Providing Culturally Competent Care to Sexual and Gender Minority Patients in the Perioperative Area by Utilizing an Evidence-Based Guideline

Courtney White

Touro University, Nevada

Course Title: In partial fulfillment of the requirements for the Doctor of Nursing Practice

DNP Project Team: Denise Zabriskie DNP, RN, ACUE, WCC

Dulce Santacroce DNP, RN, ACUE

October 13, 2022

Table of Contents

Abstract

This paper evaluates the effectiveness of an evidence-based guideline regarding culturally competent care for the SGM community on participant knowledge and delivery of culturally competent care in the preoperative setting. The SGM community faces several challenges in accessing quality care within the healthcare system (Safer et al., 2016; Tollinche et al., 2018). The lack of knowledge of healthcare staff contributes to negative experiences faced by the SGM community. These experiences result in the avoidance and delay of care, which contributes to the overall poor health of the population (Safer et al., 2016). The project site has recorded complaints of SGM patients experiencing bias, vulnerability, and being mistreated (J. Rapues, personal communication, August 1, 2021). To answer this question, the project lead compared the scores of a pre- and post-knowledge assessment, the completion of a SO/GI checklist, and an observational analysis of adherence to a newly introduced guideline. The population of interest included the preoperative nursing staff in a city and county-owned, 281-bed hospital in an urban area with a diverse patient population. For data collection and interpretation, each nurse was assigned a letter for identification purposes. The guideline and educational material were introduced to the nurses at a staff meeting in a PowerPoint presentation. The knowledge assessments were randomly distributed and de-identified while results were analyzed for improvement of knowledge in the care of SGM patients. The checklist was audited at the end of each week for each nurse working during the implementation phase to assess for compliance post-education. The project lead observed RNs at random one day per week for nurses' compliance during handoff for the inclusion of patient pronouns, preferred names, and/or gender identity.

The PowerPoint presentation discussed the health disparities faced by the SGM community and introduced a guideline to aid in delivering culturally competent care. The preoperative nurses were tasked with complying with the guideline as evidenced by charting SO/GI data for each patient and using the correct pronouns, preferred name, and gender identity during handoff. The results indicated that the education session moderately improved participants' knowledge regarding culturally competent care of the SGM community. Most of the participants were compliant with charting SO/GI data (62.75%), and there was a nonsignificant difference in correct pronoun use (55%). This educational project with the implementation of a practice guideline is significant for the nursing profession to improve the quality of care of the SGM population. Implementing the first guideline of this nature at the project site has drawn the Preoperative nurses' attention to the importance of this community (Hobster & McLuskey, 2020; Shires et al., 2018). While some results were not significant, the initiation of culturally competent care occurred. This project is easy to replicate in other departments and sites because it consists of translatable educational material and a guideline.

Keywords: LGBTQ, SGM, culturally competent care, culturally congruent care

Providing Culturally Competent Care to Sexual and Gender Minority Patients in the Perioperative Area by Utilizing an Evidence-Based Guideline

The lesbian, gay, bisexual, transgender, and queer (LGBTQ) population makes up 5.6% of the United States (US) population and increases an average of 0.3% per year (Jones, 2021). Approximately 1.4 million people within this group identify as transgender (trans) (World Population Review, 2021). *Transgender* is an umbrella term referring to someone who identifies as a different gender than assigned at birth. The term *cisgender* refers to a person who identifies as the same gender assigned at birth. A transgender man identifies as male but was born with female anatomy. In contrast, a transgender woman was born with male genitalia but identifies as female (University of California San Francisco [UCSF] Gender Affirming Health Program, 2016).

The National Institutes of Health (NIH) has recently exchanged the acronym *LGBTQ* for the term *sexual and gender minority (SGM)* to include all whose sexual orientation, gender identity, or reproductive development varies from traditional, societal, cultural, or physiological norms (Balik et al., 2020). For clarity, this paper will use the acronym SGM to refer to the population of interest.

The SGM population experiences several disparities, which can be detrimental to their well-being. These disparities include discrimination, societal exclusion, poverty, and lower educational achievement (Singh & Durso, 2017). These disparities can result in increased rates of mental illness, joblessness, homelessness, substance use disorders (SUD), victimization/violence, criminality, and participation in risky behaviors such as unprotected sex in this population (Reisner et al., 2016). The most alarming result of the SGM experience is the heightened rate of suicide, suicide attempts, and suicidal ideation (Christian et al., 2018).

Due to their experiences with discrimination and violence within the healthcare system, SGM patients avoid and delay seeking care, which can be attributed to a lack of awareness of healthcare professionals, fear of experiencing discrimination, and hostile encounters (Safer et al., 2016; Tollinche et al., 2018). A literature review by Balik et al. (2020) discovered that the reported rate of discrimination in healthcare of the SGM community varied from 2% to 41.8%. The predominant forms of discrimination were refusal to prescribe needed medications and the inability to access transgender-related surgery, counseling, psychotherapy, and gynecologic care (Balik et al., 2020).

According to Healthy People 2020, LGBT youth are two to three times more likely to attempt suicide (U.S. Department of Health and Human Services, 2021). Gay men are more likely to have the Human Immunodeficiency Virus (HIV) or sexually transmitted diseases (STDs) (U.S. Department of Health and Human Services, 2021). Transgender individuals are more likely to have HIV and STDs, experience victimization, have mental health issues, attempt suicide, and are less likely to have health insurance than heterosexuals (U.S. Department of Health and Human Services, 2021). Lesbians are less likely to have preventive cancer services (U.S. Department of Health and Human Services, 2021). These health disparities are driven by social exclusion and socioeconomic marginalization (Lagos, 2018).

Discrimination rates doubled among SGM patients of racial/ethnic minority, while male patients reported a higher incidence of discrimination and more negative experiences due to the increased risk of Human Immunodeficiency Virus (HIV) (Balik et al., 2020). The evidence presented in this Doctor of Nursing Practice (DNP) proposal demonstrates that the SGM community is at higher risk for suicide attempts, substance abuse, HIV, mental health issues, violence, and loss of employment than other populations (Balik et al., 2020). Therefore, this

community has a greater need for healthcare services but avoids them due to a lack of inclusiveness by healthcare workers and blatant discrimination. The increased risks faced by the SGM population coupled with the avoidance of healthcare leads to significant health disparities within the SGM community (Balik et al., 2020; Safer et al., 2016; Tollinche et al., 2018).

Hobster and McLuskey (2020) conducted a literature review and reported that transgender patients feel vulnerable, anxious, and have a sense of poor self-worth when accessing healthcare due to negative experiences with providers. They also found that transgender individuals had positive interactions when the healthcare providers were knowledgeable. Therefore, Hobster and McLuskey (2020) suggest that additional education of trans-specific needs and services be addressed to provide holistic care.

The proposed DNP project is to create and implement practice guidelines and educate the perioperative staff about the challenges faced by the SGM population when accessing healthcare. The guidelines are intended to improve the knowledge of the perioperative team regarding the care of and communication with SGM patients. Positive interactions between SGM patients and staff will create a safe environment and help patients feel accepted and comfortable at the project site (The Gay and Lesbian Medical Association, n.d.).

Background

Lesbian, gay, and bisexual (LGB) social recognition and movements began roughly 150 years ago due to state, church, and medical persecution (Morris, 2009). The persecution has led to homophobia, exposing individuals to physical violence and discrimination (Balik et al., 2020; Morris, 2009). In contrast, transgender activism was not emphasized until the early 21st century (Morris, 2009). “Transgender individuals are exposed to more discrimination than gay men and lesbians due to their gender identity without taking into account their choices about disclosing

their transgender identity" (Balik et al., 2020, p. 45). Due to the discrimination and stigma, the SGM population faces significant health burdens and inequality.

According to Safer et al. (2016), the main barrier to care, specific to the transgender population, is access, due to the lack of knowledgeable providers in this field. Additional barriers are issues with insurance coverage, unemployment, discrimination, lack of cultural competence of healthcare providers, inaccurate medical records, unavailable transportation, homelessness, and mental health issues (Safer et al., 2016). These barriers lead to poor health outcomes such as higher rates of the human immunodeficiency virus (HIV), sexually transmitted diseases (STDs), substance abuse, mood disorders, and suicide (Tollinche et al., 2018). The transgender population has a 40% suicide attempt rate and a 39% rate of severe psychological distress (Strousma et al., 2019).

In 2020, Hobster and McLuskey conducted a literature review of the complex needs specific to transgender patients. Six studies were reviewed and revealed that system navigation, vulnerability, and health professionals' knowledge and attitudes contributed to the lack of healthcare access (Hobster and McLuskey, 2020). The 2018 survey by Shires et al. noted similar barriers: negative experiences with a healthcare provider in the last year; being asked unnecessarily invasive questions; being refused care; and the need to teach the provider about trans-related care. Shires et al. (2018) also surveyed 163 internal and family medicine clinicians about their willingness to care for the transgender community. The providers responded that barriers include a lack of training, exposure, and knowledge of trans-related care.

According to a poll by Strousma et al. (2019), 33% of trans individuals reported avoiding or delaying healthcare resulting from their need to teach medical providers about transgender health. When providers lack knowledge of transgender-specific healthcare needs, they may ask

the patients for guidance on their care. This is a reported negative experience among trans individuals (Strousma et al., 2019). Therefore, the SGM community must have access to knowledgeable healthcare providers.

Problem Identification

There is no guideline for perioperative nurses regarding delivering culturally competent care to the SGM patient population at the project site. The project site serves all San Francisco (SF) people regardless of immigration or insurance status. It offers a Transgender Clinic and Gender Health SF program (San Francisco Department of Public Health [SFDPH], n.d.). The project site provides multiple services to the LGBTQ+ community, including primary care, prevention, behavioral health, hormone therapy, specialty, and inpatient care (SFDPH, n.d.).

The Centers for Medicare and Medicaid Services (CMS) issues the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which is the first national, standardized, publicly reported survey of patients' perspectives of hospital care (2021). The Joint Commission has launched a Speak Up Against Discrimination campaign, which encourages patients to report discrimination or substandard care to the Joint Commission (2021). According to the Program Director at Gender Health SF, there have been reported issues concerning ongoing bias around trans and non-binary people at the project site. Patients have reported feeling vulnerable and mistreated, and these complaints have escalated to management (J. Rapues, personal communication, August 1, 2021). Improving patient satisfaction while reducing discrimination and complaints at the project site is necessary. Therefore, implementing practice guidelines to improve the delivery of competent care would greatly benefit the perioperative staff in improving patient satisfaction with care delivery.

Project Question

The project question was formulated utilizing the Problem/Population, Intervention, Comparison, Outcome, and Timeline (PICOT) format. Among perioperative staff (P), will an evidence-based guideline regarding culturally competent care for the SGM community (I) compared with the current practice of no guideline (C) improve participant knowledge and the delivery of culturally competent care (O) within the time frame of the DNP project (T)?

Search Methods

The databases accessed for the literature search were Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Nursing and Allied Health Database, and the Touro University Jay Sexter Library. Government organizations such as the Centers for Disease Control and Prevention (CDC), National Institute for Health (NIH), World Health Organization (WHO), and the Agency for Healthcare Research and Quality (AHRQ) databases were searched for national guidelines, policies, and protocols regarding healthcare delivery for the SGM population. The search terms used for the literature search with Boolean operators were "LGBTQ" OR "transgender" AND "healthcare," which yielded over 39,000 results. The Boolean phrase AND "cultural competence" was added to refine the results. The results were then limited to published within the last five years, peer-reviewed literature, English language, free full text, and academic journals. To demonstrate an exhaustive search, keywords and phrases were added, such as: *healthcare in the LGBTQ population* and *disparities within the LGBTQ community.* Articles were excluded if specific to specialties other than urology/gynecology, anesthesia, primary care; or if duplicate publications; included irrelevant information; specific to age groups; or specific to HIV to further narrow the results for the project topic. Literature was not excluded if an article or website was highly significant but published more than five years ago.

The reference list of chosen articles was also used to obtain relevant material. UptoDate.com was used to find perioperative-specific care of the LGBTQ population. The Intranet of the project site was accessed to search for guidelines and protocols regarding the education of staff on LGBTQ healthcare. The grey literature was searched for online curricular content from websites of professional organizations such as the World Professional Association for Transgender Health (WPATH), the Endocrine Society, and the National LGBT Cancer Network. A total of five articles and websites resulted from this search.

National Organizations such as the Association of PeriOperative Registered Nurses (AORN), the Agency for Healthcare Research and Quality (AHRQ), the American Nurses Association (ANA), and the American Association of Nurse Anesthesiology (AANA) were also accessed for information regarding guidelines and protocols. A total of 91 results were reviewed, and one was relevant to the project topic. Further narrowing of content was performed by removing duplicate articles, a review of titles that were deemed irrelevant to the project. Finally, a review of the abstracts was conducted to determine the relevance of the articles to the project. The final number of the literature obtained for this review was 16.

Review of Study Methods

Upon reviewing the study methodologies in the discussed literature, quality improvement projects, literature reviews, qualitative studies, surveys, one quasi-experimental intervention study, and cross-sectional studies were included in this literature review. National guidelines were also included, supported by current evidence from professional associations and government research agencies.

Review Synthesis

The literature discusses common themes such as the fact that SGM patients lack access to healthcare and have significant health disparities. Cultural competence, an environment of trust, and positive experiences within the healthcare system can reduce these health disparities (Hobster & McLuskey, 2020). To obtain cultural competence and rectify modifiable disparities, standards of care and staff education are recommended to provide an inclusive environment (Shires et al., 2018*).* Utilizing guidelines and education proved to be successful in providing better care to the SGM community in many of the studies and articles reviewed (Christian et al., 2018; Hana et al., 2021; Kamen et al., 2019; Rosa et al., 2020; Safer et al., 2016; Sherman et al., 2021; Tollinche et al., 2018; Walia et al., 2019). Therefore, the project will involve adopting and implementing guidelines and education to deliver culturally competent care for the SGM patient population to comply with national standards of care set by The Joint Commission (TJC) and the CDC.

Theme Development

Four themes emerged from a literature search based on the keywords, key phrases, and the project question. The first is the SGM population's barriers to healthcare. The second theme is the societal impact of health disparities on the SGM population. The third theme is the call to educate healthcare staff on the culturally competent care of the SGM population. The fourth is the standards of care and the utilization of guidelines related to delivering culturally competent care. The literature review will explore these themes related to the project question.

Impact of the Problem

Barriers to Healthcare

The SGM population faces numerous barriers to healthcare, which leads to avoidance and poor health outcomes. Hana et al. (2021) and Hobster and McLuskey (2020) provide articles detailing the complex web of barriers that result in the challenges of obtaining healthcare. Oppression, marginalization, discrimination, and violence often precede unemployment, poverty, homelessness, and a lack of social support and education (Hana et al., 2021; Hobster & McLuskey, 2020). These circumstances make accessing care difficult. The lack of education in the medical environment regarding the specific healthcare needs of the SGM population often manifests in discrimination, microaggressions, and overall negative experiences (Walia et al., 2019). These negative and frequently painful experiences contribute to the SGM population's avoidance of healthcare, thus increasing health disparities (Sherman et al., 2021). Surveys from healthcare providers and SGM patients have shown the need for the education of hospital staff (Kamen et al., 2019; Walia et al., 2019).

If care is accessible, the historical trauma and fear of discrimination and harassment contribute to the avoidance of healthcare. The historical trauma the SGM population faces is from "dehumanizing and marginalizing experiences when interacting with health care systems and professionals who often lack the training and infrastructure needed to equitably and inclusively respond to these populations" (Rosa et al., 2020, para. 1). Hana et al. (2021) and Hobster & McLuskey (2020) also agree that fear of discrimination and harassment causes many SGM individuals to avoid seeking care at all. The lack of healthcare, in many cases, leads to disparities within this population.

Societal Impact

The societal impacts of poor health outcomes resulting from healthcare barriers are isolation, invisibility, social marginalization, lower societal and socioeconomic status, and lower

educational achievements (Henriquez & Ahmad, 2021; Lagos, 2018). The SGM population report feelings of isolation and invisibility due to a lack of inclusive data forms and staff not asking sexual orientation and gender identity (SO/GI) questions (Henriquez & Ahmad, 2021). The SO/GI questions help the SGM population by improving data collection and identifying SGM health disparities (U.S. Department of Health and Human Services, 2021). The lack of inclusive public restrooms and discrimination experienced in educational and medical institutions contributes to social marginalization, psychosomatic stress, and lower academic achievements. (Lagos, 2018). The social exclusion and marginalization lead to the numerous health disparities faced by the SGM population (Lagos, 2018).

Henriquez and Ahmad (2021) conducted a study based on the interviews of 12 participants to understand the unique health needs and experiences of the SGM community in rural Manitoba, Canada. The participants provided their negative experiences along with recommendations for improvement. To improve this marginalized community's social well-being and mental health, the participants suggested building safe spaces within the community that are queer-friendly (Henriquez & Ahmad, 2021). These supportive and inclusive spaces allow everyone to be "themselves," which promotes positive experiences and success in reducing health disparities (Henriquez & Ahmad, 2021).

Addressing the Problem with Current Evidence

Education

Another theme that emerged from the literature review is the call to educate healthcare staff. As mentioned previously, the main barrier to care for the SGM population is the lack of healthcare provider education (Walia et al., 2019). The interviews with the Henriquez and Ahmad study participants confirmed that they experienced refusal of care due to a "lack of

knowledge" reported by the medical provider (2021). "Education and cultural competency within the healthcare system can facilitate a more positive experience and better healthcare outcomes for the LGBTQ community" (Walia et al., 2019, Introduction section).

In 2019, a survey was conducted among anesthesia providers before and after a two-part educational session (Walia et al., 2019). The survey questions consisted of a self-reported questionnaire about the comfort level of caring for transgender patients and an objective knowledge questionnaire. The findings showed that the comfort level of anesthesia providers was high before the education session; therefore, the results after the educational session were not statistically significant. However, the objective knowledge assessment suggested some improvement after the education session; neither the subjective nor objective assessments were statistically significant (Walia et al., 2019). Despite the lack of significance and limitations, the authors concluded that ensuring a proper knowledge base provides the best care for the SGM patient population (Walia et al., 2019).

A qualitative study investigating recommendations from 273 LGBTQ patients to improve cancer care was conducted by Kamen et al. in 2019. The survey was online and open-ended in which response codes revealed the community's difficulty accessing competent cancer treatment. After careful analysis, the authors recommend "training providers about diverse LGBTQ communities and acknowledging the strengths of LGBTQ patients diagnosed with cancer to improve provider/patient relationships" (Kamen et al., 2019, para 1).

To educate nursing students, the Johns Hopkins School of Nursing (JHSON) LGBTQI Health Initiative (LHI) "was established to develop a strategic, innovative response to the gaps in LGBTQI health education among faculty and nursing students" (Sherman et al., 2021, para. 2). The authors point to the literature that suggests nursing faculty do not feel educated to teach

SGM-specific issues to students. Many nurses report feeling uncomfortable and underprepared to provide care to SGM patients (Sherman et al., 2021). This is likely because nursing programs (nationwide) provide on average 2.12 hours of SGM health-specific education (Sherman et al., 2021). A professional code of ethics obligates nurses to provide optimal care and advocate for all patients and populations (Sherman et al., 2021).

The perioperative setting is an increasingly accessed and unique environment for the transgender patient population (Tollinche et al., 2018). A review by Tollinche et al. (2018) stressed the need to educate the perioperative staff on the guidelines for preoperative, intraoperative, and postoperative management of transgender patients. The review guides terminology, health and wellness, hormone therapy considerations, laboratory testing, drug interactions, anatomical considerations, room assignments, and psychosocial issues. Staff equipped with perioperative-specific knowledge of the transgender patient population is imperative to improving the health and well-being of the community (Tollinche et al., 2018).

National Guidelines, Protocols, and Standards of Care

Healthcare institutions are required to provide safe, high-quality patient care. To accomplish this, standards of care and guidelines should be implemented. Standards of care aid in measuring, assessing, and improving performance (The Joint Commission [TJC], 2021b). Guidelines are recommended courses of interventions that healthcare providers should consider when treating patients (National Institutes of Health [NIH], 2021). The CDC and TJC have released guidelines to instruct healthcare staff to create a welcoming environment and improve the treatment of the SGM population (Centers for Disease Control and Prevention [CDC], 2014; TJC, 2011). The National LGBT Health Education Center provides a guide for staff that presents

information for gaining a better understanding of SGM people, strategies for healthcare staff, and helpful resources (see Appendix C).

The CDC endorses the pamphlet published by the Gay and Lesbian Medical Association (GLMA) as guidelines for the care of SGM patients (CDC, 2014). The pamphlet guides healthcare staff on how to improve the treatment and experience of these patients:

- maintain open dialogue
- display LGBTQ friendly flags, posters, and brochures
- provide inclusive intake forms
- be knowledgeable of interview tips and prepare in advance
- maintain confidentiality
- conduct depression, mental health, and violence screening
- ask about preferred words/pronouns/names and use them
- provide periodic staff sensitivity training
- provide gender-inclusive restrooms (CDC, 2014).

The Field Guide published by TJC focuses on advancing effective communication, cultural competence, and patient- and family-centered care for the SGM community (TJC, 2011). Effective communication improves patient satisfaction, increases adherence to treatment regimens, and improves health outcomes. In 2011, standards of care for the SGM population were published and focused on patient-centered communication and elements of performance that "prohibit discrimination based on sexual orientation, gender identity, and gender expression, and that ensure access to a support person of the patient's choice" (TJC, 2011, p. 2). The Field Guide is a collection of strategies, practice examples, resources, and testimonials to create a safe and inclusive environment for the SGM population (TJC, 2011).

Specific to the care of transgender patients, in 2012, the WPATH issued the 7th version of the standards of care for transsexual, transgender, and gender-nonconforming people (Coleman et al., 2012). The document was created by an international, multidisciplinary, professional association that aims to promote "evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health" (Coleman et al., 2012, p. 1). The document addresses language standards, epidemiologic considerations, therapeutic approaches for gender dysphoria, pediatric gender dysphoria, mental health, hormone therapy, reproductive health, voice and communication therapy, surgery, postoperative care, and lifelong primary care (Coleman et al., 2012).

After searching for policies, protocols, toolkits, and guidelines of hospitals in the U.S., four were found relevant. Stanford issued a culturally inclusive care document of the SGM population's key components that briefly discuss respect, transparency, precision, and openness (Stanford University, 2020). The University of Louisville published a 56-page eQuality Toolkit to help providers obtain inclusive clinical skills for SGM competent care (Weingartner et al., 2019). The University of Washington adopted the Fenway Institute's policy on gathering SO/GI data (Bradford et al., n.d.). The gathering of SO/GI data is essential to advance our understanding of SGM health and improve the population's health (Bradford et al., n.d.). Finally, a transgender care and treatment guideline was produced by the University of California San Francisco (UCSF) (Deutsch, 2016).

Project Aim

The overarching aim of the proposed DNP project is to improve access to healthcare and reduce disparities within the healthcare system by providing culturally competent care to SGM patients in the perioperative area utilizing an evidence-based guideline.

Project Objectives

The objectives will be achieved within the timeframe of this DNP project:

1. Introduce a guideline to increase the knowledge and culturally competent care of the SGM population among participants.
2. Provide training regarding the guideline and the disparities and discrimination of the SGM population at the project site.
3. Using a pre- and post-test, measure the improvement in knowledge of the participants about the guideline and the healthcare barriers faced by the SGM population.
4. Measure guideline usage through Epic/IT chart audit and observational analysis.

Theoretical Framework

The Donabedian model promotes improvements in healthcare quality by providing a conceptual framework for evaluation and implementation (Franklin, 2019). The framework consists of three tenets: structure, process, and outcome. *Structure* describes the setting in which care is delivered. The act of providers delivering healthcare to patients describes the *process*. The *outcome* informs how the patients and populations are affected by healthcare (Franklin, 2019). *Structure*, *process*, and *outcome* are interconnected and dependent upon one another for successful quality improvement (see Appendix A). Donabedian purposefully designed this model to be widely applicable to various healthcare scenarios (Best & Neuhauser, 2004; Franklin, 2019).

Donabedian's model is directly related to his professional career as a Public Health Professor. His attention to healthcare quality led to the creation of the transformative Donabedian model. This theoretical framework was relevant to healthcare when it was developed. However, since the focus on healthcare quality has shifted from fee-for-service to value-based care, it has

become more relevant to the nursing profession (Franklin, 2019). Value-based care focuses on optimizing health outcomes for all patients, which are measured by the quality of care (Leung, 2018). Nurses are an integral part of the quality-of-care algorithm.

Historical Development of the Theory

Avedis Donabedian was born in Beirut, Lebanon, in 1919, into a family that prioritized education in medicine (Best, 2004). His grandmother was a village midwife and folk healer, and his father was a village doctor (Franklin, 2019). As a result of the Armenian Holocaust, the Donabedian family fled to a Christian town in Palestine, where Avedis received an excellent education (Best, 2004). He returned to Beirut to attend medical school and finished in 1944. Avedis worked as a General Practitioner in Jerusalem and Beirut for a decade (Best & Neuhauser, 2004; Franklin, 2019). He then went on to study Public Health at Harvard and became a professor that made many contributions to healthcare (Best, 2004).

Avedis Donabedian taught epidemiology and social medicine at the New York Medical College and was recruited to the Michigan School of Public Health to teach Healthcare Administration (Franklin, 2019). He authored over 100 articles and published 11 books, many of which were on health services research. He died in the year 2000 after achieving the prominent roles of professor emeritus and the Nathan Sinai Distinguished Professor of Public Health (Franklin, 2019). Donabedian's contributions to healthcare offer a way to examine and improve the quality of healthcare services (Franklin, 2019).

Donabedian's traumatic past and professional family history likely shaped his passion for the realm of public healthcare. He began by changing the historical thought process on health systems from a collection of random events to a framework that follows loose principles (Frenk, 2000). In 1966, he published a paper introducing what is now known as the Donabedian model to

assess the quality of healthcare. This transformative contribution to the field has been widely adopted to improve the quality of healthcare (Frenk, 2000).

Application to DNP Project

The problem at the project site is the absence of a guideline to aid the staff in providing culturally competent care to the SGM community. The SGM community faces discrimination in the healthcare environment and requires staff to possess culturally competent knowledge. Donabedian's model provides a conceptual framework for evaluating the quality of care and guiding improvements (Franklin, 2019). It is a flexible framework that applies to various situations, including the problem at the project site. The model for quality care comprises of three tenets: structure, process, and outcome. Using the tenets at the project site provides a way to evaluate and improve the services and the quality of care delivered to the SGM community.

Structure

The *structure* component of the Donabedian framework describes the physical and organizational characteristics where healthcare occurs (Franklin, 2019). This includes funding, healthcare facilities, equipment, and personnel (Franklin, 2019). As it relates to this DNP project, the *structure* refers to the perioperative area, perioperative nurses, and electronic medical records (EMR). How welcoming the perioperative environment is to the SGM community impacts the project by setting the tone for engagement. This may be in the form of appropriate questions on intake forms, all-gender restrooms, welcoming staff, and SGM brochures or pamphlets. The perioperative nurses' educational exposure, personal biases, and staffing ratios impact how they care for the SGM patient population. Finally, the questions prompted by the EMR dictate the nurses' discussions with the patients.

Process

The *process* component of the Donabedian model explains the actions that allow for the satisfactory delivery of healthcare (Franklin, 2019). The *process* depends on the *structure* component and affects the *outcome* (Franklin, 2019). Standards of care, patient education, treatment, and preventive maintenance are some examples of Donabedian's *process* (ACT Academy, n.d.; Franklin, 2019). A national standard prohibiting discrimination is explained in Section 1557 of the Patient Protection and Affordable Care Act: "Section 1557 prohibits discrimination on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), in covered health programs or activities" (Office for Civil Rights, 2021, para. 1). Therefore, a guideline addressing culturally competent care, standards of care, and patient treatment in the perioperative area applies to the implementation of this DNP project.

Outcome

The *outcome* component of the Donabedian model describes the effect of healthcare on the patients' and population's health (Franklin, 2019). The *outcome*, dependent upon *structure* and *process,* is the result of the improvement efforts (ACT Academy, n.d.). "Examples of outcome measures are reduced mortality, reduced length of stay, reduced hospital-acquired infections, adverse incidents or harm, reduced emergency admissions and improved patient experience" (ACT Academy, n.d., Outcome measures section). This relates to the DNP project because outcomes will be measured to determine the project's effectiveness.

Setting

The project setting is a city and county-owned, 281-bed hospital located in a diverse, upper-middle class, family-oriented neighborhood in northern California. The project site

provides comprehensive emergency services, trauma care, skilled nursing, HIV/AIDS care, mental health, substance abuse, psychiatric mental health, forensics, medical education, and medical research (Zuckerberg San Francisco General Hospital and Trauma Center [ZSFG], 2018). It serves a diverse population in more than 20 languages. The hospital utilizes the Epic software system for documentation within the electronic health record (EHR). The project site is the Pre-Operative Unit within this project setting, which includes 14 operating rooms and four off-site procedure rooms. Appendix B includes the affiliation agreement to conduct the project at the project site.

Population of Interest

The direct population of interest will include the 15 registered nurses (RN)s employed Pre-Operative Unit at the project site. Inclusion criteria include employment as an RN within the specific unit. Exclusion criteria include RNs hired in any other unit, temporary staff, those on personal leave, residents, clerical staff, and patient care technicians (PCTs). The indirect population of interest is the perioperative patient population, with a focus on the SGM community, who will benefit from this practice change.

Stakeholders

The identified stakeholders for this project include the Pre-Operative Unit RNs, the Nurse Manager, the Nursing Director of Surgical and Procedural Services, the Clinical Nurse Educator, the Clinical Informatics Nurse, and the Nurse Practitioner (NP) for the Gender Health SF Clinic. The Pre-Operative Unit RNs are the population of interest and will be educated in the current issues regarding SGM disparities and lack of access within the healthcare system and the SGM protocol. They will implement the guideline and provide the culturally competent patient care. The Nurse Manager of the Pre-Operative Unit will facilitate approval and delivery of the

education and guideline. The Nursing Director will provide guidance and approval of the entire project. The Clinical Nurse Educator (CNE) will provide guidance and assist the project lead with education. The CNE will be available for questions from the staff daily when the project lead is not on site. The CNE will be the liaison by informing the project lead of any questions or concerns when the project lead is not present at the project site and inform the project lead of any problems. The Clinical Informatics Nurse will aid in collecting compliance data from the EHR. Finally, the NP for the Gender Health SF Clinic will serve as a content expert.

Intervention

The DNP project will be implemented on June 22, 2022. The implementation phase will consist of educating the participants, employment of the new guidelines into practice, and data collection over a five-week period. Following the implementation period, data will be compiled and analyzed, results will be evaluated and disseminated. The timeline for the DNP project is below.

	Date	**Activity**	**Responsible Party**	**Participants**
Week 1	6/22/2022	-Data collection measures prior to the education of the participants such as a pre-test will be completed. -An education session for the direct population of interest and a post-test at a staff meeting. -Guideline implementation -All staff not in attendance at the staff meeting will be targeted individually throughout the week.	Project Lead	Pre-Operative Unit RNs
Week 2	6/29/2022	- The implementation phase will continue. -The chart audit to measure the use of the SO/GI checklist and observational analysis will begin in	Project Lead, Nurse Educator, and IT	Pre-Operative Unit RNs

		week two to measure the previous week. -The project lead will provide support, address concerns, and answer questions.		
Week 3	7/6/2022	-The implementation phase will continue with support from the project lead. The chart audit to measure the use of the SO/GI checklist and observational analysis will begin in week three to measure the previous week.	Project Lead, Nurse Educator, and IT	Pre-Operative Unit RNs
Week 4	7/13/2022	-The implementation phase will continue with support from the project lead. The chart audit to measure the use of the SO/GI checklist and observational analysis will continue in week four to measure the previous week.	Project Lead. Nurse Educator, and IT	Pre-Operative Unit RNs
Week 5	7/20/2022	- The project lead will compile, organize, and analyze the data collected.	Project Lead, Nursing Informatics, and IT	

Tools

Tools that will be utilized in this DNP project are a guideline, a pre- and post-knowledge test, a PowerPoint, a Content Validity Index tool, a checklist from the EHR, and a handoff communication form.

Guideline

The Fenway Institute issued a 22-page guideline: Providing Inclusive Services and Care (PISC) for LGBT People: A Guide for Health Care Staff (see Appendix C). The guideline was adopted by the National LGBT Health Education Center and approved for use (see Appendix D) by the Fenway Institute for the purpose of this project. The PISC for LGBT People guideline consists of three sections: gaining a better understanding of LGBT people; strategies for healthcare staff; and helpful resources. Within these sections, there are tips and strategies to

improve communication and create a more affirming and inclusive environment. This guideline will be introduced within a PowerPoint presentation at the monthly staff meeting. The educational content will also be made available to staff on information boards and by email.

Pre- and Post-Knowledge Assessment

A pre- and post-knowledge assessment created by the project lead (see Appendix E) will be completed by the participants before and after the PowerPoint presentation. The knowledge assessment consists of 10 multiple choice questions to evaluate the learners' knowledge regarding terminology, characteristics of the SGM population, providing inclusive environments, and offer guidance on handling mistakes. The answers will be provided after the post-test is completed by all participants.

Content Validity Index

The pre- and post- knowledge assessment gained expert approval through a content validity index process (CVI). Three doctoral-prepared nurses on the project team evaluated and rated the knowledge assessment to ensure validity. The multiple-choice test questions were deemed representative of the content of the educational PowerPoint and SGM guideline. The content validity ratio (CVR) was 1 for all questions except number seven, which had a CVR of 0.33 (see Appendix H). All ten questions remained on the test. The mean total of all the means was 3.89 indicating that all the questions were moderately/highly relevant.

PowerPoint Presentation

The educational material to be used for introduction of the guideline and participant training is a PowerPoint presentation (see Appendix F). The project lead developed this tool, and it was approved by the content experts at the project site. The purpose of this education is to improve the Pre-Operative Unit nurses' knowledge of interacting with the SGM patient

population in the perioperative arena. The course will provide education on terminology, health disparities, and how to create a welcoming environment for all patients with a focus on the SGM population.

SO/GI Checklist

The project site offers a SO/GI checklist (see Appendix G) for RNs to complete during the care of all patients. The checklist aligns with the guideline and should be completed for each patient upon entry to the preoperative unit. The checklist includes the following items: sexual orientation, legal name, legal sex, gender identity, sex assigned at birth, patient pronouns, and affirmation steps taken if any.

This field was part of the foundation build within the EHR, and there is no contact information to request permission to use it in this project. This data source will be targeted for completion after the guideline introduction. The checklist will be considered complete or incomplete to identify compliance with the guideline.

Handoff Communication Form

The preoperative nurses at the project site may elect to use a handoff form to provide communication to the OR nurses and anesthesia team. Three items will be added to the current form (see Appendix I): patient pronouns, gender identity, and patient's preferred name if different from their legal name. The RNs will be made aware of the changes at the education session. The new handoff communication form will replace the old one and ensure compliance with the guideline. The project lead will observe nurse-to-nurse communication to identify compliance.

Data Collection Procedures

Three data sources will be collected and analyzed for this project: pre- and post-knowledge assessment, the SO/GI Checklist completion, and observed compliance with the guideline. The guideline will be introduced in the PowerPoint presentation. The knowledge assessments will be randomly distributed by the project lead before and after the PowerPoint presentation and lack participant identification. Each nurse will be assigned a letter for the project duration for identification. The pre- and post-test answers will be compared. The platform for distribution is paper and pencil at the education session. Answers to the knowledge assessment will be provided after the post-test is complete. Results from the knowledge assessment will be analyzed for an improvement of knowledge in the care of SGM patients.

The SO/GI checklist is present for each patient and allows documentation on the following items: sexual orientation, legal name, legal sex, gender identity, sex assigned at birth, pronouns, and affirmation steps taken. The checklist will be audited at the end of each week for each nurse working during the implementation phase to assess for compliance post-education. Using the letters assigned, each nurse will be considered compliant if 100% of SO/GI checklists are complete on patients they were assigned. Noncompliance is considered if less than 100% of SO/GI checklists are complete on patients assigned. The data is collected by a member of the IT team and provided to the project lead in the following format: Nurse A completed 79% of SO/GI checklists during week one of the implementation phase.

The project lead will conduct an observational analysis of nurses' handoff for the inclusion of patient pronouns, preferred name, and/or gender identity. The nurses will be randomly observed and identified by the letter assigned. The project lead will conduct the observation each Wednesday during the implementation phase of the project for six hours or until ten different nurses are observed during handoffs. Compliance will be considered if patient

pronouns, preferred name, and/or gender identity are correctly used or discussed during handoff.

The project lead will report aggregate data only, and each nurse will be given a letter for identification purposes. The data will be kept on a password-protected computer, and the paper exams will be kept in a locked file cabinet. The data collected will be kept until the conclusion of the project then the data will be destroyed. Institutional names will not be published in presentations or publications.

The recruitment methods are considered a convenience sample as this is a mandatory practice change for all preoperative nurses. Participation is not a condition of employment, and participants will not receive special treatment. Breakfast will accompany the education session. The participants will be paid their hourly rate and not be required to participate outside of their normal working hours. There are direct benefits to the participants through the improvement of practice and increased knowledge about the SGM community. Patients may experience the benefit of culturally competent care. The benefit of this project may be in the form of improved patient satisfaction scores and the participants' ability to be more confident in caring for the SGM patient. There are no risks associated with this DNP project.

The independent variable for this project is the guideline. This guideline will provide basic information on the background and disparities of the SGM community and how to provide culturally competent care. The increased consistency in the charting of SO/GI data is reflective of the culturally appropriate care of the SGM population. Therefore, this is a dependent variable. The other dependent variable is the culturally competent handoff.

Ethics and Human Subjects Protection

The protection of the privacy and confidentiality of the human subjects in this DNP project is a priority. Through the successful completion of the Collaborative Institutional Training Initiative (CITI) program, the project lead is skilled in conducting ethical project implementation regarding human rights. Touro University and the project site do not require IRB approval for quality improvement (QI) projects. Touro University requires the completion of a project determination form which determined this is a QI project, therefore there is no IRB requirement.

All participants will be de-identified and remain anonymous and incur no risk. Each RN will be assigned a letter for data collection purposes. The observational data collected for this project will not contain any identifiable information and will occur randomly. No patient names or information will be extracted from the EHR. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) policies will be followed to ensure no patient information is exploited. The information will be transferred to a spreadsheet and analyzed with the help of a statistician.

Plan for Analysis

The project lead will enter results from the pre- and post-knowledge assessment into an excel database after all the data is collected and compiled. SPSS version 26 will be used to compare data on RN knowledge regarding culturally competent care of the SGM community before and after the presentation. The knowledge assessments will be administered prior to the presentation and the post-test will be completed after the presentation. Paired t-tests will be used for statistical analysis of the improvement in knowledge for the pre- and post-assessment. The paired t-test was chosen for this portion of the project analysis because it will provide the difference between two variables for the same subject separated by time (Palant, 2016).

Compliance with the nurses' use of the SO/GI checklist will be measured through a chart audit. The project lead will evaluate the patients' charts to determine if the preoperative nurse has completed the SO/GI checklist. The post-intervention use of the checklist will be reported as a percentage. If a nurse completes 75% of the checklists on patients assigned to them, they will be considered compliant. This will be reported in a two-by-two table with the percentage of compliance. A 95% confidence interval will be used for analysis.

The final intervention to be measured is the observation of the participants' competence and ability to apply the information received from the PowerPoint presentation and guideline using correct pronouns, gender identity, and preferred name during handoff. A two-by-two table will be used with Fisher's exact test to look for differences in use/nonuse of correct pronouns as a percent match with 95% confidence interval. This test allows the project lead to ascertain whether use of correct pronouns versus nonuse is greater than chance, which in this case would be 50%. If greater than 50%, the test would reveal that the intervention was successful (Pallant, 2016).

Results

Regarding the first project objective between pretest and posttest knowledge, findings revealed that there was a statistically significant difference between pretest and posttest knowledge of the 15 participants sampled. Table 1 displays descriptive statistics of the raw correct response for the sample of participants and Table 2 contains the paired-samples *t*-test results. From descriptive statistics in Table 1 participants' knowledge, the raw score increased by 1.47 points (95% confidence interval of this mean difference: 0.75, 2.19 [standard error of the mean difference = 0.34]) between pretest and post-test knowledge assessment. As is evidenced in

Table 2, this increase in knowledge raw score between the pre-test and post-test was moderate (Cohen's d = -0.68) and statistically significant (p = 0.001).

Regarding SO/GI checklist compliance, Tables 3-6 show the two-by-two tables with percent compliant and their associated raw frequencies. Evidently, there were consistent discrepancies in the percentage of participants who complied (i.e., those who completed 75% of checklists on patients assigned to them) with the SO/GI checklist across the four-week time span from what was observed and what was statistically expected. Across the four weeks, mean percentage compliance with the SO/GI checklist was 62.75% (95% confidence interval = 55.42, 70.08), suggesting that most of the participants were compliant.

With respect to the final project objective, across the four weeks of observations, participants' application of the correct pronouns was observed 50% of the time during weeks one, two, and four, and 70% of the time in week three. Thus, only in week three did participants employ the correct pronouns by more than 50%, which represents the percentage of use of correct pronouns if by chance alone. Cumulatively, however, correct use of pronouns across the four weeks was observed 55.0% of the time (95% confidence interval = 44.36, 75.28). Nevertheless, Fisher's Exact χ^2 Test revealed a non-significant difference in correct/incorrect pronoun use, Fisher's Exact χ^2 (N = 40 observations) = 1.82, p = .71. The statistically non-significant result is attributable to the higher-than-expected standard error, leading to the lower-bound confidence interval value dipping below 50%. Table 7 displays the results of pronoun use by participants averaged across four weeks of observation. There were no modifications to the timeline from the original plan (see Appendix J).

Summary

This DNP project was successful in improving the knowledge of the preoperative nursing staff regarding the disparities and culturally competent care of the SGM patient population as evidenced by a pre- and post-education knowledge assessment quiz. The knowledge raw score increased by 1.47 points and was statistically significant. The staff were compliant with the SO/GI checklist at a rate of 62.75%. Correct use of pronouns with respect to the handoff tool across the four weeks was observed 55% of the time and was not statistically significant. The improved knowledge and culturally competent care resulting from this DNP project were overall positive and have piqued the interest of other departments within the hospital.

The strengths of this DNP project include cost-effectiveness, reliability, ease of use, and versatility. The weaknesses of the project include a) data collection methods, b) a limited time frame for implementation and data collection, c) a small number of participants, and d) implicit bias.

Interpretation

The results of the QI project aligned with the current literature. The education of staff and the implementation of practice guidelines improved the knowledge of perioperative nursing staff at one point in time as measured by the pre- and post-knowledge assessment. Most of the participants were compliant with the guideline which suggests the delivery of culturally competent care of the SGM population (Christian et al., 2018; Hana et al., 2021; Kamen et al., 2019; Rosa et al., 2020; Safer et al., 2016; Sherman et al., 2021; Tollinche et al., 2018; Walia et al., 2019).

The impact of the project on the preoperative staff was positive, given the increased knowledge and compliance with the guideline. Patient care and satisfaction would be expected to improve based on the literature that supports educated staff provide culturally competent care

(Kamen et al., 2019, Walia et al., 2019). Another expected improvement would be positive interactions between staff and patients leading to an environment of care where patients feel safe and accepted (The Gay and Lesbian Medical Association, n.d.).

Anticipated outcomes of the intervention were improved knowledge and culturally competent care of the SGM community as evidenced by adherence to the guideline, improved post-test scores, and SO/GI checklist compliance. Observed outcomes included improved post-test scores, compliance with the SO/GI checklist, and a non-significant improvement in correct pronoun use.

The cost of the project included food for the staff meeting ($90), pronoun stickers for staff badges ($40), office supplies ($10), and a statistician to analyze data ($600). The strategic trade-offs were to exclude PACU nurses due to incongruencies with data collection measures.

Limitations

While efforts were made to minimize and adjust for limitations, the limitations that occurred during the implementation of this DNP QI project include a) data collection methods, b) a limited time frame for implementation and data collection, c) a small number of participants, and d) implicit bias.

Data Collection Methods

The pre- and post-knowledge assessments were conducted during a staff meeting in which 11 staff members were in attendance. The other four staff members were targeted during their work hours outside of the staff meeting and may have been subject to interruptions, thus lowering their scores. The staff present at the staff meeting had the ability to discuss questions and answers with one another, to improve their scores. Due to the inability of the project lead to attend another meeting due to time constraints, this was the only option, which is another limitation.

Project Design

The small number of participants (15) and limited time frame for implementation and data collection (four weeks) contributed to the project design limitations. The participants included all preoperative RNs at the project site.

Implicit bias is a "form of bias that occurs automatically and unintentionally, that nevertheless affects judgments, decisions, and behaviors" (National Institutes of Health, 2022, para. 2). The staff and project team's implicit biases potentially affect test questions, results, learning outcomes, and guideline implementation.

Conclusion

This DNP QI project focused on improving the care of the SGM community in the preoperative setting by implementing a practice guideline and education session. The staff were educated about the disparities of the population when accessing healthcare. They were also given a guideline to aid in providing culturally congruent care. The preoperative nurses were asked to chart SO/GI data on each patient, discuss pronouns and preferred names during handoff, and participated in a lecture with a pre- and post-test. Data were collected to assess compliance with the guideline as well as pre- and post-test scores. The results indicated that the education session moderately improved participants' knowledge regarding culturally competent care in the SGM community. Most of the participants were compliant with charting SO/GI data (62.75%), and there was a nonsignificant difference in correct pronoun use (55%).

The SGM community faces several challenges in getting access and quality care within the healthcare system (Safer et al., 2016; Tollinche et al., 2018). The project site has recorded complaints of SGM patients experiencing bias, vulnerability, and being mistreated (J. Rapues, personal communication, August 1, 2021). Therefore, educating, encouraging, and providing

tools for staff to provide culturally competent care for the SGM community is imperative to reduce health disparities (Hobster & McLuskey, 2020; Shires et al., 2018).

To sustain the intervention at the project site, the guideline will be posted on the information board for the preoperative nurses where communication is received. The project lead will continue to answer any questions or concerns that arise related to the care of the SGM population. The project lead will also be responsible for hospital-required education of perioperative staff during facility annual updates. New information or updates to the guidelines will be communicated in staff meetings, emails, and on the information board. Although management has not yet made this a protocol, other departments have reached out to include this guideline and training in annual meetings and journal clubs.

As previously discussed, the lack of knowledge of healthcare staff contributes to negative experiences faced by the SGM community. These experiences result in the avoidance and delay of care, which contributes to the overall poor health of the population. This educational project with the implementation of a practice guideline is significant for the nursing profession to improve the quality of care of the SGM population. Implementing the first guideline of this nature at the project site will draw attention to the importance of this community (Hobster & McLuskey, 2020; Shires et al., 2018).

The project site continues to request educational presentations and guidelines to be distributed among various departments. The suggested next steps are to increase the number of participants to further improve the care of the SGM community. Including all perioperative staff (preoperative, postoperative, and intraoperative personnel) in education and guideline participation would improve the quality of care for the SGM population. In the instance that the

outcomes are not statistically significant, the care of the SGM community would not suffer from further education and guidelines on how to provide culturally competent care.

References

ACT Academy. (n.d.). Online library of quality service improvements and redesign tools: A model for measuring quality care. https://www.med.unc.edu/ihqi/wp-content/uploads/sites/463/2021/01/A-Model-for-Measuring-Quality-Care-NHS-Improvement-brief.pdf

American Nurses Association. (2018). *Nursing advocacy for LGBTQ+ populations: ANA position statement.* https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-advocacy-for-lgbtq-populations/

Balik, C. H. A., Bilgin, H., Uluman, O. T., Sukut, O., Yilmaz, S., & Buzlu, S. (2020). A systematic review of the discrimination against sexual and gender minority in healthcare settings. *International Journal of Health Services, 50*(1), 44-61. https://doi.org/10.1177/0020731419885093

Best, M., & Neuhauser, D. (2004). Avedis Donabedian: Father of quality assurance and poet. *Quality & Safety in Health Care*, *13*(6), 472–473. https://doi.org/10.1136/qhc.13.6.472

Bradford, J. B., Cahill, S., Grasso, C., & Makadon, H. J. (n.d.). *Policy focus: How to gather data on sexual orientation and gender identity in clinical settings.* The Fenway Institute. https://www.lgbtqiahealtheducation.org/wp-content/uploads/policy_brief_how_to_gather.pdf

Casey, L. S., Reisner, S. L., Findling, M. G., Blendon, R. J., Benson, J. M., Sayde, J. M., Miller, C. (2019). Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans. *Health Services Research, 54,* 1454-1466. https://doi.org/10.1111/1475-6773.13229

Centers for Disease Control and Prevention. (2014). *Guidelines for care of lesbian, gay, bisexual, and transgender patients.* https://npin.cdc.gov/publication/guidelines-care-lesbian-gay-bisexual-and-transgender-patients

Centers for Medicare and Medicaid Services. (2021). *HCAHPS: Patients' perspective of care survey.* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

Christian, R., Amy, A. M., Bui, A. G., Lee, R., Kattari, L., & Gray, C. (2018). Measuring the health of an invisible population: Lessons from the Colorado transgender health survey. *Journal of General Internal Medicine, 33*(10), 1654-1660. http://dx.doi.org/10.1007/s11606-018-4450-6

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165–232. https://doi.org/10.1080/15532739.2011.700873

Deutsch, M. (2016). *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people.* UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. https://transcare.ucsf.edu/guidelines

Donabedian A. (2005). Evaluating the quality of medical care. 1966. *The Milbank Quarterly*, *83*(4), 691–729. https://doi.org/10.1111/j.1468-0009.2005.00397.x

Franklin, B. (2019). Avedis Donabedian and the birth of healthcare quality assurance. *Healthcare Market Review.* https://healthcaremarketreview.com/avedis-donabedian-and-the-birth-of-healthcare-quality-assurance/

Frenk, J. (2000). Obituary of Avedis Donabedian. Bulletin of the World Health Organization, *70*(12). https://www.who.int/bulletin/archives/78(12)1475.pdf

Hana, T., Butler, K., Young, L. T., Zamora, G., & Sing Hong Lam, J. (2021). Transgender health in medical education. *Bulletin of the World Health Organization*, *99*(4), 296–303. https://doi.org/10.2471/BLT.19.249086

Henriquez, N. R. & Ahmad, N. (2021). "The Message Is You Don't Exist": Exploring lived experiences of rural lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) people utilizing health care services. *SAGE Open Nursing, 7,* 1-10. https://doi.org/10.1177/23779608211051174

Hobster, K., & McLuskey, J. (2020). Transgender patients' experiences of health care. *British Journal of Nursing*, *29*(22), 1348–1353. https://doi.org/10.12968/bjon.2020.29.22.1348

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 transgender survey.* National Center for Transgender Equality. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

Jones, J. (2021). *Gallup.* https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx

Kamen, C. S., Alpert, A., Margolies, L., Griggs, J. J., Darbes, L., Smith-Stoner, M., Lytle, M., Poteat, T., Scout, N., & Norton, S. A. (2019). "Treat us with dignity": a qualitative study of the experiences and recommendations of lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients with cancer. *Supportive Care in Cancer: Official Journal of the*

Multinational Association of Supportive Care in Cancer, *27*(7), 2525–2532. https://doi.org/10.1007/s00520-018-4535-0

Lagos, D. (2018). Looking at population health beyond "Male" and "Female": Implications of transgender identity and gender nonconformity for population health. *Demography, 55*(6), 2097-2117. http://dx.doi.org/10.1007/s13524-018-0714-3

Leung T. I., & van Merode G. G. (2018). Value-based health care supported by data science. *Fundamentals of Clinical Data Science [Internet].* Springer. Available from https://www.ncbi.nlm.nih.gov/books/NBK543518/ doi: 10.1007/978-3-319-99713-1_14

Morris, B. (2009). The history of lesbian, gay, bisexual, and transgender social movements. *American Psychological Association.* https://www.apa.org/pi/lgbt/resources/history

National Center for Transgender Equality. (2016). *Frequently asked questions about transgender people.* https://transequality.org/issues/resources/frequently-asked-questions-about-transgender-people

National Institutes of Health. (2021). *Clinical practice guidelines.* https://www.nccih.nih.gov/health/providers/clinicalpractice

National Institutes of Health. (2022). *Implicit bias.* https://diversity.nih.gov/sociocultural-factors/implicit-bias#:~:text=Implicit%20bias%20is%20a%20form,retaining%20a%20diverse%20scientific%20workforce.

National LGBTQ Health Education Center. (n. d.). *Providing inclusive services and care for LGBT people: A guide for healthcare staff.* https://www.lgbtqiahealtheducation.org/wp-content/uploads/Providing-Inclusive-Services-and-Care-for-LGBT-People.pdf

Office for Civil Rights. (2021). Section 1557 of the Patient Protection and Affordable Care Act. https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

Pallant, J. (2016). *SPSS survival manual: A step by step guide to data analysis using IBM SPSS* (6th ed.). London, UK: McGraw-Hill Education.

Reisner, S. L., Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., Holland, C. E., Max, R., & Baral, S. D. (2016). Global health burden and needs of transgender populations: a review. *Lancet (London, England)*, *388*(10042), 412–436. https://doi.org/10.1016/S0140-6736(16)00684-X

Rosa, W. E., Shook, A., & Acquaviva, K. D. (2020). LGBTQ+ inclusive palliative care in the context of COVID-19: Pragmatic recommendations for clinicians. *Journal of Pain and Symptom Management, 60*(2), e44-e47. https://doi.org/10.1016/j.jpainsymman.2020.04.155

Rossman, K., Salamanca, P., & Macapagal, K. (2017). A Qualitative study examining young adults' experiences of disclosure and nondisclosure of LGBTQ identity to health care providers. *Journal of Homosexuality*, *64*(10), 1390–1410. https://doi.org/10.1080/00918369.2017.1321379

Safer, J. D., Coleman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016). Barriers to healthcare for transgender individuals. *Current Opinion in Endocrinology, Diabetes, and Obesity*, *23*(2), 168–171. https://doi.org/10.1097/MED.0000000000000227

San Francisco Department of Public Health. (n.d.). *Gender Health SF.* San Francisco Health Network. Retrieved June 28, 2021, from https://www.sfdph.org/dph/comupg/oprograms/THS/default2.asp

Sherman, A., Cimino, A. N., Clark, K. D., Smith, K., Klepper, M., & Bower, K. M. (2021). LGBTQ+ health education for nurses: An innovative approach to improving nursing curricula. *Nurse Education Today*, *97*, 104698. https://doi.org/10.1016/j.nedt.2020.104698

Shires, D. A., Stroumsa, D., Jaffee, K. D., & Woodford, M. R. (2018). Primary care clinicians' willingness to care for transgender patients. *Annals of Family Medicine*, *16*(6), 555–558. https://doi.org/10.1370/afm.2298

Singh, S. & Durso, L.E. (2017). Widespread discrimination continues to shape LGBT people's lives in both subtle and significant ways. *Center for American Progress* online publication. https://www.americanprogress.org/article/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways/

Stanford Health Care. (2020). *C-I-Care message of the month: LGBTQ+ key components.* https://mail.google.com/mail/u/0/#inbox/FMfcgzGmtNbPmjGXpFcVWDzKqTXKzksx?projector=1&messagePartId=0.1

Stroumsa, D., Shires, D. A., Richardson, C. R., Jaffee, K. D., & Woodford, M. R. (2019). Transphobia rather than education predicts provider knowledge of transgender health care. *Medical Education*, *53*(4), 398–407. https://doi.org/10.1111/medu.13796

The Joint Commission. (2011). *Advancing effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender (LBGTQ) community: A field guide.* https://www.jointcommission.org/-

/media/tjc/documents/resources/patient-safety-topics/health-equity/lgbtfieldguide_web_linked_verpdf.pdf?db=web&hash=FD725DC02CFE6E4F21A35EBD839BBE97&hash=FD725DC02CFE6E4F21A35EBD839BBE97

The Joint Commission. (2021a). *Speak Up campaigns.* https://www.jointcommission.org/resources/for-consumers/speak-up-campaigns/

The Joint Commission. (2021b). *Standards: Measure, assess, and improve your performance.* https://www.jointcommission.org/standards/

Tollinche, L. E., Walters, C. B., Radix, A., Long, M., Galante, L., Goldstein, Z. G., Kapinos, Y., & Yeoh, C. (2018). The perioperative care of the transgender patient. *Anesthesia and Analgesia*, *127*(2), 359–366. https://doi.org/10.1213/ANE.0000000000003371

U.S. Department of Health and Human Services. (2014). *Providing enhanced resources: Cultural competency resources.* https://www.hhs.gov/programs/topic-sites/lgbt/enhanced-resources/competency-resources/index.html

U.S. Department of Health and Human Services. (2021). *Lesbian, gay, bisexual, and transgender health.* https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

University of California San Francisco Gender Affirming Health Program. (2016). *Terminology and definitions.* https://transcare.ucsf.edu/guidelines/terminology

University of California San Francisco Gender Affirming Program. (2019). *Transition roadmap.* https://transcare.ucsf.edu/transition-roadmap

Walia, H., Banoub, R., Cambier, G. S., Rice, J., Tumin, D., Tobias, J. D., Raman, V. T. (2019). Perioperative provider and staff competency in providing culturally competent LGBTQ

healthcare in the pediatric setting. *Advances in Medical Education and Practice*, *10,* 1097-1102. https://doi.org/10.2147/AMEP.S220578.

Weingartner, L. A., Noonan, E. J., Holthouser, A., Potter, J., Steinbock, S., Kingery, S., & Sawning, S. (2019). *The eQuality toolkit: Practical skills for LGBTQ and DSD-affected Patient Care.* University Press of Kentucky. https://doi.org/10.18297/faculty/391

World Population Review. (2021). *What percentage of the population is transgender?* Retrieved on November 17, 2021, from https://worldpopulationreview.com/state-rankings/transgender-population-by-state

Zuckerberg San Francisco General Hospital and Trauma Center. (2018). *About us.* Retrieved on March 1, 2022, from https://zuckerbergsanfranciscogeneral.org/about-us/

Table 1

Descriptive Statistics of Pretest and Posttest Knowledge Raw Scores

Variable	Pretest		Posttest	
	M	*SD*	*M*	*SD*
Knowledge	7.33	2.06	8.80	1.15

N = 15

Table 2

Dependent Samples t-tests Results Pretest and Posttest Knowledge Raw Scores

Pair (Pretest – Posttest)	*t*	*p*	Cohen's *d*	$CI_{95\%}$ [a]
Knowledge	-4.36	0.001	-0.68	-1.12, -0.25

[a] 95% confidence interval of the standardized mean difference between pretest and posttest scores (Cohen's *d*).

N = 15

Table 3

Week 1 SO/GI Checklist Compliance

Compliance	Observed *N*	%	Expected *N*	%	Residual *N*	Residual %
Non-Compliant	4	28.6	7	50	-3	-21.4
Compliant	10	71.4	7	50	3	21.4
Total	14	100	14	100		

Table 4

Week 2 SO/GI Checklist Compliance

Compliance	Observed *N*	%	Expected *N*	%	Residual *N*	Residual %
Non-Compliant	6	46.2	7	53.8	1	-7.6
Compliant	7	53.8	6	46.2	-1	7.6
Total	13	100	13	100		

Table 5

Week 3 SO/GI Checklist Compliance

Compliance	Observed *N*	%	Expected *N*	%	Residual *N*	Residual %
Non-Compliant	5	35.7	7	50	-2	-14.3
Compliant	9	64.3	7	50	2	14.3
Total	14	100	14	100		

Table 6

Week 4 SO/GI Checklist Compliance

Compliance	Observed *N*	%	Expected *N*	%	Residual *N*	Residual %
Non-Compliant	5	38.5	6	46.2	-1	-7.7
Compliant	8	61.5	7	53.8	1	7.7
Total	13	100	13	100		

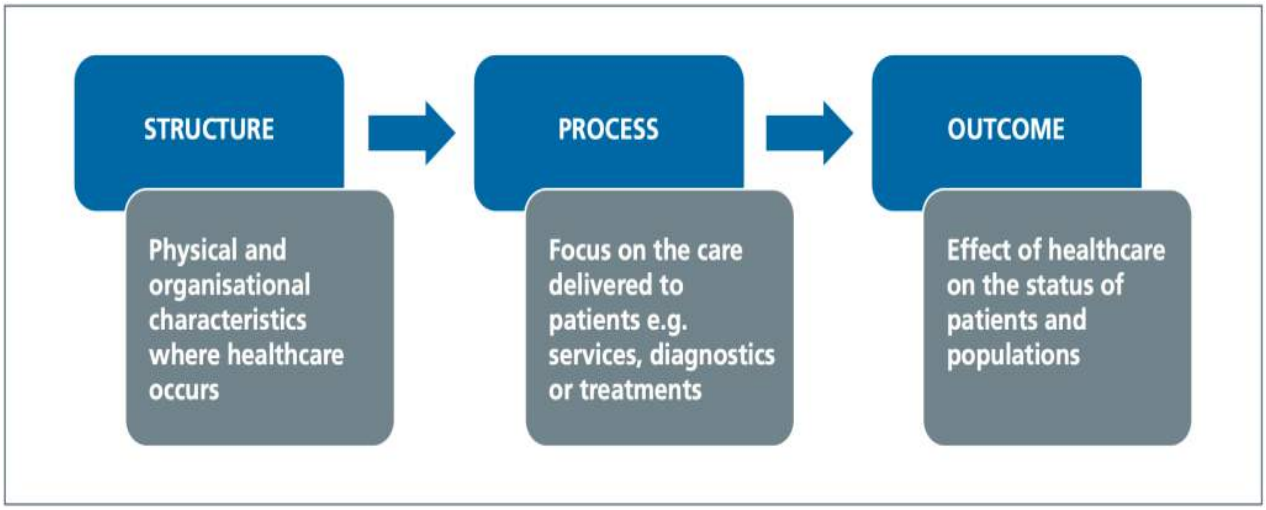
Table 7

Pronoun Use Observations Averaged Across Four Weeks (10 Total Observations per Week)

Pronoun Use Observation	Observed *N*	%	Expected *N*	%	Residual *N*	Residual %
Correct	22	55.0	20	50.0	2	5.0
Incorrect	18	45.0	20	50.0	-2	-5.0
Total	40	100	40	100		

Appendix A

The Donabedian Model for Quality Care



(Franklin, 2019)

Appendix B

Affiliation Agreement

Agreement for Use of Facilities
for Clinical Experience

between

San Francisco Department of Public Health

and

Touro University Nevada

This agreement is made this **1st** day of **December** 2021, in the City and County of San Francisco, a municipal corporation, through its Department of Public Health ("CITY") and **Touro University Nevada** ("SCHOOL").

WHEREAS, SCHOOL has an approved and accredited clinical experience program, and such program requires the use of clinical facilities for use in teaching STUDENTS in the clinical experience program, and

WHEREAS, CITY has suitable clinical and observation facilities for such clinical experience program and is willing to allow SCHOOL to use such facilities for the benefit of STUDENTS in the clinical experience program.

NOW, THEREFORE, it is agreed as follows:

1. DEFINITIONS

a. When any word or phrase defined below is used, or a pronoun is used in place thereof, it shall have the meaning herein set forth:

CITY:	The City and County of San Francisco, a municipal corporation, through its Department of Public Health.
DIRECTOR:	The Director of Public Health or his/her designated agent
SCHOOL:	**Touro University Nevada**
PROGRAM:	An approved and accredited educational program of SCHOOL, and such program requires the use of clinical facilities for STUDENTS to gain clinical experience.
STUDENT:	A Student, Resident, Fellow or other health care worker in a clinical experience program named in Appendix 1.

b. Wherever the words "as directed", "as required", or words of like effect are used, it shall be understood that the direction, requirement, or permission of the Director of Public Health is intended. The words "sufficient", "necessary", or "proper", and the like, means sufficient, necessary, or proper in the judgment of the Director of Public Health. The words "approval", "acceptable", "satisfactory", or words of like import shall mean approved by, or acceptable to, or satisfactory to the Director of Public Health unless otherwise indicated by the context.

2. PROGRAM

a. PROGRAM for STUDENTS to be conducted pursuant to this agreement is an educational program of the SCHOOL and not of the CITY. The SCHOOL will be responsible for the content of the educational program and will provide for necessary instruction in a manner that is acceptable to the CITY and SCHOOL. A statement of the philosophy and objectives of SCHOOL'S clinical experience program and an updated

Appendix C

Providing Inclusive Services and Care for LBGT People: A Guide for Health Care Staff

PROVIDING INCLUSIVE SERVICES AND CARE FOR LGBT PEOPLE

A Guide for Health Care Staff

NATIONAL LGBT HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

Appendix D

Permission to Use the Guideline

Good afternoon Courtney,

Thank you for reaching out to us at the National LGBQIA+ Health Education Center and for the work that you're doing! Please feel free to utilize our resources with your time. We only ask that you maintain our logo and proper attribution. Thank you again, and have a great day!

Best,
Jack Bruno
Operations Coordinator
The Fenway Institute

Jack Bruno | Operations Coordinator – Division of Education and Training | Pronouns: They, Them, Theirs
The Fenway Institute | 126 Brookline | 1340 Boylston St. | Boston, MA 02215
Office: 857.313.6688 | www.lgbtqiahealtheducation.org

THE FENWAY INSTITUTE

From

Appendix E

Pre- and Post– Knowledge Assessment for Culturally Competent Care

1. The National Institutes of Health (NIH) has recently exchanged the acronym *LGBTQ+* for the term _____ to include all whose sexual orientation, gender identity, or reproductive development varies from traditional, societal, cultural, or physiological norms.
    a. Lesbian, Gay Bisexual (LGB)
    b. Sexual and Gender Minority (SGM)
    c. All-gender (AG)
    d. None of the above
2. Common characteristics of the LGBTQ+ population *(circle all that apply):*
    a. Hiding sensitive information from healthcare professionals
    b. Avoiding or delaying healthcare due to bad experiences
    c. Have trouble finding healthcare where they feel included and accepted
    d. Being refused care because of sexual and/or gender preferences
3. Gender identity is
    a. Sexual orientation
    b. A person's internal sense of being male, female, both, neither, or another gender
    c. Sex assigned at birth
    d. A person's appearance as interpreted by the community at large
4. A transgender man was assigned _____ at birth and identifies as a _____.
    a. Male, male
    b. Male, female
    c. Female, female
    d. Female, male
5. How do you handle a situation of misgendering, using the wrong pronoun, or name?
    a. Make a big deal of the mistake with apologies and lengthy discussions
    b. Correct yourself, apologize, and move on
    c. Ignore the mistake, continue the interaction, and use the correct gender/pronoun/name in the future
    d. Continue using the gender/pronoun/name that makes you feel the most comfortable
6. How can you create an affirming and inclusive environment for LGBTQ+ patients *(select all that apply)*?
    a. Avoid asking unnecessary questions
    b. Understand diversity and fluidity of expression
    c. Maintain a non-judgmental attitude
    d. Practice making LGBTQ+ patients feel comfortable

e. Create an environment of accountability

7. True or False: The American Nurses Association has released a position statement that states the role of nurses is to deliver culturally congruent, safe care and advocate for LGBTQ+ populations.

8. True or False: The gathering of sexual orientation/gender identity data is not essential to advance our understanding of LGBTQ+ health and improve the population's health.

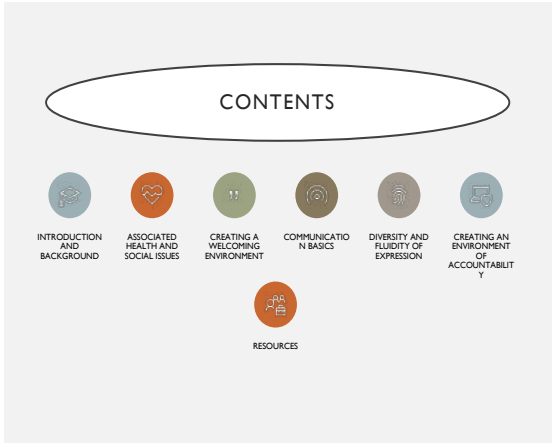
9. Which of the following are common health issues among LGBT people?
   a. Homelessness
   b. Suicide
   c. Behavioral health issues
   d. All of the above

10. True or False: Having to teach your healthcare provider about the lived experience of being trans and/or queer is a burden the LGBTQ+ population faces.

Appendix F

PowerPoint Presentation

- This power point aims to help you, as healthcare staff, to provide an affirmative, inclusive, respectful environment for all patients with a focus on lesbian, gay, bisexual, and transgender (LGBT) people.



INTRODUCTION & BACKGROUND

- LGBT = 5.6% OF US POPULATION
- INCREASES ~ 0.3% PER YEAR
- 1.4 MILLION PEOPLE IDENTIFY AS TRANSGENDER
- TRANSGENDER (TRANS) – UMBRELLA TERM FOR SOMEONE WHO IDENTIFIES AS A DIFFERENT GENDER THAN ASSIGNED AT BIRTH

- The NIH has exchanged the acronym LGBTQ+ for SGM (sexual and gender minority) to include all whose sexual orientation, gender identity, or reproductive development varies from traditional, societal, cultural, or physiological norms.

DISPARITIES LEAD TO POOR HEALTH

SOCIETAL IMPACT OF DISCRIMINATION

DISCRIMINATION & NEGATIVE EXPERIENCES IN HEALTHCARE

- Fear of discrimination, hostile encounters, violence, and lack of awareness cause SGM patients to avoid and delay seeking care.
- According to a literature review, the reported rate of discrimination in healthcare was 2%-42.8%.
- In many cases, problems arise from simple oversights or mistakes made by well-meaning staff who lack understanding about how to interact with LGBT people.
- 33% of trans individuals reported avoiding or delaying healthcare resulting from their need to teach the medical providers about transgender health. When providers lack knowledge of transgender-specific healthcare needs, they may ask the patients for guidance on their care.

THE ROLE OF NURSES

- ANA Position Statement: "American Nurses Association condemns discrimination based on sexual orientation, gender identity, and/or expression in health care and recognizes that it continues to be an issue despite the increasing recognition and acceptance of LGBTQ+ populations. Many LGBTQ+ individuals have reported experiencing some form of discrimination or bias when accessing health care services. Persistent societal stigma, ongoing discrimination, and denial of civil and human rights impede individuals self-determination and access to needed health care services, leading to negative health outcomes including increased morbidity and mortality. Nurses must deliver culturally congruent, safe care and advocate for LGBTQ+ populations."

HOW CAN WE IMPROVE THE CARE OF SGM INDIVIDUALS?

CAPTURING SO/GI DATA

Sexual Orientation/Gender Identity

The gathering of SO/GI data is essential to advance our understanding of SGM health and improve the population's health.

PROVIDE CULTURALLY COMPETENT CARE

GUIDELINE

Providing Inclusive Services and Care for LBGT People: A Guide for Healthcare Staff

by

National LBGT Health Education Center, A Program of the Fenway Institute

CREATE A WELCOMING ENVIRONMENT

Expectations

Emotional reactions

Mistakes

Practical Thinking

- "I apologize for using the wrong pronoun. I did not mean to disrespect you."
- Use problem solving skills
  - Help provide comfort and confidentiality
- Our primary focus is making patients feel comfortable and safe.

COMMUNICATION BASICS

1st to interact with patients

The goal is to make patients feel comfortable and safe.

Avoid assumptions about gender identity.

Use	Avoid
The terms people use to describe themselves & their partners. Parents Partner Relationship	Assumptions • Do not assume people have an opposite sex partner. Disrespectful language, acting surprised about someone's appearance, and gossiping about behavior.

PRONOUNS & PREFERRED NAMES

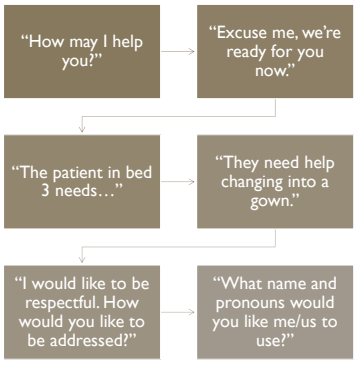
DO

- Use someone's first or first & last name
- Use gender pronouns if certain about gender identity
- Collect SO/GI data
- Politely and privately ask what names or pronouns they prefer to use

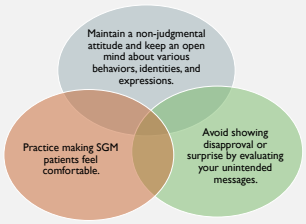
DON'T

- Guess gender
- Use sir, ma'am, Mr., Ms., etc.
- Use gender pronouns unless gender is known

EXAMPLES

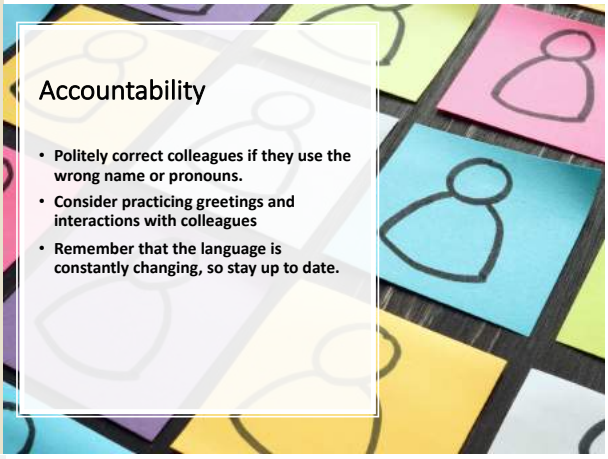


ATTITUDE AND PRACTICE



DIVERSITY & FLUIDITY OF EXPRESSION

- Gender identity and expressions can vary and change over time:
  - "Coming out" later in life
  - No fixed gender identity
  - Dislike using certain terms



Accountability

- **Politely correct colleagues if they use the wrong name or pronouns.**
- **Consider practicing greetings and interactions with colleagues**
- **Remember that the language is constantly changing, so stay up to date.**

REFERENCES AND OTHER RESOURCE DOCUMENTS

The National LGBT Health Education Center, www.lgbthealtheducation.org, has online webinars

- The following websites also provide helpful information:
- Human Rights Campaign: www.hrc.org
- Center of Excellence for Transgender Health: www.transhealth.ucsf.edu
- Do Ask, Do Tell: A Toolkit for Collecting Data on Sexual Orientation and Gender Identity in Clinical Settings: www.doaskdotell.org
- National Gay and Lesbian Task Force: www.thetaskforce.org
- CDC: Lesbian, Gay, Bisexual, and Transgender Health: www.cdc.gov/lgbthealth
- Gay and Lesbian Medical Association (GLMA): www.glma.org
- World Professional Association for Transgender Health: www.wpath.org
- National Center for Transgender Equality: www.transequality.org
- Parents, Families, and Friends of LGBT People (PFLAG): www.pflag.org
- Family Acceptance Project: www.familyproject.sfsu.edu
- Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE): www.sageusa.org
- LGBT Aging Project: www.lgbtagingproject.org
- Bisexual Resource Center: www.biresource.net
- National Network of STD Clinical Prevention Training Centers (NNPTC): www.nnptc.org
- AIDS Education and Training Centers: www.aids-ed.org
- GLBTQ Domestic Violence Project: www.glbtqdvp.org

GLOSSARY OF TERMS

- Sex: Designation assigned at birth based on external genitalia
- Gender: Socially constructed roles, behaviors, activities, and attributes typically associated with sex
- Gender Identity: The gender a person internally identifies with
- Gender Expression: The way a person acts, dresses, speaks, and behaves within the context of gender roles
- Gender Non-Conforming (GNC)/ Genderqueer: Someone whose gender identity does not conform to the socially constructed roles for men and women
- Cisgender: A person whose gender identity and sex assigned at birth correspond
- Sexual Orientation: How a person characterizes their sexual and emotional attraction to others

- **L**esbian: A woman who is primarily attracted to women.
- **G**ay: A man who is primarily attracted to men. Sometimes a broad term for individuals primarily attracted to the same gender.
- **B**isexual: An individual attracted to people of more than one gender.
- **T**ransgender: A person whose gender identity differs from their sex assigned at birth.
- **T**ransexual: An outdated term that originated in the medical and psychological communities for people who have permanently changed their gender identity.
- **Q**ueer: An umbrella term to be more inclusive of the many identities and variations that make up the LGBTQ+ community.
- **Q**uestioning: The process of exploring and discovering one's own sexual orientation, gender identity, and or gender expression.
- **I**ntersex: An individual whose sexual anatomy or chromosomes do not fit with the traditional markers of "female" and "male."
- **A**lly: Typically, a non-queer person who supports and advocates for the queer community.
- **A**sexual: An individual who generally does not feel sexual desire or attraction to any group of people.
- **P**ansexual: A person not limited to sexual choice with regards to biological sex, gender, or gender identity.

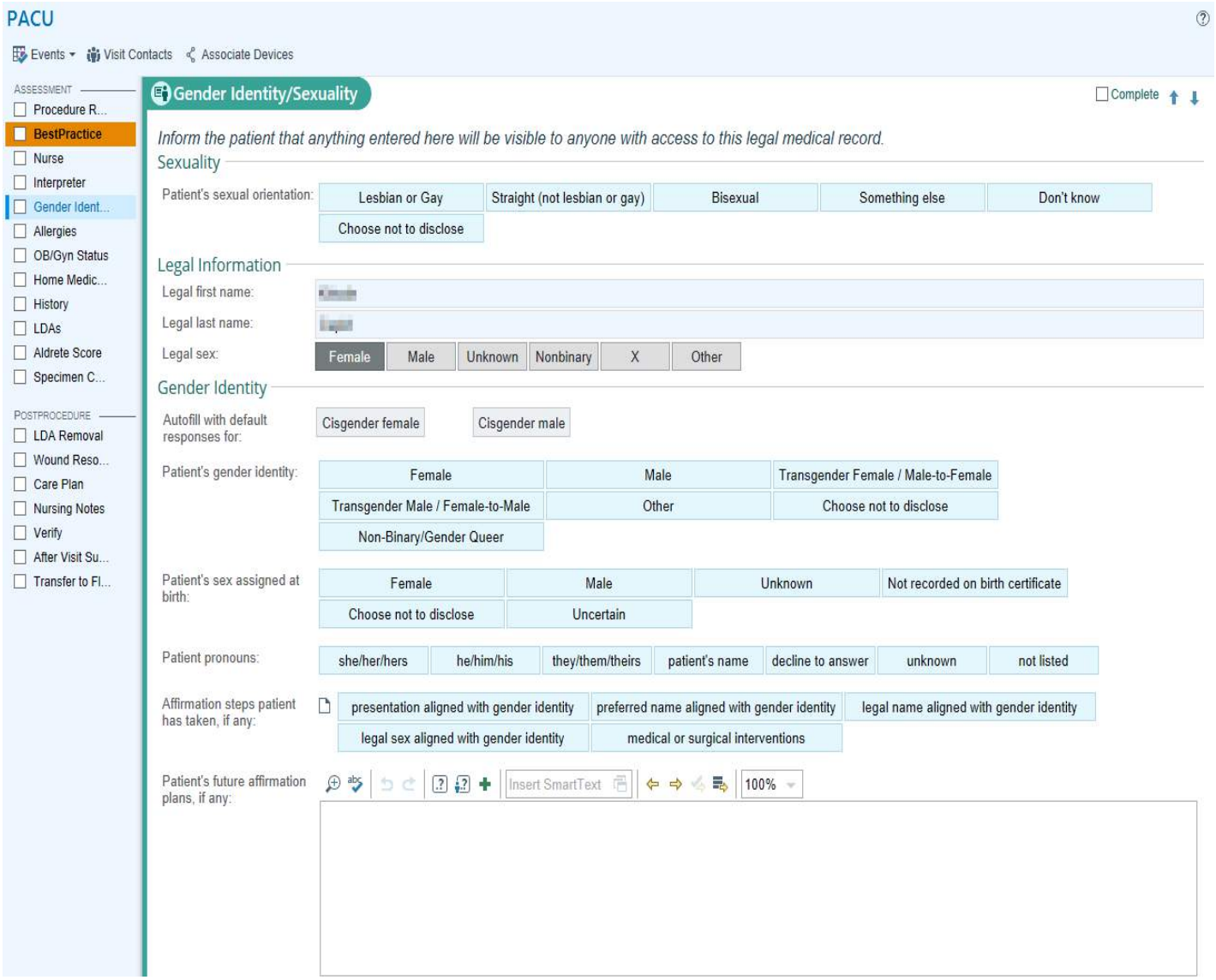
References

- American Nurses Association. (2018). *Nursing advocacy for LGBTQ+ populations: ANA position statement.* https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-advocacy-for-lgbtq-populations/
- Balik, C. H. A., Bilgin, H., Uluman, O. T., Sukut, O., Yilmaz, S., & Buzlu, S. (2020). A systematic review of the discrimination against sexual and gender minority in healthcare settings. *International Journal of Health Services, 50*(1), 44-61. https://doi.org/10.1177/0020731419885093
- Bradford, J. B., Cahill, S., Grasso, C., & Makadon, H. J. (n.d.). *Policy focus: How to gather data on sexual orientation and gender identity in clinical settings.* The Fenway Institute. https://www.lgbtqiahealtheducation.org/wp-content/uploads/policy_brief_how_to_gather.pdf
- Christian, R., Amy, A. M., Bui, A. G., Lee, R., Kattari, L., & Gray, C. (2018). Measuring the health of an invisible population: Lessons from the Colorado transgender health survey. *Journal of General Internal Medicine, 33*(10), 1654-1660. http://dx.doi.org/10.1007/s11606-018-4450-6
- Henriquez, N. R. & Ahmad, N. (2021). "The Message Is You Don't Exist": Exploring lived experiences of rural lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) people utilizing health care services. *SAGE Open Nursing, 7*, 1-10. https://doi.org/10.1177/23779608211051174
- Jones, J. (2021). *Gallup.* https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx
- Lagos, D. (2018). Looking at population health beyond "Male" and "Female": Implications of transgender identity and gender nonconformity for population health. *Demography, 55*(6), 2097-2117. http://dx.doi.org/10.1007/s13524-018-0714-3

- National LBGT Health Education Center. (n.d.). *Providing inclusive services and care for LGBT people: A guide for healthcare staff.* https://www.lgbtqiahealtheducation.org/wp-content/uploads/Providing-Inclusive-Services-and-Care-for-LGBT-People.pdf
- Reisner, S. L., Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., Holland, C. E., Max, R., & Baral, S. D. (2016). Global health burden and needs of transgender populations: a review. *Lancet (London, England)*, *388*(10042), 412–436. https://doi.org/10.1016/S0140-6736(16)00684-X
- Safer, J. D., Coleman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016). Barriers to healthcare for transgender individuals. *Current Opinion in Endocrinology, Diabetes, and Obesity*, *23*(2), 168–171. https://doi.org/10.1097/MED.0000000000000227
- Singh, S. & Durso, L.E. (2017). Widespread discrimination continues to shape LGBT people's lives in both subtle and significant ways. *Center for American Progress* online publication. https://www.americanprogress.org/article/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways/
- Stanford Health Care. (2020). *C-I-Care message of the month: LGBTQ+ key components.* https://mail.google.com/mail/u/0/#inbox/FMfcgzGmtNbPmjGXpFcVWDzKqTXKzksx?projector=1&messagePartId=0.1
- Stroumsa, D., Shires, D. A., Richardson, C. R., Jaffee, K. D., & Woodford, M. R. (2019). Transphobia rather than education predicts provider knowledge of transgender health care. *Medical Education*, *53*(4), 398–407. https://doi.org/10.1111/medu.13796
- Tollinche, L. E., Walters, C. B., Radix, A., Long, M., Galante, L., Goldstein, Z. G., Kapinos, Y., & Yeoh, C. (2018). The perioperative care of the transgender patient. *Anesthesia and Analgesia*, *127*(2), 359–366. https://doi.org/10.1213/ANE.0000000000003371
- University of California San Francisco Gender Affirming Health Program. (2016). *Terminology and definitions.* https://transcare.ucsf.edu/guidelines/terminology
- U.S. Department of Health and Human Services. (2014). *Providing enhanced resources: Cultural competency resources.* https://www.hhs.gov/programs/topic-sites/lgbt/enhanced-resources/competency-resources/index.html
- U.S. Department of Health and Human Services. (2021). *Lesbian, gay, bisexual, and transgender health.* https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health
- World Population Review. (2021). *What percentage of the population is transgender?* Retrieved on November 17, 2021, from https://worldpopulationreview.com/state-rankings/transgender-population-by-state

Appendix G

Sexual Orientation/Gender Identity Checklist (Blank)



Appendix H

Content Validity Index

Content Validity Index Table

Item	Expert 1	Expert 2	Expert 3	Mean
1	4	4	3	3.66
2	4	4	4	4
3	4	4	4	4
4	4	4	4	4
5	4	4	4	4
6	4	4	4	4
7	4	4	2	3.33
8	4	4	4	4
9	4	4	4	4
10	4	4	4	4

The procedure consists of having experts rate items on a four-point scale of relevance. Then, for each item, the item (CVI) (I-CVI) is computed as the number of experts giving a rating of 3 or 4, divided by the number of experts-the proportion in agreement about relevance.

The content validity index is calculated using the following formula:
CVR = [(E-(N/2)) / (N/2)] with E representing the number of judges who rated the item as Moderately Relevant or Highly Relevant and N being the total number of judges.

The mean total of all of the means was 3.89 indicating that all of the questions were moderately/highly relevant.

The calculation is as follows:
CVR = [(3-(3/2)) / (3/2)]
CVR = [(3-1.5) /1.5]
CVR = 1 for all questions except #7. Question #A7 had a CVR of 0.33.

Appendix I

Handoff Communication Form

SF HEALTH NETWORK

SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER
Dept. of Anesthesia &
Perioperative Care

Surgerycenter Checklist

Name
MRN
DOB Age
Gender
CCN

Planned Procedure: (not specified)
Surgeon:
Planned Procedure Date: (not specified)
Admission Type: (not specified)

Language: English fluency:
Phone:
Discharge Planning:
Patient Disposition:
Impairments:
ASA: (not specified) Anesthesia Type: (not specified)

Consent ☐
H&P: ☐
Metal in body:
PSH:

Gender Identity:
Preferred Pronouns:
Chosen name (if different than legal):

Nuclear Med:

Belongings

☐ Eyeglasses ☐ Contact Lenses
☐ Clothes ☐ Jewelry
☐ Dentures ☐ Hearing Aids
☐ Crutches ☐ Cane ☐ Walker
☐ Wheelchair ☐ Scooter ☐ Prothetics

Surgerycenter Vital Signs

NIBP: _____ / _____ HR: _____ Pain: _____
SpO2: _____ RR: _____ Temp: _____

OR checklist

☐ ID Band verified ☐ Card

NPO Status

Clears: _____ Solids: _____
Bowel Preop: _____

Allergies:

Meds Taken:

Meds Given:

Pending Tests:

☐ CBC ☐ Chem ☐ PT/PTT
☐ K+ ☐ FS _____ ☐ Upreg: pos/neg
☐ T&S ☐ T&C

Clinical Alert:

Encounter #:

ModuleID: TransactionID: - Page 1 of 1

Appendix J

Project Timeline

Week 1 (6/22/22-6/28/22)	Pre- and post-knowledge assessment distributed, and data collected. Education session for direct population of interest (preoperative RNs) complete. Guideline implemented. Week one observational analysis conducted, and data collected.
Week 2 (6/29/22-7/5/22)	- Implementation phase continued -Chart audit to measure the use of the SO/GI checklist and observational analysis was conducted to measure performance in week 1. -The project lead provided support, addressed concerns, and answered questions. -Questions and incongruencies in charting led to the project lead requesting changes within the EHR. -2 Staff members not in attendance of meeting were targeted on Friday of week 1.
Week 3 (7/6/22-7/12/22)	Implementation phase continued -Chart audit to measure the use of the SO/GI checklist and observational analysis was conducted to measure performance in week 2. -The project lead provided support, addressed concerns, and answered questions. -Questions and incongruencies in charting led to the project lead requesting changes within the EHR: Participant pointed out the charting of a preferred name in EHR triggered only the preferred name to display on main screen of the EHR, but only the legal name is listed on the patient armband. The project lead formally requested that the legal name and the preferred name appear on all forms.
Week 4 (7/13/22-7/19/22)	Implementation phase continued -Chart audit to measure the use of the SO/GI checklist and observational analysis was conducted to measure performance in week 2. -The project lead provided support, addressed concerns, and answered questions. - EHR changes pending
Week 5 (7/20/22-7/26/22)	Data was compiled, organized, and sent to a statistician for analysis.