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# Effectiveness of an Educational Intervention on LGBTQ Clinical Competence Among Undergraduate Nursing Students

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**Abstract**

Persons who identify as lesbian, gay, bisexual, transgender, and queer (LGTBQ) are at increased risk for poor health outcomes. LGBTQ patients have higher incidences of poor health outcomes due to fear of mistreatment, bias, and stigmas. More education and training for healthcare professionals are needed regarding LGBTQ patients' care to change this patient population's current trend. The project implemented an educational intervention consisting of a learning module and panel discussion. The sample included 63 undergraduate nursing students at a rural central Georgia university. The project was a quantitative research design with pretest and posttest quantitative data. Written reflections from students served as qualitative data collected as part of the course evaluation. Surveys included a Knowledge Assessment and the Sexual Orientation Counselor Competency Scale Version 2, a tool that utilizes a 7-point Likert scale to measure three subscales: skills, awareness, and knowledge of LGBTQ clinical care. Participants had a statistically significant mean increase of .91, 95% CI [1.05, 0.78], $t$ (62) = -13.41, $p < .001$, $d = 1.69$, in total mean Sexual Orientation Counselor Competency post-intervention ($M = 5.36$, $SD = 0.73$) as opposed to the baseline total mean sexual orientation competency prior to the intervention ($M = 4.45$, $SD = 0.70$). Results indicated a statistically significant increase in perceived clinical competence, as measured by the SOCCS, after the educational intervention.

*Keywords:* LGBTQ, Clinical Competency, The Sexual Orientation Counselor Competency Scale, SOCCS, Undergraduate Nursing

## Table of Contents

# Effectiveness of an Educational Intervention on LGBTQ Clinical Competence Among Undergraduate Nursing Students

## Chapter 1: Introduction to the Project

The lesbian, gay, bisexual, transgender, and queer (LGBTQ) community consists of people who identify as non-heterosexual and non-cisgender. A poll of 340,000 people completed in 2017 by Gallop revealed that 4.5% of adults in America identified as LGBTQ, which equates to approximately 14.65 million people. In 2012, 3.5% of people identified as LGBTQ in the United States (U.S.). The number has steadily increased since 2012 (Newport, 2018). Sexual minorities are at an increased risk of poor health outcomes over the sexual majority (Eliason & Chinn, 2018). LGBTQ patients have higher incidences of poor health outcomes due to fear of mistreatment, bias, and stigmas (Eliason & Chinn, 2018). A change in the health culture of LGBTQ patients is required to improve outcomes and disparities.

The American Nurses Association has stated that nurses need to provide both clinical and culturally competent care to LGBTQ patients (Stokes, 2019). Healthcare providers require more education about LGBTQ patients' needs to reduce the incidence of poor health outcomes and enact change in this at-risk population's health culture (Eliason & Chinn, 2018). Education of students, healthcare workers, and clinicians will increase awareness and change misperceptions that contribute to poor health outcomes (Eliason & Chinn, 2018). A survey of Nurse Educators in 2015 revealed that current nursing curricula stipulate approximately 2 hours should be spent educating nursing students on LGBTQ topics (Lim et al., 2015). Having minimal training on LGBTQ topics has resulted in nursing students feeling underprepared to care for this patient population (Carabez et al., 2014). This project's primary aim was to improve nursing students' ability to provide clinically competent care to LGBTQ patients.

## Background

There are three main contributors to the need for this translational project: 1) the impact of minority stress and stigma on LGBTQ persons, 2) insufficient curriculum on LGBTQ patient care in nursing programs, and 3) low LGBTQ clinical competence among healthcare staff. People who identify as LGBTQ are more likely to experience bias and discrimination, leading to minority stress and stigma. Due to this stigmatization and stress, they have higher rates of alcohol-related problems, illicit drug and tobacco use, and suicide (Eliason & Chinn, 2018). Nursing school LGBTQ curriculum typically is limited to HIV and AIDS education, which leaves students feeling underprepared to care for this patient population (Eliason & Chinn, 2018). Healthcare staff has reported confusion related to variations of gender identity and sexual orientation and a lack of understanding of the transgender experience (Carabez et al., 2016).

### *Impact of Minority Stress and Stigma*

Minority stress and stigma have contributed to higher rates of alcohol-related problems, illicit drug, and tobacco use, and suicide among LGBTQ persons (Eliason & Chinn, 2018). Of most concern are the staggeringly high suicide rates among LGBTQ youth. In 2016, the Centers for Disease Control reported findings that youth who identify as LGBT contemplate suicide three times more often than youth who identify as heterosexual (Kann, 2011). The suicide attempt rate among lesbian, gay, and bisexual (LGB) youth is 15.1 to 34.3, which is approximately five times higher than the heterosexual youth suicide attempt rate of 3.8 to 9.6 (Haas et al., 2011).

Risk factors associated with suicide among LGBTQ persons include being the victim of physical or verbal abuse and parental rejection (Eliason & Chinn, 2018). LGB youth that has experienced verbal or physical abuse or harassment and youth that have experienced parental rejection have higher incidences of suicide attempts and suicide completions. An LGB youth

who has experienced parental rejection is 8.4 times more likely to attempt suicide than an LGB youth with low to no parental rejection (Ryan et al., 2009). The likelihood of self-harming behavior among LGB youth increases with each episode of physical or verbal harassment (Mustanski et al., 2010).

Census data indicates that more people identify as LGBTQ, gender fluid, non-cisgender, and pansexual (Newport, 2018). Millennials have been more likely to identify as LGBT than in previous generations (Newport, 2018). With the increase in people identifying as LGBT, there is a concern that this will increase suicide incidence. As a result, there is an urgent need to raise awareness and education on the risk of suicide among LTBQ persons, especially LGB youth.

### *LGBTQ Curriculum in Nursing*

Nursing students and nursing instructors report insufficient curriculum on LGBTQ patient care in nursing programs, leaving new graduates feeling underprepared to care for this patient population (Eliason & Chinn, 2018). Undergraduate nursing programs typically allocate an average of 2.12 hours of the curriculum for LGBT health and associated clinical care (Lim et al., 2015). Additionally, most of the textbooks used by nursing strictly focus on HIV and AIDS-related to the LGBTQ community even though LGBTQ patient care far extends the risk for HIV and AIDS (Eliason & Chinn, 2018). Surveys reveal that nurse educators often recognize the importance of LGBTQ issues in the curricula but report a lack of confidence or sufficient knowledge on the topic to teach it properly (Sirota, 2013). When HIV and AIDS are the only information students learn about the LGBTQ community, it can perpetuate stigmas and bias among healthcare workers (Eliason & Chinn, 2018).

### *Low Clinical Competence Among Healthcare Staff*

Healthcare staff report low LGBTQ clinical competence; this is due to minimal LGBTQ content in the school curriculum, minimal exposure to LGBTQ content in clinical rotations, and lack of hospital training on LGBTQ issues and care (Eliason & Chinn, 2018). For these reasons, new graduate nurses, medical students, and other health disciplines report feeling underprepared to care for this patient population (Carabez et al., 2014). Healthcare workers need to receive sufficient education about LGBTQ patients' needs to reduce the incidence of poor health outcomes and reduce stigma among healthcare professionals (Eliason & Chinn, 2018).

## Significance

Nursing education on LGBTQ issues is essential for four reasons: the universality of gender and sexuality, the rapidly growing LGBTQ population, personal relevance, health equality, and ethics. Every patient has a gender identity and a sexual orientation, whether it is that of the sexual majority or the minority. As a result, it is essential to incorporate gender and sexuality into the patient’s nursing plan of care (Eliason & Chinn, 2018). The most recent census has revealed that the LGBTQ population is steadily growing (U.S. Census Bureau, 2015). Thus, healthcare professionals must be adequately educated and trained to provide quality care to this patient population. With the growing rate of persons identifying as LGBTQ, one is increasingly likely to have a coworker, neighbor, relative, or friend that identifies as LGBTQ. Personal knowledge of how to communicate compassionately and be an ally can foster a healthier relationship. The American Nurses Association states that no patient should be discriminated against due to their gender or sexual identity. Discrimination is in direct conflict with the principle of justice as stated in the Nursing Code of Conduct (Stokes, 2019).

### *The Universality of Gender and Sexuality*

Some patients' sexual preferences may follow the sexual majority, while others are the sexual minority; it remains relevant to their clinical picture and care plan. In any case, sexuality and sexual health are components of a patient's health. Healthcare professionals need to confidently ask about and discuss a patient's sexuality and any associated issues (Eliason & Chinn, 2018). Nursing students require education on how to discuss sexual health with patients who belong to both the sexual majority and the sexual minority. Studies have found how a healthcare professional responds to a patient disclosing their sexuality can impact if that patient returns to that facility and if they will be hesitant to seek care in the future (Eliason & Schope, 2001). Thus, it is crucial that healthcare professionals be prepared to ask and react appropriately to patient disclosure of their sexuality.

### *Rapidly Growing LGBTQ Population*

Census data reflects a growing number of the population is identifying as LGBTQ. A poll of 340,000 people, done in 2017 by Gallop, revealed that, which equates to approximately 14.65 million people (Newport, 2018). The percent of people identifying as LGBT has steadily increased since 2012, when the percent of LGBT adults in the United States was 3.5%. The same poll determined that Millennials, people born between 1981 and 1999, had a higher identification incidence when compared to other generations, such as Generation X, people born between 1961 and 1981(Newport, 2018).

It is theorized that 10% of the US population do not belong to the sexual majority, meaning that they are not solely heterosexual or do not identify as the gender assigned at birth (Eliason & Chinn, 2018). Even this number may under-represent the LGBTQ population as people continue to have reservations about revealing their gender and sexuality due to stigma

(Eliason & Chinn, 2018). As a result, this growing portion of the population must be represented when training and educating healthcare workers, including nurses.

### *Personal Relevance*

LGBTQ education is important because it is relevant to everyone. As more people identify as LGBTQ, it is more likely that one will have a friend, relative, coworker, neighbor, or child that identify as LGBTQ (Eliason & Chinn, 2018). Everyone has interactions with LGBTQ persons, whether personal or professional, and can therefore benefit from increased knowledge and improved perceptions. With this increased exposure to the LGBTQ community, it is beneficial to be educated on appropriate vocabulary and compassionate communication. Education on LGBTQ terms and definitions, health disparities, bias, and health risks can increase personal awareness (Eliason & Chinn, 2018). Having an increased awareness of the health disparities faced by LGBTQ persons and how to support them is necessary. With increased awareness, the likelihood of compassion and advocation for LGBTQ equality is higher (Eliason & Chinn, 2018). Culture and health trends can continue to change and improve with increased knowledge and awareness.

### *Health Equality and Ethics*

The inclusion of LGBTQ education among healthcare workers, particularly nurses, is an essential component of healthcare equality and ethics in healthcare (Eliason & Chinn, 2018). The Joint Commission prohibited discrimination based on sexual orientation or gender identity in 2011 (Human Rights Campaign, 2020). Medicare and Medicaid services are required to allow patients to designate the visitors of their choosing and prohibited discriminating against visitors based on sexual orientation and gender identity, as defined by the Condition of Participation federal regulations for healthcare facilities. The Affordable Care Act states that federally funded

hospitals and health programs cannot discriminate based on sex or gender identity. The American Nurses Association (ANA) has condemned discrimination against a person based on their sexual orientation or gender identity (Stokes, 2019). Healthy People 2020 established a goal to improve LGBTQ individuals' health, safety, and well-being by eliminating health disparities (Mitchell et al., 2016). Healthy People 2030 went on to declare the goal of improving the health of LGBTQ adolescents and increasing the amount of data on health issues of the LGBTQ community (Office of Disease Prevention and Health Promotion [ODPHP], n.d.). These organizations actively encourage nurses to serve as advocates for the LGBTQ community to increase recognition and acceptance.

**Problem Statement**

LGBTQ persons experience significant health disparity compared to the heterosexual, cis-gendered population. Lack of LGBTQ clinical competency among healthcare workers perpetuates these health disparities. To reduce the health disparities among LGBTQ persons and improve LGBTQ clinical competence in the healthcare workforce, a more robust LGBTQ education for undergraduate nursing students is needed.

**Project Aim**

This translational project aimed to improve nursing students' ability to provide clinically competent care to LGBTQ patients.

**Project Objectives**

Three objectives were established to help achieve the aim of the project.

1. Increase undergraduate nursing students’ perceived LGBTQ clinical competency.
2. Increase undergraduate nursing students’ knowledge related to LGBTQ patients.
3. Improve undergraduate nursing students’ attitudes towards LGBTQ patients.

**Research Questions**

1. Among undergraduate nursing students, what is the effectiveness of an educational intervention on perceived clinical competency for LGBTQ patient care?
2. What relationship, if any, exists between the participant's demographic data and LGBTQ clinical competency?
3. What are undergraduate nursing students' perceptions of the benefits of an LGBTQ educational intervention?

**Theoretical Framework**

Leininger's cultural care theory of diversity and universality guided the development and implementation of this project. The primary researcher chose this theory due to its promotion of culturally congruent care among diverse populations, support of continuous education, and promotion of nursing knowledge related to patient care (Leininger, 1988). The theory supports this translational project's aim to improve nursing students' ability to provide clinically competent care to LGBTQ patients.

Leininger's cultural care theory of diversity and universality promotes culturally congruent care among diverse populations (Leininger, 1988). Leininger identified a "lack of cultural and care knowledge as the missing component to a nurse's understanding of the many variations required in patient care to support compliance, healing, and wellness" (Leininger & Reynolds, 1991). This theory asserts that one must know a patients' culture and have adequate knowledge about the care that the patient requires (Leininger, 1988). If either of these is lacking, patients are at risk for poor healthcare satisfaction and adverse outcomes, the LGBTQ community is no exception.

Leininger's theory supports continuous education (Leininger, 1988). The promotion of a constant learning process is congruent with the project's message. The theory asserts that nurses increase

their competence through continuous education (Leininger, 1988). The importance of continuous education is imperative when considering the care of LGBTQ patients as LGBTQ terms and vocabulary are rapidly evolving. The project was developed with the awareness that learners will have to be continuously educated on new terminology to remain up to date and provide competent, culturally appropriate care.

Leininger's cultural care theory of diversity and universality promotes increasing nursing knowledge related to patient care (Leininger & Reynolds, 1991). This idea guided the development of the project. The theory supports the primary researcher's assumption that by increasing student knowledge and awareness, incoming nurses are better prepared to provide clinically competent care for LGBTQ patients. The theory asserts that education on various cultures promotes understanding and respecting others' values, choices, and beliefs (Leininger, 1988). The educational intervention implemented in the project included educating the students on LGBTQ terms, definitions, and healthcare needs to increase the students' awareness of LGBTQ health disparities and increase their ability to communicate compassionately with LGBTQ patients.

**Definition of Terms**

For this project, the definitions of key terms were as follows:

- Clinical competence- Clinical competence is providing competent clinical care through a combination of skills, awareness, and knowledge (Bidell, 2005).
- Cultural competence- Cultural competence is the ability to interact with people from different cultures respectfully; it comprises of four components: knowledge, cross-cultural skills, attitudes towards different cultures, and awareness of personal bias (Gandy-Guedes, 2018).

- Cultural humility- a lifelong process of learning to increase cultural competency; with repeated reflection on knowledge, personal awareness of bias and attitudes as they relate to privilege and social justice (Tervalon & Murray-Garcia, 1998).
- Gender fluid- A person who does not identify with a single fixed gender or has a fluid or unfixed gender identity (Human Rights Campaign, 2020).
- Gender identity- An individual's self-concept as male, female, a blend of both, or neither (Eliason & Chinn, 2018)
- Gender minority- All people who identify in a way that is not male or female (Eliason & Chinn, 2018).
- Healthcare professional/worker- Individuals who work in any type of healthcare setting or situation, including professional schools, and health policy settings (Eliason & Chinn, 2018).
- LGB- Lesbian, gay, and bisexual people (Eliason & Chinn, 2018).
- LGBTQ- Lesbian, gay, bisexual, transgender, and queer-identified people (Eliason & Chinn, 2018).
- LGBTQIA+ - Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual and/or Ally (Sherer & Levounis, 2020).
- Minority stress- The additional stresses experienced by those who identify with an oppressed minority group (Eliason & Chinn, 2018).
- Non-cisgender- A term used to describe a person whose gender identity does not align with those typically associated with the sex assigned to them at birth (Human Rights Campaign, 2020).

- Pansexual- Describes someone who has the potential for emotional, romantic or sexual attraction to people of any gender though not necessarily simultaneously, in the same way or to the same degree (Human Rights Campaign, 2020).
- Sexual minority- All people who identify as nonheterosexual or “not entirely heterosexual” (Vrangalova & Savin-Williams, 2012).
- Sexual orientation- Sexual orientation is the emotional, romantic, and sexual attraction towards others; it is independent of an individual's identified gender (Eliason & Chinn, 2018).
- Transgender- An individual whose gender identity or gender expression is different than their sex assigned at birth (Eliason & Chinn, 2018).
- Transgender men- A transgender individual who has transitioned from female to male (Eliason & Chinn, 2018).
- Transgender women- A transgender individual who has transitioned from male to female (Eliason & Chinn, 2018).

**Summary**

The primary researcher's objective was to increase undergraduate nursing students' knowledge, awareness, and skills required for the clinical care of LGBTQ patients, with the aim to improve nursing students' ability to provide clinically competent care to LGBTQ patients. Thus, increasing their ability to work effectively and care compassionately for LGBTQ patients, their families, and other community members. This topic is of significance because gender and sexuality are universal, LGBTQ is a growing population, clinically competent care is of personal relevance, health equality and healthcare ethic demand that the disparity in LGBTQ patient care be addressed.

Project objectives for undergraduate nursing students included increasing perceived LGBTQ clinical competence, increasing LGBTQ knowledge, and improving attitudes towards LGBTQ patients. Research questions that guided the project included (1) among undergraduate nursing students, what is the effectiveness of an educational intervention on perceived clinical competency for LGBTQ patient care (2) what relationship, if any, exists between the participant's demographic data and LGBTQ clinical competency (3) what are students' perceptions of the benefits of an LGBTQ educational intervention?

Leininger's cultural care theory of diversity and universality guided the development and implementation of this project due to its promotion of culturally congruent care among diverse populations, support of continuous education, and promotion of nursing knowledge related to patient care. The primary researcher provided the participants with the knowledge necessary to provide culturally congruent care to LGBTQ patients, which included providing terms and their definitions at the time of the project’s implementation. The idea that learning is a constant process is consistent with LGBTQ training, which counsels’ learners that LGBTQ terms are continually evolving, and advocates must stay abreast of current vocabulary. The theory also supported the primary researcher's assumption that by increasing student knowledge and awareness, they were better prepared to provide clinically competent care for LGBTQ patients.

# Chapter 2: Review of Literature

Chapter two of this translational project synthesizes literature as it relates to LGBTQ clinical competency. The chapter includes the search strategy that was implemented by the primary investigator and selection of included literature. Both empiric and non-empiric literature are reviewed and synthesized. The chapter concludes with an overview of the theory that guided the translational project: Leininger's cultural care theory of diversity and universality.

## Search Strategy

An initial literature search was conducted using the university's virtual library, Galileo. Databases searched included Medline, CINAHL, Cochrane, Science Direct, and CINAHL Complete. Search terms included LGBTQ, LGBTQ clinical competency, undergraduate nursing, and clinical competency. Inclusion criteria included articles in academic journals, available in English, adult participants, and peer reviewed. Exclusion criteria was articles that were unavailable in English, not peer reviewed, or not from an academic journal.

## Selection

Implementing the aforementioned search strategy yielded 104 articles. Initially, no additional records were identified through other sources. After duplicates were removed, 76 articles were included. Of those, 20 were screened for appropriateness. Fifty-eight articles were excluded due to their exploration of cultural competence unrelated to LGBTQ patients, counseling LGBTQ patients, or education unrelated to LGBTQ patients. Full-text versions of articles were obtained through Galileo, Google Scholar, or Interlibrary loans. Articles related to improving mental health and treatment for substance abuse among members of the LGBTQ community were excluded, as the desired focus was nursing clinical competence and not medical

treatment. This yielded 19 articles that were included in the synthesis. As topics were explored, more specific literature searches were conducted using Galileo and Google Scholar.

**Best Practice**

Best practice reflects an organization's choice to implement evidence-based guidelines and knowledge as it relates to patient care, disease management, and associated interventions (Driever, 2002). The goal of best practice in healthcare is to improve the quality of care and optimize the patient experience. When best practice is utilized, it reduces care variation and improves outcomes (Driever, 2002). Healthcare organizations, including The Joint Commission and the ANA, have both published recommendations for best practices for the care of LGBTQ patients.

In 2010, The Joint Commission released a guide to best practices in the care of LGBTQ patients. The Joint Commission recognized the high rates of mental health issues, alcohol and substance addiction, sexually transmitted diseases, and some cancers among the LGBTQ community (Tschurtz & Burke, 2010). Consistent with the literature, they attributed these health disparities to lack of awareness, stigma, and healthcare barriers. The standards were designed to serve as an educational tool for healthcare organizations to increase awareness and improve care quality (Tschurtz & Burke, 2010). Through specific suggestions and strategies tailored for LGBTQ patients, the standards guide healthcare organizations to better care for the LGBTQ community (Tschurtz & Burke, 2010).

The Joint Commission implemented additional LGBTQ standards for LGBTQ healthcare in 2011 (Ding et al., 2020). The first standard stated that under no circumstances should a person be discriminated against based on their sexual orientation or gender identity and expression. The second standard guaranteed that LGBTQ patients have access to a support person of their

choosing (Ding et al., 2020). The Joint Commission specifically sought to address these two issues as they were critical to the LGBTQ community.

The ANA contends that all nurses must provide culturally congruent care to LGBTQ patients while also advocating for the lesbian, gay, bisexual, transgender, and queer populations (Stokes, 2019). In the position statement, the ANA condemns any discrimination against a person based on their sexual orientation or gender identity. ANA demands that nurses must not only provide culturally congruent, competent, and safe care for LGBTQ patients, additionally they insist that nurses must actively advocate for the human and civil rights of all members of the LGBTQ community (Stokes, 2019).

The Code of Ethics for Nurses stipulates that nurses practice respect and compassion for every person regardless of their sexual orientation, gender identity, or gender expression (American Nurses Association, 2015). When a nurse demonstrates bias or prejudice, they jeopardize the nurse-patient relationship. To maintain trust and provide culturally congruent care, nurses must reflect on their own biases and prejudices (Stokes, 2019). Adopting a position of "treating all patients equally" is not sufficient. The ANA insists nurses must actively advocate for the equality of LGBTQ patients. The Code of Ethics states that nurses must advocate and support equality for the LGBTQ community in conjunction with providing culturally congruent care (Stokes, 2019).

Nurses have an ethical and legal responsibility to provide culturally congruent care and implement best practices related to the LGBTQ community (Stokes, 2019). By implementing best practices, variation in care is reduced, and outcomes are improved (Driever, 2002). The Joint Commission and the ANA support adherence to best practices and advise that healthcare workers advocate for equality for the LGBTQ community. Nurses are encouraged to be leaders

in the campaign to change current healthcare trends and reduce disparities among the LGBTQ community (Stokes, 2019).

## LGBTQ Disparities

Health disparities are preventable differences experienced by a defined social group or population that impacts the burden of disease or ability to achieve optimal health and wellness (Braveman, 2014). The LGBTQ community has notable health disparities. Significant disparities among the LGBTQ community include a high incidence of mental health issues such as depression and anxiety, which contribute to a disproportionately high suicide rate, and high rates of alcohol, tobacco, and substance abuse (Eliason & Chinn, 2018). The disparities experienced by the LGBTQ community are not a result of their sexual orientation or gender identity/expression. The health disparities result from stigma and discrimination (Cochran et al., 2016). When healthcare providers are improperly trained in LGBTQ care or have explicit/implicit bias against LGBTQ persons, it can result in a negative healthcare experience, further perpetuating health disparities (Eliason & Chinn, 2018).

### *LGBTQ Health Issues*

Minority stress theory proposes that exposure to discrimination and maltreatment, especially in the long term, results in stressors that create the health disparities seen among sexual minorities (Dentato, 2012). People who belong in the sexual minority have higher mood and anxiety disorders (Cochran et al., 2003). In an attempt to cope with the prolonged stress, LGBTQ persons may participate in unhealthy behaviors such as smoking, drinking, or illicit drug use (Eliason & Chinn, 2018). Chronic stress experienced by sexual minorities damages organs and contributes to the development of physical health problems. The risk for health problems is

compounded by limited access to routine care and preventative screenings (Eliason & Chinn, 2018).

The mental health disorders noted among the LGBTQ community include depression and anxiety disorders, as these are directly affected by the stigma and stress LGBTQ persons often endure (Eliason & Chinn, 2018). The incidence of depression is highest among sexual minority adults who have experienced religious fundamentalism, parental rejection, and lack a parent-child relationship (Heiden-Rootes et al., 2019). One study published in 2010 reviewed a national survey conducted from 2004 to 2005 of 34,653 participants. The study revealed a 28-29% higher rate of mood disorders (59%) and anxiety disorders (58%) among bisexual women when compared to heterosexual women, with 31% reporting anxiety disorders and 31% reporting mood disorders (Bostwick et al., 2010). The highest incidence of mood disorder was among gay men, 42%, while only 20% of heterosexual men reported any mood disorder. Forty-one percent of gay men reported any anxiety disorder, while only 19% of heterosexual men reported any anxiety disorder (Bostwick et al., 2010). If a person of color identifies as LGBTQ, the rates of depression and anxiety are higher due to the stigma from multiple sources, including racial and sexual orientation stigma. (Cochran et al., 2003).

The correlation between people who suffer from mental health disorders and substance use is notable. The link may result from a person using substances as a coping mechanism for existing mental health disorders or using substances that contribute to mental health problems (Eliason & Chinn, 2018). Numerous studies have established that LGBTQ persons have higher rates of problems related to alcohol and a higher incidence of current or previous use of illicit drugs (Cochran et al., 2004). One national survey noted that bisexual women had the highest rates of reported heavy alcohol drinking and alcohol dependence, with 25% of bisexual women

reporting heavy drinking within the last year and 16% reporting alcohol dependence within the last year. Of the heterosexual women surveyed, 8% reported heavy drinking within the last year, and 3% reported alcohol dependence within the last year (McCabe et al., 2009).

The highest rates of reported marijuana use were by gay men, 25%, while only 6% of heterosexual men reported marijuana use. The second-highest rate of reported marijuana use was among bisexual women, 22% (McCabe et al., 2009). The incidence of alcohol and marijuana use among LGBTQ individuals is higher than the incidence of injection drug use. However, the incidence of injection drug use among LGBTQ persons is higher than the incidence of use among heterosexuals (Eliason & Chinn, 2018). A study of bisexual and lesbian women living in low-income households revealed a 22% rate of lifetime drug injection use, significantly higher than heterosexual women living in low-income households, which had a 3% rate (Scheer et al., 2002).

LGBTQ persons are at risk for developing physical health issues due to chronic stress, limited access to quality healthcare, and lack of preventative health screenings (Eliason & Chinn, 2018). As a result of chronic stress and higher incidences of high-risk behaviors, health experts suspect higher rates of chronic physical conditions among LGBTQ persons (Eliason & Chinn, 2018). Nonetheless, the data relating chronic diseases to gender identity and sexuality is inconsistent. One study revealed higher rates of hypertension among gay men when compared to heterosexual men (Everett et al., 2014). However, this was contradicted by other studies that found no difference in hypertension rates when comparing LGB people to heterosexuals (Cochran et al., 2016). More data is needed to establish trends and draw conclusions on physical health disorders among LGBTQ persons. Healthy People 2030 recognizes the need for more data on LGBTQ persons and has established this as an objective for 2030 (ODPHP, n.d.).

Access to routine healthcare and preventative health screenings is essential for the early identification of disease and overall wellness promotion. Persons belonging to the LGBTQ community may be hesitant to routine healthcare due to a fear of discrimination or anxiety related to the disclosure of sexuality or gender identity (Matthews & Lee, 2014). Data from the early 2000s consistently showed lower rates of mammograms and pap tests among lesbian and bisexual women (Cochran et al., 2001). Fortunately, recent data reveal increased rates of mammography among lesbian and bisexual women. Rates are now consistent with heterosexual women (Conron et al., 2010). Although mammography incidence is improving, the utilization of routine pap tests among lesbian and bisexual women remains low compared to heterosexual women (Charlton et al., 2011). The incidence of routine pap testing is even lower among transgender men who still have a cervix (Peitzmeier et al., 2014).

***Stigma and Bias in Healthcare***

Despite the Joint Commission prohibiting discrimination based on sexual orientation or gender identity, LGBTQ people continue to report negative experiences in healthcare settings (Human Rights Campaign, 2020; Lambda Legal, 2010). In a 2010 survey of LGBTQ people and their healthcare experiences, 11% of LGB patients and 20% of transgender people reported poor treatment, including being blamed for their illness. Five percent of LGB and 8% of transgender people reported being mistreated. Eleven percent of LGB patients and 21% of transgender patients reported that their care provider used harsh language. The survey revealed that 8% of LGB and 26% of transgender people reported that they had been refused care (Lambda Legal, 2010). LGBTQ healthcare consumers have stated that after experiencing a stigma-related incident in a healthcare setting, future healthcare utilization can be negatively impacted (Bauer et

al., 2009). When LGBTQ patients are deterred from seeking out healthcare, the incidence of poor health outcomes increases (Quinn et al., 2015).

## Barriers to Quality Care

Identifying the barriers to quality care is the first step to advocating for equitable healthcare in the LGBTQ community. The literature recognizes three main barriers to quality LGBTQ care: 1) negative attitudes and bias towards LGBTQ persons, 2) insufficient healthcare worker knowledge on the care LGBTQ patients require, and 3) the negative impact of religion (Eliason & Chinn, 2018). For this project, a healthcare worker is a skilled professional who provides any health service (Eliason & Chinn, 2018).

### *Healthcare Worker Attitudes*

Accessing healthcare requires patients to disclose personal information and medical history at numerous points. In one encounter, a patient may have to state their reason for seeking care and personal history to a front office staff member, a nurse, and a provider. When an LGBTQ person has to come out to numerous people, the process can produce anxiety (Eliason & Chinn, 2018). This anxiety is worsened when the patient is met with judgment, negativity, or ambivalence. The impact of healthcare workers attitudes towards LGBTQ patients is unsurmountable (Eliason & Chinn, 2018).

A recent study conducted among nursing students and faculty at a four-year Nursing Program in South East Georgia noted that 3% of the studied population reported that they would refuse to care for patients based on their sexual orientation. While 32.3% of the students (N= 167) stated, they were not interested in receiving more information on LGBT individuals (Mitchell et al., 2016). These findings are consistent with another study with a larger sample size of 525 undergraduate and graduate nursing students at an urban public university. The study

stated that 85% of the senior nursing students stated they felt underprepared to competently care for LGBTQ patients. Furthermore, 1 in 10 nursing students reported that they felt their religious view would impede their ability to provide quality care to an LGBTQ patient (Carabez et al., 2014).

This is of significance for two reasons. Nurses refusing to care for patients due to their sexual orientation violates the principle of Justice as stated in the Nursing Code of Ethics (Stokes, 2019). This principle stipulates that every nurse must care for all patients with the same fairness level, despite the patient's race, gender, religion, financial abilities, or sexual orientation. The American Nurses Association code of Ethics position statement stipulates that nurses must actively advocate for equality and defend the rights of the LGBTQ community (Stokes, 2019). That it is not sufficient for nurses to provide quality care for all patients regardless of sexual or gender identity, they must promote equality.

In addition to violating their code of ethics, by expressing explicit bias nurses are perpetuating the health disparities of LGBTQ persons (Eliason & Chinn, 2018). After a negative experience with healthcare, LGBTQ persons have reported reservations about seeking out healthcare in the future. When patients delay seeking care, it delays diagnosis and treatment, resulting in a poor prognosis. Negative experiences can range from discrimination, microaggressions, or stereotyping (Eliason & Chinn, 2018). Although over 50% of the study participants reported a positive response after disclosing their sexual orientation, others reported judgmental behaviors and stereotyping (Eliason & Schope, 2001).

### *Healthcare Worker Knowledge*

LGBTQ health disparities and barriers to quality care are perpetuated by healthcare workers that have not been adequately trained on the care that LGBTQ patients require (Eliason

& Chinn, 2018). When healthcare workers have not received updated clinical training on best practices and the standards of care for LGBTQ patients, they are not prepared to meet the needs of the LGBTQ patients (Ding et al., 2020). Healthcare workers must have knowledge on how to communication compassionately with LGBTQ patients, recognize the effects of stigma on health, and know the necessary health screenings (Eliason & Chinn, 2018). Traditionally, if LGBTQ health is included in healthcare worker education, it relates only to HIV and AIDS. When LGBTQ health is diminished to only include HIV and AIDS, it not only fails to incorporate the unique health needs of the LGBTQ population but it further perpetuates harmful stereotypes (Eliason & Chinn, 2018).

A study of 268 nurses working in the San Francisco Bay discovered that 80% of the interviewed nurses claimed to have had no training on LGBTQ issues, this included nursing school curriculum, continuing education, or in-services provided by an employer (Carabez et al., 2015). The study included nurses in multiple roles, including charge nurse, nurse practitioner, nurse educator, staff nurse, public health nurse and case manager. Almost half of the nurses (46%) had been practicing for 10 or more years. Of the 268 nurses, 79% reported that their employer does not offer LGBTQ care training (Carabez et al., 2015). Another study consisting of interviews with medical school deans and hospital chief medical officers revealed that over half (52%) of the hospitals did not offer any LGBTQ training to its healthcare workers. Limited training was available at 32% of the hospitals and comprehensive training available at only 16% of the hospitals (Khalili et al., 2015).

When there is a lack of LGBTQ continuing education or training by healthcare organizations, healthcare workers will lack the skills and knowledge to provide quality care to LGBTQ patients (Eliason & Chinn, 2018). When healthcare workers lack sufficient knowledge

on how to communicate, screen, and treat LGBTQ persons it results in poor health outcomes for the patients. The lack of training of healthcare workers is a significant barrier preventing LGBTQ persons from having access to quality healthcare (Eliason & Chinn, 2018).

### *Impact of Religion*

Religion can also impact attitudes towards LGBTQ persons. A 2014 survey among nurse administrators found a statistically significant correlation between religion and negative attitudes towards LGBTQ people. Approximately 25% of the studied population self-reported that they were very religious (Klotzbaugh & Spencer, 2014). Study facilitators were able to link this with a higher incidence of bias towards LGBTQ people (Klotzbaugh & Spencer, 2014). Nurse administrators serve as leaders and can determine staff training and continuing education for their staff. When the administration prevents the staff from adequate training, it serves as a barrier to quality care for the LGBTQ patients they serve (Eliason & Chinn, 2018).

A study conducted at Georgia Southern University in 2016, surveyed 167 nursing students and 16 nursing faculty members about their knowledge of LGBT health issues and their competence in providing care to the LGBT community (Obedin-Maliver et al., 2011). When surveyors asked the nursing students if their personal views would directly affect their ability to provide care to an LGBT patient, 6.6% (n = 11) responded yes. Five students reported that they would refuse to care for a patient based on their sexual orientation, however the survey did not specifically state that the nurse would refuse to care for the patient based on their personal religious views (Mitchell et al., 2016). These findings are consistent with another study of senior nursing students, that reported one in ten students felt as though their religious values may prevent them from delivering quality care to LGBTQ patients (Carabez et al., 2014).

## LGBTQ Education

Research suggests that providing education and increasing knowledge decreases stigma, bias, and discrimination (Eliason & Chinn, 2018). Successful LGBTQ education requires a robust curriculum, well-informed educators, and evidence-based educational interventions. Literature suggests that the current curriculum for healthcare workers on the care of LGBTQ patients is inadequate, leaving healthcare workers feeling underprepared to care for this population of patients (Eliason & Chinn, 2018; Lim et al., 2015). Surveyed educators report a desire to include LGBTQ care into the curriculum. However, they feel ill-equipped to teach on the topic (Mitchell et al., 2016). Implementation of well-developed and established educational interventions are necessary to change the current trend of poor health outcomes among LGBTQ persons.

### *Inadequate Curriculum*

Numerous studies conclude little to no LGBTQ curriculum is included in the education of healthcare workers. This predisposes healthcare workers to enter the workforce unprepared to provide quality care to LGBTQ patients (Eliason & Chinn, 2018). Recent studies reveal health care curriculum continues to be insufficient when it comes to LGBTQ issues. In 2015, a survey was conducted among over 1,000 nursing faculty members. Faculty reported that, on average, 2 hours of class time was allocated for LGBTQ topics and 17% of nursing faculty admitted that there was no LGBTQ content included in the curriculum (Lim et al., 2015). Medical schools have only slightly more LGBTQ content included in their curriculum. A survey of 176 allopathic or osteopathic medical schools, revealed that a median of 5 hours of LGBTQ content is included in the curriculum. Of the surveyed schools, 33% disclosed that they had no LGBTQ content (Obedin-Maliver et al., 2011).

A study that included 167 Nursing Students noted that 75.5% of the students reported feeling underprepared to care for LGBTQ patients and felt they were unable to meet the needs of LGBTQ patients due to lack of information and knowledge (Mitchell et al., 2016). There was a statistically significant correlation, 35.4%, between students and faculty who had reported not feeling equipped with the necessary resources to care for an LGBTQ patient and participants who were interested in gaining more knowledge in this area. Although the student included a small sample size, the sample demographics may be similar to the sample included in this project because the study was conducted at a four-year Nursing Degree Program in South East Georgia.

***Nurse Educators***

Nurse educators must feel confident and well informed about their own understanding of the LGBTQ patient population and be willing to include LGBTQ health issues into their curriculum. A study surveying nursing faculty in southern Georgia, revealed that 81.3% (n = 13) of Nursing Faculty disagreed when asked if LGBT health topics are important (Mitchell et al., 2016). Fortunately, these findings are not consistent with a larger national study including 721 nursing schools (Lim et al., 2015). Of the surveyed nurse educators 79% felt that education regarding the care of sexual minorities is very important or extremely important. Furthermore, 70% were willing to teach LGBTQ health topics and 75% felt they had adequate knowledge to teach on the topic. The study determined that faculty identifying as LGBTQ felt more ready than heterosexual faculty (Lim et al., 2015). Despite their personal preparedness to teach the topic, 75% reported that their current curriculum did not currently include LGBTQ health topics, or had limited inclusion of the topic (Lim et al., 2015).

### *Educational Interventions*

After determining that more substantial education was necessary for healthcare workers, research was conducted to determine the best educational interventions and learning modalities for content related to LGBTQ health issues and care. A Mixed-method systematic review of the effects of educational curricula and training on LGBT-specific health issues for healthcare students and professionals revealed that all the studies reported a statistically significant improvement in knowledge, attitude and/or practice, post-training (Lindsay et al., 2019). Training content among the studies included: LGBTQ terminology, health inequalities, discrimination and stigma, and communication skills. The study concluded that training healthcare providers increases knowledge and improves skills which will positively impact the quality of healthcare for LGBT people (Lindsay et al., 2019).

A web-based resource for LGBT cultural competency training among oncologists was developed by a diverse group of stakeholders and three cancer centers in Florida (Seay et al., 2019). The resource was developed to provide education and training to oncologists on LGBTQ patient needs and how to improve the quality of care. Learning modules were created to educate providers on creating an inclusive environment, initiating oncology care for LGBTQ patients, and cancer survival issues LGBTQ patients encounter. The modules were interactive and modeled appropriate communication (Seay et al., 2019). The impact of the educational intervention was noteworthy. Study participants had a significant increase in LGBTQ knowledge, attitudes, and clinical practices (Seay et al., 2020). Furthermore, 82% of the participants rated the web-based resource training as a high-quality training. When asked if they would recommend the training to a colleague, 97% said yes (Seay et al., 2020).

Although more research is being done to evaluate the most effective method to train and educate healthcare workers on LGBTQ health needs, there are an abundance of resources available to support curriculum development (Eliason & Chinn, 2018). Practitioner training and continuing education is available through journal articles and online modules. The Fenway Institute's National LGBT Health Education Center has educational programs, resources materials, and continuing education available (Fenway Institute, n.d.). The Gay & Lesbian Medical Association (GLMA) annual conference is open to all healthcare workers and provides continuing education on a variety of topics related to LGBTQ care (Eliason & Chinn, 2018). Inclusion of any format of LGBTQ training or education, will increase knowledge among healthcare workers and improve the quality of care provided to LGBTQ patients (Eliason & Chinn, 2018).

**LGBTQ Health Promotion**

There are numerous approaches to increase awareness and encourage a culture change. Individually reflecting on personal bias and beliefs can help an individual become a better ally to the LGBTQ community. Encouraging the use of inclusive language both personally and professionally promotes an inclusive environment (Eliason & Chinn, 2018). It is also important to support civil rights for all people, including LGBTQ. When same-sex marriage was legalized in the United States, the suicide rate among LGBTQ persons decreased (Haas et al., 2011). Political and religious factors present challenges when addressing this disease.

Due to the link between parent rejection and increased risk for suicide or suicide attempts, efforts should be made to increase parental awareness of the impact of rejecting youth identifying as LGBT (Ryan et al., 2009). This can be done through encouraging education and communication related to sexuality and gender identity within faith communities. Efforts also

need to be made to increase awareness of resources for LGBTQ persons suffering from depression.

### *Inclusive Terminology*

Making healthcare settings more inclusive reduces a structural barrier to quality care for LGBTQ persons. When gender neutral language is used in conjunction with equality signs, health care settings are perceived as safer by LGBTQ patients (Quinn et al., 2015). Waiting rooms and reception areas should have a posted nondiscrimination statement, pictures posted should be diverse and depict people of various genders, races, and ethnicities. Studies indicate that LGBTQ patients assess for visual cues that the healthcare setting is nondiscriminatory and safe (Eliason & Schope, 2001). Health intake forms that include inclusive language is best practice. In an effort to reduce barriers for LGBTQ patients, the Williams Institute has published best practices for inclusive language on medical forms (Genius Group, 2014).

### *Promoting Clinical Competence*

To change the current health trend for the patient population, quality healthcare needs to be delivered by healthcare professionals who have been adequately trained and have the understanding to provide clinically competent care (McCann & Brown, 2018). A review of studies that implemented gender-sensitivity trainings revealed that 37% of the studies had significant improvement in participants knowledge and attitudes regarding gender-sensitive care (Lindsay et al., 2019).

The New York State LGBTQ Health and Human Services Network provided an estimated 2,500 LGBTQ cultural competency trainings in 2013. The New York State LGBTQ Health and Human Services Network recommend choosing educational intervention methods based on how the target population learns (ODPHP, n.d.). The desired outcomes and goals of

the training should also be considered when choosing the educational intervention. For an effective LGBTQ training, GLMA recommends combining various training methods. Three effective training methods include the use of 1. Modules 2. Case Studies and 3. Panel discussion. Each module should take 15-20 minutes to complete, to optimize learner retention as the average adult attention span is 20 minutes (Murphy, 2007). Using different methods allows for participants to process information in their preferred learning style and increases interest.

**Theoretical Framework**

In order to improve LGBTQ patients' outcomes, it is essential first to understand the cultural background and learn about the population's individual needs. Leininger's Cultural Care Theory of Diversity and Universality supports seeking knowledge and increased awareness to provide culturally competent care (Leininger, 1991). Once equipped with knowledge and awareness, a nurse can provide culturally competent care (Leininger, 1988). A study exploring undergraduate nursing students and faculty perceptions on LGBTQ health issues sited Leininger's Cultural Care Theory of Diversity and Universality as the supporting theory. The study researchers sought to determine if students and faculty were seeking out continuous education on LGBTQ health issues (Mitchell et al., 2016). Without continuously learning and seeking updated information a nurse cannot adequately provide culturally competent care (Leininger, 1988).

**Summary**

Providing clinically competent care to the LGBTQ community is important because it is best practice and compliant with the Joint Commission and the American Nurses Association’s Code of Ethics. Disparities experienced by the LGBTQ person include health issues, stigma and bias in healthcare. Barriers to quality care include healthcare worker attitudes, knowledge, and

the impact of religion. LGBTQ education for nursing students and nurse educators is insufficient. Curriculum on LGBTQ issues and care is minimal or nonexistent in medical and nursing schools. Nurse educators must be willing and confident to educate healthcare workers on best practices for providing quality care to LGBTQ persons. Numerous educational interventions that have shown beneficial for training healthcare workers. LGBTQ health promotion can be done through the use of inclusive terminology and promoting clinical competence among healthcare workers. Recent literature sites Leininger's Cultural Care Theory to support the necessity of continuous LGBTQ education for nurses.

## Chapter 3: Methodology

This project was a pretest posttest quantitative project to examine the effectiveness of an educational intervention aimed at increasing clinically competent LGBTQ patient care among prelicensure nursing students. The proposed project was phase one of a two-phase project, and the first phase included the educational modules and panel discussion. The second phase of the overall project was proposed by a second investigator who utilized simulation to apply the LGBTQ clinical competency knowledge received in phase one. The conceptual framework of Leininger's cultural care theory of diversity and universality guided this project, as it promotes the implementation of culturally congruent care among diverse populations (Leininger, 1988).

The phase one educational intervention consisted of two parts, online modules and a panel discussion, aimed at increasing nursing students' knowledge of LGBTQ health needs. Part one of the educational interventions utilized established learning modules through The National LGBT Health Education Center. The modules provided learners with an introduction on how to provide quality care to lesbian, gay, bisexual, and transgender patients. The modules covered topics that included LGBTQ terms and definitions, health disparities, and skills to communicate effectively and compassionately through slides, lectures, interactive participation, and case studies.

In part two, students virtually attended a panel discussion with experts in LGBTQ in healthcare. Five panelists discussed five topics: How to develop clinical skills and be an LGBTQ advocate; their personal experiences of LGBTQ healthcare; the different issues faced by sexual minorities; discrimination, bias, and disparities faced by LGBTQ patients; and the importance of effective communication when providing care. Panelists included a Family Nurse Practitioner, a Doctor of Nursing Practice, a university Star Ally representative, and two members of the LGBT

community. The panel discussion allowed participants to hear personal viewpoints and professional expertise from the panelists' lived experiences. Following the panel discussion, time was allowed for questions. This allowed participants to clarify misconceptions or unclear information.

The primary researcher followed recommendations from the GLMA: Health Professionals Advancing LGBT Equality. GLMA encourages LGBTQ trainings to combine various training methods to create the most effective LGBTQ healthcare (Snowdon, 2013). Thus, online learning modules and panel discussion were the ideal training method for the educational intervention. The learning modules encompassed all three learning styles. Modules were visual because the student could see and read the information on the slides. The modules were auditory because the students heard the presenter talk about the information. The modules also supported kinesthetic learners as they required the student to interact as they completed the case studies within the second module (Margolies et al., 2014).

Leininger's cultural care theory of diversity and universality encourages nurses to continuously learn and reflect on how to best care for patients of different cultures (Leininger, 1988). Leininger's theory reflects the primary researcher's goal of encouraging cultural humility among undergraduate nursing students. Cultural humility is cultural competency as a continuous learning process that includes self-reflection, awareness, and desire to learn more about different cultures (Tervalon & Murray-Garcia, 1998). Through the educational modules and the panel discussion, the importance of continuous learning and self-reflection was encouraged.

**Research Questions**

1. Among undergraduate nursing students, what is the effectiveness of an educational intervention on perceived clinical competency for LGBTQ patient care?

2. What relationship, if any, exists between the participant's demographic data and LGBTQ clinical competency?
3. What are students' perceptions of the benefits of an LGBTQ educational intervention?

**Clinical Questions**

1. Among undergraduate nursing students, what is the perception of baseline skills, awareness, and knowledge of LGBTQ healthcare needs?
2. What is the impact of an LGBTQ clinical competency educational intervention on the perceived communication skills of BSN students in caring for LGBTQ patients?
3. What effect does an LGBTQ clinical competency educational intervention have on perceived awareness of bias against LGBTQ patients?
4. What effect does an LGBTQ clinical competency educational intervention have on perceived knowledge of health disparities faced by LGBTQ patients?
5. What effect does an LGBTQ clinical competency educational intervention have on knowledge of LGBTQ healthcare needs?

**Setting**

The project setting and implementation site was a rural, central Georgia university during the fall semester of 2020. The primary investigator utilized a virtual setting within the School of Nursing.

**Resources**

The lead investigator used the University System of Georgia's online learning management system: Georgia View (GAView). All students enrolled in the course had access to the GAView course site. The primary investigator had access to the GAView course site and had instructors' access to manage the content within the course site. Qualtrics was used to administer

the proposed tools. Qualtrics is a survey software tool that the university employs for student surveys. The primary investigator posted links to the surveys in Qualtrics within the GAView course. The learning modules, "Providing Quality Care to Lesbian, Gay, Bisexual, and Transgender Patients: An Introduction for Staff Training," "Affirming LGBT People through Effective Communication," "Implicit and Provider Bias, " and "Caring for LGBT Older Adults" were posted within GAView. A panel of experts and LGBTQ community members spoke on their experiences in accessing and delivering affirming health care through a virtual panel discussion. The virtual panel discussion was live streamed through Zoom, and the recording was posted within the GAView course.

**Project Population**

The project utilized a convenience sample of nursing students at a rural central Georgia university enrolled in the BSN program. Inclusion criteria included current enrollment as an undergraduate nursing student at the university. Exclusion criteria included students enrolled in other nursing programs at the university, including masters and doctoral nursing students. There were no age, gender, or race restrictions within the project sample. All students enrolled in the mandatory course were eligible for the project. The primary investigator posted a video introducing the project within the course site on GAView. The video instructed students interested in enrolling in the project to complete the informed consent within the GAView course site.

**Sources of Data**

Students' sexual orientation competency was measured with the Sexual Orientation Counselor Competency Scale (SOCCS) Version 2. The SOCCS is a 29-question tool that utilizes a 7-point Likert scale to measure three subscales: skills, awareness, and knowledge of LGBTQ

patients. Higher Likert scores indicate greater levels of sexual orientation competency. The SOCCS was originally aimed at assessing clinical competency among mental health professionals. Two additional versions of the SOCCS were generated utilizing the same theoretical factor modeling, administration, and scoring. SOCCS Version 2 was created to assess clinical competency among healthcare professionals. The project utilized SOCCS Version 2. Creators of the SOCCS encourage the utilization of the tool for pretest and posttest outcome measurement for LGBTQ educational programs and trainings (Bidell, 2005).

At this time, only the original SOCCS has published psychometric data. Three studies comprised of mental health students, healthcare providers, and educators established the reliability and validity of the SOCCS. The total sample included 300 participants. The SOCCS has a coefficient alpha of 0.90 (Bidell, 2005). The skills subscale consists of 11 items that focus on clinical skills required for affirmative care of LGBT patients, with a coefficient alpha of 0.91. The awareness subscale examines self-awareness and potential bias or stigmas. It consists of 10 items with a coefficient alpha of 0.88. The subscale for knowledge evaluates knowledge of psychological issues among LGBTQ patients. This subscale consists of 8 items with a coefficient alpha of 0.76 (Bidell, 2005).

A Knowledge Assessment was administered to the students before the educational intervention and 4-weeks after the intervention. The assessment included 15 multiple choice questions developed by the primary researcher and reviewed by supporting faculty. The questions were developed from the information reviewed in the modules and panel discussion. The Knowledge Assessment allowed the primary researcher to assess knowledge gained through the educational intervention.

Qualitative data was used to "help explain and interpret the results" (Polit & Beck, 2008) via student reflections after completing the module and panel. Students wrote and submitted a 75-word reflection on their experience and their perceptions of the learning experience. This reflection was read by the primary investigator and supporting faculty to gain insight into the student's learning experience and the benefit of the project to future students. Students had writing prompts and wrote 75 words or less for each prompt.

The writing prompts were:

1. Describe what you have learned from the NRSG 001 Human Cultures course.
2. What has the NRSG 4001 Human Cultures course meant to you? Why?
3. What is your opinion of the NRSG 4001 Human Cultures course? What is the value of this experience?
4. How will you apply what you learned in NRSG 4001 Human Cultures course?

**Procedures for Implementation of Project**

The NRSG 4001 Human Cultures course was required for all nursing students. Subsequently, all the students were required to complete the modules and panel discussion for the course. However, enrollment into the project remained optional. Enrollment into the project did not impact the student's grade in the course. All undergraduate nursing students enrolled in the GAView course on August 12th, 2020. Within the homepage of the GAView course, there was a video of the primary investigator explaining the project objectives and aims. On August 24th, 2020, a consent form for enrollment into the project was posted on the course site. The consent was electronic signature enabled with E-Sign. After the student signed the consent, they then completed the demographic survey, the knowledge assessment, and the SOCCS. There was a link to Qualtrics posted within the GAView course site to access the surveys.

After signing the consent and completing the aforementioned surveys, the student completed the National LGBT Health Education Center modules. The first module was entitled Providing Quality Care to Lesbian, Gay, Bisexual, and Transgender Patients: An Introduction for Staff Training. This module had three sections: section 1 reviewed terms and definitions, section 2 discussed LGBTQ stigma, discrimination, and health, and section 3 explored effective communication. This module took approximately 15-20 minutes to complete.

The second module, titled Affirming LGBTQ People Through Effective Communication, also had three sections. The module summarized LGBT terms and explained the importance of basic communication principles for LGBT health. The last section used case scenarios to practice using terms and principles. The module took approximately 20 minutes to complete.

The students were also asked to complete a module discussing implicit and provider bias and a module on caring for LGBT older adults. The module on implicit and provider bias was a recorded talk from the 2020 Advancing Excellence in Sexual and Gender Minority Health conference. The talk first defined implicit bias and then explores the bias most often experienced by gender-diverse people. Most importantly, the module guided students on how to acknowledge their own biases. The primary researcher included the module on caring for LGBT older adults to recognize LGBT persons age 65 and older as they are often disregarded. The module described the specific medical and behavioral needs of LGBT older adults. The module concluded by discussing available services and appropriate ways to offer support.

Upon the student's completion of each module, they received a certificate of completion from the National LGBT Health Education Center. The student then submitted these certificates into a drop box within the course site. Students had three weeks to complete the posted modules and to submit their certificate of completion.

On September 14th, 2020, students virtually attended a panel discussion with experts in LGBTQ in healthcare. The panel discussion occurred via ZOOM. Five panelists discussed five topics.

1. How to develop clinical skills and be an LGBTQ advocate
2. Their personal experiences of LGBTQ healthcare
3. The different issues faced by sexual minorities
4. Discrimination, bias, and disparities faced by LGBTQ patients
5. The importance of effective communication when providing care

Each speaker spoke on one designated topic for 10 minutes. After the session, there was an opportunity for questions. The session lasted approximately 50 minutes, with an additional 10-15 minutes allocated for student questions at the conclusion.

On September 25th, 2020, the SOCCS posttest, knowledge assessment, and writing reflection became available, through the Qualtrics link, to students. The posttest links were made available within the GAView course from September 25th through September 29th, 2020. The administration of the pretests and the posttest was four weeks apart.

**Budget**

The budget required for the implementation of the project was minimal. The SOCCS were free and did not require purchasing for use. GAView has a pre-existing contract with the university and did not require an additional payment for the project's use of the course site.

**Human Subjects Protection**

The project included human subjects; therefore, the protection of participant information and wellbeing was a priority. The primary investigator submitted the project proposal to the University Institutional Review Board (IRB) for review and approval before implementation.

Only adults over the age of 18 were eligible for enrollment in the project. After explaining the project's details and intention, the primary investigator obtained informed consent from each willing participant. There were no consequences for declining enrollment into the project or for students who chose to drop out of the project. All students received the standard of care. Only the primary researcher and supporting faculty member had access to the survey responses to ensure participants' anonymity.

**Risks, Benefits, Threats**

Due to the project's design, there was a low risk for participants enrolled and an excellent opportunity to benefit participants, educators, and the community. Students were informed that their grades would not be negatively or positively impacted by enrolling or declining to enroll in the project.

There were many benefits from student participation in this project. The students who chose to enroll benefited in three ways. Students built the necessary communication skills to provide care to LGBTQ patients. Students gained awareness of LGBTQ patients and their unique healthcare needs. Additionally, students increased their knowledge of inclusive LGBTQ vocabulary; thus, increasing the student's ability to communicate compassionately and inclusively. The project findings also benefited the School of Nursing. The American Nurses Association has stated that nurses need to provide both clinical and culturally competent care to LGBTQ patients (Stokes, 2019). Project findings implicating a significant positive impact on students' perception of clinical competence encourage the SON to consider including the modules and panel discussion into the nursing curriculum. The project also benefited the LGBTQ community. By educating nursing students, the project increased awareness of LGBTQ needs in healthcare. The project promoted a change in culture to encourage a more inclusive

environment for LGBTQ patients through education and increasing awareness. With a change in LGBTQ healthcare culture, the primary investigator hoped to reduce poor health outcomes among LGBTQ patients.

Because this educational intervention contained two parts, several threats have been identified. Threats to the project's implementation included being unable to gather the panel speakers on campus due to campus closure. The university implemented campus closures and group gathering restrictions due to Coronavirus precautions and state social distancing guidelines. Due to this barrier, the primary investigator transitioned to a completely virtual setting for the panel discussion. Panel speakers were sent links to a ZOOM meeting and were present from their homes via personal computers. The students attended the panel discussion virtually, as previously planned.

**Timeline**

The primary investigator submitted the project proposal to the University Institutional Review Board on July 21st for review and approval. NRSG 4001 Human Cultures is a required course for all nursing students. The course is offered every semester with rotating topics every four semesters. Consequently, the students were required to complete the modules and panel discussion for the course, but enrollment in the project was not mandatory. Fall semester classes started on August 12th at that time. All undergraduate nursing students were enrolled in the NRSG 4001 Human Cultures course within GAView. The recruitment was through a video of the primary investigator posted on the GAView course's homepage explaining the project and process for optional enrollment. By August 24th, consents were obtained, and the SOCCS pretest was administered. The consent was a signable document within GAView, and the SOCCS pretest was delivered via a Qualtrics link within GAView. At this time, the learning modules

were made available through a link to the established National LGBT Health Education Center modules within GAView. Students had three weeks to complete the posted modules. On September 14th, the students attended the panel discussion. From September 25th through September 29th, the students completed the SOCCS posttest, the knowledge assessment, and the self-reflection of the educational intervention, delivered via Qualtrics link within GAView. After this, the primary investigator analyzed the data and conducted correlation studies.

**Data Analysis Plan**

The proposed project was a quantitative research design with pretest and posttest quantitative data. The primary investigator ran descriptive statistics on the data collected with SPSS software. Pretest and posttest survey results provided quantitative data for analysis. After completing normalcy testing, a paired-samples *t*-test analyzed the surveys' findings and determined the impact of the educational intervention (Polit & Beck, 2008). Data from the SOCCS subscales were analyzed individually. In order to determine a possible correlation between demographic information and survey results, the primary investigator ran correlation studies.

Student reflections provided qualitative data. The primary researcher used in vivo coding to conceptualize data. For coding the qualitative data, the primary researcher created a document within Excel that contained every students' writing reflection response. In vivo coding was chosen due to the primary researcher's decision to use the participants' own words and terms to summarize data (Polit & Beck, 2008). The primary researcher organized and read each response and identified repeated words. The participants' words were reviewed, in vivo codes created, and themes formulated. The primary researcher established themes from the in vivo codes and then

compared these themes to those established by the literature (Polit & Beck, 2008).

**Dissemination Plan**

The Georgia Association for Nursing Education, Inc. (GANE) is an organization that works to improve Georgians' healthcare by promoting nursing research and collaboration among nurse educators. The primary researcher presented the translational project at the 2021 Georgia Association for Nursing Education Annual Conference. On September 25th, 2020, the primary researcher applied to present at the conference; the application included the project abstract. GANE accepted the application to present on November 6th, 2020. On Friday, February 26th, the primary researcher led a 30-minute podium presentation with a PowerPoint visual aid to explore the project's development, implementation, findings, and discussion of results.

GLMA: Health Professional Advancing LGBTQ Equality holds annual conferences on LGBTQ health and the latest research in LGBTQ health. The conference is open to healthcare workers, researchers, policy experts, and LGBTQ supporters/advocates. GLMA abstract submission deadline for the 2021 conference is March 22nd, 2021. Only clinically focused and evidence-based abstracts are encouraged for submission by GLMA. As the project was both clinically focused and evidence-based, it met these requirements. The primary investigator has applied to present the proposed project at the 2021 GLMA annual conference.

The primary investigator designed a research poster that presents the project's background information, method, results, and conclusion. The poster utilizes supportive images and graphs. A QR code on the poster provides viewers access to all project documents. The poster can be used for future poster presentations at conferences or university events.

# Chapter 4: Results

This chapter will present the results of the translational project. An educational intervention was first implemented to increase LGBTQ clinical competency among undergraduate nursing students. The Sexual Orientation Counselor Competency Scale (SOCCS) Version 2 and a Knowledge Assessment were administered before and after the intervention. After data cleaning was performed, exploratory data analysis and descriptive statistics were conducted. Reliability analysis was performed on all instrumentation that was utilized in the project. Statistical tests were conducted to answer the project's established research questions.

## Data Screening

Data were collected through the survey platform Qualtrics. Pretest and posttest survey results were exported from Qualtrics to Excel. Within Excel, pretest results were matched to posttest results through matched I.P. addresses. Entries without matching I.P. addresses were discarded. Entries with multiple I.P. address matches were also discarded. I.P. address matches were confirmed with matching location latitude and longitude.

Exploratory data analysis was conducted on the quantitative results of this research project and its impact on clinical competency. Findings reported here include results for central tendencies, correlation, and multicollinearity. Data screening was performed prior to conducting statistical analyses. Data were verified using a random verification method, and no discrepancies were identified. The Knowledge Assessment was coded as a "1" indicating a correct response, or a "0" for an incorrect response. Missing data in the Knowledge Assessment was coded as incorrect. Mean score replacement was utilized for missing SOCCS entries missing less than 20% of total data. Questions 2, 10, 11, 15, 17, 21, 22, 23, 27, 28, and 29 were reverse coded per the instrument developers’ instructions.

Total scores were generated both for the pretest Knowledge Assessment and the posttest Knowledge Assessment. Pretest total SOCCS mean score and the posttest total SOCCS mean score were calculated by adding all 29 items, making note to use the reverse score items for the aforementioned questions, and dividing the total raw score by 29 per the developers' instructions. The pretest SOCCS attitudinal awareness subscale was calculated by totaling the scores for the pretest questions 2, 10, 11, 15, 17, 21, 23, 27, 28, and 29. The raw score was then divided by 10. The same was done for the posttest SOCCS attitudinal awareness subscale. It should be noted that all questions included in the attitudinal awareness subscale were reverse coded. The SOCCS skills subscale for pretest and posttest were calculated by adding the responses to questions 1, 3, 4, 6, 7, 8, 12, 14, 18, 22, and 26, then dividing the raw score by 11. When calculating the SOCCS knowledge subscale for both the pretest and the posttest, the mean score was calculated for questions 5, 9, 13, 16, 19, 20, 24, and 25. The raw score was then divided by 8 to generate the knowledge subscale mean score.

Examination of all continuous variables was conducted to determine distribution using descriptive statistics for central tendency and Fisher's exact for skewness and kurtosis, histogram, and Q-Q normality plots. The data were assessed for multicollinearity, and it was determined that multicollinearity did not exist. Statistical assumptions were met for the paired-samples *t*-test. All assumptions were met for performing Pearson’s product-moment correlation with the removal of the one identified outlier for the age variable.

Qualitative data were collected through written reflections from students at the completion of the course. Students were asked to reflect on four writing prompts:

1. Describe what you have learned from the NRSG 4001 Human Cultures course.
2. What has the NRSG 4001 Human Cultures course meant to you? Why?

3. What is your opinion of the NRSG 4001 Human Cultures course? What is the value of this experience?
4. How will you apply what you learned in NRSG 4001 Human Cultures course?

Student responses were collected through the survey platform Qualtrics and then exported from Qualtrics to Excel for analysis. Each writing response was analyzed individually. Responses were categorized as positive or negative and then further subcategorized by similar verbiage, words, or categorized idea. Categories noted in reflections were tallied and totaled to determine the most frequently referenced categories.

**Sample Characteristics**

Descriptive statistics and frequencies were performed on all categorical variables, including gender, sexual orientation, the gender of sexual partners, marriage status, ethnicity, religious upbringing, and semester in nursing school (see Table 1). The sample included 63 participants. Of the sample population, the majority were females (92.1% (n = 58)), Heterosexual (93.7% (n = 59)), and reported having Male sexual partners (87.3% (n = 55)). The majority were single (98.4% (n = 62)) White (92.1% (n = 58)) and reported having a spiritual or religious upbringing (88.9% (n = 56)). Participants were evenly enrolled in all four semesters of nursing school, with 27% (n = 17) in their First Semester, 28.6% (n =18) in their Second Semester, 22.2% (n = 14) in their Third Semester, and 22.2% (n = 14) in their Fourth Semester.

**Table 1**

*Demographic Characteristics of Sample*

| Variables | | *N* | (%) |
|---|---|---|---|
| Gender Identity | | 63 | |
| | Male | 5 | (7.9) |
| | Female | 58 | (92.1) |
| Self-Identified Sexual Orientation | | 63 | |
| | Heterosexual | 59 | (93.7) |
| | Homosexual | 2 | (3.2) |
| | Bisexual | 2 | (3.2) |
| Gender of Sexual Partners | | 63 | |
| | Male | 55 | (87.3) |
| | Female | 7 | (11.1) |
| | Both | 1 | (1.6) |
| Marital Status | | 63 | |
| | Single | 62 | (98.4) |
| | Married | 1 | (1.6) |
| Ethnicity | | 63 | |
| | White | 58 | (92.1) |
| | African American | 1 | (1.6) |
| | Native American/Alaskan Native | 1 | (1.6) |
| | Asian | 3 | (4.8) |
| Spiritual/Religious Upbringing | | 63 | |
| | Yes | 56 | (88.9) |
| | No | 7 | (11.1) |
| Semester of Nursing School | | 63 | |
| | First Semester | 17 | (27.0) |
| | Second Semester | 18 | (28.6) |
| | Third Semester | 14 | (22.2) |
| | Fourth Semester | 14 | (22.2) |

The mean age of the sample was 20.81, with a median of 21 years and a range of 19 to 33 years old. The Fisher's exact for skewness was 17.063 (*S.E.* = .302), and the Fisher's exact for

kurtosis was 7.654 (*S.E.* = .595). As a result, age did not demonstrate normal distribution (Thode, 2002). Upon review of the Q-Q plot, one outlier was noted. The outlier was the participant who reported an age of 33 years old. After removing the outlier, the new mean age was 20.61. The Fisher's exact for skewness without the outlier was 0.480 (*S.E.* = .304), and the Fisher's exact for kurtosis without the outlier was 0.476 (*S.E.* = .599). With the one outlier removed, the assumption of normality for age was satisfied, as assessed by visual inspection of the histogram and normal Q-Q plots.

**Table 2**

*Age Descriptive Statistics*

| | | *N* | Mean (*S.D.*) | Range |
|---|---|---|---|---|
| Age | | 63 | 20.81 (1.8) | 19-33 |
| Age | Outlier removed | 62 | 20.61(0.9) | 19-23 |

**Instrumentation**

A pretest Knowledge Assessment questionnaire was employed to measure LGBTQ knowledge before the educational intervention. The scale has a low level of internal consistency, as determined by a Cronbach's alpha of 0.494. The same Knowledge Assessment questionnaire was employed to measure LGBTQ knowledge after the educational intervention. The scale revealed a low level of internal consistency, as determined by a Cronbach's alpha of 0.653. A notable increase in internal consistency was apparent compared to the pretest Knowledge Assessment's Cronbach's alpha. As this was a self-made instrument being used for the first time, a lower level of internal consistency, approximately 0.6 to 0.7, is acceptable (DeVellis, 2016).

**Table 3**

*Knowledge Assessment Reliability Analysis*

| | Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
|---|---|---|---|
| Pretest Knowledge Assessment | .494 | .491 | 15 |
| Post Test Knowledge Assessment | .653 | .674 | 15 |

The Sexual Orientation Counselor Competency Scale (SOCCS) was developed to assess clinical competency among mental health professionals. The SOCCS was employed to measure perceived clinical competency prior to the educational intervention. The scale had a high level of internal consistency, as determined by a Cronbach's alpha of 0.85. The SOCCS was employed a second time to measure clinical competency after the educational intervention. Reliability testing revealed a high level of internal consistency, as determined by a Cronbach's alpha of 0.89 (Cronbach, 1951).

The SOCCS skills subscale measured perceived skills prior to the educational intervention. The scale had a high level of internal consistency, as determined by a Cronbach's alpha of 0.86. The SOCCS skills subscale measured perceived skills after the educational intervention. The scale had a high level of internal consistency, as determined by a Cronbach's alpha of 0.87. The SOCCS awareness subscale measured perceived awareness prior to the educational intervention. The scale had a high level of internal consistency, as determined by a Cronbach's alpha of 0.90. The SOCCS awareness subscale measured perceived awareness after the educational intervention. The scale had a high level of internal consistency, as determined by a Cronbach's alpha of 0.90. The SOCCS knowledge subscale measured perceived knowledge prior to the educational intervention. The scale had a high level of internal consistency, as

determined by a Cronbach's alpha of 0.86. The SOCCS knowledge subscale measured perceived knowledge after the educational intervention. The scale had a high level of internal consistency, as determined by a Cronbach's alpha of 0.79.

**Table 4**

*Reliability Statistics of the SOCCS*

| | Published Findings | Project Findings | | N of Items |
|---|---|---|---|---|
| | | Pretest | Posttest | |
| SOCCS Total Mean Score | .90 | .85 | .89 | 29 |
| Skills Subscale | .91 | .86 | .87 | 11 |
| Awareness Subscale | .88 | .90 | .92 | 10 |
| Knowledge Subscale | .76 | .86 | .79 | 8 |

## Research Questions

### *Results for Research Question 1*

Research Question 1: Among undergraduate nursing students, what is the effectiveness of an educational intervention on perceived clinical competency for LGBTQ patient care? A paired-samples *t*-test was used to determine if the implementation of an educational intervention would increase undergraduate nursing student's LGBTQ clinical competency. No outliers were detected, and all assumptions of normality were met. Participants had a significant increase in total mean Sexual Orientation Clinical Competency from baseline (M = 4.453, SD = 0.698) to post-intervention (M = 5.364, SD = 0.727), t (62) = -13.411, $p < .001$.

A paired-samples *t*-test was used to determine if the implementation of an educational intervention would increase undergraduate nursing students' perceived clinical competence, skills, and knowledge. No outliers were detected. All normality assumptions were met for all variables in each analysis that follows except awareness, and parametric testing was used to analyze all skills except awareness. Participants had a significant increase in SOCCS skills from baseline (M= 3.15, SD = 1.04) to post-intervention (M = 4.63, SD = 1.04), t (62) = -11.045, $p$ <.001. A paired-samples *t*-test was used to determine if the implementation of an educational intervention would increase undergraduate nursing student's perceived knowledge. Participants had a significant increase in SOCCS knowledge from baseline (M = 4.30, SD = 1.12) to post-intervention (M =5.24, SD = .90), t (62) = -7.60, $p$<.001. A paired-samples *t*-test was used to determine if the implementation of an educational intervention would increase undergraduate nursing students' knowledge, as measured by the knowledge assessment. Participants had a significant increase in knowledge from baseline (M = 8.70, SD = 2.32) to post-intervention (M = 10.76, SD = 2.44), t (62) = -6.434, $p$<.001.

The SOCCS subscale measuring students' perception of awareness was not normally distributed. As a result, a Wilcoxon signed-rank test was conducted to determine the effect of the educational intervention on awareness. There was a statistically significant mean increase in SOCCS awareness from baseline (M = 6.01, SD = 1.16) to post-intervention (M = 6.27, SD 1.11), z = 2.53, $p$ = .011.

**Table 5**

*Paired-samples t-test*

| | Pre-Intervention (n = 63) M (SD) | Post-Intervention (n = 63) M (SD) | Paired t-value | *p* value |
|---|---|---|---|---|
| SOCCS Total Mean Score | 4.45 (0.70) | 5.36 (0.73) | -13.41 | <.001 |
| SOCCS Skills | 3.15 (1.04) | 4.63 (1.04) | -11.05 | <.001 |
| SOCCS Knowledge | 4.30 (1.12) | 5.24 (.90) | -7.60 | <.001 |
| Knowledge Assessment | 8.70 (2.32) | 10.76 (2.44) | -6.43 | <.001 |

***Results for Research Question 2***

Research Question 2: What relationship, if any, exists between the participant's demographic data and LGBTQ clinical competency? Correlational analysis was used to test for a relationship between age and baseline SOCCS total mean score. Preliminary analysis showed the relationship to be linear with both variables normally distributed assessed by Fisher's exact for skewness and kurtosis. One outlier was removed. No statistically significant correlation existed between age and Pretest SOCCS total mean score, $r$ (60) = .17, $p$ = .201.

**Table 6**

*Pearson Correlation between Age and Pretest SOCCS Total Mean*

| | | Age | Pretest SOCCS Mean Score |
|---|---|---|---|
| Age | Pearson Correlation | 1 | .165 |
| | Sig (2-tailed) | | .201 |
| | N | 62 | 62 |
| Pretest SOCCS Mean Score | Pearson Correlation | .165 | 1 |
| | Sig (2-tailed) | .201 | |
| | N | 62 | 62 |

Correlational analysis was used to test a possible relationship between gender and LGBTQ clinical competency. Data indicated no significant correlation between gender and LGBTQ clinical competency among the project sample, $r$ (61) = -.07, $p$ = .612. One participant in the studied sample was married (n = 1), all other participants reported being single (n = 62). The sample does not demonstrate enough variability to establish a relationship.

An independent-samples *t*-test was conducted to determine if there were differences in LGBTQ clinical competency between heterosexual participants and participants who identified as homosexual or bisexual. Homosexual and bisexual participants were combined into one category (n = 4) and compared to heterosexual participants (n = 59). Participants who identified as homosexual or bisexual had a significantly higher LGBTQ clinical competency (M 5.5, SD .64) than heterosexual participants (M 4.38, SD .65) t (61) = 3.41, $p$ = .001.

An independent-samples *t*-test was conducted to determine if there were differences in LGBTQ clinical competency between participants who reported male partners (n = 55) and female partners (n = 7). Only one participant reported both male and female partners and therefore was excluded from this test due to the low number within the sample. Equal variance was not assumed; there was no significant difference between gender of sexual partners. There was no difference in LGBTQ clinical competency between participants who reported male partners (M 4.37, SD .59) than participants who reported female partners (M 5.02, SD 1.23) t (60) = -2.37, $p$ = .216.

An independent-samples *t*-test was conducted to determine if there were differences in LGBTQ clinical competency between white and ethnic minority participants. Participants who reported being white (n = 58) were compared to participants who reported being a minority (n =5), including African American, Native American/Alaskan, and Asian. There was no significant

difference in LGBTQ clinical competence between white students (M 4.46, SD .66) and students belonging to the ethnic minority (M 4.28, SD 1.13) t (61) = .54, *p* = .590.

An independent-samples *t*-test was conducted to determine if there were differences in LGBTQ clinical competency between participants who reported a religious or spiritual upbringing (n = 56) and participants who denied a religious or spiritual upbringing (n = 7). There was no significant difference in LGBTQ clinical competence between participants who reported a religious or spiritual upbringing (M 4.41, SD .71) and participants who denied a religious or spiritual upbringing (M 4.75, SD .54) t (61) = -1.22, *p* = .228.

A one-way analysis of variance (ANOVA) was conducted to determine if LGBTQ clinical competency was different for students in different semesters of nursing school. Participants were classified into four groups: First semester (n = 17), Second semester (n = 18), Third Semester (n = 14) and Fourth semester (n = 14). The LGBTQ clinical competence varied in each group from the First semester (M= 4.43, SD= .77), to Second semester (M= 4.22, SD= .58), to Third semester (M= 4.45, SD= .69), and Fourth semester (M= 4.77, SD= .71), but the differences between semesters was not statistically significant, F (3,59) =1.612, *p* = .196.

**Qualitative Data**

After completing the modules and attending the panel discussion, participants completed written reflections. There were four writing prompts with space for 75 words or less for each prompt. The primary researcher categorized the responses. Supporting faculty then reviewed the categories established.

***Results for Research Question 3***

Research Question 3: What are students' perceptions of the benefits of an LGBTQ educational intervention? The qualitative data were reviewed and responses were content coded.

After reviewing and organizing recurrent words, the primary investigator identified common subcategories. The most frequently identified subcategories included: improving patient care, learning/increasing knowledge, and preparedness.

In the first writing prompt, participants were asked to describe what they learned in the NRSG 4001 Human Cultures Course. The most frequently used terms related to "patient care" and or "LGBTQ care." These phrases were noted in 71 (35.3%) of student responses. The second most frequently used term was "communication," with 65 (32.3%) of students reporting that communication was a component of what they learned from the course. The third most frequently noted terms in student reflections related to "discrimination," "bias," "barriers," or "disparities" of the LGBTQ community, with 57 (28.4%) students using one or all these terms in their response.

In the second writing prompt, participants were asked to describe what the NRSG 4001 Human Cultures Course meant to them and why. Sixty-two (30.8%) responses included either "nursing" or "patient care." "Nursing" and "patient care" were the most frequently referenced terms when students were asked what the course meant to them. The second most frequently referenced term was a form of the word "learn" or reference to "increased knowledge," with 55 (27.4%) responses including a variation of this phrasing. The third term that was noted most recurrently was "preparedness," with 39 (19.4%) responses including a reference to this term.

In the third writing prompt, participants were asked to reflect on the value of the NRSG 4001 Human Cultures Course experience and their opinion of the course. Half, 102 (50.8%) of the course participants reported that the course was "good," "valuable," or "beneficial." The opinion that the information discussed in the course was "important information" was referenced 46 (22.9%) times by respondents. The opinion that the course provided information that will

contribute to the participants providing "quality care" or "holistic care" to their patients was referenced 34 (16.9%) times by respondents. The frequent use of these terms in written reflections and the significant improvement in clinical competence, as seen in the qualitative data, indicate the training was both perceived as beneficial and was statistically impactful.

One student responded, "It was very valuable for people like me who are deeply immersed in southern and Christian culture to better learn how to treat patients and just people in everyday life." Other students also reported the value of the information covered in the project when they wrote, "[I] think it is important for everyone to experience this seminar class." Another student spoke to the importance of the training because of the awareness it raises about an at-risk population when they wrote,

> This is a great class to include because it addresses a topic that isn't just medicine, but rather how to treat others kindly and respectfully. It pertains to a specific group that has been overlooked and treated unfairly in the past.

Of the responses, 5% (n = 10) reported that the panel discussion was beneficial or that they enjoyed the panel discussion. However, 3 (1.5%) students reported that they did not find value in the course due to the virtual platform or did not find value in the panel discussion. A student who did not find value in the virtual panel discussion wrote,

> I think that the course could have been completed without a live panel. I feel like because we are having to do everything virtually, the quality and overall organization of the panel discussion lacked the necessary components to make the session informative and interesting. I believe I would have benefited more from modules and an interactive scenario.

Another student reported that although the course was "important," it was "hard to learn with just the online modules." The student went on to say, "I realize that the COVID pandemic definitely limits the faculty's ability to do in-person lectures, but I don't think I learned or retained this information as well as I would have liked to." One student noted that they would have preferred the course be in person due to a poor attention span. Stating, "I really liked it although I wish it could have been in person because my attention span was terrible."

Of the students who reported a benefit of the virtual panel discussion, one student reported that they "learned the most information from the zoom meeting we had at the end." Another student reported, "Being able to see and hear the perspectives of the speakers during the [zoom] meeting with the cohorts was great, and it helped me take these worries further into consideration when viewing nursing as a holistic job."

The written reflections did reveal some student bias against the LGBTQ community. When asked their opinion of the course, 2.5% of participants reported that they disagreed with the training for religious reasons. One student wrote:

> I do not agree with the LGBTQ lifestyle because it just goes against my beliefs as a Christian. I would never push my beliefs on someone else, and I would never let my beliefs get in the way of providing proper care for my patients. This topic is always shoved on us, and we shouldn't have to sit through these modules, when it's common sense and basic human decency to treat patients equally. ALL of my patients will be treated with respect, regardless.

Another student wrote:

> I am a strong Christian and believe that the Bible is the ultimate truth and under the new covenant of Christ sexual immorality and homosexuality is a sin. I view this sin as equal

> to all others and know that I myself am a sinner. I am able to care for patients while not agreeing with them or endorsing their behavior. I will never give my opinion to a patient but I [am] not willing encourage sinfulness [and] I hope someone would do for me.

The final writing prompt asked the students how they would apply what they learned in the course. Ninety-three (46.3%) students reported that they would apply what they learned in their job, at clinical, or when providing care. Four students (2.0%) reported they would apply what they learned in their personal life. While 22 (10.9%) students stated that they would apply what they learned to their professional and personal lives. Seventy-seven (38.3%) students reported that they would apply what they learned when communicating with patients. Thirty-four (16.9%) of students stated that they would apply what they learned to create/promote a safe environment or advocate for LGBTQ patients.

These findings indicate that participants intend to apply the skills, awareness, and knowledge learned through the training when providing care, while in clinical, or while at work. One student wrote:

> I will apply what I learned in this course to take much better care of my patients and their families. I really did enjoy that I had the opportunity to learn about how I can communicate and better care for patients a part of the LGBT+ community. My cousin is a proud member of the LGBT+ community, and it is an honor to be able to use his story to help motivate me to learn, listen and become better so I can care for my patients with the best of my ability.

Another student wrote about how the training was important to them because of the patient population they intend on serving,

> I will definitely apply what I learned about providing holistic and competent care to my patients through this course. I think because I want to work near or in Atlanta, I have a greater chance of taking care of many patients that are a part of the LGBTQ community. I was already aware of the things I had to do to be respectful and a supporter for them, but this seminar helped me to be more aware.

The importance of communication and respectful use of preferred pronouns was stressed in both the modules and the panel discussion. One student reported:

> From this course, I will be able to apply all of the communication techniques that I learned into my assessments of new patients. Furthermore, I may even be able to use this information in a leadership position to try and decrease the percentage of abuse and violence that occurs.

This response recognizes the importance of communication and how respectful communication can reduce health disparities for LGBTQ patients. Similar themes were noted in this student's response as well as recognition of implicit bias,

> During my initial interactions with patients/clients, I will use gender neutral phrases to see if the patient/client will self-identify. If not, I will ask for the person's pronouns so that I may be respectful. Also, I will be aware of any implicit bias I may have so that I can correct myself and make the client feel safe and comfortable in my care.

**Table 7**

*Qualitative Data Analysis*

| | Prompt 1 n (%) | Prompt 2 n (%) | Prompt 3 n (%) | Prompt 4 n (%) |
|---|---|---|---|---|
| Knowledge | | | | |
| Learning or Increase Knowledge | | 55 (27.4%) | | |
| Preparedness | | 39 (19.4%) | | |
| Create/Promote Safe Environment, Advocate | | | | 34 (16.9%) |
| Awareness | | | | |
| Good, Valuable, or Beneficial | | | 102 (50.8%) | |
| Discrimination/Barriers/ Disparities | 57 (28.4%) | | | |
| Job, Clinical, Providing Care | | | | 93 (46.3%) |
| Communication, Correct Pronouns | | | | 77 (38.3%) |
| Skills | | | | |
| Quality Care or Holistic Care | | | 34 (16.9%) | |
| Nursing or Patient Care | | 62 (30.8%) | | |
| Patient Care/LGBTQ Care | 71 (35.3%) | | | |
| Communication | 65 (32.3%) | | | |
| Important Information | | | 46 (22.9%) | |

## Conclusion

Results indicated a statistically significant increase in perceived clinical competence, as measured by the SOCCS, after the educational intervention. All SOCCS subscales revealed a statistically significant increase from baseline to post-intervention. There was a significant increase in LGBTQ knowledge from baseline to post-intervention, as measured by the Knowledge Assessment. There was not a statistically significant relationship between age and baseline perceived clinical competence. However, participants who identified as homosexual or bisexual had a significantly higher LGBTQ clinical competency than heterosexual participants. Qualitative data supported the project's quantitative findings. Discussion of findings will be explored in the following chapter.

# Chapter 5: Discussion

This translational project examined the effectiveness of an educational intervention aimed at increasing clinically competent LGBTQ patient care among prelicensure nursing students. This chapter will discuss project findings, implications of findings, limitations, and a conclusion. Findings discussed include the project's impact on clinical competency, the relationship of demographics, and student perceptions of the training. The project had implications for nursing practice, education, nurse educators, and research. Identified limitations of the project included 1) the evolution of LGBTQ terms, 2) the personal preference of participants, and 3) the impact of a strictly virtual platform. Overall, the project results indicate a statistically significant increase in perceived LGBTQ clinical competence as measured by the SOCCS Version 2. The qualitative data revealed that students felt better prepared to care for LGBTQ patients.

## Discussion

This section will interpret and discuss the project findings. The primary researcher will discuss the impact the project had on clinical competency, the relationship of demographics, and students' perceptions of the training.

### *Impact on Clinical Competency*

The first research question explored the effectiveness of the project's educational intervention on the undergraduate nursing students' perceived LGBTQ clinical competence. To determine the effectiveness of the educational intervention, the primary researcher compared participants' baseline total mean sexual orientation competency, as measured by the SOCCS Version 2, to the post-intervention total mean utilizing a paired-samples *t*-test. The results were statistically significant. Results indicate that the educational intervention, consisting of online

modules and a panel discussion, can significantly increase undergraduate nursing students' perceived LGBTQ clinical competence, including their skills, awareness, and knowledge. The findings also indicate that the educational intervention can increase students' overall LGBTQ knowledge. These findings validated the modules and panel discussion as successful methods to significantly improve undergraduate nursing students' perceived LGBTQ clinical skills, awareness, knowledge, and overall LGBTQ knowledge.

These findings are consistent with the literature, suggesting LGBTQ competency can increase with education and training (Grosz et al., 2017; Lindsay et al., 2019; Margolies et al., 2014). A mixed-methods systematic review of gender-sensitivity training programs similarly found a significant improvement in participants' gender-related knowledge and attitudes after receiving an educational intervention (Lindsay et al., 2019). The studies included in the review utilized training content that was consistent with the primary researcher's content. Training content included sex and gender terminology, health issues and inequalities, stigma, and communication skills (Lindsay et al., 2019). A study that consisted of a 2-hour LGBTQ training with a subsequent panel discussion for medical students at a university in Ohio reported similar findings. The study revealed a statistically significant increase in participant's LGBTQ knowledge and confidence in providing care to LGBTQ patients (Grosz et al., 2017).

### *Relationship of Demographics*

The primary researcher presumed that there would be an inverse correlation between age and LGBTQ competency. Presuming that younger participants would have higher LGBTQ tolerance, translating to a higher perceived sexual orientation competency. Traditionally, Americans aged 18 to 34 years old are the most tolerant of LGBTQ individuals (Miller, 2019). Higher tolerance among this age group supported the primary researcher's assumption that

younger participants would have a higher pretest or baseline SOCCS total mean score. However, a Pearson correlational analysis found no statistically significant correlation existed between age and pretest SOCCS total mean score, $r$ (60) = .17, $p$ = .201, with age explaining 2.7% of the variation in pretest SOCCS total mean score. The study did not reveal a relationship between age and pretest SOCCS total mean score.

These study findings could be a result of the study sample or a change in the trend of generational tolerance. The study sample included 63 participants aged 19 to 23, a relatively narrow range that does not provide variability of the sample and strongly influences the test's power (Rusticus & Lovato, 2014). The test's overall power is strongly influenced by the sample size, the amount of variability in the sample, and the size of the difference in the population (Rusticus & Lovato, 2014). Although the sample demonstrated normality, a more significant variation in the sample's ages was needed to determine a relationship between age and pretest SOCCS total mean score.

Additionally, recent surveys reveal that Americans age 18 to 34 are less tolerant of LGBTQ people when compared to previous years (Miller, 2019). The Harris Poll survey conducted in 2018 revealed that 36% of persons age 18 to 34 are uncomfortable learning that they have a family member who is LGBTQ. This is a 7% increase from 2017 when 29% reported they would be uncomfortable and a 12% increase from 2016 (Bateman et al., 2016). The incidence of discomfort among this age group is the highest among all age groups, revealing a disturbing trend that this age group is the least tolerant and is becoming less tolerant (Miller, 2019). More research and data are needed to determine if a statistically significant relationship exists between age and baseline perceived sexual orientation competency.

Analysis of the demographic data revealed homosexual and bisexual participants (n = 4) to have a higher baseline LGBTQ clinical competency when compared to heterosexual participants (n = 59). Homosexual or bisexual participants had a baseline clinical competency mean of 5.5, heterosexual participants had a baseline mean of 4.38. These findings are congruent with validity testing of the SOCCS, which revealed that LGB participants (n = 38) generate higher sexual orientation competency scores and score higher on each subscale compared to heterosexual participants (n = 266) (Bidell, 2005). Validity testing revealed LGB participants to have an overall baseline SOCCS mean score of 5.33 and heterosexual participants to have a mean score of 4.53 (Bidell, 2005). These findings support the project's findings that participants who identify as homosexual or bisexual have a higher baseline mean clinical competency among a larger sample size.

Studies have revealed that ethnic minorities typically demonstrate higher competency levels when evaluated utilizing tools to appraise knowledge, skills, and awareness of multicultural issues, including the SOCCS (Bidell, 2005). Researchers contribute the higher competency to a lived understanding of multicultural issues (Bidell, 2005). The project was unable to establish a significant difference in LGBTQ clinical competence between white students (M 4.46, SD .66) and students belonging to the ethnic minority (M 4.28, SD 1.13). The primary researcher contributed this to the project's small sample size, with 92% of the participants reporting being white (n = 58) and 8% (n = 5) reporting being a minority, which could have impacted the ability to establish a correlation. The primary researcher suspects a difference would have been evident among a larger sample size.

Otherwise, the demographic data collected did not yield any significant impact on baseline LGBTQ clinical competency. The primary researcher suspects that the small sample

size with low variation impacted the ability to establish a significant correlation between demographic data and baseline LGBTQ clinical competence.

### *Student Perceptions of Training*

Qualitative data collected through students' written reflections gained insight into their perception of the training and validated quantitative data. After completing the modules and attending the panel discussion, participants completed written reflections. There were four writing prompts with space for 75 words or less for each prompt. A mixed-method systematic review of the effect of educational curricula and training on LGBTQ-specific health issues for healthcare students and professionals categorized outcomes into three categories: knowledge, awareness, and skills (Sekoni et al., 2017). This translational project categorized qualitative responses, and the same categories were recognized. Supporting faculty then reviewed the categories established.

Participants of the project reported that the training was "good," "valuable," or "beneficial" and that they intended to use the knowledge gained from the training while at work, clinical, or providing care to patients. Multiple students reported that the training improved their ability to communicate with patients and awareness of the importance of correct pronouns. The primary researcher noted that a small percentage of participants reported disagreements with the training for religious reasons.

**Good, Valuable, or Beneficial.** The project’s qualitative findings were congruent with findings from a study conducted at Johns Hopkins School of Nursing. The study assessed the impact of a Transgender Curriculum Integration Project on undergraduate nursing students' health knowledge and attitudes towards transgender and gender diverse people (Sherman et al., 2020). Like the primary researcher's project, participants in the Johns Hopkins study reported

that the information was important. One of the themes identified in the study's free-text responses was an appreciation for the taught content. Of the 25 free-text responses, four students felt the training should be made mandatory for all nursing students (Sherman et al., 2020). These responses in both the primary researcher's project and the Johns Hopkins study speak to nursing student's perceived value in the information and training.

**Job, Clinical, Providing Care.** Participants in similar studies have reported increased feelings of preparedness and confidence in providing care for LGBTQ patients after completing LGBTQ training. A study of the benefits of student-led LGBTQ training to medical students at Case Western Reserve University School of Medicine in Cleveland, Ohio, revealed similar outcomes to the project (Grosz et al., 2017). The study's training was a 2-hour training that included a student-led presentation and a panel discussion (Grosz et al., 2017). The course, conducted by second-year and fourth-year students, was mandatory for all first-year medical students (n = 167). Pretest and posttest assessments revealed a statistically significant increase in students' perceived preparedness and comfort in providing care for LGBTQ patients (Grosz et al., 2017). When asked if they felt adequately prepared to be a member of the care team for a lesbian, gay, or bisexual patient and for a transgender patient, there was a statistically significant increase in mean scores from 3.58 (1.05) to 4.01 (0.77) and 2.89 (1.09) to 3.70 (.91) respectively (Grosz et al., 2017). These findings are congruent with this project's students' reflections reporting increased preparedness and intention to use the information in the clinical setting.

This translational project was aimed at increasing LGBTQ clinical competence among prelicensure nursing students. Adequate clinical competence is essential for new nurses entering the workforce and caring for the LGBTQ patient population. The quantitative data indicated the

students increased their skills, awareness, and knowledge, and the qualitative data indicated that they intended to utilize the information learned in the clinical setting.

**Communication, Correct Pronouns.** Reflection responses indicated that the students comprehended the information reviewed in the modules and the panel. Communication was thoroughly discussed throughout the training due to its implications with clinically competent care. In a survey of LGBTQ patients, participants reported noting the nurses' use of heteronormative language during admission and history taking, leaving little opportunity to disclose gender identity or sexual orientation (Stewart & O'Reilly, 2017). The high rate of students reporting that they will implement the communication techniques and vocabulary discussed speaks to the study's positive implications on nursing practice.

A pilot study conducted among advanced practice nursing students revealed similar findings. The study included a 90-minute module designed to increase medical knowledge and awareness of health disparities among gender minorities (Klotzbaugh et al., 2020). Similar to the translational project, the study utilized a module that reviewed appropriate terminology and the importance of using clients' preferred pronouns. The study sample (n = 11) was exclusively female, with a mean age of 33.5 years. Results revealed a statistically significant increase in mean medical knowledge from pretest 4.73 (1.3) to posttest 7.55 (1.4) (Klotzbaugh et al., 2020). Like this translational project, the pilot study's primary researcher included knowledge of appropriate pronouns and gender-sensitive communication under the domain of knowledge.

**Religion.** A study conducted in rural Southeast Georgia noted a similar impact of religion among nursing students on LGBTQ care (Mitchell et al., 2016). Of the 167 participating nursing students, 139 (76%) self-identified as Christian (Mitchell et al., 2016). The study noted a comparable impact of religion on willingness to care for LGBTQ patients and improve

awareness of LGBTQ issues. Of the surveyed students, 3% reported that they would refuse to care for an LGBTQ patient (Mitchell et al., 2016). When asked if they would like to learn more about LGBTQ patient care, 32.3% of students reported they were not interested (Mitchell et al., 2016).

The study reported qualitative comments from participants, including: "They aren't different from normal people"; "Their care shouldn't differ from the average patient"; and "All the hours in class I have spent learning patient care: they would not be treated any different" (Mitchell et al., 2016). The primary researcher noted similar statements among this translational project's student reflection responses. These statements do not align with the nursing profession's objective of patient-centered care. Patient-centered care commands nurses to account for the patient's diverse background, environment, and health issues when providing care (Mitchell et al., 2016). These responses indicate a continued need for formal LGBTQ education, training, and self-reflection among undergraduate nursing students (Mitchell et al., 2016).

The primary researcher recognized that religion could impact participants' willingness to engage in the project and incorporate the information into their clinical practice. It was unlikely that one training would invoke change among participants with notable bias against LGBTQ persons (Morris et al., 2019). Students who demonstrated bias in their written reflection will require awareness education and training on bias reduction strategies (Morris et al., 2019). The SOCCS Version 2 awareness subscale examines the participants' self-awareness of LGBT biases and stigmatization (Bidell, 2005). Despite noting a small percent of participant bias in the written reflections, the educational intervention significantly impacted participants' awareness. This significant increase indicates that students increased self-awareness of bias and stigmatization after completing the training.

## Implications of Findings

This translational project has significant implications for nursing practice, education, and research. The project positively impacts nursing practice as nurses are better prepared to use inclusive language, provide clinically competent care, and advocate for LGBTQ patients. Education is affected since project findings support the utilization of specific teaching modalities. Nurse educators benefit by gaining insight into students' perspectives on educational intervention and the impact of educational intervention on students' clinical competence. Implications for research include the project findings and their congruency with current research and possibilities for future research.

### *Implications for Nursing Practice*

This project can improve nursing practice through its education of undergraduate nurses on how to provide clinically competent care to LGBTQ patients. As future nurses, the students pledge to care for all patients (Stokes, 2019). In order to provide quality care to all their patients, nurses need to ensure they have the clinical competency to care for LGBTQ patients (Stokes, 2019). Through educational sessions, training, and open discussions, nurses feel better equipped for caring for LGBTQ patients in any clinical setting (Margolies et al., 2014). Note that training and education should be continuous and not only one educational occasion (Leininger, 1988). LGBTQ terms and vocabulary are likely to change and evolve. Thus, nurses must stay up to date on current verbiage (Eliason & Chinn, 2018).

Adequately trained nurses are more likely to use inclusive language, perform necessary screenings, and provide a safe environment for LGBTQ patients. Through these quality practices, nurses can begin to change the current trend in the health culture of LGBTQ patients (Eliason & Chinn, 2018). As nursing students enter the workforce, they have the unique

opportunity to change the current healthcare culture for LGBTQ patients (Eliason & Chinn, 2018). By increasing undergraduate nursing education and training on LGBTQ patient care, the nursing students are better prepared to care for this patient population while simultaneously improving patient outcomes. With the additional training in LGBTQ clinical care, these nurses can lead by example. Their colleagues will also learn to use inclusive language and create a safe environment for LGBTQ patients (Eliason & Chinn, 2018).

### *Implications for Education*

After reviewing Best Practices in Creating and Delivering LGBTQ Cultural Competency Trainings for Health and Social Service Agencies, specific teaching methods were chosen that supported the aim of the project and high-quality pedagogical practices (Margolies et al., 2014). When aiming to increase cultural competence, training is most successful when it includes a didactic component and focus groups or discussion (Calvillo et al., 2009). The project fulfilled this by utilizing online learning modules as the didactic component and a panel discussion for open discussion between panelists and students.

When the training goal is to increase knowledge related to LGBTQ health and needs, it is best to utilize training methods, including lectures with visual aids such as PowerPoint slides, group exercises, or media (Margolies et al., 2014). The Curriculum for Oncologists on LGBTQ populations to Optimize Relevance and Skills (COLORS) Training, a web-based LGBT cultural competency training developed for Oncologists (Seay et al., 2019). The training included four modules, each taking 30 minutes to complete. Two of the modules were related to LGBTQ basics and how to create an inclusive environment. The other two modules were related to oncology care specifically (Seay et al., 2019). Similar to the translational project, the modules included interactive content to engage the learner. Participants in the study demonstrated a

statistically significant increase in LGBTQ knowledge, attitudes, and clinical practices after completing the training (Seay et al., 2019).

When aiming to decrease negative attitudes and increase LGBTQ-affirming attitudes, training methods should include individual reflective exercises, guest speakers or panel discussions, or small group discussions (Margolies et al., 2014). A similar study utilized a 2-hour LGBTQ training that included a student-led presentation and a panel discussion (Grosz et al., 2017). Panelists in the study shared personal health care experiences as LGBTQ patients and answered student questions. Student rating of each component of the training revealed that the students found the panel discussion most helpful (Grosz et al., 2017).

After the seminar, students completed reflection questions to encourage thoughtful reflection on the information discussed and its relevance to their clinical practice. Qualitative methods in the form of student reflection encourage students to consider personal assumptions, values, and beliefs (Calvillo et al., 2009). Participants' comments can have subjective value for the study findings (Mitchell et al., 2016). Through the qualitative data in this translational project, the impact of religion on LGBTQ awareness was noted.

The project revealed a positive impact on the students' perceived clinical competence and LGBTQ knowledge using the aforementioned learning modalities, as the literature suggested it would. Surveyed students reported that the seminar benefitted them as future nurses. These findings contribute to the literature exploring how to effectively educate undergraduate nurses on the clinical care of LGBTQ patients. Results support the utilization of online modules and panel discussion to increase LGBTQ clinical competence for undergraduate nursing students. Nurse Educators can refer to this study when determining learning modalities for LGBTQ content in their nursing curriculum.

### *Implications for Future Research*

The project implemented educational modalities that were supported by current literature. The project findings revealed an increase in perceived LGBTQ clinical competency and LGBTQ knowledge, further supporting the literature. Additionally, the findings suggest three possible opportunities for future research 1) long-term impact, 2) regional impact and, 3) impact of educational level. Research could be done evaluating the outcomes of patients who have received care from nurses who have participated in LGBTQ clinical competency training. One could evaluate the impact that region has on the baseline findings. It would also be of value to duplicate the project and implement it among graduate students to determine if baseline results differ.

The long-term impact of LGBTQ clinical competency training could be evaluated. Research could be conducted to evaluate the outcomes of patients who have received care from nurses who have participated in LGBTQ clinical competency training. Nurses who have received clinical competency training are better equipped to recognize signs of minority stress, use inclusive language, and provide fair treatment (Eliason & Chinn, 2018). When an LGBTQ patient is under the care of a nurse who has received training and is utilizing skills learned in training, the patient should have higher satisfaction in the care they receive. Research suggests that the patient would have a higher incidence of positive outcomes when being cared for by a healthcare worker who has been adequately trained (Eliason & Chinn, 2018).

Research could be conducted to evaluate the regional impact on LGBTQ clinical competence. The project could be duplicated in a different region and compare baseline findings and impact. This translational project revealed similar bias as another study conducted in

southern Georgia. However, different results may be revealed if the study was implemented in the northern United States or the western United States (Obedin-Maliver et al., 2011).

The impact of education level on baseline LGBTQ clinical competence may also be significant. Future research could include replicating the project among graduate students and comparing the findings. Graduate students typically have more work experience and are more racially and ethnically diverse (Bidell, 2005). Both work experience and diversity of the study sample could significantly impact baseline clinical competence and possibly the impact of an educational intervention. Validity testing of the SOCCS revealed a statistically significant increase in overall SOCCS score among participants with higher education levels (Bidell, 2005). The study revealed master's students to have a higher overall SOCCS score when compared to undergraduates, and doctoral students to have higher overall SOCCS scores than both masters and undergraduate students (Bidell, 2005). More research is needed to thoroughly explore the relationship between LGBTQ clinical competence and its correlation with education level.

**Limitations**

The primary researcher identified three limitations of the translational project: 1) the evolution of LGBTQ terms, 2) the personal preference of participants, and 3) the impact of a strictly virtual platform. The project utilized modules developed by The National LGBTQIA+ Health Education Center, the oldest module included in the project was created in 2015. LGBT terms are evolving; as a result, there is the possibility that the modules utilized outdated terminology by the time the project was implemented. Participants' personal preferences can be a limitation, as some students have personal views and biases that impact their experience participating in the project. As a result of university social distances guidelines, the project was

implemented utilizing a strictly virtual platform. The use of a virtual platform may have negatively impacted the participant's experience.

### *Evolution of LGBT terms*

LGBTQ terminology is evolving (Eliason & Chinn, 2018). At the time of this project's implementation, definitions were as defined in Chapter 1. However, the terms or their definitions could change at any time. An example of a term that has evolved is the term "queer." Previously, this term was an insult. Now, a growing number of young adults and some adults use the term as an inclusive identity. However, some may still find the term offensive (Eliason & Chinn, 2018). The modules utilized in the project were developed by The National LGBTQIA+ Health Education Center in 2015, 2016, and 2020. The modules utilized up-to-date terms and definitions at the time of the project but may become out of date at any point.

### *Personal Preference*

Personal preference affects one's acceptance of the educational intervention and associated information. The students' written reflections revealed that some students harbor both implicit and explicit bias. Although training has proven to increase participants' awareness of bias against LGBTQ persons, more research is needed to assess a training's impact on changing bias (Morris et al., 2019). Persons with unacknowledged implicit bias would require more than one intervention to recognize and then change their bias (Eliason & Chinn, 2018). Current literature suggests that participants with explicit bias are unlikely to drastically change their views after receiving one training (Morris et al., 2019). Bias reduction requires education on awareness and training on bias reduction strategies (Morris et al., 2019). This translational project did include bias awareness education but did not explore bias reduction strategies.

### *Virtual Platform*

Due to the coronavirus pandemic, the project was implemented on a strictly virtual platform. The educational intervention consisted of online modules that the students were to complete at home, and the panel discussion was done virtually via Zoom. All pretest and posttest surveys were done online. The decision to make the course virtual was made to comply with university guidelines that restricted large gatherings and ensured staff, students, and panelists' safety.

The primary researcher would have preferred to conduct the panel in person, as it would be more impactful and engaging for the audience. Literature supports the utilization of a panel discussion when educating students about LGBTQ patients and their care (Margolies et al., 2014). Panel discussions encourage open dialog between learners and panelists and create a safe place for questions (Human Rights Campaign, 2020). Student engagement was a concern in a virtual panel discussion due to the inundation of virtual classes in compliance with university social distancing guidelines. Studies evaluating the impact of a virtual panel discussion compared to an in-person panel discussion have not been published. If replicating this project, an in-person panel discussion should be considered instead of a virtual panel discussion to encourage student engagement.

## Conclusion

The translational project revealed a statistically significant increase in total mean sexual orientation competency, as measured by the SOCCS Version 2. Results were consistent with the literature and supported the conclusion that education and training increase clinical competence. No correlation was found between age and baseline sexual orientation competency. The lack of correlation may be due to the small sample size with low variability or a change in the trend of

LGBTQ acceptance among persons age 18 to 34. The students' perceptions of the benefits of an LGBTQ education intervention could be categorized by knowledge, awareness, and skills. Limitations of the project included the evolution of LGBTQ terms, personal preferences of the project participants, and the impact of a strictly virtual platform on the project's findings. The project had implications for nursing practice, education, nurse educators, and future research. This translational project achieved its aim of improving nursing students' ability to provide clinically competent care to LGBTQ patients. There was a statistically significant increase in undergraduate nursing students' perceived LGBT clinical competency. There was an increase in undergraduate nursing students' knowledge related to LGBTQ patients. The project also improved undergraduate nursing students' attitudes towards LGBTQ patients.

## References

American Nurses Association. (2015). *Code of ethics for nurses*. American Nurses Publishing.

Bateman, R. M., Sharpe, M. D., Jagger, J. E., Ellis, C. G., Sole-Violan, J., Lopez-Rodriguez, M., . . . Prandi, E. (2016). Erratum to: 36th International Symposium on Intensive Care and Emergency Medicine: Brussels, Belgium. 15-18 March 2016. *Critical Care, 20*, 347. doi:10.1186/s13054-016-1358-6

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I don't think this is theoretical; This is our lives": How erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care, 20*(5), 348-361.

Bidell, M. P. (2005). The sexual orientation counselor competency scale: Assessing attitudes, skills, and knowledge of counselors working with lesbian, gay, and bisexual clients. *Counselor Education & Supervision, 44*(4), 267-279. doi:10.1002/j.1556-6978.2005.tb01755.x

Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health, 100*(3), 468-475.

Braveman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports, 129*(12), 5-8.

Calvillo, E., Clark, L., Ballantyne, J. E., Pacquiao, D., Purnell, L. D., & Villarruel, A. M. (2009). Cultural competency in baccalaureate nursing education. *Journal of Transcultural Nursing, 20*(2), 137-145.

Carabez, R., Pellegrini, M., Mankovitz, A., Eliason, M., Ciano, M., & Scott, M. (2015). “Never in all my years…”: Nurses' education about LGBT health. *Journal of Professional Nursing, 31*(4), 323-329. doi:10.1016/j.profnurs.2015.01.003

Carabez, R., Pellegrini, M., Mankovitz, A., Eliason, M. J., & Dariotis, W. M. (2014). Nursing students’ perceptions of their knowledge of lesbian, gay, bisexual, and transgender issues: Effectiveness of a multi-purpose sssignment in a public health nursing class. *Journal of Nursing Education, 54*(1), 50-53.

Carabez, R. M., Eliason, M. J., & Martinson, M. (2016). Nurses' knowledge about transgender patient care. *Advances in Nursing Science, 39*(3), 257-271.

Charlton, B. M., Corliss, H. L., Missmer, S. A., Frazier, A. L., Rosario, M., Kahn, J. A., & Austin, S. B. (2011). Reproductive health screening disparities and sexual orientation in a cohort study of U.S. adolescent and young adult females. *Journal of Adolescent Health, 49*(5), 505-510.

Cochran, S. D., Ackerman, D., Mays, V. M., & Ross, M. W. (2004). Prevalence of non-medical drug use and dependence among homosexually active men and women in the U.S. population. *Addiction, 99*(8), 989-998.

Cochran, S. D., Björkenstam, C., & Mays, V. M. (2016). Sexual orientation and all-cause mortality among U.S. adults aged 18 to 59 years, 2001–2011. *American Journal of Public Health, 106*(5), 918-920.

Cochran, S. D., Mays, V. M., Bowen, D., Gage, S., Bybee, D., Roberts, S. J., . . . White, J. (2001). Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women. *American Journal of Public Health, 91*(4), 591.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53.

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health, 100*(10), 1953-1960.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16*(3), 297-334.

Dentato, M. P. (2012). The minority stress perspective. *Psychology and AIDS Exchange Newsletter*,12-15.

DeVellis, R. F. (2016). *Scale development: Theory and applications* (Vol. 26). Sage Publications.

Ding, J. M., Ehrenfeld, J. M., Edmiston, E. K., Eckstrand, K., & Beach, L. B. (2020). A model for improving health care quality for transgender and gender nonconforming patients. *The Joint Commission Journal on Quality and Patient Safety, 46*(1), 37-43.

Driever, M. J. (2002). Are evidenced-based practice and best practice the same? *Western Journal of Nursing Research, 24*(5), 591-597.

Eliason, M. J., & Chinn, P. L. (2018). *LGBTQ cultures : What health care professionals need to know about sexual and gender diversity* (Vol. 3rd edition). Wolters Kluwer Health.

Eliason, M. J., & Schope, R. (2001). Does “don't ask don't tell” apply to health care? Lesbian, gay, and bisexual people's disclosure to health care providers. *Journal of the Gay and Lesbian Medical Association, 5*(4), 125-134.

Everett, B. G., Rosario, M., McLaughlin, K. A., & Austin, S. B. (2014). Sexual orientation and gender differences in markers of inflammation and immune functioning. *Annals of Behavioral Medicine, 47*(1), 57-70.

Fenway Institute, The. (n.d.). LGBTQIA+ Health Education Center. https://www.lgbtqiahealtheducation.org/

Gandy-Guedes, M. E. (2018). The queer youth cultural competency (QYCC) scale: Measuring competency in direct-care behavioral health workers. *Journal of Gay & Lesbian Social Services, 30*(4), 356-373.

Genius Group, The. (2014). *Best practices for asking questions to identify transgender and other gender minority respondents on population-based surveys.* J.L. Herman (Ed.). UCLA: The Williams Institute.

Grosz, A. M., Gutierrez, D., Lui, A. A., Chang, J. J., Cole-Kelly, K., & Ng, H. (2017). A student-led introduction to lesbian, gay, bisexual, and transgender health for first-year medical students. *Family Medicine, 49*(1), 52-56.

Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., . . . Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality, 58*(1), 10-51. doi:10.1080/00918369.2011.534038

Heiden-Rootes, K., Wiegand, A., & Bono, D. (2019). Sexual minority adults: A national survey on depression, religious fundamentalism, parent relationship quality & acceptance. *Journal of Marital and Family Therapy, 45*(1), 106-119.

Human Rights Campaign (2020). *Healthcare equality index 2019*. HRC Foundation. https://www.hrc.org/resources/healthcare-equality-index

Kann, L. (2011). *Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12: Youth risk behavior surveillance, selected sites, United States, 2001-2009* (Vol. 60). DIANE Publishing.

Khalili, J., Leung, L. B., & Diamant, A. L. (2015). Finding the perfect doctor: identifying lesbian, gay, bisexual, and transgender–competent physicians. *American Journal of Public Health, 105*(6), 1114-1119.

Klotzbaugh, R., & Spencer, G. (2014). Magnet nurse administrator attitudes and opportunities: toward improving lesbian, gay, bisexual, or transgender–specific healthcare. *The Journal of Nursing Administration, 44*(9), 481-486.

Klotzbaugh, R. J., Ballout, S., & Spencer, G. (2020). Results and implications from a gender minority health education module for advance practice nursing students. *Journal of the American Association of Nurse Practitioners, 32*(4), 332-338. doi:10.1097/JXX.0000000000000249

Lambda Legal. (2010). *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People With HIV*. Lambda Legal.

Leininger, M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. *Nursing Science Quarterly*(4), 152.

Leininger, M. (1991, November). The theory of culture care diversity and universality. *National Nursing League Publications* (15-2402):5-68.

Lim, F., Johnson, M., & Eliason, M. (2015). A national survey of faculty knowledge, experience, and readiness for teaching lesbian, gay, bisexual, and transgender health in baccalaureate nursing programs. *Nursing Education Perspectives, 36*(3), 144-152. doi:10.5480/14-1355

Lindsay, S., Rezai, M., Kolne, K., & Osten, V. (2019). Outcomes of gender-sensitivity educational interventions for healthcare providers: a systematic review. *Health Education Journal, 78*(8), 958-976.

Margolies, L., Joo, R., & McDavid, J. (2014). *Best practices in creating and delivering LGBTQ cultural competency trainings for health and social service agencies.* National LGBT Cancer Network.

Matthews, D. D., & Lee, J. G. (2014). A profile of north carolina lesbian, gay, and bisexual health disparities, 2011. *American Journal of Public Health, 104*(6), 98-105.

McCabe, S. E., Hughes, T. L., Bostwick, W. B., West, B. T., & Boyd, C. J. (2009). Sexual orientation, substance use behaviors and substance dependence in the United States. *Addiction, 104*(8), 1333-1345.

McCann, E., & Brown, M. (2018). The inclusion of LGBT+ health issues within undergraduate healthcare education and professional training programmes: A systematic review. *Nurse Education Today, 64*, 204-214.

Miller, S. (2019). The young are regarded as the most tolerant generation. That's why results of this LGBTQ survey are 'alarming'. *USA Today.* https://www.usatoday.com/story/news/nation/2019/06/24/lgbtq-acceptance-millennials-decline-glaad-survey/1503758001/

Mitchell, K. M., Lee, L., Green, A., & Skyes, J. (2016). The gaps in health care of the LGBT community: Perspectives of nursing students and faculty. *Papers & Publications: Interdisciplinary Journal of Undergraduate Research, 5*(1), 5.

Morris, M., Cooper, R. L., Ramesh, A., Tabatabai, M., Arcury, T. A., Shinn, M., . . . Matthews-Juarez, P. (2019). Training to reduce LGBTQ-related bias among medical, nursing, and

dental students and providers: A systematic review. *BMC Medical Education, 19*(1), 1-13.

Murphy, M. (2007). *Improving learner reaction, learning score, and knowledge retention through the chunking process in corporate training*. University of North Texas.

Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health, 100*(12), 2426-2432.

Newport, F. (2018). In U.S., estimate of LGBT population rises to 4.5%. *Gallup News Service*, 1-1. https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx

Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., Brenman, S., Wells, M., Fetterman, D. M., Garcia, G., & Lunn, M. R. (2011). Lesbian, gay, bisexual, and transgender–related content in undergraduate medical education. *The Journal of the American Medical Association*, *306*(9), 971. https://doi.org/10.1001/jama.2011.1255

Office of Disease Prevention and Health Promotion (n.d.). LGBTQ. *Healthy People 2030*. U.S. Department of Health and Human Services.

Peitzmeier, S. M., Khullar, K., Reisner, S. L., & Potter, J. (2014). Pap test use is lower among female-to-male patients than non-transgender women. *American Journal of Preventive Medicine, 47*(6), 808-812.

Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice*. Lippincott Williams & Wilkins.

Quinn, G. P., Sutton, S. K., Winfield, B., Breen, S., Canales, J., Shetty, G., . . . Schabath, M. B. (2015). Lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) perceptions and health care experiences. *Journal of Gay & Lesbian Social Services, 27*(2), 246-261.

Rusticus, S. A., & Lovato, C. Y. (2014). Impact of sample size and variability on the power and type I error rates of equivalence tests: A simulation study. *Practical Assessment, Research, and Evaluation, 19*(1), 11.

Ryan, C., Huebner, D., Diaz, R. M., & Sanches, J. (2009). Family rejection as a predictor of negative health outcomes in white and latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*(1), 346-352. doi:10.1542/peds.2007-3524

Scheer, S., Parks, C. A., McFarland, W., Page-Shafer, K., Delgado, V., Ruiz, J. D., . . . Klausner, J. D. (2002). Self-reported sexual identity, sexual behaviors and health risks: Examples from a population-based survey of young women. *Journal of Lesbian Studies, 7*(1), 69-83.

Seay, J., Hicks, A., Markham, M. J., Schlumbrecht, M., Bowman, M., Woodard, J., . . . Schabath, M. B. (2019). Developing a web-based LGBT cultural competency training for oncologists: The COLORS training. *Patient Education and Counseling, 102*(5), 984-989. doi:10.1016/j.pec.2019.01.006

Seay, J., Hicks, A., Markham, M. J., Schlumbrecht, M., Bowman-Curci, M., Woodard, J., . . . Schabath, M. B. (2020). Web-based LGBT cultural competency training intervention for oncologists: Pilot study results. *Cancer, 126*(1), 112-120.

Sekoni, A. O., Gale, N. K., Manga-Atangana, B., Bhadhuri, A., & Jolly, K. (2017). The effects of educational curricula and training on LGBT-specific health issues for healthcare students and professionals: A mixed-method systematic review. *Journal of the International AIDS Society, 20*(1), 21624.

Sherer, J., & Levounis, P. (2020). LGBTQIA: Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual or allied. *Absolute Addiction Psychiatry Review*, 277-287.

Sherman, A. D., McDowell, A., Clark, K. D., Balthazar, M., Klepper, M., & Bower, K. (2020). Transgender and gender diverse health education for future nurses: Students' knowledge and attitudes. *Nurse Education Today*, 104690.

Sirota, T. (2013). Attitudes among nurse educators toward homosexuality. *Journal of Nursing Education, 52*(4), 219-227.

Snowdon, S. (2013). *Recommendations for enhancing the climate for LGBT students and employees in health professional schools*. GLMA: Health Professionals Advancing LGBT Equality.

Stewart, K., & O'Reilly, P. (2017). Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: An integrative review. *Nurse Education Today, 53*, 67-77.

Stokes, L. (2019). ANA position statement: Nursing advocacy for LGBTQ+ populations. *Online Journal of Issues in Nursing, 24*(1), 2-2. doi:10.3912/OJIN.Vol24No01PoSCol02

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125.

Thode, H. C. (2002). *Testing for normality*. CRC Press.

Tschurtz, B., & Burke, A. (2010). *Advancing effective communication, cultural competence, and patient-and family-centered care: A roadmap for hospitals*. Joint Commission.

U.S. Census Bureau. (2015). *Population trends in incorporated places: 2000 to 2013*. The United States Census Bureau. https://www.census.gov/library/publications/2015/demo/p25-1142.html

Vrangalova, Z., & Savin-Williams, R. C. (2012). Mostly heterosexual and mostly gay/lesbian: Evidence for new sexual orientation identities. *Archives of Sexual Behavior, 41*(1), 85-101.

## Appendix A

### 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.

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| *1* | *2* | *3* | *4* | *5* | *6* | *7* |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 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.

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 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.

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 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.

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 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 LGB.

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 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.

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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

| *Not at all True* | | | *Somewhat True* | | | *Totally True* |
|---|---|---|---|---|---|---|
| 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'.

| ***Not at all True*** | | | ***Somewhat True*** | | | ***Totally True*** |
|---|---|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** | **6** | **7** |

Thank you for completing he S.O.C.C.S©
Markus P. Bidell, Ph.D.

## Appendix B

Demographic Questions

What is your gender identity?

0- Male
1- Female
2- Agender
3- Bigender

How old are you? _____

What is your sexual orientation?

0- Heterosexual
1- Homosexual
2- Bisexual
3- Pansexual

My sexual partner(s) are:

0- Male
1- Female
2- Both

What is your marital status?

0- Single
1- Married
2- Divorced
3- Widowed

Ethnicity:

0- White
1- African American
2- Native American/Alaskan Native
3- Pacific Islander
4- Asian
5- Native Hawaiian

Semester in Nursing School

0- First Semester
1- Second Semester
2- Third Semester
3- Fourth Semester

Were you raised within a religious or spiritual home?

0- No
1- Yes

## Appendix C

Knowledge Assessment

1. Select the true statement.
    a. Sexual orientation and gender identity are interchangeable terms.
    b. Sexual orientation and gender identity are not interchangeable terms.
    c. Sexual orientation is no longer a socially accepted term, the LBBTQ population prefers to use the term gender identity.
    d. Gender identity further defines and clarifies one's sexual orientation.

2. Select the true statement.
    a. Sexual orientation and gender identity are fixed and unchanging.
    b. Sexual orientation is dependent on one's gender identity, which is not fixed.
    c. Gender identity is dependent on one's sexual orientation, which is not fixed.
    d. Sexual orientation and gender identity are dynamic and may develop and change over time, depending on the individual.

3. All of the following are dimensions of sexual orientation, except:
    a. Attraction
    b. Preference
    c. Identity
    d. Behavior

4. Gender fluid is defined as…
    a. A person whose gender identity falls outside the traditional binary paradigm.
    b. A person whose gender identify corresponds with their birth sex.
    c. A person who identifies as gender neutral.
    d. A person whose gender identity is not fixed.

5. What is the incidence of LGBT people being threatened or physically attacked?
    a. 1 in 3
    b. 1 in 5
    c. 1 in 7
    d. 1 in 10

6. All of the following are health disparities in the LGBT population, except:
    a. Suicide attempts
    b. Hypertension
    c. Homelessness
    d. Smoking

7. All of the following statements avoid making assumptions about gender identity or sexual orientation, except:
    a. What are the names of your mother and father?
    b. The patient is in the exam room.
    c. Are you in a relationship?

d. How may I help you?

8. Effective communication includes all of the following except:
    a. Avoiding assumptions
    b. Staying up to date on terminology
    c. Using patient preferred pronouns
    d. Labelling patients based on their appearance

9. What is sexual orientation?
    a. How a person characterizes their physical and emotional attraction to others.
    b. A person's internal sense of being a male, female, both, neither, or another gender.
    c. A person who is emotionally and sexually attracted to people regardless of gender.
    d. The assumption that everyone is heterosexual.

10. Which statement reflects effective communication that avoids assumptions about gender identity or sexual orientation?
    a. Do you have a wife?
    b. How may I help you, sir?
    c. She is here for her appointment?
    d. What are you parent(s) or guardian(s) names?

11. Which of the following statements is incorrect?
    a. Transgender people often change their name to affirm their gender identity.
    b. It is important to identify transgender people as the name on their insurance or identity documents.
    c. Transgender described a person whose gender identity and assigned sex at birth do not correspond.
    d. It is a key principle to learn patients' correct name and pronouns.

12. A nurse walks into an exam room of a new patient and says, "Good morning William, I am going to be your nurse today." The patient explains to the nurse that she transitioned to a female many years ago and prefers to be called Sara. This is an example of what?
    a. Deadnaming
    b. Passing
    c. Outing
    d. Transitioning

13. Which of the following is a true statement?
    a. The word queer is embraced by all members of the LGBT community
    b. The term queer means having a sexual orientation that is something other than heterosexual
    c. Using the term queer is an insult to members of the LGBT community
    d. A decreasing number of people self-identify as queer.

Sally is a nurse at Sacred Heart hospital, she is admitting a new patient as a direct admission from a clinic in town. The patient's medical records and admission orders have been received. The patient is named Michelle Miller. She is a 38-year-old female being admitted for diverticulitis. The patient care technician notifies Sally that "her new guy is here." When Sally enters the patient room, she finds a man lying in the hospital bed. Sally introduces herself and the patient introduces themselves as Mitchell.

14. What is the best way for Sally to proceed with the patient?
    a. Sally should say, "I'm sorry, but the chart I was given has a different name. Is it possible that your chart is listed under a different name?"
    b. After confirming this is the correct patient, Sally should refer to the patient as Michelle because the patient did not have her name legally changed.
    c. Inform the patient that they will need to use their legal name while hospitalized.
    d. Use pronouns Ze/Zir when charting to notate that the patient has transitioned.

After clarifying the patients preferred name and pronouns. Mitchell tells Sally about his partner Allen, who will be arriving to the hospital soon. They have been together for 2 years.

15. Is it indicated for the nurse to do an intimate partner violence screening?
    a. No, the incidence of intimate partner violence is very low.
    b. Yes, transgender people have higher rates of intimate partner violence compared to cis gender people.
    c. Yes, screening should be done on all patients. However, cis gender people have higher rates of intimate partner violence compared to transgender people.
    d. Yes, screening should be done on all patients. Community resources are well prepared for LGBTQ victims of abuse.

## Appendix D

NRSG 4001
Human Cultures

**Course Outcomes:**

Upon completion of this course, the student will:

-Define LGBTQ terms and definitions.
-Identify the healthcare needs of LGBT persons.
-Acknowledge LGBTQ health disparities.
-Communicate compassionately and inclusively with LGBTQ patients.

**Dates and Deadlines:**

- Georgia College fall semester classes start on **August 12th.**
- On **August 12th**, 2020, a consent form for enrollment into the study will be available on the course site.
- Qualtrics Pretest **(Available 8/12 and will close on 8/23 at 2359)**
  - Qualtrics Pretest survey (Consent, knowledge quiz, and SOCCS) available within GAView.
  - NRSG4001HumanCulturesPretest
- Modules (**Available 8/24 and will close on 9/13 at 2359**)
  1. Implicit and Provider Bias
  2. Providing Quality Care to LGBTQ
  3. Affirming LGBTQ through Effective Communication
  4. Caring for LGBT Older Adult
- On **September 14th, 2020, at 6pm-8pm** students will virtually attend a ZOOM panel discussion with experts in the field of LGBTQ in healthcare.
- Qualtrics Post-test **(Available 9/15 and will close on 9/29 at 2359)**
  - Available within GAView from 9/15-9/29; Post-test includes: Knowledge quiz, SOCCS, and written reflection
  - NRSG4001HumanCulturesPosttest

**Modules:**

1. Implicit and Provider Bias
   https://www.lgbtqiahealtheducation.org/courses/implicit-and-provider-bias-2020/
2. Providing Quality Care to LGBTQ: An introduction for staff training
   https://www.lgbtqiahealtheducation.org/courses/providing-quality-care-to-lesbian-gay-bisexual-and-transgender-patients-an-introduction-for-staff-training/
3. Affirming LGBT People through Effective Communication
   https://www.lgbtqiahealtheducation.org/courses/affirming-lgbt-people-through-effective-communication/
4. Caring for LGBT Older Adult
   https://www.lgbtqiahealtheducation.org/courses/caring-for-lgbt-older-adults/

Please communicate through GAView course site
Taylor Hall, MSN, FNP-C

## Appendix E

NRSG 4001 Human Cultures
LGBTQ Panel Discussion
Agenda

I. Welcome and introduction to panelists
Ms. Taylor Hall, MSN, FNP-C

II. Discrimination, bias, and disparities faced by LGBTQ patients
Mr. Christopher Rodriguez, MSN, RN, CEN

III. Different issues faced by sexual minorities
Mrs. Kimberly Griffin, MSN, NP-C

IV. Importance of effective communication when providing care
Mrs. Melissa Gerrior

V. Personal experiences of LGBTQ healthcare
Dr. Jeffrey S. Fouche-Camargo, DNP, APRN, WHNP-BC, RNC-OB, C-EFM

VI. How to develop clinical skills and be an LGBTQ advocate
Dr. Eva Martin, MD

VII. Questions for panelists
Ms. Taylor Hall, MSN, FNP-C

-Use the chat box to submit questions to the host

VIII. Announcements and reminders
Ms. Taylor Hall, MSN, FNP-C

-Qualtrics Post-Test will open tomorrow and close 9/29/2020 at midnight

IX. Adjourn