was determined by comparing pre-test and post-test data. To analyze data under this design, a paired sample t-test was utilized. Additionally, participants in this project were asked to complete a one-month post-test survey to assess if educational programming focused on the care of the LGBT community had longer term impact. A repeated measures

analysis of variance (RM-ANOVA) was used to assess if a statistically significant change in means occurred over time.

Setting and resources

A large south Florida university had identified education on LGBT cultural competence as an area of need in their current curriculum. As such, several professors as well as the Associate Dean for Research and the Associate Dean for Undergraduate Nursing Programs showed great enthusiasm for and support of this educational initiative for their nursing students. While the ultimate goal of this type of educational initiative would be to develop scaffolded programming that is reinforced across the curriculum in multiple areas, for the purposes of this DNP project, LGBT cultural competence training was included during the community and public health nursing (CPHN) course for two cohorts of accelerated BSN students. In addition, future avenues for this type of LGBT competency training would ideally include both university faculty as well as key personnel from the clinical agencies at which nursing students complete clinical hours.

Description of the group, population or community. A large university setting for this project comprised the sample with nursing students from a variety of locations, socioeconomic statuses and political affiliations. According to the most current data available, during the 2015-2016 school year, roughly 800 students were enrolled at the university. University-wide, approximately 20% of the student body is culled from the local area and just under 20% of students come from other parts of Florida. Half of the study body comes from other areas of the United States and roughly 15% of the students are from international locations. Nearly half of the students are Caucasian (47%), followed by Hispanic/Latino students (25%), then by

Asian/Pacific Islander (10%). The remainder of the student body identifies as Black, American Indian, or two or more races.

As noted, there was strong organizational support on the part of the school leadership, given the identified need for inclusion of LGBT-specific healthcare provider curriculum. While the focus of this project necessarily involved the input of the CPHN faculty, it is hoped that faculty in other nursing specialties will eventually include elements of the LGBT educational content in their coursework with students. Importantly, this university is home to a National Institutes of Health (NIH) National Institute on Minority Health and Health Disparities Centers (NIHMD) Center for Excellence. The research, teaching, and service mission of all university faculty revolves around addressing health disparities. Therefore, the aims of this DNP project in mitigating the health disparities experienced by the LGBT community were well aligned with the overall mission of the university.

Organizational analysis of project site. This DNP capstone project has received strong support from the university leadership and Community and Public Health Nursing (CPHN) faculty. Notably, the Director for the Community Engagement, Dissemination, and Implementation (CEDI) Core was the faculty advisor for this DNP project. Through continued collaboration with the CEDI director and other CPHN faculty, the educational content was developed at an appropriate level for baccalaureate nursing students and integrated into the CPHN curriculum. The CEDI director was the site faculty preceptor for this DNP student since Spring 2016 and continued to supervise the DNP student's learning and capstone evaluation through Spring 2017.

Additionally, the course coordinator for the CPHN course in which this DNP project was disseminated served as a strong advocate for the inclusion of LGBT content in the CPHN

curriculum. During the Spring 2016 semester, the DNP student guest-lectured in the CPHN course on the topic of optimizing the health and health care of the LGBT community. Finally, the DNP student and CPHN course coordinator have recently submitted a manuscript for consideration describing the efficacy of health fairs in reducing health disparities among participants. Therefore, the DNP student has been well integrated into the fabric of the university research and teaching mission, and maintains close working relationships with key faculty members that supported the successful implementation and evaluation of the DNP project.

Facilitators and Barriers. Several factors aided in facilitating the inclusion of LGBT cultural competence education at the university. First, there is an existing, heightened societal awareness of LGBT issues, due in large part to inclusion of these topics in the media. For example, the recent public gender transition of Caitlin Jenner has created widespread exposure to transgender issues. Second, as previously discussed, nursing educators have generally less homophobic and transphobic attitudes today than in the past (Sirota, 2013; Lim, Johnson, & Eliason, 2015). Importantly, as noted, university leadership expressed strong support for the inclusion of this content in their curriculum. Lastly, the criticality of including education for healthcare providers on the topics of gender identity, sexual orientation and health disparities among sexual and gender minorities has gained a considerable amount of traction in recent years. For example, the Healthy People 2020 (2016) initiative includes objectives specific to the LGBT population for the first time since the Healthy People initiative's inception. Additionally, recent changes in healthcare due to the Affordable Care Act have disallowed the denial of health insurance based on pre-existing conditions, such as gender dysphoria (Obama Care Facts, 2015). As such, more transgender individuals now have access to healthcare, which underscores the

importance of nurses receiving specialized training for working competently with this population.

On the other hand, several barriers to longer term implementation of an effective LGBT cultural competence training for nursing students exist. First, although recent evidence has pointed to a positive shift in attitudes regarding the LGBT community among both nursing students and faculty, heterosexism, homophobia, and transphobia remain significant concerns and are distinct barriers to providing culturally competent care. Second, as previously noted, nursing educators, generally, do not have the knowledge or skills to competently provide education about the needs of the LGBT community (Sirota, 2013; Lim, Johnson, & Eliason, 2015). Finally, nursing curricula across the country are constantly evolving to meet the needs of a changing patient population; as such, priority areas of focus are being continuously revised, making the inclusion of LGBT cultural competence training a competing priority. Although the university has been immensely supportive of this initiative, the sustainability of including LGBT cultural competence education as part of the curriculum may be a challenge because of numerous competing curricular priority areas.

Goals and Objectives. The overall goal of this DNP project was to produce an increase in nursing provider competency, through a formative educational intervention, in working with the LGBT population. Additionally, the effectiveness and applicability of the educational program was assessed from a program evaluation perspective. Several objectives were measured to support the attainment of these goals:

1. Nursing students will demonstrate a statistically significant improvement in knowledge, skills, and attitudes related to LGBT cultural competence from pre-test to post-test

2. Nursing students will maintain their post-test improvement in LGBT cultural competence, as measured four weeks after the educational program
3. Nursing students will demonstrate an increased understanding of unique LGBT needs and health disparities post-test (Knowledge domain)
4. Nursing students will learn new skills and techniques for interacting with LGBT patients post-test (Skills domain)
5. Post-test, nursing students will articulate the importance of, and methods for, creating an LGBT inclusive healthcare environment, despite potentially negative personal feelings about the LGBT community (e.g. inclusive intake forms, inclusive sexual history taking, etc.) (Attitudes domain)
6. Nursing students will express agreement or strong agreement with the benefit of this educational program
7. Nursing students will express agreement or strong agreement with the applicability of this educational program to their practice

Implementation Plan

The educational program involved students first completing a pre-survey (Appendix A) that asked questions about attitudes toward, knowledge of, and skills in providing care to the LGBT community. The survey was anonymous; students created a four-character pseudonym consisting of the first two letters of their mother's first name and the last two digits of their phone number (e.g. MA01). Students were asked to remember their pseudonym as it was used to link pre-, post-, and one-month survey data. After completing the pre-survey, students completed online modules containing didactic content on delivering culturally competent care to the LGBT population (Appendix B). Once all the modules were completed, students went through an in-

class table top simulation. A tabletop simulation entails bringing together a group of people to review and discuss a hypothetical emergency situation step-by-step to determine how effectively the overall team would respond to an actual emergency. It allows participants to talk through plans or problems related to a chosen topic in an informal and stress-free environment. The scenario involved a disaster management plan, wherein a transgender individual and their significant other needed to be appropriately sheltered in emergency housing during a hurricane in south Florida. Students were each assigned a role, as described in Appendix C, and were divided into small groups to role play the scenario. The simulation allowed students to practice several techniques from the didactic content, including use of preferred pronouns, consideration of transgender safety in shared sleeping areas, identification of written, approved policy in Miami-Dade County on housing transgender families, and therapeutic communication, among others. Once the scenario was complete, a transgender individual assisted nursing faculty in debriefing the students on the simulation and offered perspective on which aspects of the scenario were appropriately carried out versus those that could be improved.

Immediately following the simulation, students completed a post-test survey (the SOCCS measure) that assessed any change in knowledge, skills, or attitudes. The quality and usefulness of the educational program was also evaluated during the post-test survey per the National LGBT Cancer Network guides for implementing and evaluating LGBT cultural competence trainings (n.d.). Program evaluation questions focused on the preparation and knowledge of the DNP student as a trainer and assessed the most useful aspects of the intervention (learning module, simulation, discussion, etc.). One month after the post-educational program, students completed an additional survey to assess if the education had a longer-term impact. Data was collected through the Qualtrics® data-management system and was analyzed and reported as described.

As clinical simulation is still an emerging field, research results regarding its utility have been mixed. However, for the purposes of this project, table top simulation was used to target students' self-efficacy in dealing with members of the LGBT population. Several studies have demonstrated an increase in nursing students' self-efficacy following simulated scenarios (Dunn, Osborne & Link, 2014; Goldenberg, Andrusyszyn, & Iwasiw, 2005; Karabacak, Serbest, Öntürk, Aslan, & Olgun, 2013; Kimhi, Reishtein, Cohen, Friger, Hurvitz & Avraham, 2016; Lee, Lee, Lee, & Bae, 2015).

Originally, the DNP capstone project was planned to be implemented with one group of accelerated BSN students (n = approximately 50) in the Fall of 2016. However, an opportunity arose to implement the project with an additional cohort of students (n = approximately 70), so the DNP student implemented the program twice. As of December 1, 2016, 124 students completed the pre-survey, 119 completed the post-survey, and 108 students completed the one-month follow-up survey.

Ethics and human subjects' protection. The population for which this DNP project was designed is BSN nursing students at a large south Florida university. Since the DNP student is an educator at the university and participation in the study should not affect course grades, no students participating in this program were graded by the DNP student for any assignment. As the project utilized a quality improvement educational design based on published best practices, it was proposed to be minimal risk by the University of Massachusetts (UMass) IRB. Due to this designation, the project was deemed by the Human Research Protection Office at the UMass IRB to not meet the criteria for human subjects research or full IRB review (Appendix D).

However, because the DNP project involved potentially sensitive topics that explored attitudes and beliefs about sexual orientation and gender identity, confidentiality of student

participants was a paramount concern. No identifying information was collected from students. All data was de-identified and reported in aggregate form. No survey answers were linked to individuals. As previously stated, students chose a four character pseudonym consisting of the first two letters of their mother's first name and the last two digits of their phone number (e.g. MA01) allowing linkage of data from baseline, post-intervention, and one-month follow-up.

Results

Outcomes evaluation.

As a result of LGBT cultural competence training, it was expected that nursing students would have improved attitudes towards the LGBT community, greater knowledge of LGBT needs and health disparities, and enhanced skills in assessing and planning for the health needs of this population. Collectively, these three domains (attitudes, knowledge, and skills) were defined as cultural competence. Therefore, the hypothesis was that this intervention would contribute to an improvement in cultural competence among nursing students. In keeping with the tripartite framework that guides this intervention, outcome evaluation similarly measured these three domains.

Demographics. Demographic information is summarized in Tables 1-3. As shown in Table 1, most of the sample (n=51) was comprised of individuals ages 20-24 (48.7%), followed by participants ages 25-30 (37.8%). Students ages 31-40 represented 10.9% of the sample, and the remaining 2.5% was made up of individuals ages 41-50. Table 2 displays the ethnicities of the student participants. Approximately one third of the sample (35.7%) identified as being non-Hispanic European descent. Roughly one quarter (26.4%) of students identified as Hispanic/Latino, and 8.5% self-identified as being of African descent. Nearly 8% (7.8%) of

students did not identify as any of the ethnicities listed and 7% of students identified as Caribbean. The remaining 14.8% of students selected “Asian”, “Prefer Not to Say”, “Middle Eastern”, “Native American”, “Indian” or “Pacific Islander”. Lastly, most students (83.2%) preferred “she” pronouns; 14.3% of students preferred “he” pronouns; and 2.5% of respondents did not identify with either male or female pronouns.

Objective 1. *Nursing students will demonstrate a statistically significant improvement in knowledge, skills, and attitudes related to LGBT cultural competence from pre-test to post-test.*

As noted, cultural competency was defined as the aggregate of knowledge, skills, and attitudes, and was thus reflected in the overall SOCCS score. Individual item scores were totaled and divided by 29 to arrive at an overall cultural competence score per the SOCCS Scoring Instructions to achieve an overall cultural competency score of between 1 (very low) and 7 (very high) (Bidell, n.d.). Because lesbian, gay, and bisexual (LGB) cultural competence was measured on one scale and transgender cultural competence was measured with a separate scale, paired-samples t-tests were run on both overall LGB and overall transgender SOCCS scores and are reported in Table 4. Results of the paired-samples t-test show a statistically significant improvement in overall LGB SOCCS scores before the DNP project implementation ($M = 4.5794$, $SD = .76208$) and after project implementation ($M = 5.2713$, $SD = .78953$) at the .05 level of significance ($t = -10.625$, $df = 75$, $n = 76$, $p = .000$, 95% CI for mean difference $-.82165$ to $-.56220$). On average overall LGB SOCCS scores improved by 0.6919 points from pre- to post- intervention. Results of the paired-samples t-test showed a statistically significant improvement in overall transgender SOCCS scores before the DNP project implementation ($M = 4.2069$, $SD = .75776$) and after project implementation ($M = 5.1076$, $SD = .84135$) at the .05 level of significance ($t = -12.574$, $df = 73$, $n = 74$, $p = .000$, 95% CI for mean difference -1.04351

to -.75798). On average, overall transgender SOCCS scores improved by almost a full point (0.9007) from pre- to post- intervention. Based on this analysis, overall SOCCS scores improved significantly from pre- to post-test and therefore, this objective was strongly met.

Objective 2. *Nursing students will maintain their post-test improvement in LGBT cultural competence, as measured four weeks after the educational program.*

As described above, cultural competency was defined as the aggregated total scores on the SOCCS instrument. Again, LGB and transgender cultural competence were assessed using separate scales, and the results are accordingly reported separately. As noted LGB cultural competence scores improved from pre-survey to post-survey. For the RM-ANOVA for overall LGB SOCCS scores, Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = 7.024, p = .030$ (Table 5). There was a significant effect of time on overall LGB SOCCS score, $F(2, 78) = 31.576, p = .000$ (Table 6). Overall LGB cultural competence SOCCS scores improved from pre- ($M = 4.418$) to post-test ($M = 5.204$), and did not significantly decrease at one-month post-project implementation ($M = 5.033$) (Tables 7 and 8).

For the RM-ANOVA analysis of overall Transgender SOCCS scores, Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = 3.447, p = .178$ (Table 9). There was a significant effect of time on overall Transgender SOCCS score, $F(2, 76) = 63.706, p = .000$ (Table 10). Overall Transgender cultural competence SOCCS scores improved from pre- ($M = 4.0212$) to post-test ($M = 5.0743$), and did not significantly decrease at one-month post-project implementation ($M = 4.9151$) (Tables 11 and 12). Based on the repeated measures analysis of variance for both LGB and transgender overall SOCCS scores, nursing students' scores improved from pre- to post-test and did not significantly decline at four weeks post-intervention. Therefore, this objective was strongly met.

Objective 3. *Nursing students will demonstrate an increased understanding of unique LGBT needs and health disparities post-test (Knowledge domain).*

As noted, the SOCCS instrument is sub-divided into three subscales: knowledge, skills, and attitudes. The knowledge subscale totals responses to items 5, 9, 13, 16, 19, 20, 24 and 25 and then that sum is divided by 8 to arrive at the knowledge sub-score. Overall, students' mean scores on the LGB knowledge sub-scale improved from pre- to post-intervention and did not decline significantly at one-month. For the RM-ANOVA analysis of the LGB knowledge sub-scores, Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = 1.317, p = .518$ (Table 13). There was a significant effort of time on LGB knowledge sub-scores, $F(2, 78) = 24.204, p = .000$ (Table 14). Overall LGB knowledge sub-scores improved from pre- ($M = 3.9500$) to post-test ($M = 4.9844$), and did not significantly decrease at one-month post-project implementation ($M = 4.9125$) (Tables 15 and 16).

On the transgender knowledge subscale, overall, students' mean scores improved from pre- to post-intervention and did not decline significantly from post-test to one-month. For the RM-ANOVA analysis of the transgender knowledge sub-scores, Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = 3.483, p = .175$ (Table 17). There was a significant effort of time on transgender knowledge sub-scores, $F(2, 76) = 23.028, p = .000$ (Table 18). Overall transgender knowledge sub-scores improved from pre- ($M = 3.9744$) to post-test ($M = 5.1667$), and did not decline significantly at one-month post-project implementation ($M = 4.9808$) (Tables 19 and 20). Thus, the fact that both LGB and transgender knowledge scores improved from pre- to post-test and did not decline significantly indicates that this objective was strongly met.

Objective 4. *Nursing students will learn new skills and techniques for interacting with LGBT patients post-test (Skills domain).*

The skills subscale totals responses to items 1, 3, 4, 6, 7, 8, 12, 14, 18, 22 and 26 and then that sum is divided by 11 to arrive at the skills sub-score. Overall, students' mean scores on the LGB skills sub-scale improved from pre- to post-intervention and increased slightly at one-month, though not a statistically significant amount. For the RM-ANOVA analysis of the LGB skills sub-scores, Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = 4.018, p = .134$ (Table 21). There was a significant effect of time on LGB skills sub-scores, $F(2, 78) = 34.383, p = .000$ (Table 22). Overall LGB skills sub-scores improved from pre- ($M = 3.2500$) to post-test ($M = 4.3841$), and increased slightly, though not significantly at one-month post-project implementation ($M = 4.4427$) (Tables 23 and 24).

On the transgender skills subscale, overall, students' mean scores improved from pre- to post-intervention and increased slightly at one-month, though not a statistically significant amount. For the RM-ANOVA analysis of the transgender skills sub-scores, Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = .345, p = .841$ (Table 25). There was a significant effect of time on transgender skills sub-scores, $F(2, 76) = 78.636, p = .000$ (Table 26). Overall transgender skills sub-scores improved from pre- ($M = 2.3310$) to post-test ($M = 4.0559$), and increased slightly, though not significantly at one-month post-project implementation ($M = 4.0839$) (Tables 27 and 28). Thus, the fact that both LGB and transgender knowledge scores improved from pre- to post-test and continued to increase slightly at one-month, albeit non-significantly indicates that this objective was strongly met.

Objective 5. *Post-test, nursing students will articulate the importance of, and methods for, creating an LGBT inclusive healthcare environment, despite potentially negative personal*

feelings about the LGBT community (e.g. inclusive intake forms, inclusive sexual history taking, etc.) (Awareness domain).

The awareness subscale totals responses to items 2, 10, 11, 15, 17, 21, 23, 27, and 28 and then that sum is divided by 10 to arrive at the awareness sub-score. Overall, students' mean scores on the LGB awareness sub-scale improved from pre- to post-intervention but declined significantly at one-month. For the RM-ANOVA analysis of the LGB awareness sub-scores, Mauchly's Test of Sphericity indicated that the assumption of sphericity had been violated, $\chi^2(2) = 20.049, p = .000$, and therefore, a Greenhouse-Geisser correction was used (Table 29). There was a significant effect of time on LGB awareness sub-scores, $F(1.148, 55.320) = 8.591, p = .002$ (Table 30). Overall LGB awareness sub-scores improved from pre- ($M = 6.0775$) to post-test ($M = 6.2825$), but significantly decreased at one-month post-project implementation ($M = 5.800$) (Tables 31 and 32).

On the transgender skills subscale, overall, students' mean scores improved from pre- to post-intervention; however, this increase was not statistically significant. Additionally, transgender awareness subscale scores declined from post-test to one-month, but not significantly. For the RM-ANOVA analysis of the transgender awareness sub-scores, Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = 2.827, p = .243$ (Table 33). There was not a significant effect of time on transgender awareness sub-scores, $F(2,76) = 3.782, p = .027$ (Table 34). Overall transgender awareness sub-scores improved from pre- ($M = 5.8590$) to post-test ($M = 6.1205$), but not significantly, and scores decreased a non-statistically significant amount at one-month post-project implementation ($M = 5.7769$) (Tables 35 and 36).

LGB awareness sub-scores improved significantly from pre- to post-intervention, but declined significantly at one-month. Transgender awareness sub-scores did not significantly improve from pre- to post-intervention and a non-significant decline from post-intervention to one-month was observed. Thus, this objective was partially met in that scores did improve on both the LGB and transgender awareness sub-scales, but LGB awareness declined significantly at one month and the observed change in the transgender awareness sub-scale was not statistically significant.

Objective 6. *Nursing students will express agreement or strong agreement with the benefit of this educational program.*

Students were asked to rate the DNP student and presentation in several areas post-intervention. These domains included 1) the DNP candidate's knowledge about the topic; 2) the clarity of the training content; 3) overall satisfaction with the training; and 4) the DNP candidate's ability to create engagement with the content. Additionally, students provided qualitative feedback which will be discussed below. Overall, the results were very favorable. Table 37 provides a breakdown of student responses for each of the four domains. The majority of students (n=117, 93.6%) agreed or strongly agreed that the DNP candidate was knowledgeable about the topic. Similarly, 93.6% (n=117) expressed agreement or strong agreement that the DNP candidate created opportunities for students to actively engage in the training. Overall, students expressed agreement or strong agreement (n=115, 92%) that they were satisfied with the training. Lastly, 88.8% (n=111) of students felt the content was clearly presented. Given the high percentages of students who agreed or strongly agreed, this objective was strongly met.

Objective 7. *Nursing students will express agreement or strong agreement with the applicability of this educational program to their practice.*

After the educational program, students were asked to rate the usefulness and applicability to nursing practice of several aspects of the program content. Table 38 summarizes these results. According to student feedback, the most useful component of the program was discussion about common LGBT terminology, including terms used to describe variances in gender identity or orientation. Nearly 94% (93.6%, n=117) found terminology content to be very or extremely useful. Next, most students felt that content related to creating welcoming spaces for LGBT people and personal stories of LGBT to be very or extremely useful for their practice (92.8% in both domains, n=116). A discussion of LGBT health disparities was very or extremely useful for 92% (n=115) of participants. The LGBT hurricane shelter simulation was rated as being very or extremely useful by 88.8% (n=111) of students. Additionally, students provided substantive input on the educational program via qualitative feedback that will be discussed below. Lastly, 85.6% (n=107) found diagrams and visuals included in the presentation to be very or extremely useful; 13 students (10.4%) found these to be somewhat useful. Given the reports of content being very or extremely useful for the majority of students, this objective was strongly met.

Educational Module Improvements.

As noted, in addition to the quantitative analysis of the DNP project, students also provided qualitative feedback on various aspects of the program, and were asked specifically for comments regarding what could have improved the modules. For the purposes of this reporting, the qualitative comments were categorized in the following way: 1) comments expressing

positive presenter feedback, or recommending no changes; 2) comments requesting additional background information; 3) feedback on the simulation activity; and 4) other feedback.

Student responses to what changes they would suggest to the module are detailed in Table 39. A total of 81 students responded to this question. Just over half of students (51%, n=41) expressed positive feedback about the presenter and/or content, with comments such as “I would not change anything about these modules. I feel like they were very informative and I learned a lot that I did not know about the LGBT community”. Other responses expressing positive feedback are coded as “P” in Table 39.

Aside from the positive feedback, the majority of comments related to the simulation activity. Approximately 36% of students (n=29) provided comments as to how the simulation activity could be improved. Overall, students expressed wanting clearer instructions and more guidance in their simulation roles. For example, one student noted, “I think it would be better if the descriptions of each role was clearly outlined because there were times during the activity I was unsure of what to say or do.” Some students felt that the characters they played needed more definition and/or direction: “... the only thing that I would change is for the facilitator to have more of a role during the Hurricane shelter. In the beginning scenarios I just asked questions that were on my card but on the scenario where the public health person and the nurse were arguing I took it further and challenged everyone’s view. But otherwise it was fun and it hits exactly where it had to. Thank you!”. Other feedback included suggestions such as having one smaller group perform the simulation in front of the class and then debriefing as a group, and a recommendation for the inclusion of a pre-briefing to orient students to their roles before actually engaging in the simulation. The responses related to the simulation are coded as “S” in Table 39.

Approximately 5% (n=4) of students expressed wanting more background information in the educational program. For example, one student requested more videos on current events related to LGBT health; another wanted more information on basic terminology. Responses coded as “B” in Table 39 list all student comments related to wanting more background information.

Roughly 9% (n=7) of students provided comments categorized as “other” (“O” in Table 39). One student reported wanting more information on how to conduct a culturally sensitive health assessment, “I would have liked to maybe go through a head-to-toe assessment with a pt who was trans or in transition just because I am still unsure how to get their past history. I feel as though it might be important to know if they were born female and became male or vice versa because you may be thinking about S&S that only correlate to the original gender and may not pick up on a disease.” Several other students reported wanting to hear more personal stories and/or more LGBT speakers in the educational programming. Lastly, one student expressed wanting to know the results of the pre- and post-surveys.

Additional Comments.

In addition to comments regarding improving the modules, students were provided space to make any additional comments they had. As shown in Table 40, in total, 65 students provided additional comments. As above, the comments were categorized in the following manner: 1) comments expressing positive presenter feedback, or recommending no changes; 2) comments about the guest speaker during the presentation; 3) comments requesting additional background information; 3) feedback on the simulation activity; and 4) other feedback. The majority of comments (68%, n=44) were positive in their feedback about the educational program. For example, one student expressed, “Was very informative and opened my mind more as a HCP

how to make people feel more comfortable in a health care setting without offending or coming off as rude”. Another student remarked, “Thank you, I appreciate any presentations where we have open conversations with others about social norms and social progress. I think it’s very important and the most effective way to create positive social change”. Other comments regarding positive program feedback are summarized in Table 40 and are coded as “P”.

The next comment category focused on the guest speaker who participated in the educational content. This speaker identified as “genderqueer” and thus did not identify with either entirely male or entirely female identities. Instead, this speaker used “they” pronouns. Approximately 15% (n=10) of students that provided additional comments remarked that they felt the guest speaker was a good addition to the educational program. One student remarked, “I really enjoyed hearing the guest speaker's story. I think that we should have more activities like this where we get to hear actual people's experiences”. Another student commented on the importance of a personal perspective on LGBT health issues shared by the speaker, “I really enjoyed this activity and lecture. The guest speaker Chaplain was a great addition to the course content. I thought it was very useful to be able to hear from and speak with an individual who had personal experience of living in an accepting environment versus one that was less than ideal”. The remainder of comments regarding the guest speaker are included in Table 40 and are coded as “SP”.

Some students also used the “additional comments” section to provide feedback about the simulation activity. Approximately 9% (n=6) students included suggestions about how to improve the simulation. One student posited that having various scenarios that students would act out in front of the class would be beneficial. In fact, several of the students who provided comment related to the simulation exercise recommended having groups of students “perform”

in front of the entire class with a group discussion to follow. The remaining comments related to enhanced clarity of the simulation instructions and actor roles. Specific comments related to the simulation can be found in Table 40 coded as “S”.

The final two categories were related to background information and other comments. Two students requested additional information regarding the underlying reasons LGBT individuals were fearful or felt unsafe in clinical settings or otherwise. The other student asked the following, “could you add something about developmental psychological aspects of gender identity and talk more about how people identify their own gender? It is easier to understand those terms in this way in my opinion.” These answers are coded as “B” in Table 40. Finally, three students provided comments that were classified as other. One student expressed that they had done similar exercises in the past and did not directly benefit from the DNP project, but felt that other students may have. Another student wanted more information about how providers can set aside their own biases when providing care. Lastly, one student remarked:

This activity has opened my eyes to all the struggles that LGBT face on a day to day basis. In the activity, I was the transgender person, and I felt hated upon (even though we were acting). I couldn't imagine feeling like this on a day to day basis. I am extremely interested in learning more, so I can avoid having someone feel less of a person and provide the best possible care possible.

The majority of student comments reflected a positive experience with this DNP project, which supports objectives 6 and 7 in terms of the benefit of this educational initiative as well as its applicability to nursing practice. Important themes also emerged regarding potential improvements for the educational program, specifically pertaining to the simulation activity. These themes and additional exploration of the program results are discussed below.

Discussion

Healthcare Provider Cultural Competency

The primary goal of this DNP project was to increase cultural competence in working with the LGBT community among nursing students who took part in the educational intervention. Data measuring each construct of cultural competence (knowledge, skills, and attitudes) as defined by Bidell (2015) and described within the tripartite framework (Sue, Arrendondo & McDavis, 1992) supports an educational program that targets each of these domains. Overall, cultural competence in working with the LGBT communities as measured by total SOCCS score improved significantly from baseline to post-intervention. In terms of LGB cultural competence, overall mean scores improved more than half a point (0.69) from pre-test (4.5794, SD = .76208) to post-test (M = 5.2713, SD = .78953). Overall transgender cultural competence showed an even greater significant improvement of almost one full point (0.90) from a baseline mean score of 4.2069 (SD = .75776) to a mean score of 5.1076 (SD = .84135) post-intervention. Furthermore, mean SOCCS scores did not decline significantly at the one-month post-survey for either LGB (M = 5.033) or transgender (M = 4.9151) cultural competence.

Results for the sub-scales similarly showed improvement, but several interesting phenomena were observed. In the knowledge domain, LGB sub-scores improved from pre- (M = 3.9500) to post-test (M = 4.9844), and did not significantly decrease at one-month post-project implementation (M = 4.9125). Similar results for the transgender knowledge subscale demonstrated that scores improved from pre- (M = 3.9744) to post-test (M = 5.1667), and did not decline significantly at one-month post-project implementation (M = 4.9808).

In terms of the skills sub-domain, LGB skills sub-scores improved from pre- ($M = 3.2500$) to post-test ($M = 4.3841$), and increased slightly, though not significantly at one-month post-project implementation ($M = 4.4427$). Mean transgender skills sub-scores improved significantly from pre- ($M = 2.3310$) to post-test ($M = 4.0559$), and increased slightly, though not significantly at one-month post-project implementation ($M = 4.0839$). The findings of improvement from post-test to one-month follow-up were unexpected, as students did not receive any intervention between the post-test and one-month survey. However, although the mean one-month scores improved over the mean post-test scores on both LGB and transgender skills sub-scales, these changes were not statistically significant.

Lastly, in the awareness sub-scale, LGB awareness sub-scores improved from pre- ($M = 6.0775$) to post-test ($M = 6.2825$), but significantly decreased at one-month post-project implementation ($M = 5.800$). Transgender awareness sub-scores improved from pre- ($M = 5.8590$) to post-test ($M = 6.1205$), but not significantly, and scores decreased a non-statistically significant amount at one-month post-project implementation ($M = 5.7769$). Notably, LGB baseline awareness scores were very high with a mean of roughly 6 out of a possible 7, so the lack of significant change from pre- to post-test was not particularly surprising. It appears that students possessed a strong awareness of LGB issues before the intervention. The fact that a statistically significant decrease from post-test to one-month follow-up was observed was unexpected, in that the one-month mean follow-up scores were lower than the baseline scores. Like the LGB sub-scale scores, transgender baseline mean awareness scores were relatively high at roughly 5.9 out of a possible 7. Although some improvement was observed from baseline to post-test on the transgender awareness sub-scale, one-month follow-up mean scores demonstrated a non-statistically significant decrease to a score lower than the baseline score. The

relatively high pre-test scores and subsequent decrease in mean LGB and transgender awareness scores suggests the occurrence of a statistical phenomenon known as regression to the mean, or regression artifact. This can occur when an initial measurement, such as pre-test awareness scores, is very high, and subsequent measurements will tend to be closer to the true average or mean (Trochim, 2006). Additionally, the observed decrease in scores suggests the need to include additional educational content to enhance provider awareness of LGBT issues to support sustained improvement. Several recent studies explore intergroup contact theory, wherein an in-group (e.g. heterosexuals) gains exposure to an outgroup (e.g. the LGBT community), leading to reductions in prejudice and increases in awareness (Heinze & Horn, 2009; Jones, Brewster & Jones, 2014; Knaak & Patten, 2016; Walch, Sinkkanen, Swain, Francisco, Breaux & Sjoberg, 2012). Therefore, educational content that provides repeated exposure to LGBT health needs and is reinforced throughout the nursing curriculum may result in more sustained improvements in LGBT awareness.

Cultural Competency Program Appraisal

The other goal of this DNP project was to assess the perceived value of LGBT cultural competency training and its application to practice for all who attended the program. Evaluation data provided by participants provided strong support that participants found the program to be valuable to their practice and that the DNP student was knowledgeable on the content.

Participants reported an increased awareness of LGBT needs and learning new ways and better ways to communicate with LGBT patients. The majority of qualitative feedback was positive, and respondents provided thoughtful recommendations on how the educational program might be further improved. Specifically, students requested more role clarification and guidance for the LGBT disaster simulation. While the simulation was intentionally designed to be open-ended

and draw students out of their comfort zone, student feedback was immensely helpful in designing future iterations of the simulation activity. Namely, several respondents suggested selecting a group of students to perform the simulation activity in front of the class and then debrief the scenario as a large group. This method is in keeping with the way simulations are typically run at the university and thus, might be an avenue to promote engagement and discussion of relevant LGBT topics.

Strengths and Limitations

A primary strength of this project was the relatively large sample size (n=120), comprised of pre-licensure nursing students. Targeting knowledge, skills, and awareness of LGBT issues before these providers formally enter the workforce may assist them in providing culturally competent care to LGBT patients they may encounter in their practice. Another strength of this DNP project was the use of the SOCCS instrument, a reliable and valid measure, for the pre-post-test assessment. Furthermore, the project utilized a mixed methods evaluation design with qualitative and quantitative measures, which garnered a rich dataset. An additional strength is the theoretical and evidence-based framework on which this intervention was built. By designing the intervention around the tripartite framework, the educational program was based in a context that directly supported education targeting awareness, skills, and knowledge. Lastly, having a transgender individual present for the simulation activity assisted in providing a human element to the program, and was well received by participants. As previously noted, healthcare practitioners' personal attitudes, knowledge of the unique needs and disparities faced by the LGBT population, and the ability to provide competent assessments and develop appropriate interventions can help mediate LGBT health disparities.

One significant limitation of this DNP project is that it was self-contained and implemented in two cohorts of accelerated BSN nursing students. Evidence suggests that scaffolding content across the curriculum may be preferable in terms of creating sustained change (Bosse, Nesteby, & Randall, 2015; Lim & Bernstein, 2012; Lim, Brown, & Jones, 2013; Strong & Folse, 2015). However, this educational program forms a base upon which additional educational content may be built. Several opportunities for LGBT cultural competence training have arisen as a result of this DNP project. For example, faculty are now incorporating a lab dedicated to transgender health assessment where several of the principles from this educational program will be incorporated. Lastly, the short four-week follow-up period may not have been sufficient to allow for changes over time from baseline to one-month.

Conclusion

As noted throughout this discussion, the LGBT community has distinct needs and experiences unique health disparities compared to the general population. In particular, these disparities include and increased risk for suicide and numerous negative physiologic, mental, and social health outcomes. These disparities stem from discrimination, stigmatization, and healthcare provider bias. Several leading LGBT health authorities, such as the Institute of Medicine and the Joint Commission, have put forth comprehensive guidelines regarding culturally competent care of the LGBT community.

However, the field of nursing has lagged behind other healthcare disciplines in incorporating LGBT competence training for nursing students, largely because nursing educators do not feel equipped to provide this training. As such, LGBT cultural competence must be addressed at the provider level, namely by focusing on the knowledge, skills, and awareness of nursing students. This DNP project was developed to target these domains about providing care

to the LGBT community based on the recommendations highlighted in this paper. Through the utilization of online modules to present the content and an innovative classroom simulation, students were given an opportunity to first learn didactic content and then put that knowledge into practice by providing compassionate and competent care to a transgender individual. This DNP project examined nursing students' knowledge, skills, and attitudes pre- and post-intervention, as well as one-month following the program. It is hoped that this project will help prepare these future healthcare providers to enter the nursing field with the perspective and tools to lead the charge in addressing and improving LGBT health outcomes. Moving forward, this DNP project will be incorporated into the public health nursing curriculum on a permanent basis. Moreover, this project has ignited interest among faculty in other nursing specialties within the university. For example, in the ongoing undergraduate health assessment and promotion course, faculty have invited transgender volunteer patients to come to labs to promote competence in history taking and cultural sensitivity among nursing students in caring for this population. In addition, several faculty members have expressed enthusiasm for including LGBT themes in existing scripted simulations for clinical coursework in the undergraduate curriculum. Thus, this DNP project lays a foundation for incorporating LGBT competence training into existing nursing coursework and suggests opportunities for inclusion of this content throughout nursing curricula.

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Table 1

Age

	<u>Age</u>	<u>Frequency</u>	<u>Percent</u>	<u>Cumulative Percent</u>
Valid	20-24	58	48.7	48.7
	25-30	45	37.8	86.6
	31-34	8	6.7	93.3
	35-40	5	4.2	97.5
	41-44	1	.8	98.3
	45-50	2	1.7	100.0
	Total	119	100.0	

Table 2

Ethnicity

<u>Ethnicity</u>	<u>Number</u>	<u>Percent</u>
European descent non-Hispanic	46	35.7%
Hispanic/Latino	34	26.4%
African descent	11	8.5%
None of these	10	7.8%
Caribbean	9	7.0%
Asian	5	3.9%
Prefer Not to Say	5	3.9%
Middle Eastern	3	2.3%
Native American	3	2.3%
Indian	2	1.6%
Pacific Islander	1	0.8%
Total	129	100.0%

Table 3

Preferred Pronoun

	<u>Frequency</u>	<u>Percent</u>	<u>Cumulative Percent</u>
He	17	14.3	14.3
She	99	83.2	97.5
Neither of these	3	2.5	100.0
Total	119	100.0	

Table 4

Results of t-test and Descriptive Statistics for Overall SOCCS Score – LGB and Transgender

	Pre-survey		Post-survey		n	95% CI for Mean Difference		t	df
	M	SD	M	SD					
LGB	4.5794	.76208	5.2713	.78953	76	-.82165, -.56220	-10.625*	75	
Transgender	4.2069	.75776	5.1076	.84135	74	-1.04351, -.75798	-12.574*	73	

* p = .000

Table 5

Mauchly's Test of Sphericity – Overall LGB SOCCS Score

Within Subjects Effect	Approx.				Epsilon		
	Mauchly's W	Chi-Square	df	Sig.	Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Time	.831	7.024	2	.030	.856	.891	.500

Table 6

Tests of Within-Subjects Effects – Overall LGB SOCCS Score

Source		Sum of Squares	df	Mean		Partial Eta	
				Square	F	Sig.	Squared
Time	Sphericity Assumed	13.671	2	6.836	31.576	.000	.447
Error(Time)	Sphericity Assumed	16.886	78	.216			

Table 7

Overall LGB SOCCS Score by time point

	Mean	Std. Deviation	N
Overall LGB SOCCS Score – Pre-survey	4.4181	.79566	40
Overall LGB SOCCS Score – Post-survey	5.2043	.84665	40
Overall LGB SOCCS Score – One Month	5.0328	.97725	40

Table 8

Bonferroni Comparison for Overall LGB Cultural Competence

Comparisons	Mean LGB SOCCS score difference	Std. Error	95% CI	
			Lower Bound	Upper Bound
Post- vs. pre-survey	.786*	.085	5.75	.998
One-month vs. pre-survey	.615*	.122	.310	.919
One-month vs. post-survey	-.172	.102	-.428	.085

* p = .000

Table 9

Mauchly's Test of Sphericity – Overall Transgender SOCCS Score

Within Subjects Effect	Approx.				Epsilon		
	Mauchly's W	Chi-Square	df	Sig.	Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Time	.911	3.447	2	.178	.918	.963	.500

Table 10

Tests of Within-Subjects Effects – Overall Transgender SOCCS Score

Source		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta
							Squared
Time	Sphericity Assumed	25.133	2	12.566	63.706	.000	.626
Error(Time)	Sphericity Assumed	14.992	76	.197			

Table 11

Overall Transgender SOCCS Score by time point

	Mean	Std. Deviation	N
Overall LGB SOCCS Score – Pre-survey	4.0212	.80270	39
Overall LGB SOCCS Score – Post-survey	5.0743	.91659	39
Overall LGB SOCCS Score – One Month	4.9151	.93237	39

Table 12

Bonferroni Comparison for Overall Transgender Cultural Competence

Comparisons	Mean LGB SOCCS score difference	Std. Error	95% CI	
			Lower Bound	Upper Bound
Post- vs. pre-survey	1.053*	.087	.836	1.270
One-month vs. pre-survey	.894*	.113	.611	1.176
One-month vs. post-survey	-.159	.101	-.411	.093

* p = .000

Table 13

Mauchly's Test of Sphericity – LGB Knowledge Sub-score

Within Subjects Effect	Approx. Mauchly's W	Chi-Square	df	Sig.	Epsilon		
					Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Time	.966	1.317	2	.518	.967	1.000	.500

Table 14

Tests of Within-Subjects Effects – LGB Knowledge Sub-score

Source		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta
							Squared
Time	Sphericity Assumed	26.687	2	13.343	24.204	.000	.383
Error(Time)	Sphericity Assumed	43.001	78	.551			

Table 15

LGB Knowledge Sub-score by time point

	Mean	Std. Deviation	N
Overall LGB Knowledge Sub-score – Pre-survey	3.9500	1.17935	40
Overall LGB Knowledge Sub-score – Post-survey	4.9844	1.12382	40
Overall LGB Knowledge Sub-score – One Month	4.9125	1.22579	40

Table 16

Bonferroni Comparison for LGB Knowledge Sub-score

Comparisons	Mean LGB Knowledge Sub-score difference	Std. Error	95% CI	
			Lower Bound	Upper Bound
Post- vs. pre-survey	1.034*	.157	.641	1.427
One-month vs. pre-survey	.962*	.181	.511	1.414
One-month vs. post-survey	-.072	.159	-.470	.327

* p = .000

Table 17

Mauchly's Test of Sphericity – Transgender Knowledge Sub-score

Effect	Approx.				Epsilon		
	Mauchly's W	Chi-Square	df	Sig.	Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Time	.910	3.483	2	.175	.918	.962	.500

Table 18

Tests of Within-Subjects Effects – Transgender Knowledge Sub-score

Source		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta
							Squared
Time	Sphericity Assumed	32.097	2	16.049	23.028	.000	.377
Error(Time)	Sphericity Assumed	52.965	76	.697			

Table 19

Transgender Knowledge Sub-score by time point

	Mean	Std. Deviation	N
Overall Transgender Knowledge Sub-score – Pre-survey	3.9744	1.44504	39
Overall Transgender Knowledge Sub-score – Post-survey	5.1667	1.16286	39
Overall Transgender Knowledge Sub-score – One Month	4.9808	1.31556	39

Table 20

Bonferroni Comparison for Transgender Knowledge Sub-score

Comparisons	Mean Transgender Knowledge Sub- score difference	Std. Error	95% CI	
			Lower Bound	Upper Bound
Post- vs. pre-survey	1.192*	.193	.708	1.676
One-month vs. pre-survey	1.066 *	.210	.480	1.532
One-month vs. post-survey	-.186	.161	-.588	.216

* p = .000

Table 21

Mauchly's Test of Sphericity – LGB Skills Sub-score

Effect	Approx.				Epsilon		
	Mauchly's W	Chi-Square	df	Sig.	Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Time	.900	4.018	2	.134	.909	.951	.500

Table 22

Tests of Within-Subjects Effects – LGB Skills Sub-score

Source		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta
							Squared
Time	Sphericity Assumed	35.506	2	17.753	34.383	.000	.469
Error(Time)	Sphericity Assumed	40.274	78	.516			

Table 23

LGB Skills Sub-score by time point

	Mean	Std. Deviation	N
Overall LGB Skills Sub-score – Pre-survey	3.2500	1.23551	40
Overall LGB Skills Sub-score – Post-survey	4.3841	1.19501	40
Overall LGB Skills Sub-score – One Month	4.427	1.13593	40

Table 24

Bonferroni Comparison for LGB Skills Sub-score

Comparisons	Mean LGB Skills Sub-score difference	Std. Error	95% CI	
			Lower Bound	Upper Bound
Post- vs. pre-survey	1.134*	.171	.705	1.563
One-month vs. pre-survey	1.173*	.174	.736	1.609
One-month vs. post-survey	.039	.133	-.294	.371

* p = .000

Table 25

Mauchly's Test of Sphericity – Transgender Skills Sub-score

Effect	Approx.				Epsilon		
	Mauchly's W	Chi-Square	df	Sig.	Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Time	.991	.345	2	.841	.991	1.000	.500

Table 26

Tests of Within-Subjects Effects – Transgender Skills Sub-score

Source		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta
							Squared
Time	Sphericity Assumed	78.636	2	39.318	85.685	.000	.693
Error(Time)	Sphericity Assumed	34.874	76	.459			

Table 27

Transgender Skills Sub-score by time point

	Mean	Std. Deviation	N
Overall Transgender Skills Sub-score – Pre-survey	2.3310	1.06906	39
Overall Transgender Skills Sub-score – Post-survey	4.0559	1.31816	39
Overall Transgender Skills Sub-score – One Month	4.0839	1.07815	39

Table 28

Bonferroni Comparison for Transgender Skills Sub-score

Comparisons	Mean Transgender Skills Sub-score difference	Std. Error	95% CI	
			Lower Bound	Upper Bound
Post- vs. pre-survey	1.725*	.156	1.334	2.116
One-month vs. pre-survey	1.753*	.158	1.358	2.148
One-month vs. post-survey	.028	.146	-.337	.393

* p = .000

Table 29

Mauchly's Test of Sphericity – LGB Awareness Sub-score

Effect	Approx.				Epsilon		
	Mauchly's W	Chi-Square	df	Sig.	Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Time Table 30	.590	20.049	2	.000	.709	.728	.500

Tests of Within-Subjects Effects – LGB Awareness Sub-Score

Source		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta
							Squared
Time	Greenhouse-Geisser	4.691	1.148	3.307	8.591	.002	.181
Error(Time) Table 31	Greenhouse-Geisser	21.296	55.320	.385			

LGB Awareness Sub-score by time point

	Mean	Std. Deviation	N
LGB Awareness Sub-score – Pre-survey	6.0775	.99807	40
LGB Awareness Sub-score – Post-survey	6.2825	1.00763	40
LGB Awareness Sub-score – One Month	5.8000	1.35439	40

Table 32

Bonferroni Comparison for LGB Awareness Sub-score

Comparisons	Mean LGB Awareness Sub- score difference	Std. Error	95% CI	
			Lower Bound	Upper Bound
Post- vs. pre-survey	.205*	.071	.028	.382
One-month vs. pre-survey	-.277	.138	-.622	.067
One-month vs. post-survey	-.482*	.130	-.809	-.156

* p = .002

Table 33

Mauchly's Test of Sphericity – Transgender Awareness Sub-score

Within Subjects Effect	Approx.				Epsilon		
	Mauchly's W	Chi-Square	df	Sig.	Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Time	.926	2.827	2	.243	.931	.978	.500

Table 34

Tests of Within-Subjects Effects – Transgender Awareness Sub-Score

Source	Sphericity Assumed	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta
							Squared
Time	Sphericity Assumed	2.511	2	1.256	3.782	.027	.091
Error(Time)	Sphericity Assumed	25.235	76	.332			

Table 35

Transgender Awareness Sub-score by time point

	Mean	Std. Deviation	N
Transgender Awareness Sub-score – Pre-survey	5.8590	1.21498	39
Transgender Awareness Sub-score – Post-survey	6.1205	1.15853	39
Transgender Awareness Sub-score – One Month	5.7769	1.35403	39

Table 36

Bonferroni Comparison for Transgender Awareness Sub-score

Comparisons	Mean Transgender Awareness Sub- score difference	Std. Error	95% CI	
			Lower Bound	Upper Bound
Post- vs. pre-survey	.262	.111	-.017	.541
One-month vs. pre-survey	-.082	.139	-.431	.267
One-month vs. post-survey	-.344	.139	-.691	.004

Table 37

Student Evaluation of Instructor

	Strongly Disagree		Disagree		Neutral		Agree or Strongly Agree	
	n	%	n	%	N	%	n	%
The instructor was knowledgeable about the topic.	6	4.8%	0	0	2	1.6%	117	93.6%
The training content (information) was clearly presented.	6	4.8%	1	0.8%	7	5.6%	111	88.8%
Overall, I am satisfied with the training I attended today.	6	4.8%	1	0.8%	3	2.4%	115	92%
The instructor created opportunities for participants to actively engage in the training.	7	5.6%	0	0	1	0.8%	117	93.6%

Table 38

Usefulness of Program Content

	Not At All Useful		A Little Useful		Somewhat Useful		Very or Extremely Useful	
	n	%	n	%	n	%	n	%
Terminology (LGBT Basics)	2	1.6%	0	0	6	4.8%	117	93.6%
LGBT Health Disparities	3	2.45%	1	0.8%	6	4.8%	115	92%
Creating Welcoming Spaces	2	1.6%	1	0.8%	6	4.8%	116	92.8%
Personal Stories of LGBT People	2	1.6%	0	0	7	5.6%	116	92.8%
Diagrams and Visuals	4	3.2%	1	0.8%	13	10.4%	107	85.6%
LGBT Hurricane shelter simulation	3	2.4%	3	2.4%	8	6.4%	111	88.8%

Table 39

What could be changed about this module?

B = background information; S = simulation feedback; P = positive presenter feedback, no change; O = other

<p align="center">What would you have changed about this module, if anything?</p> <p align="center">n = 81 responses</p>	
S	- have a couple of lines as suggestions to what to say, because its hard to come up with responses. and have prompts of when you are suppose to say what.
S	adding more information so that even though each character does not need to know everything about the other characters, we still needed a little more information to understand where we were going with the simulation
B	Better therapeutic communication with LGBT population
S	Clearer instructions on the index cards
S	Evacuee #1 knew what we were arguing about.
P	Evan did a great job!
P	Everything was presented in an organized manner.
S	Give #2 more to do.
S	Having more descriptions on the Cisgender and Transgender card so we could have a little more guidance on what things we need to do to challenge the group.
S	having the roles be a little more defined would have been helpful but overall it was very helpful
S	I really liked class today and I learned a lot, especially from the guest speaker. I thought the skit may have been more helpful if one or two groups acted and presented in front of the entire class instead of having several groups going at the same time.
S	I think a little more instruction before the excericise would be useful and maybe on the cards making it known that complete freedom within your role is allowed such as changing your mind or not being able to change your mind.

What would you have changed about this module, if anything? n = 81 responses	
S	I think I might have done the simulation as a whole in front of the class. There was a bit of a gray area in what role each person was supposed to play and while I think it was a great exercise there was some confusion in terms of how it should play out.
S	I think it would be better if the descriptions of each role was clearly outlined because there were times during the activity I was unsure of what to say or do.
S	I think it would have been interesting to be able to see other groups act out their scenario, or if there were a couple different scenarios to think about.
S	I think that there could have been more direction in terms of our roles during the acting. I thought the idea was very useful and a very unique idea.
S	I think that this module was very educational and it helped bring up things that I personally didn't know because I have not been exposed to this. However, the only thing that I would change is for the facilitator to have a more of a role during the Hurricane shelter. in the beginning scenarios I just asked questions that were on my card but on the scenario where the public health person and the nurse were arguing I took it further and challenged everyone's view. but other wise it was fun and it hits exactly where it had to. Thank you!
S	I think there should have been a number of role playing groups that presented in front of the whole class. There was too much going on with all the groups.
B	I thought the modules were very helpful. Some videos on the topic or videos on current events relating to LGBT would have been the only thing i'd change.
S	I thought there could be more specific details about each role. It was a little hard to defend my side with information.
S	I wish the instructions for the LGBT hurricane activity were a little more clear. We were often confused as to what to do next.
S	I would have enjoyed it more if it was in class, as it could have stirred up more conversation and more participation while learning

What would you have changed about this module, if anything? n = 81 responses	
O	I would have liked to maybe go through a head-to-toe assessment with a pt who was trans or in transition just because I am still unsure how to get their past history. I feel as though it might be important to know if they were born female and became male r vice versa because you may be thinking about S&S that only correlate to the original gender and may not pick up on a disease.
SP	I would have loved more speakers like they. They had a very insightful story and shared so much knowledge about the community.
B	I would like to know more basic terminology of the LGBT
P	I would not change a think about this module, I thought it was very complete.
P	I would not change anything
P	I would not change anything about these modules. I feel like they were very informative and I learned a lot that I did not know about the LGBT community.
P	I would not change this module
P	I would not have changed anything!
B	I would put the lecture ppt seperate from the module
P	I wouldn't have changed anything, evan did a great job teaching this course.
P	It was a great module
P	It was excellent. I wouldn't have changed anything. It was really helpful to have the interactive piece.
P	It was great. I really enjoyed the simulation.
S	Just a little more details on expectations of staying in and out of roles for the table top interaction.
O	may have more speakers who can speak on stories that have affected them

	What would you have changed about this module, if anything? n = 81 responses
P	Module was awesome.
S	More info about my specific role
O	More personal experiences with LGTB individuals, particular transgenders and their personal experiences in healthcare.
O	More speakers, less role play
P	n/a
P	N/A
P	No
P	No, was great
P	No. This simulation was great. He was able to give us an idea as to how to respond and advocate for our patient.
P	None
P	None
P	none.
P	Nothing
P	Nothing
P	NOTHING
P	nothing :)
P	Nothing I thought it allowed engagement of all students. It allowed for the sharing of thoughts and perspective of concerns and ideas about addressing LGBTQ patients in the healthcare field.
P	nothing it was very informative and made me look at life in a different perspective

<p style="text-align: center;">What would you have changed about this module, if anything?</p> <p style="text-align: center;">n = 81 responses</p>	
P	Nothing needs to be changed - thank you for making it short and very informative. Loved also the fact you incorporated videos and Prezi.
P	nothing, Evan did an amazing job.
P	NOTHING, EVAN IS GREAT !
P	Nothing, Evan was great at teaching a sensitive topic with a friendly, open minded attitude
P	Nothing, I thought it was very well done.
P	Nothing!
P	Nothing! Very informative.
P	Nothing.
O	Prior to the simulation I would let the class know the results of the per-module survey, or surveys reflecting the sentiment of the participants toward the topic before and after the exercise. I would delve a bit deeper into what causes fear or safety issues for non LGBT community
S	Providing a briefing before the simulation to orient ourselves would be beneficial.
S	some of the scripts could have had more guidance
P	The instructions were fine.
P	the modules themselves were great. Loved this!
P	The modules were very informative although some seemed a little long. Otherwise the information was good and educational.
P	The modules were very informative. Really enjoyed them.
P	The online modules were extremely thorough and well written. Very informative.

What would you have changed about this module, if anything? n = 81 responses	
S	The only thing I would change is to make the in class simulation activity a class participation as a whole because it was somewhat confusing with each breakout group doing their own thing.
S	The only thing that was challenging about the module was trying not to get ahead in the simulation; it was easy to progress to the next update without meaning to.
S	The scenario's on the cards were a bit difficult to act out because I felt like I didn't have enough information sometimes to join the interaction. My prompts were more background but it was hard to actually convey it
S	the scripts and rules needed clearer instructions. everything else was great! great job even :)
S	the simulation was a little bit confusing in the beginning. overall the activity was very helpful.
O	The speaker was okay. It would have been nice if you had a FTM individual as well.
S	Think maybe having only one group act it out and have the entire class discuss in a whole
P	This whole experience was very informative! I loved having the guest speaker and hearing about the proper use of pronouns etc.
S	Would have been better to have had one group to do the acting simulation and have the rest of us observe.
P	your modules are great, you don't have to change it.

Table 40

Additional Comments

B = background information; S = simulation feedback; P = positive presenter feedback, no change; O = other; SP = speaker

	Please provide any additional comments you may have.
	n=65
S	The scripts can be more specific and indications can be more direct in order to get a better outcome.
B	. I would delve a bit deeper into what causes fear or safety issues for non LGBT community
SP	Awesome job incorporating both the group activity and the guest speaker!
P	Awesome!
S	But have individuals that really like to act do the roles.
SP	Chaplin was really insightful to have as a guest speaker.
B	could you add something about developmental psychological aspects of gender identity and talk more about how people identify their own gender? It is easier to understand those terms in this way in my opinion.
P	Educate and advocate!
P	Evan is great.
P	EVAN IS THE BEST!!!!!!!
P	Evan was great, he was very knowledgable and a great leader!
P	even is great!
SP	Great insight! Love the guest speaker.
P	Great job Evan!!!
P	Great Job, I found these modules and the simulation a big eye opener

	Please provide any additional comments you may have. n=65
P	Great modules and class activity. Very informative.
SP	Guest speaker Chaplin was excellent.
P	Happy to be a part of this simulation and broaden my perspective.
P	I actually enjoyed the exercise.
P	I enjoyed this exercise and the LGBT community, i hope with education like this the healthcare system becomes easier for them to partake in.
P	I feel like this entire experience with the modules were very informative and Evan made it really fun.
P	I feel that as a whole, society is the issue. it's not just about knowing how to handle/communicate with the LGBT community, but it's about respecting EVERYONE as people in the end.
P	I felt that the modules really provided a great exposure to the content. It was very informative.
P	I found it very educating, I was not aware of all the different terminologies surrounding the LGBT community.
SP	I loved the speaker! It was very informative and I learned a lot.
SP	I really enjoyed having the guest speaker.
SP	i really enjoyed hearing the guest speaker's story. I think that we should have more activities like this where we get to hear actual people's experiences
SP	I really enjoyed this activity and lecture. The guest speaker Chaplain was a great addition to the course content. I thought it was very useful to be able to hear from and speak with an individual who had personal experience of living in an accepting environment versus one that was less than ideal.
P	I think today was super helpful and eye opening.
P	I thought it was a good experience and helpful

<p>Please provide any additional comments you may have.</p> <p>n=65</p>	
O	I wanted to know more about the application of naming your biases and how to set them aside. I know I do not like fat people but what do I do about just knowing? The same process is used for the LGBTQ community. Also it would have been helpful if the identification of the difficulties for a LGBTQ person has when finding a provider, establishing care with a provider, etc.
P	If it was fun!
P	It is very helpful
P	it was a great learning experience and engaging, i learned a lot
P	It was fun I learned a lot because the scenario seemed realistic.
P	It was great to hear about the LGBT community and thoughts that I never concerned about. It will be very helpful for my career to take care of patients in different genders.
S	it would be fun to see people improv in front of the class so that everyone could see whats going on and then discuss it afterwards
S	Just a little more guidance in the shelter simulation. Was unaware that we were supposed to stay in character the whole time.
P	Keep up the good work
P	Loved this presentation
S	Maybe it would be interesting to have several different scenarios with the same concept and have people act it out in class
P	n/a
P	N/A
P	NA
P	None
P	None

<p>Please provide any additional comments you may have.</p> <p>n=65</p>	
P	none.
P	Nothing
P	overall I felt it was a very good experience, I myself did not have a lot of education and awareness about this topic and how to approach them as a health care provider.
SP	Really enjoyed listening to the guest speaker.
P	Such a great lecture! Really enjoyed being educated on this topic that is so prevalent in our society.
P	thank you for teaching this very important subject
P	Thank you, I appreciate any presentations where we have open conversations with others about social norms and social progress. I think its very important and the most effective way to create positive social change.
P	The module itself was good
P	The modules were very informative as well as I felt that Evan created a safe and open environment for us to communicate in.
P	The simulation activity was helpful to start off the conversation and put ourselves into a real life situation.
S	The simulation would have been effective but the group I was in did not take simulation seriously. Most people weren't contributing to the conversation, laughing, and not participating. I think It would be more effective to maybe have different scenarios ssigned and they be performed in front of the whole class or half class
SP	They and Evan are a great duo!
O	This activity has opened my eyes to all the struggles that LGBT face on a day to day basis. In the activity, I was the transgender person, and I felt hated upon (even though we were acting). I couldn't imagine feeling like this on a day to day basis. I am extremely interested in learning more, so I can avoid having someone feel less of a person and provide the best possible care possible.

Please provide any additional comments you may have.	
n=65	
O	This is biased because I have done many LGBT training exercises and have interviewed transgendered, asexual, and questioning individuals, so none of this information was new to me and I got nothing new out of the exercise, however I am sure it was beneficial for many other people.
P	This module is one of the important tools this program has given me to become a better and more compassionate nurse.
P	This was a great exercise and very informative! I hope we get more opportunities for these types of activities to learn about this topic.
P	This was a wonderful experience!!!!
P	Very thought provoking!
P	Was very informative and opened my mind more as a HCP how to make people feel more comfortable in a health care setting without offending or coming off as rude

Appendix A – Sexual Orientation Counseling Competency Scale (SOCCS) Version 2 and 3

S.O.C.C.S. – Assessment (Version 2)

Instruction: Using the provided scale, rate the truth of each item as it applies to you. It is important to provide the most candid response, often your first one. LGB = Lesbian, Gay, and Bisexual.

1. I have received adequate clinical training and supervision to work with LGB clients/patients.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

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

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

3. I develop my clinical skills regarding LGB clients/patients via consultation, supervision, and continuing education.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

4. I have experience working with gay male clients/patients.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

5. LGB clients/patients receive less preferred forms of clinical treatment than heterosexual clients/patients.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

6. At this point in my professional development, I feel competent, skilled, and qualified to work with LGB clients/patients.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

7. I have experience working with LGB (Lesbian/Gay/Bisexual) couples and/or families.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

8. I have experience working with lesbian clients/patients.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

9. I am aware some research indicates that LGB individuals are more likely to be diagnosed with mental illnesses than are heterosexual individuals.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

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

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

11. Being highly discreet about their sexual orientation is a trait that LGB individuals should work towards.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

12. I have been to professional in-services, conference sessions, or workshops focusing on LGBT issues.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

13. Heterosexist and prejudicial concepts have permeated the health professions.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

14. I feel competent to assess a person who is LGBT (Lesbian/Gay/Bisexual) in a therapeutic setting.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

15. LGBT couples don't need special rights (domestic partner benefits, or the right to marry).

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

16. There are different issues (i.e., psychosocial, medical) impacting gay men versus lesbian women.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

17. It would be best if my clients/patients viewed a heterosexual lifestyle as ideal.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

18. I have experience working with bisexual (male or female) clients/patients.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

19. I am aware of institutional barriers that may inhibit LGBT (Lesbian/Gay/Bisexual) people from using health services.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

20. I am aware that healthcare practitioners impose their values concerning sexuality upon LGBT clients/patients.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

21. I think that my clients/patients should accept some degree of conformity to traditional sexual values.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

22. Currently, I do not have the skills or training to do a case presentation or consultation if my client/patient were LGBT.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

23. LGBT clients/patients will benefit most from a heterosexual provider endorsing conventional values and norms.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

24. Being born a heterosexual person in this society carries with it certain advantages.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

25. Sexual orientation differences between providers and clients/patients may serve as an initial barrier to effective clinical care with LGB individuals.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

26. I have done a training role-play involving a LGB (Lesbian/Gay/Bisexual) clinical issue.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

27. Homosexuality is a mental disorder that can be treated through mental health/psychiatric care.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

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

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

29. When it comes to homosexuality, I agree with the statement: 'You should love the sinner but hate or condemn the sin'.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

Thank you for completing the S.O.C.C.S.®
Markus P. Bidell, Ph.D.

S.O.C.C.S. – Assessment (Version 3)

Instruction: Using the provided scale, rate the truth of each item as it applies to you. It is important to provide the most candid response, often your first one.

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

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

 2. The lifestyle of a transgender individual is unnatural.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

 3. I develop my clinical skills regarding transgender clients/patients via consultation, supervision, and continuing education.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

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

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

 5. Transgender clients/patients receive less preferred forms of clinical treatment than non- transgender individuals.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

 6. At this point in my professional development, I feel competent, skilled, and qualified to work with transgender clients/patients.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

 7. I have experience working with transgender couples and/or families.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

 8. I have experience working with male to female transgender individuals.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

 9. I am aware some research indicates that transgender individuals are more likely to be diagnosed with mental illnesses than are non-transgender individuals.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

 10. A transgender person is not as psychologically stable as a non-transgender person.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

 11. Being highly discreet about their gender identity and expression is a trait that transgender individuals should work towards.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

12. I have been to professional in-services, conference sessions, or workshops focusing on transgender issues.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

13. Prejudicial concepts about gender have permeated the health professions.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

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

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

15. Transgender people don't need special rights (e.g., employment, marriage, housing, or legal).

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

16. There are different issues (i.e., psychosocial, medical) impacting male-to-female versus female-to-male transgender individuals.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

17. It would be best if my clients/patients viewed traditional gender expression as ideal.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

18. I have experience working with transgender female to male individuals.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

19. I am aware of institutional barriers that may inhibit transgender people from using healthcare services.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

20. I am aware that healthcare practitioners impose their values concerning gender upon transgender clients/patients.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

21. My clients/patients should accept some degree of conformity to traditional gender roles and expression.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

22. Currently, I do not have the skills or training to do a case presentation or consultation if my client/patient were a transgender individual.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

23. Transgender individuals will benefit most from a provider endorsing conventional values and norms about gender.

<i>Not at all True</i>			<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7

24. Being born a non- transgender person in this society carries with it certain advantages.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

25. Gender identity differences between providers and clients/patients may serve as an initial barrier to effective clinical care with transgender individuals.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

26. I have done a training role-play involving a transgender clinical issue.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

27. I think being transgender is a mental disorder.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

28. Transgender individuals must be discreet about their gender identity and expression around children.

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

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

<i>Not at all True</i>				<i>Somewhat True</i>			<i>Totally True</i>
1	2	3	4	5	6	7	

Thank you for completing the S.O.C.C.S.®
Markus P. Bidell, Ph.D.

Appendix B – LGBT Cultural Competence Modules

Available from author upon request

Appendix C – Tabletop Simulation Outline

Available from author upon request

Appendix D – IRB Determination of non-human subjects research



University of Massachusetts Amherst
108 Research Administration Building
70 Butterfield Terrace
Amherst, MA 01003-9242

**Human Research Protection Office
Research Affairs**

Telephone: 545-3428
FAX: 577-1728

MEMORANDUM

To: Evan McEwing, College of Nursing
From: Human Research Protection Office
Date: June 3, 2016

Project Title: **Culturally Competent Care of the Lesbian, Gay, Bisexual, and Transgender (LGBT) Population**

IRB Number: 16-50

The Human Research Protection Office (HRPO) has evaluated the above named project and has made the following determination:

- The activity does not involve research that obtains information about living individuals.
- The activity does not involve intervention or interaction with individuals OR does not use identifiable private information.
- The activity is not considered research under the human subject regulations. (Research is defined as “a systematic investigation designed to develop or contribute to generalizable knowledge.”)
- The activity is determined to meet the definition of human subject research under federal regulations and requires submission of applicable materials for IRB review.

For activities requiring review, please see our web pages for more on [types of review](#) or [submitting a new protocol](#). For assistance do not hesitate to contact the Human Research Protection Office at 545-3428 for assistance.