Enhancing Inclusive and Affirmative Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Clinical Practice

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Abstract

Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) persons are a diverse community disproportionately impacted by significant health disparities. The health care disparities for this diverse population are due in part to lack of culturally competent providers. This perpetuates perceived prejudice and discrimination, presenting as a barrier to access and utilization of care.

Purpose: The overall purpose of this evidence-based DNP project was to implement an evidenced protocol to improve the health experiences and outcomes of LGBTQ persons through the identification and reduction of barriers affecting health care access and utilization.

Methods: EBP protocol and strategies to enhance safe, inclusive, affirmative, and culturally competent clinical practice. The protocol synthesizes EBP recommendations to guide transformation of the clinical care environment into a safe space whereas healthcare providers and staff are culturally competent and sensitive to the needs to this population. The SOCCS consisting of 29 questions with three subscales: (1) Skills, which includes 11 items focused on LGBTQ affirmative clinical work; (2) Attitudinal Awareness, which includes 10 items examining self-awareness of LGBTQ biases and stigmatization; and (3) Knowledge, which consists of 8 items assessing knowledge of LGBTQ issues was used to assess LGBTQ cultural competencies in an outpatient mental healthcare setting.

Results: An increase in providers' and staffs' skills, attitudinal awareness, knowledge, and preparedness when caring for LGBTQ persons four weeks post-implementation of the safe space protocol. The results, implications and future recommendations are discussed.

Keywords: lgbtq cultural competency, lgbtq care guidelines, Sexual Orientation Counselor Competency Scale, SOCCS, lgbtq safe space, lgbtq inclusive care, lgbtq staff cultural competence, affirmative care, inclusive care, and lgbtq barriers to care access.

Enhancing Inclusive and Affirmative LGBTQ Clinical Practice

Introduction

Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) persons are a diverse community disproportionately impacted by significant health disparities (Bednarski, 2019). LGBTQ health has emerged as a national concern due to the growing body of evidence indicating significant health care disparities experienced by the LGBTQ community (Bednarski, 2019). Historical stigmatization based on sexual orientation and gender identity (SOGI) has influenced and reflect contemporary LGBTQ health disparities (Lim et al., 2014). This stigma is associated with high rates of psychiatric disorders, social isolation, victimization, substance abuse, and suicide (Russell & Fish, 2016). The National Institute of Minority Health and Health Disparities (NIMHD) officially designated LGBTQ populations as populations of focus for health disparity research, with Healthy People 2020 establishing a goal to "improve the well-being, safety, and health of the LGBTQ patient population" (Healthy People 2020, 2014).

Research asserts that health care disparities for this diverse population are due in part to lack of culturally competent providers, societal stigma, fear of discrimination, and marginalization (Lim et al., 2014). The evidence further asserts that a lack of culturally competent healthcare providers (HCPs) can perpetuate perceived prejudice and discrimination, discourage LGBTQ persons from seeking care, and increase the prevalence of disease and risk factors (Casey et al., 2019). The significance is that it presents challenges in access to care, resulting in a delay in care and an increased risk of adverse health outcomes (Felsenstein, 2018).

The National Transgender Discrimination Survey of 6,450 transgender and nonconforming participants found that 19% were denied care due to their transgender status, and 28% delayed or avoided care due to perceived discrimination within the health care setting

(Casey et al., 2019). During the clinical encounter, experiences of discrimination persist (Casey et al., 2019). The prevalence of these discriminatory experiences correlated with adverse health outcomes and health-related behaviors (Casey et al., 2019). Critical to advancing and understanding LGBTQ health and underpinning, many of these health disparities are societal stigma, discrimination, and marginalization (Russell & Fish, 2016). The social and cultural constructs perpetuating this phenomenon need to be disrupted and reoriented to an inclusive and affirming approach to better meet the health needs of this increasingly diverse population (Eckstrand et al., 2017).

Nurse leaders can foster inclusive and affirming environments through the construct of cultural humility and the development and implementation of inclusive policies to reduce barriers affecting access to care (Hook et al., 2013). Leadership can sustain inclusion initiatives by setting expectations, establishing organizational priorities, modeling appropriate behavior, advocacy, awareness efforts, and fostering diversity programs (Hook et al., 2013). Nurse leaders can take further action to improve this population's care experiences by evaluating their practices, offices, policies, procedures, and training to identify gaps in practice, adopting and applying evidence-based practices to improve patient-level and system-level outcomes (Eckstrand et al., 2017). This DNP project is structured to implement recommended best practices that can reduce barriers to access by creating an LGBTQ welcoming, affirming, and inclusive environment (Theriault, 2017).

Background

Throughout the 19th century, gender and sex were synonymous, as these were based on an exclusive binary paradigm (male/female) (Opportunities, Populations, Board on the Health of Select, & Medicine, 2014). Concepts and theories regarding gender, gender roles, and gender

identity were introduced and defined in the literature during the 1950s (LGBT health guide, 2016). Research to further understand gender and gender identity expanded during the mid-1960s to early 1980s (LGBT health guide, 2016). This expansion of research was considered progress at the time because it offered treatment and cure for a phenomenon that society criminalized and pathologized (Russell & Fish, 2016). The mental health profession perpetuated the pathologizing of gender variance by classifying this phenomenon as a "sociopathic personality disturbance" and subsequently as "gender dysphoria" in the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) (Russell & Fish, 2016).

There is a history of discriminatory attitudes toward homosexuality throughout health-related organizations and systems that emerged during the "gay rights" movement in the 1970s and the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic in the 1980s ((Rowe et al., 2016). Historically, gender variance has been stigmatized and marginalized through the law, emphasizing the development of laws and policies that influence the care experience of this disadvantaged population (Williams & Cooper, 2019). The consequence of this historical stigmatization is reflective of the current health disparities and inequities experienced by this population (Hafeez et al., 2017).

The literature supports a need for focused efforts to improve the care experiences of this diverse population (Hafeez et al., 2017). The literature concluded that their experiences affect how they perceive and interact with health-related organizations and systems and can be better understood from a historical perspective deeply rooted in societal stigma and discrimination (Improved patient engagement for LGBT populations, 2017). The literature further demonstrates a need for interventions focused on decreasing stigma in the health care environment through evidence-based strategies that foster inclusive and affirming practices (Bristowe et al., 2018).

Problem Statement

The Institute of Medicine (IOM, 2011) has identified LGBTQ persons as underserved, at-risk, and disadvantaged. Healthy People 2020 described the health disparities and adverse health outcomes affecting the LGBTQ as majorly concerning (Healthy People 2020, 2014). The National Institute of Health (NIH) and the IOM have prioritized LGBTQ health, with the explicit intent to advance knowledge and understanding of LGBTQ health. LGBTQ persons surveyed by the Human Rights Campaign (HRC) reported experiencing barriers in accessing culturally competent, inclusive, and affirming care (Khalili et al., 2015). A survey of United States (U.S.) clinical practices found 16% of practices reported having comprehensive LGBTQ training, 32% reported having limited training, 52% reported having no training, and 13% reporting having policies and procedures to identify as an LGBTQ inclusive and affirming clinical practice site (Khalili et al., 2015). Healthy People 2020 describe the lack of HCPs who are culturally competent in LGBTQ health as a significant system-level barrier affecting access to care (Healthy People, 2020,2014).

This rural outpatient mental health clinic's current practice is to recognize and respond to the clients' culturally diverse needs. However, several gaps in current knowledge and practice were identified. The care of LGBTQ persons is compromised by gaps in clinical care and practice systems; moreover, few clinical practice environments demonstrate acceptability, awareness, or receptivity of this diverse community (Theriault, 2017). Improving this vulnerable population's health requires an integrated, strategic, process-oriented approach to implement system-level changes to transform health environments (Theriault, 2017). The evidence suggests that LGBTQ inclusive and affirmative clinical practice environments can reduce health disparities and improve access to culturally competent, patient-centered care (Theriault, 2017).

A lack of LGBTQ inclusive policies, available, affirming, inclusive materials, and low staff respondent knowledge regarding the unique healthcare needs and culture of LGBTQ persons identified were suggestive that this rural outpatient mental health clinic would benefit from evidence-based guidelines to enhance inclusive and affirmative clinical practice (Hadland et al., 2016).

There is a breadth of evidence-based guidelines, initiatives, strategies, and resources available to assist health organizations in their efforts to improve cultural competency and enhance inclusive and affirming clinical practice environments that have not been translated into practice at this project site (Nisly et al., 2018). This Doctor of Nursing Practice (DNP) project intends to implement an evidence-based protocol using the current strategies recommended by the Gay, Lesbian and Straight Education Network (GLSEN) to "Create a Safe Space" in an outpatient mental healthcare setting, to educate and inform clinical practice concerning LGBTQ care and culture, employ best practices to reduce barriers to access by creating an inclusive, affirming, welcoming, safe, and supportive clinical environment (Craig et al., 2016).

Project Question

Will implementing a protocol using evidence-based strategies to "Create a Safe Space" when adopted and applied by clinical and non-clinical staff reduce barriers affecting access to inclusive, affirming, culturally competent care in a rural outpatient mental healthcare clinical practice setting?

The project question developed uses the PICOT format and includes:

1. Population- Clinical and non-clinical staff encountering LGBTQ patients in a rural outpatient mental healthcare clinic.

2. Intervention- A protocol using evidence-based recommendations and strategies to transform the physical care environment into an environment that fosters LGBTQ inclusivity and gender-affirming clinical practices using a checklist of recommended best practice standards, specifying as present, limited, or absent.
3. Comparison-The comparison is current practice.
4. Outcome- To reduce system-level, structural, and interpersonal barriers affecting care access by enhancing inclusive and affirmative clinical practice. To increase requisite staff knowledge of LGBTQ care and culture, as indicated, to improve preparedness and access to LGBTQ culturally competent healthcare providers.
5. Time-The timeline proposed for the actualization of this project, starting with proposal approval, and continuing through data collection through analysis of and preliminary interpretation of outcomes, is six months with a plan for ongoing evaluation of outcomes.

Search Methods

A literature search was performed to determine the impact of creating a safe space to enhance inclusive and affirming care, when adopted and applied by clinical and non-clinical staff, in an outpatient care setting. The following search engines were utilized accessing the Touro University Library database: PubMed, UpToDate, ProQuest, MEDLINE, PsychINFO, Cumulative Index of Nursing, and Allied Health Literature (CINAHL) Plus with full text, Cochrane Collaborations/Cochrane Nursing Care Network, EBSCO, Ovid, and JAMA. Some Google Scholar and the Journal of the American Association of Nurse Practitioners (JAANP) searches were performed. The key terms used for the review of literature were: “lgbtq safe space,” “lgbtq inclusive care,” “lgbtq staff cultural competence,” “affirmative care,” “inclusive

care," and "lgbtq barriers to care access." The search performed resulted in 209 articles. To further narrow the search results, the boolean search terms "OR" and "AND" were utilized, which resulted in 83 articles. The search terms were designed to methodically identify articles focusing on LGBTQ inclusive and affirming care practices in the primary care setting. After critical appraisal, 19 articles were found pertinent and considered for use in this project.

A google search for national guidelines, initiatives, and recommendations published by regulatory agencies and other pertinent organizations and the review of relevant protocols was also performed. The google search for national guidelines, initiatives, and recommendations resulted in guidelines published by the Gay and Lesbian Medical Association (GLMA), American Academy of Family Physicians (AAFP), Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), American Psychological Association (APA), the World Professional Association for Transgender Health (WPATH), the Joint Commission Field Guide on LGBT Patient-Centered Care, the National Association of Lesbian and Gay Addiction Professionals (NLGAP), Gay, Lesbian and Straight Education Network (GLSEN), the Fenway Institute National LGBT Health Center, Healthy People 2020, the National Institutes of Health (NIH) and the Institute of Medicine (IOM) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. Key terms used were "LGBTQ care guidelines", "LGBTQ care protocols", "LGBTQ care guidelines for outpatient clinic," "LGBTQ culturally competent care" and "LGBTQ inclusive and affirming practices in outpatient setting". Most documents contained recommendations that related to clinical care and practice environments. The recommendations were assessed for whether they provide consistent recommendations useful for the primary care setting.

Inclusion and Exclusion Criteria

Inclusion criteria consisted of articles published within the past five years, full-text available, written in the English language, and peer-reviewed. The literature had to discuss barriers affecting access and utilization of health care services, inclusive and affirming strategies to reduce those barriers and or improve the care experiences of LGBTQ. The literature reviewed was not restricted to specific age groups. The exclusion criteria included abstract-only articles, non-English articles, articles that were not appliable to the project, articles published prior to the last five years, and sources that were not peer-reviewed.

Review of Study Methods

The review of the literature included randomized controlled trials, a meta-analysis of randomized controlled trials, retrospective and observational studies, mixed-methods comparative studies, integrative reviews, and a systematic review of peer-reviewed research studies. These study methods are relevant to this DNP project because they are reliable, valid, and produce similar findings.

Reducing system-level, structural and interpersonal barriers, undermining access to safe, culturally competent care, inclusive and affirming clinical practice environments were recurrent themes extracted from the literature.

Review Synthesis

Considerable research has been done to address the significant health disparities experienced by the LGBTQ community (Healthy People, 2020). However, there exists a limited translation of the research designed to improve the health outcomes of this population into practice. Historical stigmatization and discrimination, specifically with respect to health care experiences, were factors demonstrated to have contributed to and influence the contemporary

health care disparities experienced by this population and appear throughout the review of the literature as major barriers to access to care (Felsenstein, 2018; Russell & Fish, 2016). Most of the literature reviewed addresses barriers to access to care and interventions focused on improving the care experiences of this population. “Creating a Safe Space” emerged in the literature as a best practice strategy to enhance an inclusive and affirming clinical environment (Kuzma et al., 2019). The history of safe space originates from the gay rights movement in the 1970s with LGBT activists and antiviolence organizations from San Francisco and New York who sought protection against discrimination, victimization, and criminalization (Hanhardt, 2013). The safe space was pivotal to the history and advancement of sexual minority communities (Hanhardt, 2013). The safe space has since evolved and integrated into academic settings, workplaces, and health systems (Kuzma et al., 2019). Developed to best fit into its own setting, it can be used by HCPs in any field and with a variety of client systems (Kuzma et al., 2019). The project site, an outpatient rural mental healthcare clinic setting, will be the setting for the proposed intervention.

Impact of the Problem

The persistent impact of the constructs of stigma and discrimination as barriers to access to care has resulted in adverse health outcomes (Emlet, 2016). LGBTQ health is now a national priority (Emlet, 2016). The significantly disproportionate health disparities experienced by this population make them a primary area of interest to public health research and practice (Emlet, 2016). The literature asserts that efforts to improve access to care and reduce health disparity are critical to the health and well-being of this population (Emlet, 2016). To improve access to care, it is important that HCPs, environments, and policies are inclusive and affirming (Goldenberg et al., 2019). To achieve this, HCPs need to be trained on the specific needs of this population

(Goldenberg et al., 2019). The literature further highlighted the physical environment and its importance, asserting that physical cues demonstrating inclusivity contribute to improving access and affirmation (Goldenberg et al., 2019). The current research findings supporting training to improve culturally competent and affirming care, strategies to improve the physical environment, and organizational policies and initiatives inclusive of this population are often not implemented into the practice setting (Goldenberg et al., 2019). The translation of this research knowledge into practice can advance the health and well-being of this population, increase access and utilization of health care, and allow for improved health outcomes.

Providing Inclusive and Affirmative Care

Inclusive and affirmative care is an approach to health care delivery that recognizes, validates, and supports the identities stated or expressed by those served and has been established throughout the literature as a best-practice approach in the provision of care for LGBTQ persons (Reisner et al., 2015). To improve the care experiences of this population and reduce barriers affecting access to quality care, the Joint Commission (2010) recommended that health care systems transform health care environments into safer, culturally competent, inclusive, and affirming care environments for LGBTQ persons and their families (Rowe et al., 2017). To better understand what constitutes such an environment, an integrative review by Laiti et al. (2019) applying a variety of research methods: qualitative interview and qualitative questionnaire, mixed-methods studies, quantitative survey studies, and literature, with more than half of the studies being done from the perspective of health professionals and in the U.S. (Laiti et al., 2019), summarized how heteronormativity affected the health care experiences of LGBTQ persons. The review identified challenges related to heteronormative assumptions and health professionals' lack of knowledge about LGBTQ relevant health issues (Laiti et al., 2019).

Heteronormative assumptions were described as negative attitudes appearing as condescending, stigmatizing, and marginalizing by LGBTQ persons (Laiti et al., 2019). Health care professionals reported a lack of knowledge and skills to provide care for LGBTQ persons and that gender-affirming practices were unfamiliar (Laiti et al., 2019). Those health care professionals indicating having knowledge gaps about LGBTQ relevant health issues considered training and education on this topic to be significant (Laiti et al., 2019). Gender-affirming practices were described as an interactional process whereby a person's sexual orientation, gender identity, and expression are recognized and championed (Laiti et al., 2019). Inclusive care was framed by three constructs: the health professional, information, and healthcare setting (Laiti et al., 2019). Inclusive health professionals were described as users of inclusive language, who asked about preferred pronouns and names, had knowledge about LGBT health, and understanding of basic definitions and concepts (Laiti et al., 2019). Inclusive information consisted of topics that were specific to LGBTQ health (Laiti et al., 2019). LGBTQ sexual health and mental health were considered important health information topics (Laiti et al., 2019).

An additional study was conducted by Cicero et al. (2019), utilizing an integrated mixed research literature review to better understand the healthcare experiences of LGBTQ persons. The literature sought to identify barriers to accessing gender-affirming health care and provide recommendations to overcome these barriers (Cicero et al., 2019). Evidence from this review identified enacted stigma, non-affirming practices, exclusive policies, and lack of cultural competence as common barriers experienced by this population when accessing health care. These barriers were demonstrated to have fostered unwelcoming healthcare environments, consequently dissuading the utilization of necessary health care services, thereby contributing to the health disparity of this population (Cicero et al., 2019).

The review by Laiti et al. implied that heteronormativity negatively impacts the health care experiences of LGBTQ persons and supports staff training, inclusive policies, and inclusive cues within the physical environment for creating an inclusive, gender-affirming healthcare setting. The literature by Cicero et al. suggests welcoming, inclusive, and affirming health care environments are needed to improve the care experiences and increase access and utilization of care by the LGBTQ population. The research asserts healthcare facilities and healthcare systems can foster welcoming, inclusive, and affirming clinical practices and care environments through staff education and training designed to increase LGBTQ cultural competencies, knowledge, and skills (Cicero et al., 2019). Both studies found that found gender-affirming care to be a critical factor in the access and utilization of health care (Cicero et al., 2019).

Barriers to Inclusive and Affirmative Care

LGBTQ persons encounter systemic, structural, and interpersonal barriers to inclusive and affirmative healthcare contributing to adverse physical and mental health outcomes (Butkus et al., 2020; Romanelli & Hudson, 2017). The research contends that reducing barriers at the system, structural, and interpersonal levels will increase access to and utilization of health care, thereby improving health outcomes and reducing the health disparity gap (Butkus et al., 2020).

An interview-based study of 40 self-identified LGBTQ adults was conducted with an aim to address systemic barriers affecting access to care (Romanelli & Hudson, 2017). The literature identified system-level barriers related to organizational structure, organizational culture, organizational leadership, exclusive environments and policy, a lack of education, training, research, and outreach. The study observed 29 of the interviewees having reported these barriers and their underpinnings as majorly concerning (Romanelli & Hudson, 2017). The study sample was small; however, the results support similar research findings and suggest opportunities for

the reevaluation and redesigning of health care systems with an aim to transform health care systems into safer, culturally competent, inclusive, and affirming care systems. To facilitate this transformation, at the system level, the evidence supports the ongoing assessment of the organization's climate, the development and or revision of mission and vision statements, institutional policies, and the strategic implementation best practices and staff education and training specific to LGBTQ cultural and communicative competencies that incorporate inclusive language, gender-affirming practices, and cultural humility into orientation for new staff, annually and updated as needed to reflect changing paradigms and social trends within LGBTQ communities to create an accessible, informed, and resourced infrastructure designed to better meet the health care needs of this diverse population (Bristowe et al., 2018).

A U.S national study identified the dearth of culturally competent providers as a significant structural level barrier to quality care access (Dahlhamer et al., 2016). Limited LGBTQ cultural competencies in the primary care clinic setting were also identified (Felsenstein, 2018). The physical environment had no visual cues to identify the clinic as LGBTQ inclusive or affirming (Felsenstein, 2018). The clinic's intake forms did not include questions for patients to self-identify as LGBTQ (Felsenstein, 2018). The staff surveyed demonstrated LGBTQ cultural competency training had not been provided during initial staff orientation or subsequent training (Felsenstein, 2018). A learning needs assessment of staff revealed 100% sought to learn LGBTQ-related terms, 88.9% sought information on LGBTQ health-related risk factors, 88.9% sought recommendations on LGBTQ health screening, and 88.9% sought information on websites for online LGBTQ educational modules (Felsenstein, 2018). A knowledge gap of LGBTQ cultural and clinical competencies of HCPs and staff was a finding in the literature (Felsenstein, 2018). This knowledge gap presented as a barrier affecting access to quality care and was shown to

contribute to the adverse outcomes experienced by this population (Felsenstein, 2018). The cultural competencies included creating a welcoming environment that is inclusive and affirmative of LGBTQ persons, the facilitation of the disclosure of SOGI, and staff education and training (Felsenstein, 2018). The guidelines for creating a welcoming and inclusive environment recommend a décor portraying LGBTQ couples and families, the display of reading materials relevant to LGBTQ health care and culture, and informative materials regarding available LGBTQ resources along with visible displays of LGBTQ-inclusive, non-discrimination policies, and LGBTQ–welcoming symbols such as the Safe Space symbol or the Safe Zone sign in waiting areas to immediately indicate an environment of cultural acceptance (GLSEN, 2019; Joint Commission, 2011). Providing a safe clinical environment was found to be an important aspect of the literature (Felsenstein, 2018).

Interpersonal stigma, characterized by overt acts of discrimination between LGBTQ persons, HCPs, and other clinical staff, encompassing the physical environment and clinic flow, were determinants shown to affect access to health care services (Eckstrand et al., 2017). A study by Alencar Albuquerque et al. (2016) illustrates the difficulties LGBTQ persons have in accessing safe, culturally competent, inclusive, and affirmative health care services because of interpersonal stigma and discrimination. The study showed that health professionals' prejudicial attitudes during the health encounter adversely impact health outcomes. Fear of having a negative health care experience led some to delay or avoid seeking care (Albuquerque et al., 2016). As a result, both physical and mental health disparities continue to disproportionately impact this population. A study conducted by Morris et al. (2019) aimed to reduce health care provider bias towards LGBTQ persons determined health care provider biases correlated with poorer access to care, quality of care, and health outcomes. A survey in a large urban primary

care center with 800 gay men 18 to 29 years old was conducted to assess access to and experiences with health care (Griffin et al., 2020). Disclosure of SOGI due to fear of stigma was found to be a critical factor in comfort discussing sexual practices and or preferences with HCPs (Griffin et al., 2020). The findings suggest that HCPs must be more effectively prepared to facilitate disclosure of SOGI to address the health care needs of this population (Griffin et al., 2020). The literature supports education and training that increases knowledge and improves attitudes towards LGBTQ persons as an effective strategy to reduce bias and showed potential for reducing disparities (Morris et al., 2019).

Addressing the Problem with Current Evidence

The Joint Commission (2011) recommends creating a safe, culturally competent, inclusive, and affirming clinical environment as best practice to reduce barriers affecting access to care. The Joint Commission field guide Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBTQ Community offers five best practice strategies to support health systems and organizations in their efforts to provide a more safe, culturally competent, inclusive, and affirming care environment. The five best practice strategies propose creating a welcoming and inclusive environment, not making assumptions of sexual orientation or gender identity, creating a safe space and context to facilitate disclosure of important health information about sexual orientation or gender identity, providing information and guidance for specific health concerns and providing staff and provider education to increase cultural competence (Joint Commission, 2011).

Creating a welcoming and inclusive environment. Many studies have demonstrated that LGBTQ persons and families assess their surroundings to determine if the environment is one in which they feel welcomed and accepted. The Joint Commission's (2011) best practice

recommendation for creating a welcoming and inclusive environment advises having reading materials and brochures, visible LGBTQ- friendly symbols, the posting of inclusive non-discrimination policies in the waiting and common areas and having unisex or single-stall bathrooms. The literature by Laiti et al. (2019) described inclusive healthcare settings as healthcare settings with signs, stickers, and policies displaying LGBTQ inclusivity and LGBTQ-oriented informational materials, leaflets, posters, and magazines.

Do not make assumptions about sexual orientation or gender identity. The current literature suggests that assumptions of about sexual orientation or gender identity are discrimination based on sex (Logie et al., 2019). A best practice recommendation is never to assume one's sexual orientation or gender identity or to rely on outer appearances to assume gender but to allow information about sexual orientation and gender identity to come from the patient (Joint Commission, 2011).

Create a safe space to facilitate disclosure of important health information about sexual identity or gender identity. The current evidence proposes gender-neutral and inclusive language on intake or registration forms that allow patients and families to self-identify (Joint Commission, 2011). The use of the individual's preferred name and pronoun during the clinical encounter is consistent with best practice recommendations. Clinical encounters that are culturally sensitive and considerate foster the trust and comfortability of patients to disclose information relevant to their specific health care and needs (Joint Commission, 2011).

Provide information and guidance for specific health concerns of the LGBTQ community. Health care organizations should be prepared to provide the necessary information, guidance, screenings, and referrals to serve this population better and holistically (Joint Commission, 2011). A best practice recommendation is for health care organizations are familiar

with resources available and prepared to provide the appropriate information and referrals for LGBTQ persons. The literature supports advocacy, community outreach, and diversity efforts that foster partnerships that promote health and disease prevention (for example, here cite the authors from your literature that overall ties into this section).

Staff and provider education. The guidelines make recommendations for educating staff and providers to increase cultural competence, humility, and comfort with the goal of preparing staff and providers to respond in a way that is caring, professional, legal, and gender-affirming.

LGBTQ care guidelines. Many guidelines, initiatives, and recommendations have been published by regulatory agencies and other pertinent organizations that influence LGBTQ health policy and practices. The Joint Commission has established itself as a global leader in quality improvement and patient safety through research, knowledge, expertise, and rigorous standards guiding and informing clinical care and practice. Other notable recommendations and guidelines have been published by the Fenway Institute National LGBT Health Education Center and the GLMA. The Fenway Institute National LGBT Health Education Center, a Federally Qualified Health Center, is one of the world's largest health centers focused on LGBTQ research, training, and health policy. Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff published by the Fenway Institute National LGBT Health Education Center offers strategies to increase staff and provider cultural and communicative competencies and create a more affirming environment. The Gay and Lesbian Medical Association (GLMA, 2006), a national leader in LGBTQ health issues, published guidelines to support organizations in creating a welcoming and inclusive environment. GLMA (2006) guidelines recommend that health systems and organizations assess their practices,

offices, policies, and staff training for ways to improve both clinical practice and the care environment. The Gay, Lesbian & Straight Education Network (GLSEN) is a national education organization established to address discrimination, harassment, and bullying based on sexual orientation, gender identity, and gender expression to cultivate environments of safety and cultural inclusion.

The guidelines published by these leading organizations and agencies were synthesized, observing the following consistent recommendations: creating a safe, inclusive, and welcoming clinical environment, the documentation and facilitation of disclosure of self-identified sexual orientation and gender identity (SOGI), staff and training in the areas of LGBTQ-specific knowledge and gender-affirming practices, and clinician-patient communication/engagement with the use of preferred name and pronouns.

Current Management

Currently, health care providers' knowledge, attitudes, clinical care, and practice environments pose as significant barriers affecting access to and utilization of health care services, highlighting that new knowledge and skills are needed to transform health care environments into safer, culturally competent, inclusive, and affirming care environments. The finding supports that health care staff and providers can serve as change agents by translating evidence-based, best practice recommendations into clinical practice. The current recommendations to support such a transformation are practical, consistent, and provide evidence-based clinical and systems support to health care systems and organizations but require a standardized approach. A well-developed, standardized, and strategic approach to implementation and evaluation of the recommended care guidelines can facilitate such a transformation in the primary care setting. In doing so, health care staff and providers increase

access to care, improve health outcomes, and reduce health disparities of the LGBTQ community.

Project Aims

The overall aim of this quality improvement project is to focus on advancing LGBTQ health, understand the underpinnings that perpetuate barriers affecting health care access and utilization, disrupt the social and cultural constructs perpetuating this phenomenon by enhancing safe, inclusive, and affirmative clinical care and practice environments through increased requisite staff knowledge and preparedness, thereby increasing access to LGBTQ culturally competent healthcare providers. The purpose of this project is to improve the health experiences and outcomes of LGBTQ persons in an outpatient mental health clinic setting through the identification and reduction of barriers affecting health care access and utilization.

Theoretical Framework

The conceptual framework underpinning this DNP project is Donabedian's Quality-of-Care Framework Model ((See Appendix A). This framework conceptualizes three domains of quality improvement: structural, process, and outcome, asserting that improvements in the structural domains of care result in improvements in clinical care processes that in turn result in improved patient outcomes (Ayanian & Markel, 2016). This model observes that the structure of health systems and organizations can both create and constrain clinical care processes and or practices that directly impact health outcomes (Ayanian & Markel, 2016). Structure influences process, and process influences outcomes (Ayanian & Markel, 2016).

Historical Development of the Theory

In 1953, Donabedian was awarded a scholarship to study epidemiology and health at the Harvard School of Public Health, and in 1961, he was recruited to the University of Michigan.

At the University of Michigan School of Public Health, he was appointed to examine the research on quality measures where he sought to define and develop methods to measure the quality of health care and assess how clinical decision-making affects quality within the health care system (Ayanian & Markel, 2016). In 1966 Avedis Donabedian published an article proposing the use of the constructs of structure, process, and outcome to evaluate the quality of health care (Berwick & Fox, 2016). The article became the core of his influential body of work on the theory and practice of quality improvement, emerging as one of the most frequently cited public health articles over the next 50 years (Berwick & Fox, 2016).

During the 1990s, Donabedian further expanded this trinity incorporating "seven pillars" of quality, in which a report by IOM titled Crossing the Quality Chasm highlighted six core aims for the 21st-century health care system: to deliver care that is safe, effective, patient-centered, timely, efficient, and equitable (Berwick & Fox, 2016). This trinity, along with his subsequent seven domains of quality, continues to inform efforts to improve care (Berwick & Fox, 2016). This model has been commonly adopted in healthcare metrics in clinics, hospitals, and health care organizations around the world, with benchmarks related to these concepts (Berwick & Fox, 2016). Donabedian's body of work remains significant as the conceptualization of structure, process, and the outcome remains central to measuring and improving quality care (Berwick & Fox, 2016). Donabedian anticipated the value of better scientific understanding of health care as a system, of the importance of the continual design and redesign of processes of care, and of the central role of executive leadership and regulatory agencies in creating a culture that supports and allows for continual improvement and innovation to meet the demands of an ever-evolving, dynamic and increasingly diverse health care system (Berwick & Fox, 2016).

Applicability of Theory to Current Practice

This framework is applicable to this DNP project as it allows for the conceptualization of causal factors and the redesigning and reevaluation of structure and processes that influence health outcomes. At a basic level, this framework can be used to influence structures and processes within a healthcare delivery system, such as a small group practice or ambulatory care setting, to influence outcomes (Ayanian & Markel, 2016).

The Donabedian Model continues to be the prevailing standard for assessing and measuring the quality and delivery of health care (Kobayashi, Takemura, & Kanda, 2011). Donabedian's structure, process, outcome approach serves as the gold standard in measuring quality and implementing improvement initiatives in healthcare (Kobayashi et al., 2011). This approach has been employed in evaluating nursing quality by the American Nurses' Association (ANA) and continues to be useful in measuring and improving the quality of nursing care (Kobayashi et al., 2011). This model is a model by which health care organizations and systems can readily identify cause and effect interrelated to structure, process, and outcome measures (Kobayashi et al., 2011). The fundamental need for evidence-based structure and process improvements within the context of health systems and organizations can positively impact health outcomes through quality assurance and measures.

Major Tenets of the Theory

This section will discuss the major tenets of Donabedian’s Quality-of-Care Framework Model: structure, process, and outcome, with a focus on structure and processes undermining access to safe, culturally competent, inclusive, and affirming clinical care and practice environments, resulting in adverse LGBTQ health outcomes. As it relates to this DNP project, the Donabedian Model and its three major tenets were used to guided and develop this project.

Structure. Structure relates to the health care system at the institutional level (Hall & Roussel, 2017). The tenet of “structure” is framed and characterized in the context of system-level barriers affecting the delivery of care within the health care organization to include the organization’s leadership, culture, institutional policies, mission and vision statements, the physical care environment, staff education and training, research, and outreach (Hall & Roussel, 2017). The proposed interventions as it relates to “structure” is representative of the assessed constraints negatively impacting the clinical processes of the host site where the DNP project will be implemented.

Process. The "process" is characterized as structural-level barriers to access to quality care and involves the interaction between patients and providers throughout the delivery of healthcare, with the focus being on culturally competent and responsive clinical encounters and experiences (Hall & Roussel, 2017). The "process" is scrutinized, assessing, and identifying the health care providers' knowledge, attitudes, biases, prejudices, assumptions, and beliefs about LGBTQ persons. The "process" is descriptive of the health care provider directly engaging and relating with clients from culturally diverse groups within the health care setting and inclusive of other clinic staff, the physical care environment, clinic flow, and other administrative and logistical functions (Hall & Roussel, 2017). The implementation of the proposed interventions as it relates to "process" is reflective of the creation of evidence-based protocols and best practice strategies supported by existing research to improve clinical care processes, increase care access and utilization, and ultimately reduce health disparities.

Outcome. The “outcome” is representative of the effect of the clinical processes on clinical and non-clinical staff encountering LGBTQ patients in a rural outpatient mental

healthcare clinic and is measured and evaluated (Hall & Roussel, 2017). The implementation of this DNP project will consider structure, process, and outcomes.

Implementation Framework

Many efforts have been focused on the implementation of sustainable quality improvement; however, sustainability has proven challenging (Moran, Burson, & Conrad, 2017). Implementation science (IS) (See Appendix B) employs best practice approaches to health care to improve outcomes (Moran et al., 2017). The Quality, Implementation, and Evaluation (QIE) model (See Appendix C) developed from Donabedian's tenet of "structure" operationalizes "structure" in four components: policy, patient preparedness, provider competency, performance, and accountability, to guide the implementation of sustainable initiatives (Talsma et al., 2014). This model can prove useful to integrate evidence into practice, as it systematically addresses the research-practice gap (Talsma et al., 2014). The QIE model aims to support clinical leadership by implementing necessary structural components to support evidence-based quality improvements (Talsma et al., 2014).

Major Tenets of the Implementation Framework

Policy. Policy refers to the various policies, guidelines, or protocols that communicate the standard of practice. The "policy" necessitates the review of current policy and revision as indicated to reflect best practice (Talsma et al., 2014).

Patient Preparedness. Patient preparedness is the component that prompts the change agent to inform patients and families about relevant information and processes in preparation for the quality initiative being pursued (Talsma et al., 2014). The essence of this component is to inform and educate patients and family members (Talsma et al., 2014).

Provider Competency. Provider competency describes the efforts a health care organization engages in to assure that its workforce is prepared, competent, trained, and safe to deliver care according to policy and protocols (Talsma et al., 2014).

Performance and Accountability. Performance and accountability describe the initiatives of a health system to evaluate its own performance and measures to hold staff and leadership accountable for performance that does not meet the standards of care (Talsma et al., 2014). This includes verification and or reporting systems to assess, monitor, and evaluate whether the health system delivers the care safely, efficiently, effectively, and in a patient-centered manner (Talsma et al., 2014). This component provides feedback about adherence to a specific evidence-based practice and is used to determine whether implementation efforts are successful or require further attention (Talsma et al., 2014).

Project Outcomes

In the timeframe of this DNP Project, the host site will:

1. Implement an evidence-based protocol to transform the physical care environment into an environment that fosters LGBTQ inclusivity and gender-affirming clinical practices using a checklist of recommended best practice standards, specifying as present, limited, or absent.
2. Revise the host organization's current non-discriminatory policy to reflect culturally appropriate, affirming, inclusive LGBTQ language and make it visible to all patients and staff.
3. Educate all staff on policy revisions and administer LGBTQ-specific training to increase staff LGBTQ cultural and communicative competencies.
4. Identify as an LGBTQ-friendly site by listing practice in the GLMA Provider

Directory as evidenced by the accessibility of practice site in GLMA directory of LGBTQ-friendly practices.

Population of Interest

The direct population of interest in this DNP project will be inclusive of all clinical and non-clinical staff employed by the mental health clinic, to comprise psychiatrists, nurse practitioners, licensed professional counselors, social workers, licensed vocational nurses, medical assistants, intake coordinators, and registrars encountering patients directly and or indirectly. The indirect population of interest is self-identified LGBTQ patients. The exclusions are students in training at the practice site, those who are not employed by the practice, and the outsourced billing/revenue cycle management company personnel. Within the medical practice, there are two practicing/consulting psychiatrists, six nurse practitioners, four counselors, two social workers, two licensed vocational nurses, and four medical assistants. The range of education varies from graduates with a minimum of two years of experience to more than 27 years of experience in the mental healthcare profession. The direct population of interest will implement the safe space protocol at the practice site and will be performing the ascribed changes.

Setting

The project site is an outpatient mental healthcare private practice clinic located in an affluent, rural area in Collin County, Texas. The practice provides comprehensive behavioral healthcare treatment and services to children, adolescents, and adults from a variety of mental health professionals. Within this setting, HCPs have their own offices and typically set their own schedules. The practice site has ten offices, a reception area, a waiting room, a designated area for the collection of any ordered lab draws, vital signs, point of care (POC) urine drug

screen (UDS) analysis, and genomic sample collections. There is also an area for psychometric testing performed on iPads. The daily schedule for psychiatrists and nurse practitioners varies from 18-23 patients a day per provider. The daily schedule for licensed professional counselors (LPCs) and social workers varies from 10-12 patients a day per provider. The practice site maintains electronic health records and documentation in compliance with local, state, and federal standards to include but not limited to registration, patient charting, progress notes, internal clinical messages, treatment plans, and other clinical functions as it relates to consultations, intra and interprofessional communications, referrals, and pharmacotherapies. The chief complaints presented include but are not limited to depression, anxiety, gender identity dysphoria, substance abuse, attention deficits, mood disorders, individual, couple, and group therapies, and a range of biopsychosocial circumstances contributing to significant impairment of academic, social, occupational and or other important areas of functioning.

Stakeholders

Identification of key stakeholders necessary to approve, implement and facilitate change within the organization was made. The stakeholders identified were the Medical Director, owner of the practice, the Chief Financial Officer (CFO), Chief Executive Officer (CEO), Nurse/Practice Manager, and all staff that met the inclusion criteria, as they all are significant and necessary for the successful implementation of this project. The Medical Director and CEO required education and informed action through the identification of practice gaps and evidence-based best practices as measured against their antiquated policies and fragmented staff educational training. The CFO also allowed for the implementation of the proposed DNP project, although clarification adjustments as needed to create the most cost-effective and sustainable change where required. Several financial implications were identified and assessed as influencing the effectiveness and sustainability of the DNP Project. These included: organizational size, leadership and staff

engagement and ownership, cost, quality, and available resources. Having identified the key stakeholders, regularly scheduled meetings were planned to lead the change process within the organization. Clarification of the project's nominal cost, feasibility, and sustainability further supported the development and implementation of the DNP project. Permission to implement the project at the practice site was given by Chief Medical Director (Owner), CEO, and CFO (See Appendix D). An affiliation agreement was not required by the practice site (See Appendix E).

Interventions/Project Timeline

The planned intervention for this DNP Project is multifaceted and involves the redesign and restructuring of evidenced-based practice (EBP) recommendations and guidelines to create a protocol designed to improve the health experiences and outcomes of LGBTQ persons by reducing systemic, structural, and interpersonal barriers to safe, culturally competent, inclusive and gender-affirmative care. The protocol synthesizes EBP recommendations used to guide transformation of the physical care environment into a safe space where LGBTQ persons feel safe to disclose sexual orientation, gender identity and gender expression, the customization of the EHR to facilitate SOGI data collection, staff and provider education and an organizational culture of acceptance and inclusion.

The protocol will guide the transformation of the physical care environment into an environment with distinct and visible cues, display of inclusive and relevant educational materials, inclusive practice policies and LGBTQ-friendly symbols/stickers that perpetuate inclusion and affirmation. The host organization's electronic healthcare record (EHR) system will be customized to capture SOGI demographic data by expanding the binary oriented responses. The project lead will collaborate with the host organization's health information technologist (HIT) consultant and its EHR vendor support personnel to expand the binary

demographic fields. The customization of the expanded fields will mandate a response to complete the patient registration/scheduling process. The protocol will incorporate staff and provider education, with a focus on the assessment, treatment, and reference to LGBTQ clients in a culturally competent and communicative manner. LGBTQ cultural competency training, educational materials and resources will be web-accessible through the Fenway Institute National LGBTQ Health Education Center. The project lead will pursue opportunities to establish an organizational culture of acceptance and inclusion through advocacy, community partnerships with local LGBTQ organizations, the acknowledgment and promotion of relevant days of observance (e.g., LGBTQ Pride Day, Agender Pride Day, Drag Day) visibility on social media platforms, the organization's website, and the hosting and or sponsoring of LGBTQ community outreach and awareness events.

The timeline established for implementation of this project is four weeks and will occur during DNP Project III. This project will involve a pre-and post-survey of skills, attitudes, and knowledge, specifically designed to assess LGBTQ culturally and communicative care competencies, data collection and compilation, analysis and interpretation of data, dissemination of findings and the ongoing evaluation and assessment of the ascribed intervention. This timeline includes educating and training providers who met inclusion criteria, the implementation of the ascribed interventions, oversight of the implementation process and support of the providers. Please refer to table one for project implementation timeline.

Table 1.

Project Implementation Timeline

Week 1: July 7th - July 13th	Administer SOCCS Survey (pre-exposure to intervention)

	Provide LGBTQ-specific trainings to increase provider and staff LGBTQ cultural and communicative care competencies. Educate and guide the implementation of the safe space protocol. Educate all staff on policy revisions and obtain policy receipt acknowledgment.
Week 2: July 14th - July 20th	The implementation of the safe space protocol by staff and providers will occur. Monitor implementation process and provide support to participants.
Week 3: July 21st- July 27th	The collection of data obtained from the SOCCS pre-implementation will be recorded.
Week 4: July 28th - August 3rd	Administer SOCCS Survey (post-exposure to intervention). The collection of data obtained from the SOCCS post-implementation will be recorded.
Week 5: August 4th - August 10th	IBM SPSS Statistics Subscription will be used to analyze data in this project. Interpretation and dissemination of the findings and the and the ongoing evaluation and assessment of the ascribed intervention.

Tools/Instrumentation

The tools/instruments that will be utilized for this DNP project are SOCCS survey pre and post implementation, a redesigned protocol, educational trainings, supplemental handouts, and an EHR system.

Sexual Orientation Counselor Competency Scale (SOCCS)

The SOCCS (See Appendix F) is a psychometrically valid and reliable instrument used to assess attitude, skill and knowledge competencies pertaining to LGBTQ persons (Bidell, 2005). Empirical methods provided a framework for establishing the SOCCS and included factor

analysis and reliability testing (Bidell, 2005). Criterion, concurrent, and divergent validity tests established the SOCCS as a psychometrically valid and reliable instrument (Bidell, 2005). Version 1 of the SOCCS is most applicable for those clinicians and/or trainees providing mental health services and assesses only sexual orientation competency (i.e., not gender identity/transgender competency) (Bidell, 2005). Version 2 is adapted for use among broader healthcare settings and specializations and Version 3 assess transgender clinical competency (Bidell, 2013). This DNP project will utilize the SOCCS Version 2 and Version 3 pre- and post-implementation to measure outcomes. The scale will be administered pre-implementation and one-month post-implementation.

The SOCCS is consists of 29 questions with three subscales: (1) *Skills*, which includes 11 items focused on LGBTQ affirmative clinical work; (2) *Attitudinal Awareness*, which includes 10 items examining self-awareness of LGBTQ biases and stigmatization; and (3) *Knowledge*, which consists of 8 items assessing knowledge of LGBTQ competencies (Bidell, 2005). There is no charge to use the SOCCS for research and/or educational purposes. SOCCS is a free to share, copy, distribute, adapt, and transmit (Bidell, 2005) (See Appendix G).

The Safe Space Protocol

The safe space protocol (See Appendix H) was redesigned/modified from the evidence gathered from the Joint Commission (2011), Fenway Institute National LGBT Health Education Center, GLSEN (2019) and GLMA (2006) to best fit into an ambulatory care setting, an outpatient mental healthcare private practice clinic, which is the setting for this DNP project. The safe space is a protocol when adopted and implemented provides a safe space that is highly visible and easily identifiable to the LGBTQ community. A safe space is where the social and cultural constructs perpetuating stigma, discrimination, and marginalization are disrupted and inclusion and gender-affirmative clinical practices are fostered (Eckstrand et al., 2017). The

protocol intends to reduce barriers to equitable care that LGBTQ persons experience by creating an inclusive and affirming clinical environment using recommended best practice standards, specifying as present, limited, or absent.

The safe space protocol will be developed by the project lead in collaboration with the medical director, clinic manager, and nursing leaders using EBP recommendations. This protocol will be used to assist providers and staff to better meet the health care needs of the LGBTQ community by delivering culturally and communicative competent care in a safe environment.

Educational Presentation

An educational presentation will be used for staff training. This will include LGBTQ cultural competency training, educational materials, and resources web-accessible through the Fenway Institute National LGBTQ Health Education Center (See Appendix I). The educational intervention will provide LGBTQ cultural competency training for the behavioral health, primary care practitioners with its focus on the assessment, treatment, and reference to LGBTQ clients in a culturally competent manner. All training focuses on system-wide change to improve access to high-quality, culturally responsive care for LGBTQ individuals. The project lead will educate all staff on the safe space protocol, policy revisions and mandatory web-based LGBTQ-specific cultural and communicative care competencies prior to implementation. The project lead will provide ongoing oversight and support as indicated during the implementation phase.

Handouts

All providers and staff will be provided supplemental handouts (See Appendix J). The handouts are informational and will further educate providers on information they should integrate into their learning and clinical practices. The handouts are evidenced-based best practices, as published by the Joint Commission (2011), intended to be utilized, hence permission

to integrate such information for use in the DNP project is not necessary and are appropriate for use.

EHR System

Collecting SOGI information in the EHR and on registration forms is critical to improving health outcomes for LGBTQ persons (Streed, Grasso, Reisner, & Mayer, 2020). The SOGI data collection will allow for improved screening, identification of the health needs of this population and foster opportunities for ongoing research to reduce LGBTQ health disparities. The host organization's existing EHR system maintains the interoperability to incorporate SOGI data collection into the workflow and expand the binary oriented demographic fields. The EHR will be customized as indicated. The incorporated SOGI data collection fields will be tested using test patients prior to implementation.

Study of Interventions/Data Collection

Data collection will occur during week one before implementation of the ascribed interventions and during week four post implementation of the ascribed interventions. The pre and post implementation results of each item of the SOCCS survey completed by staff will be compiled, organized, and entered into an excel spreadsheet, and exported into SPSS for comparative analysis. The data collected will be saved as an encrypted file to a thumb drive, a password protected laptop and backed up on Microsoft One Drive, accessible to only the project lead. To ensure confidentiality of staff information using alpha-numeric codes to link the respondent to the survey will be used. The completed surveys and identifying information about respondents will be destroyed after the responses have been entered into the excel spreadsheet. It's also important to note that the results of SOCCS survey completed by the host organization's staff will be limited to the purpose for which the survey was conducted.

This data collection supports the project's objective of to implement the safe space

protocol and will be collected in the form of a standardized checklist to evaluate protocol compliancy. The frequency in which the review of the checklist to evaluate compliancy will be weekly. Any best practice recommendations documented or identified as limited or absent will used take corrective action as indicated. Data collection of the capturing of SOGI data will occur over four weeks and measured by the percentage of completed SOGI responses. The assumption is that the capturing of SOGI percentage will increase as the customization of the expanded fields will mandate a response to complete the patient registration/scheduling process.

Ethics/Human Subjects Protection

The Institutional Review Board (IRB) determination form was submitted for review and approved by the project team to maintain compliance with Touro University of Nevada. As the project utilizes a quality improvement educational design based on published best practices and does not involve direct patient care or human subjects, it was determined that the project will not require IRB oversight. It was further determined that the project poses no potential risks to the staff and or providers.

The project implementation is a mandated practice change, all staff were made aware of the annexation, compliance, and importance of the successful completion of an onboarding hiring process encompassing LGBTQ specific cultural competency trainings. An inclusive, non-discriminatory policy receipt acknowledgment was also mandated for hire at the practice site. There will be no compensation for participating in any part of this project.

Notably, the project lead successfully completed all the required Collaborative Institutional Training Initiative (CITI) modules, which sought to provide professional development education and guidance on how to conduct ethical and confidential implementation. To maintain staff confidentiality, staff will be identified using an alpha-numeric system as

described in the section above. There will be no compensation for participating in any part of this project.

Measures/Plan for Analysis

This project will be implemented over five weeks allowing for the analysis, interpretation, and dissemination of findings. All staff members of the project site were mandated to implement the safe space protocol which encompassed transformation of the physical care environment where LGBTQ persons feel safe to disclose sexual orientation, gender identity and gender expression, the capturing of SOGI data within the EHR, staff and provider education and activities that promote the visibility of an organization that is safe, inclusive and gender-affirming. This project will involve a pre-survey of skills, attitudes, and knowledge related to the care of LGBTQ individuals, exposure to the intervention, which seeks to increase requisite staff knowledge of LGBTQ culture and communicative care competencies, and a post-survey. SPSS will be used to analyze data in this project. Pre and post scores for each item and staff member will be entered into SPSS. A paired t-test will be used to analyze any statistically significant change between pre- and post-test data. The assumption is that there will be a significant difference between pre- and post-test data of staff in their knowledge, skills, and attitudes post the intervention. A statistician will be consulted to ensure the relevant statistical analyses are being used.

Analysis of Results

Using IMB SPSS Version 28, data was analyzed using a paired *t* test to assess for any statistically significant change in staff's skills, attitudes, and knowledge pre-and post-implementation of the ascribed protocol. Descriptive statistics was used to summarize the demographic characteristics of the staff. The chosen data analysis techniques were considered

appropriate for the design, as the paired *t* test compared the mean score of the same participants pre and post exposure to the intervention, no outliers were identified, and the distribution appeared to be approximately normal which was supported by low skewness and kurtosis (Sliva & Terharr, 2018). Use of descriptive statistics provided basic demographic information about the characteristics of the participants surveyed (Pallant, 2013).

The results of the data analyzed pre-and post-implementation of the protocol provide evidence supporting prejudicial attitudes, lack of awareness, low staff respondent skill and knowledge, non-affirming practices, exclusive policies, and limited cultural competency.

Demographics

A total of 20 staff members (*n*=20) participated in this DNP project. The participants averaged in age 41-50-years old. The majority of the staff identified as 70% female and 75% white in race/ethnicity. The professional disciplines implementing the protocol were represented as 10% of licensed medical doctors, 20% master's level and 10% level doctoral prepared nurse practitioners, 20 % PhD prepared professional counselors, 10% master's degree prepared clinical social workers, 10% associate degree prepared nurses and, 20% certificate level medical assistants.

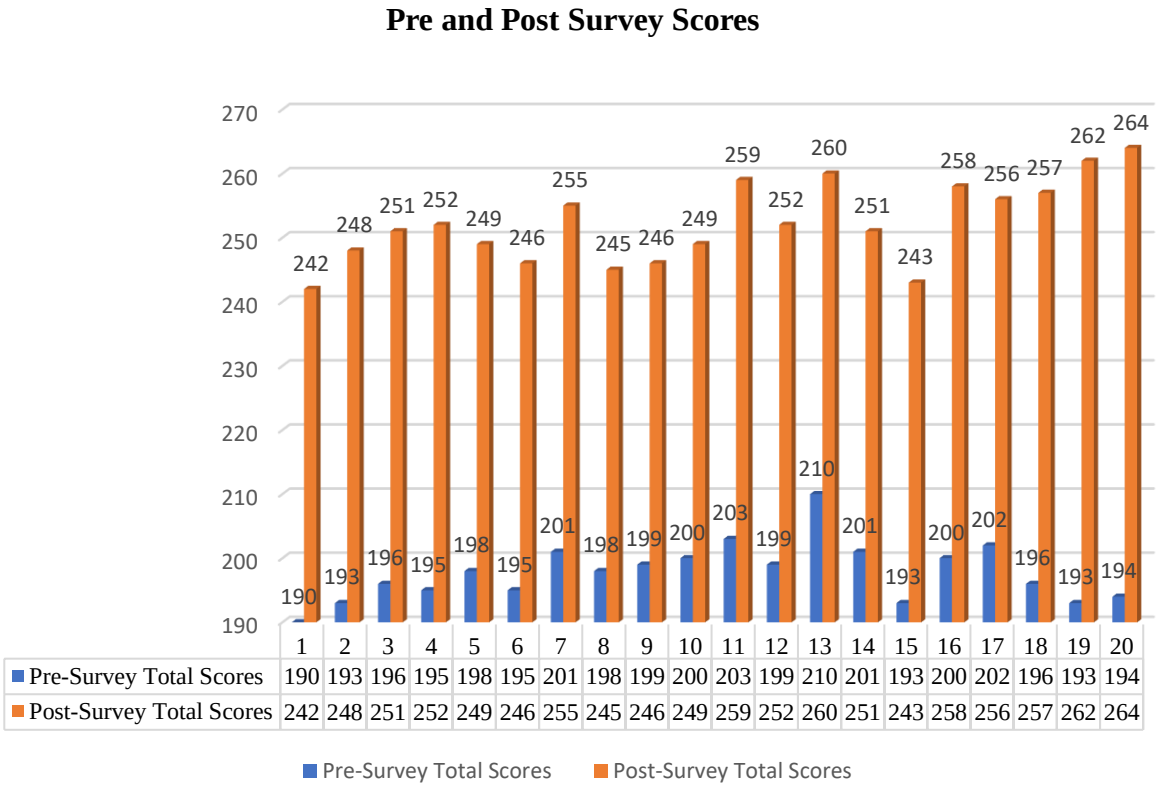
Pre and Post Survey

The SOCCS Version 2 and Version 3 (Appendix F) was administered pre-implementation on July 7th, 2021 and readministered one-month post-implementation of the DNP project to measure any significant change in staffs' cultural competency, as defined as a set of skills, attitudes, knowledge, policies, and preparedness that enable providers and staff in healthcare systems to work effectively with diverse, cross-cultural populations (Kumar et al., 2019). The minimum and maximum scores were calculated respectively, 190 indicating zero cultural

competencies (0%) and 274 (100%) indicating high-level cultural competencies, per the SOCCS measurement tool (See Chart 1). The one-month post-implementation scores resulted 88%-96% compared to pre-implementation scores of 69%-77%. The average pre-survey score for all providers and staff was 72%, and post-survey was 92% (See Chart 1). The 20% increase was highly significant. The results were approximated using a paired *t*-test. A compliance audit checklist was used to assess for compliance and to observe adherence of the protocol, pre-post compliancy increased from 2% to 91%.

Chart 1.

Provider Pre-Post Survey Scores



A paired-samples *t*-test performed determined there was a significant statistical change in staff's skills, attitudes, and knowledge pre- and post- intervention. The results from the pre-survey (M = 197.80.65, SD = 4.549) and post-survey (M = 252.25, SD = 6.406), $t(19)$=-38.73, p

<0.001 indicated an increase in staff's cultural competency. The paired samples *t*-test assume the two groups are paired, no significant outliers in the difference between the two groups and the difference of pairs follow a normal distribution.

Table 2.

Pre and Post Pre-Post Survey Paired Samples Statistics

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pre-Survey Total Scores	197.80	20	4.549	1.017
	Post-Survey Total Scores	252.25	20	6.406	1.432

Table 3.

Pre and Post Pre-Post Survey Paired Samples Correlations

Paired Samples Correlations

		N	Correlation	Significance One-Sided p	Significance Two-Sided p
Pair 1	Pre-Survey Total Scores & Post-Survey Total Scores	20	.381	.049	.097

Table 4.

Pre and Post Skills, Attitudes and Knowledge Survey Paired Samples Test

Paired Samples Test

		t	df	Significance One-Sided p	Significance Two-Sided p
Pair 1	PreTotalScore - PostTotalScore	-38.733	19	<.001	<.001

Table 5.

Pre and Post Skills, Attitudes and Knowledge Survey Paired Differences

Paired Samples Test

		Paired Differences				
					95% Confidence Interval of the Difference	
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper
Pair 1	PreTotalScore - PostTotalScore	-54.450	6.287	1.406	-57.392	-114.245

Table 6.

Pre and Post Skills, Attitudes and Knowledge Survey Paired Samples Effect Sizes

Paired Samples Effect Sizes

					95% Confidence Interval	
			Standardizer[a]	Point Estimate	Lower	Upper
Pair 1	PreTotalScore - PostTotalScore	Cohen's d	6.287	-8.661	-11.421	-5.892
		Hedges' correction	6.414	-8.489	-11.194	-5.775

a. The denominator used in estimating the effect sizes.

Cohen's d uses the sample standard deviation of the mean difference.

Hedges' correction uses the sample standard deviation of the mean difference, plus a correction factor.

Discussion

The purpose of this DNP project was to improve the clinical encounter of LGBTQ persons seeking care in an outpatient mental health clinical care setting through the identification and reduction of barriers affecting health care access and utilization. Hafeez et al., (2017), identified stigma, discrimination, marginalization, a lack of HCPs' skill, attitudinal awareness, and knowledge as major system-level barriers resulting in a delay, or avoidance in care access

and utilization (Casey et al., 2019). These barriers have been correlated with poor quality care, and health outcomes (Casey et al., 2019). This is further supported by the finding that providing safe clinical environments for LGBTQ persons was found to be an important consideration in accessing care due in part to stigma, fear of discrimination, and marginalization (Lim et al., 2014). The results of the data analyzed after the educational intervention and post-implementation of the protocol demonstrate a statistically significant upsurge in skills, knowledge, and more inclusive attitudes pre to post implementation. The results are consistent with an increase in competency. In addition, 80% of staff identified reported they felt more informed about the health risk, the health needs, and the importance of SOGI data collection after completing the computer-based educational modules.

The DNP project proposed to answer the following question: Will implementing a protocol using evidence-based strategies to "Create a Safe Space" reduce barriers affecting access to safe, inclusive, affirming, culturally competent care in a rural outpatient mental healthcare clinical practice setting? The result of this project indicates an efficacious impact of the DNP project at this rural outpatient mental health clinic, satisfying the objectives. The desired outcome of this project was met as the ascribed quality improvement initiatives were implemented, integrated into the clinical practice environment, and measured using tools determined to have good reliability and validity. The quality improvement initiative successfully reduced system-level barriers by increasing staff's skills, attitudes, knowledge, and preparedness in the provision of safe, inclusive, affirming, culturally competent care.

Significance

The LGBTQ community encounter persistent discrimination, marginalization, and stigmatization in the healthcare setting present barriers to access care, a delay in care and an

increased risk of adverse health outcomes (Felsenstein, 2018). The lack of culturally competent healthcare providers can perpetuate perceived prejudice and discrimination, dissuading LGBTQ persons from seeking care (Casey et al., 2019).

The health needs of this population were not being adequately met due to inadequate education and preparation of healthcare providers and staff (Felsenstein, 2018). Education is a key factor that can positively influence these experiences. Healthcare providers and staff can learn to provide safe, comprehensive, high-quality, culturally competent care with education (Bass & Nagy, 2021). Preparedness to care for LGBTQ persons was correlated with more training experiences (Bass & Nagy (2021). As a result, improved health outcomes can be achieved in the care of LGBTQ persons if healthcare providers and staff learn the terms, unique healthcare risks, and maintain a sound fund of knowledge in the care of these individuals (Bass & Nagy, 2021).

This DNP project used an integrative, strategic, process-oriented approach to implement a protocol that systematically addressed a research-practice gap identified in an ambulatory care setting. The results and the successful implementation of the DNP project are significant for all nurse leaders as the concept of creating a safe space has evolved and can be developed to best fit into its own setting (Kuzma et al., 2019). The nurse leader can design, implement, and evaluate evidence-based interventions, in the delivery of safe, quality, culturally sensitive, evidence-based care into a variety of clinical settings (Kuzma et al., 2019). Alternatively, nurse leaders can initiate change within their organizations and improve access by modeling this protocol to create safe, inclusive, affirming, culturally competent clinical care environments for this vulnerable population.

Limitations

There were several limitations identified during the project implementation as it relates to the project design, data, recruitment, collection methods and data analysis. This project utilized a pretest-posttest design. Although this design allows for versatility in its use, this design did not account for non-interventional influences on outcomes. Moreover, because a self-reporting tool was used to measure outcomes, posttest scores may have been higher than pretest scores because of respondents overestimating their skills, attitudes, and knowledge on the posttest.

The capturing of accurate and complete data was important, as missing responses to the survey questions could reduce the statistical power of the project and/or yield biased estimates. The review for missing responses and validation of the responses was limited to the project lead. Antiquated, binary EHR systems, poor data collection culture, and the initial reluctance to onboarding new cultural competencies were also limitations encountered during the implementation of this DNP project. The time limitations, as to implement the project without interrupting the workflow of the clinic were also a significant challenge. The number of participants at the practice site for this DNP project was limited, which provided for a small sample size.

A major methodological limitation was a lack of available and standardized instruments/tools available to measure participants cultural competency when caring for LGBTQ individuals. The self-reporting instrument used for this project exposed the data collected to social-desirability bias. This limitation could be addressed with the development of a standardized assessment tool. Data analysis of the project included a paired-samples *t*-test due to the small sample. The small sample size may limit the generalization of the findings.

Dissemination

The findings of the project were disseminated at all levels and the feedback from staff was positive. The protocol was formally adopted by the Medical Director (Owner), CEO and CFO of the practice site. This DNP project will further be presented to the Touro University faculty and students on October 19th, 2021, via "Zoom" and uploaded to Touro University's Doctor of Nursing Practice Repository. A poster presentation of the DNP project was submitted for consideration to the category of "Evidence-Based Practice" to the International Society of Psychiatric-Mental Health Nurses (ISPN) for exhibition during the 2022 Annual Conference, dated March 16th-19th in Redondo Beach, CA. The project lead further plans to submit an abstract for publication and presentation at the American Psychiatric Nurses Association (APNA) 36th Annual Conference in Long Beach, California, dated October 19th-October 22nd, 2022.

Sustainability

The protocol implemented is a mandated practice change that involves the process by which change initiatives become routine. Project sustainability will be preserved through the institutionalization of organizational policies and practices that support change initiatives. This will require ongoing cultural competency trainings, staff compliance, and accountability. This will occur through an organizational shift in culture, exemplified by key stakeholders and leadership who are positioned to facilitate and foster change within the organization, a continued commitment by staff, ongoing inter and intra professional collaboration, outreach, and engagement with community service partners.

Conclusion

This DNP project was applicable as the LGBTQ community is a diverse, cross-cultural, emerging population. The development of and access to culturally competent providers and staff has become a national priority in the advancement of the health and well-being and health disparity research of this population (Healthy People 2020). Inadequate access to safe, high-quality, affirming, culturally appropriate healthcare increases the risk of poor health outcomes, poor health-related behaviors, and disproportionate health disparities (Kuzma, Pardee, & Darling-Fisher, 2019). Improving this population's health requires an integrated, strategic, process-oriented approach to implement system-level changes (Theriault, 2017).

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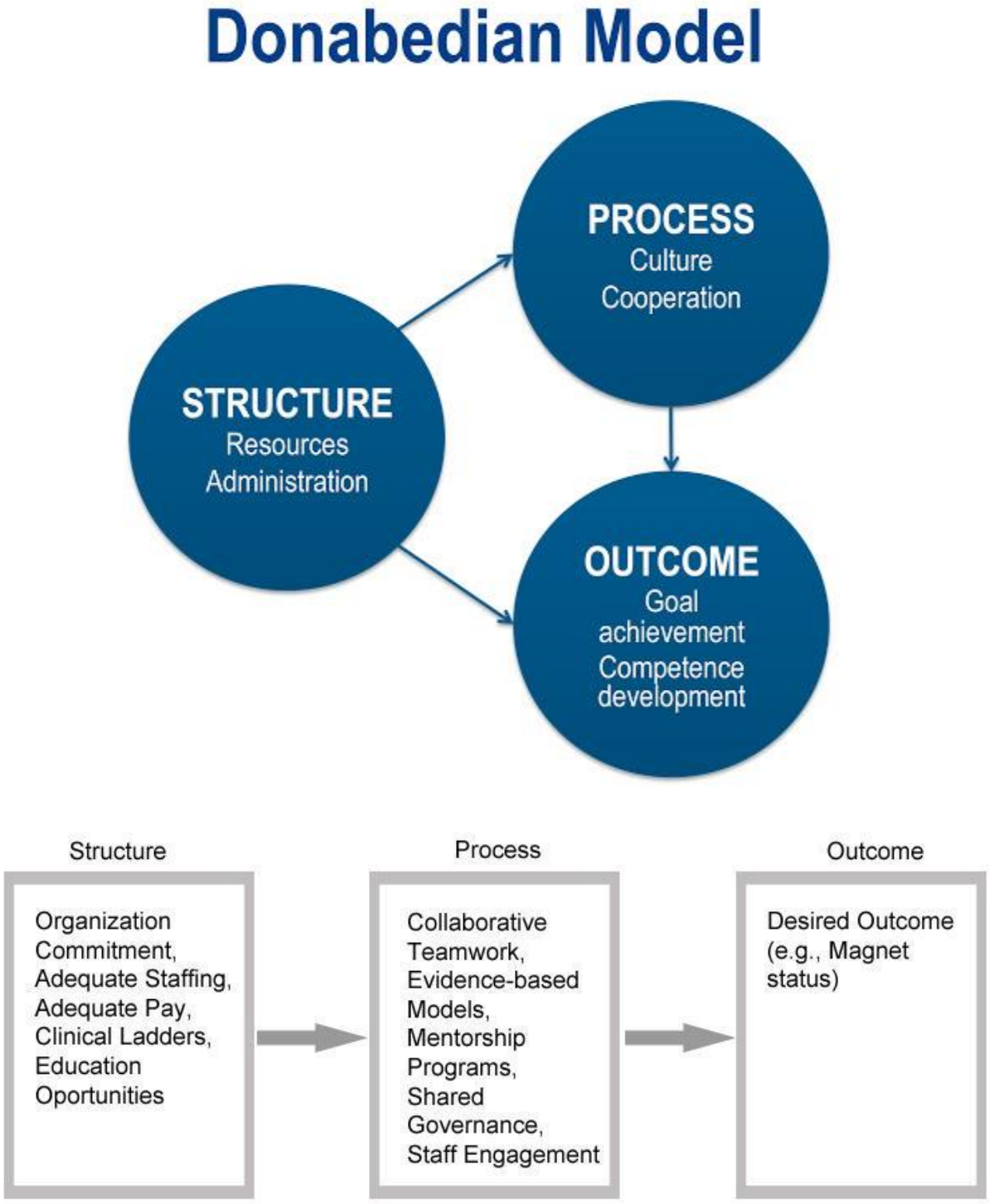
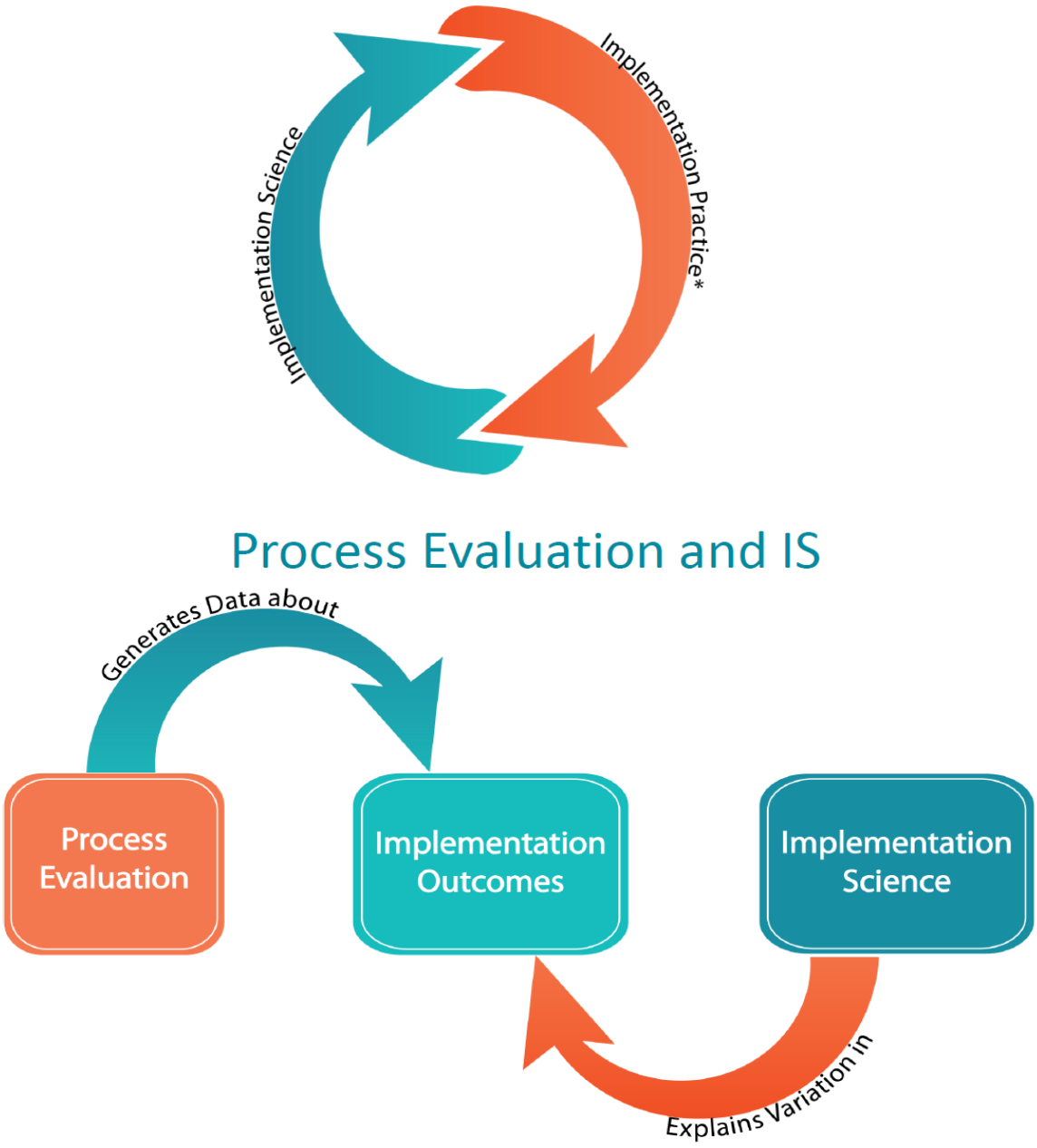
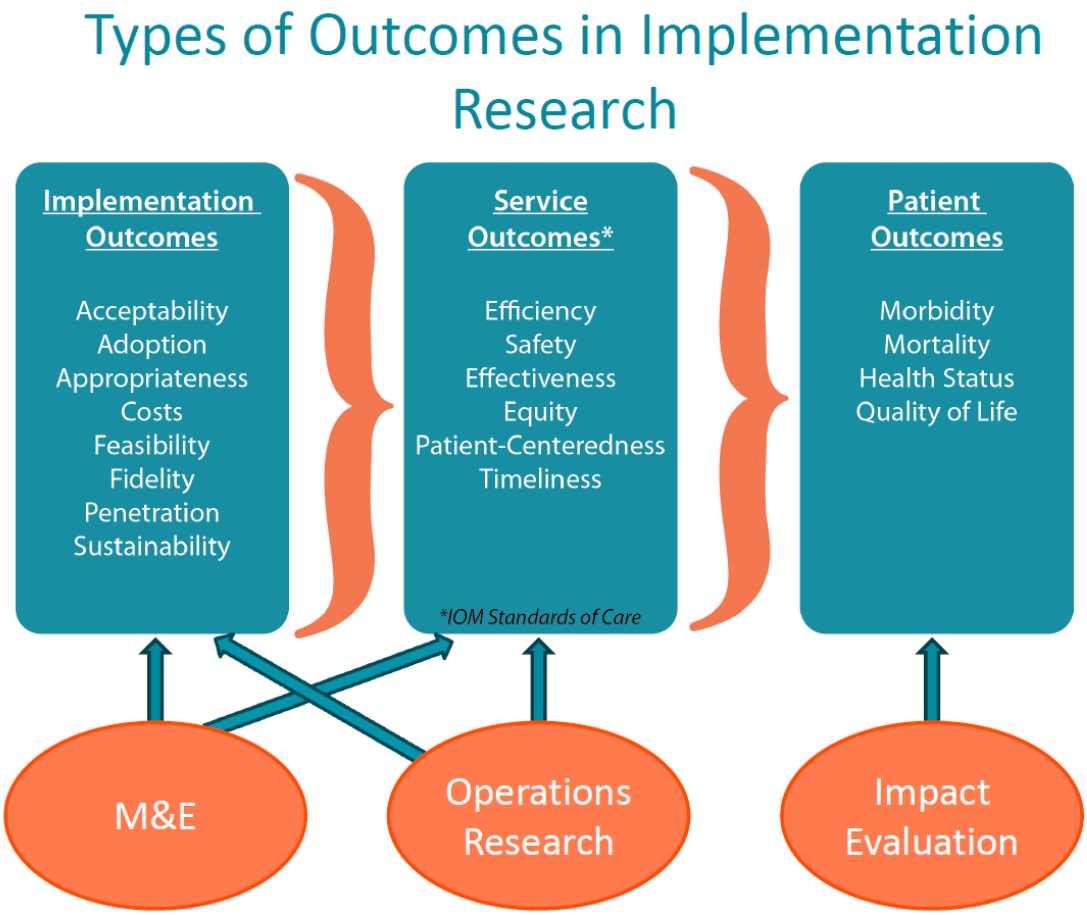
Appendix A


Donabedian Model
PROCESS
Culture
Cooperation
STRUCTURE
Resources
Administration
OUTCOME
Goal
achievement
Competence
development
Structure
Organization Commitment, Adequate Staffing, Adequate Pay, Clinical Ladders, Education Oportunities
Process
Collaborative Teamwork, Evidence-based Models, Mentorship Programs, Shared Governance, Staff Engagement
Outcome
Desired Outcome (e.g., Magnet status)

Appendix B

Implementation Science (IS) Framework

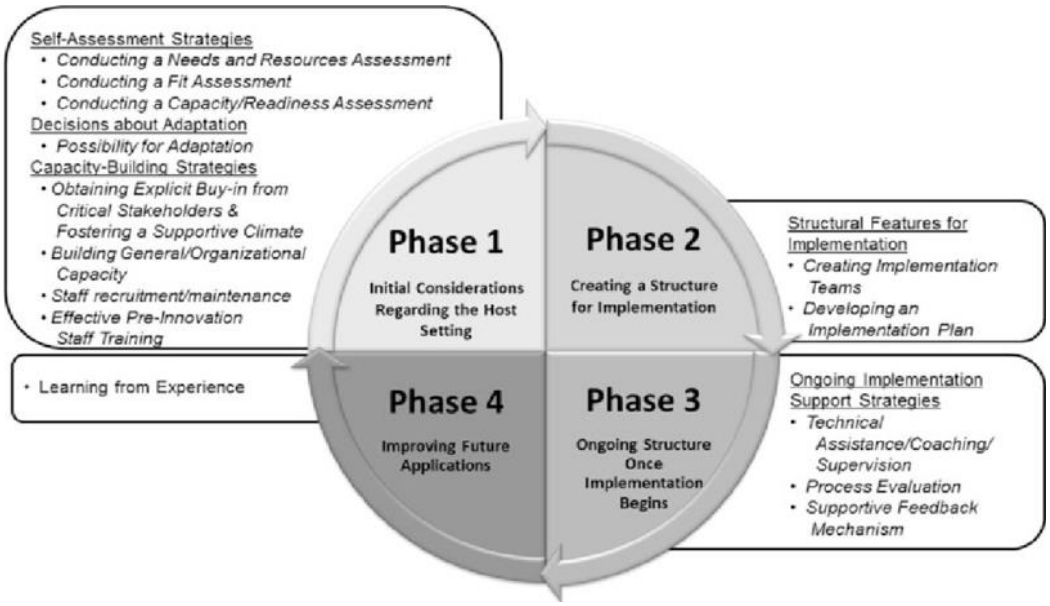




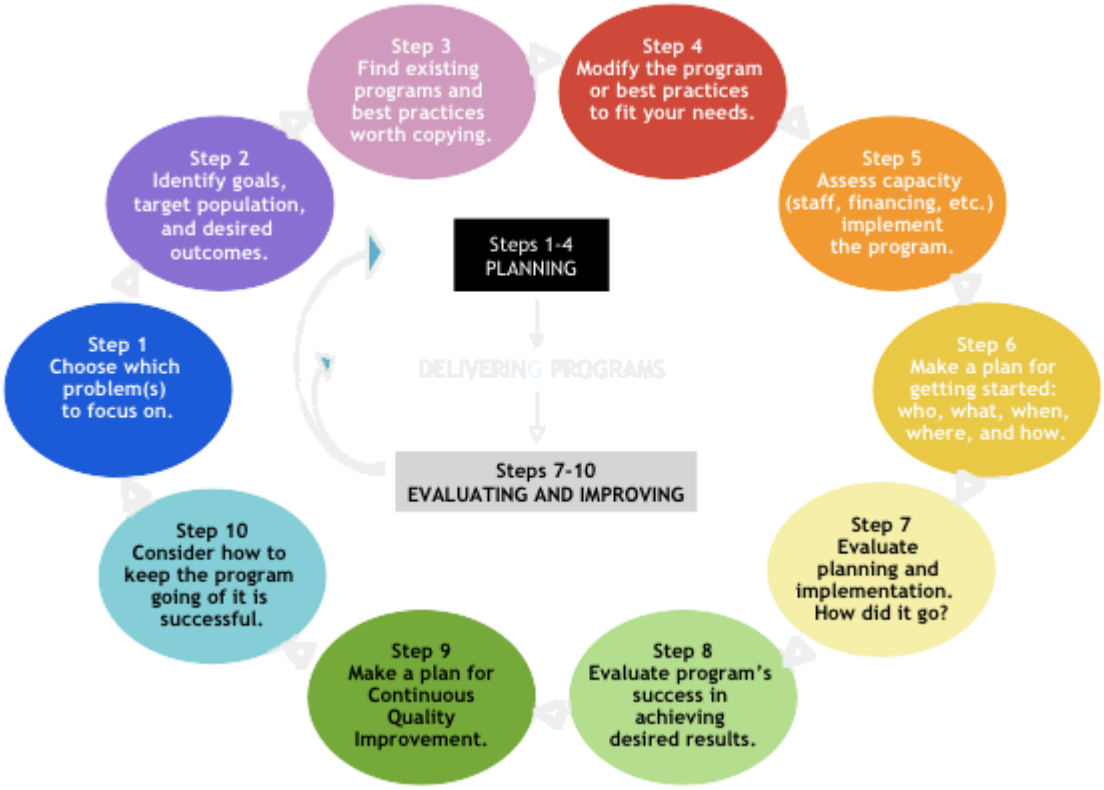
Project Implementation Process

Appendix C

The Quality, Implementation, and Evaluation Model



A Clinical Practice Model for Sustainable Interventions



Appendix D

PM and Site Contract Agreement

The Project/Practicum Mentor (PM)

Purpose

Each student will identify an individual that has practice expertise in nursing leadership. The PM needs adequate content understanding in the area related to the DNP project/practicum and agrees to mentor the student throughout the program and provide guidance with development and implementation of the DNP project/practicum experience, under the supervision of the course instructor and academic mentor.

Qualifications

The PM must:

- Hold a doctoral degree (for example, Phd, EdD, or DNP) from a regionally accredited University and have adequate knowledge and/or expertise related to the DNP scholarly project. (The exception to this rule: DNP 756 the PM may hold a Master's degree).
- In addition the PM must have expertise within the realms of nursing leadership that is documented in a CV or resume. This document should be provided to the student who will submit it for review by the project/practicum course instructor.
- The PM must have a current unencumbered RN license in the state where the DNP Project/practicum will occur. Compact license is acceptable provided both the student and the PM are authorized to practice in the state where the project/practicum will take place.
- The PM may not be the student's supervisor.
- The PM must possess adequate technology skills to read and respond to emails, and to communicate with you in a timely fashion.

Responsibilities of the PM

The PM agrees to:

- Support the student throughout the program or sessions they agree to participate. It is preferred that the PM commit to working with the student throughout the program.
- Help the student gain access to practicum experience at the practice site where applicable.
- Troubleshoot issues that arise during the planning, implementation, and evaluation of the DNP project/practicum.
- Provide encouragement and support during the project/practicum phase of the student's education.
- Share expertise regarding the project/practicum topic.
- Meet in person or virtually with the student and the Project/practicum Team as needed throughout the students' academic career at TUN.
- Mentor the student towards successful completion of the identified DNP scholarly project and/or practicum experiences, under the supervision of the Project Team and/or course instructor.
- Coach, support, and mentor the student towards success as necessary, including obtaining necessary site approvals in the identified project/practicum setting.

Responsibilities of the Student

The student agrees to:

- Utilize the time of the PM effectively and efficiently through effective communication and respect.

- Meet in person or virtually, with the Project Team at least as needed throughout the students' academic career at TUN.
- Make consistent progress towards completion of the DNP Scholarly project/practicum and to keep the PM and Project Team updated on their progress through submission of appropriate weekly Meditrek logs and communication with all parties on an as needed basis.
- Complete all project/practicum course assignments in a timely manner.
- Reach out to the PM with questions and for support as needed.

Responsibilities of the Academic Mentor and Project/Practicum Course Instructor

The Academic Mentor and Project/Practicum Course Instructor agree to:

- Maintain open communication with the PM and Student at all times.
- Schedule virtual meetings with the PM and Student at least once per session and as needed at other times.
- Review the weekly progress reports made by the student and identify and communicate issues that the committee must address.
- Support the student and the PM through availability and responsiveness to identified issues. The overall DNP Project/Practicum experience is monitored and approved by the DNP Project/Practicum course instructor to meet the rigor and clinical requirements of said experience.

I agree to abide by the respective responsibilities stated above, both implicit and inferred.

Linda Bett 10/31/2019
Signature of PM Date

LINDA BETT 10/31/2019
Printed Name of PM Date

Mind Health Psychiatry-Outpatient Private Practice
Project/practicum Site Name

4645 Wyndham Lane, Suite 240, Frisco, Texas 75033
Project/practicum Site Address

972-987-6183/6184
Project/practicum Site Phone Number

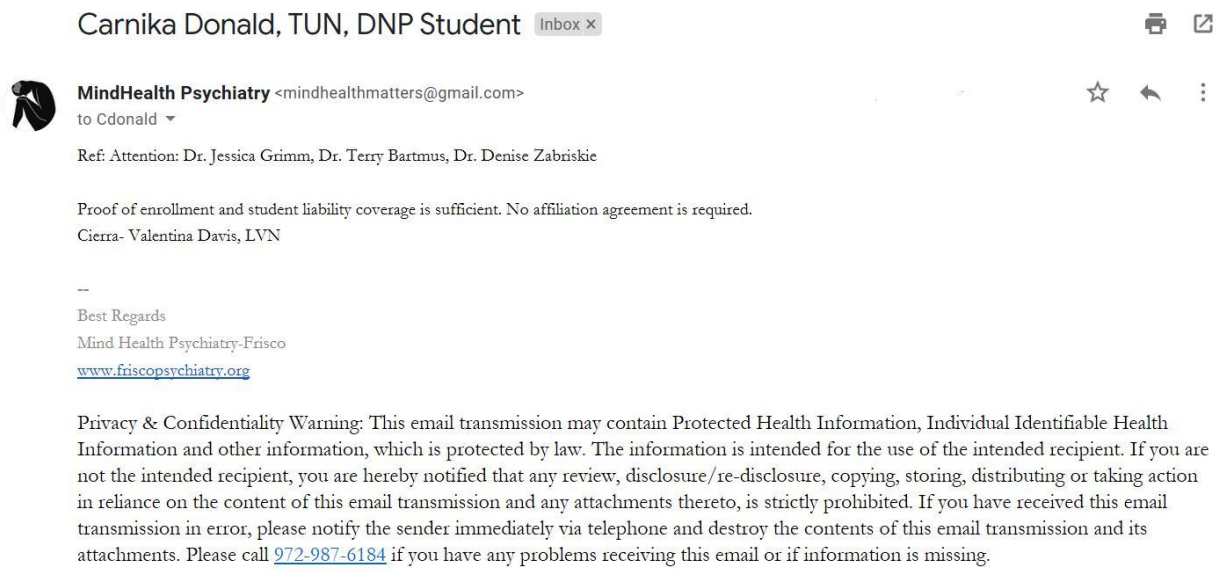
Martha Crawford, Office Manager: info@friscopsychiatry.org
Project/practicum Site Contact Person & Email Address

Carnika Donald 10/21/2019
Signature of Student Date

Carnika Donald
Printed Name of Student

A Quality Improvement Project to Improve Health Outcomes of Lesbian, Gay, Bisexual, Transgender and Queer or Questioning (LGBTQ) Youth Through Increased Requisite Knowledge
Title of DNP Scholarly Project/practicum

Appendix E



Carnika Donald, TUN, DNP Student Inbox ×

MindHealth Psychiatry <mindhealthmatters@gmail.com>
to Cdonald

Ref: Attention: Dr. Jessica Grimm, Dr. Terry Bartmus, Dr. Denise Zabriskie

Proof of enrollment and student liability coverage is sufficient. No affiliation agreement is required.
Cierra- Valentina Davis, LVN

--
Best Regards
Mind Health Psychiatry-Frisco
www.friscopsychiatry.org

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Appendix F

S.O.C.C.S. – Assessment (Version 2)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

S.O.C.C.S. – Assessment (Version 3)

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

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

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

2. The lifestyle of a transgender individual is unnatural.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27. I think being transgender is a mental disorder.

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

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

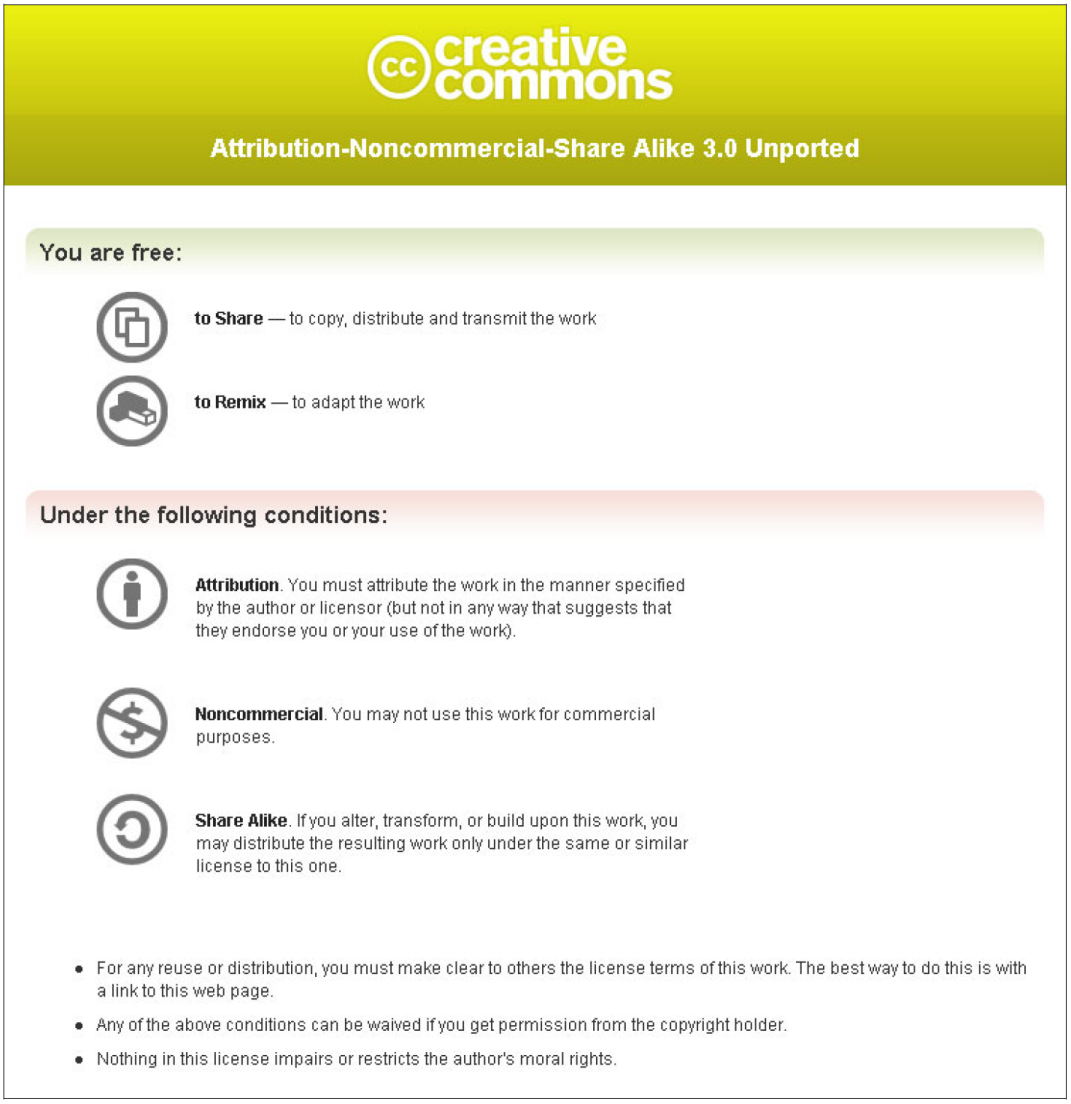
Not at all True			*Somewhat True*			*Totally True*
1	2	3	4	5	6	7

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

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

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

Appendix G



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Appendix H

The Safe Space Protocol

This protocol can be used to ascertain whether your clinical practice is an affirming and welcoming space for LGBTQ people and their families to seek care by specifying as present, limited, or absent. To achieve a wholly affirming clinic experience, the following items should be implemented.

Visibility & Physical Environment

- ☐ Non-discrimination policy, which includes sexual orientation and gender identity, is clearly posted in patient areas.
- ☐ Staff who have completed training in LGBTQ patient care wear pins, stickers, or buttons that feature a rainbow flag or transgender flag.
- ☐ Staff wear gender pronoun pins, or there is a sign indicating that patients should feel comfortable telling staff their gender pronouns.
- ☐ There is literature and/or posters in the patient waiting area that features LGBQT people and TGNC people.
- ☐ Literature in the patient waiting area reference issues relevant to LGBTQ communities, and/or feature a rainbow or transgender flag.
- ☐ Multi-user bathrooms have signage indicating inclusive access, and/or a single user bathroom is indicated with an "all gender restroom" sign.

Inclusive Language Is Consistently Used

- ☐ Staff are consistently observed addressing new patients and their families using gender neutral language.
- ☐ Staff are consistently observed using the correct and current gender pronouns and names for transgender and non-binary or gender non-conforming patients.
- ☐ Intake forms have gender neutral language where applicable:
  - Spouse/significant other instead of husband/wife
  - Parent/guardian instead of mother/father

Staff Training

- ☐ 100% of staff have completed basic training on LGBTQ health equity.
- ☐ An annual LGBTQ healthcare in-service requirement is enforced.

Sexual Orientation and Gender Identity (SOGI) Data Collection

- ☐ Registration/intake forms have options for:
  - Name used (distinct from administrative/legal name)
  - Gender identity (distinct from administrative/legal sex)
  - Gender pronouns
  - Sexual orientation
- ☐ If no forms are used, registration staff are observed asking patients for their gender and name as distinct from what may be on their government issued identification or insurance card.
- ☐ Document SOGI fields in the electronic medical record, for example:
  - In the Epic electronic medical record, these fields exist at registration, and via the SOGI

Clinical Services

- ☐ Clinical staff know to ask TGNC patients what language they use to refer to parts of their bodies that may typically be gendered (for example, saying "chest" instead of "breasts").
- ☐ Clinical staff understand LGBTQ people's cancer risks and what screenings to provide to patients of all gender identities and sexual orientations—particularly TGNC patients.
- ☐ Clinical staff understand the three dimensions of sexual orientation (behavior, identity, and attraction), and how to recommend screenings, immunizations, and safe sex advice based on the patient's sexual behavior.
- ☐ Clinical staff always use open ended/gender neutral questions are asked in order to avoid making assumptions when taking a sexual history.
- ☐ *If applicable (primary care and/or OB/GYN providers):* Clinic staff are able to provide or refer patients to applicable family planning services and/or fertility services that are affirming of all families (including same gender parents, single parents, TGNC parents).
- ☐ *If applicable (primary care providers):* Hormone therapy is available for TGNC patients.

Staff Knowledge of Inclusive Policies

- ☐ All staff are able to describe non-discrimination policy and its inclusion of gender identity/expression and sexual orientation.
- ☐ All of our staff are familiar with and able to describe policy regarding inclusive access to sex-segregated areas (i.e., restrooms, locker rooms, inpatient rooms).
- ☐ All staff are able to describe the fact that SOGI information is protected under HIPAA.
- ☐ *If applicable (inpatient facility):* all staff are familiar with and able to describe the facility's inclusive visitation policy.
- ☐ Staff are able to find these policies on the Health System's intranet.

LGBTQ Friendly Referral List

- ☐ Clinic staff know how to find a list of LGBTQ-friendly referrals for patients who require services not provided in their clinic.
- ☐ Clinic staff know how to ascertain whether a potential referral site is LGBTQ friendly.

Appendix I

Providing Quality Care to Lesbian, Gay, Bisexual, and Transgender Patients: An Introduction for Staff Training

Learning Module — Published on 19 December 2016

This course is eligible for CME credit

In this module, you will learn ways to provide affirming and inclusive health care for lesbian, gay, bisexual, and transgender, or LGBT, patients.

Read More »

Filed under Introduction to LGBTQIA+ Health, Organizational Change

Behavioral Health Care for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) People

Learning Module — Published on 19 March 2018

This course is not eligible for CME credit

In many ways, LGBTQ people have similar behavioral health care needs to the general population. For many LGBTQ people, however, living as a stigmatized minority can cause undue stress, leading to mood disorders, suicidal ideation, and unhealthy coping behaviors, such as substance use disorders or high-risk sexual activity. This module discusses behavioral health disparities faced by LGBTQ populations, explains how these may differ across LGBTQ subpopulations, and discusses evidence-based clinical practices in LGBTQ behavioral health care.

Read More »

Filed under Behavioral Health

Achieving Health Equity for LGBT People

Learning Module — Published on 4 May 2015

This course is eligible for CME credit

This module provides an overview of LGBT health disparities, demographics, and terminology, as well as key strategies for bringing high quality care to LGBT people at health centers and other health care organizations. Strategies for collection of sexual orientation and gender identity data in clinical settings will be addressed. Participants will also learn about creating LGBT-inclusive environments of care and about the intersections of LGBT health, population health and team-based care.

Read More »

Filed under Introduction to LGBTQIA+ Health, Organizational Change

Affirming LGBT People through Effective Communication

Learning Module — Published on 19 December 2016

This course is eligible for CME credit

In this module, you will learn ways to provide affirming and inclusive health care for lesbian, gay, bisexual, and transgender, or LGBT, patients through basic communication principles.

Read More »

Filed under Introduction to LGBTQIA+ Health

Appendix J

Providing Gender-Affirming Care

Increase Visibility and Create an Affirming Physical Environment

LGBTQ patients and their families will often scan a clinical area upon entering for signs that the clinic and its staff are affirming. The following are examples of how clinics can increase their visibility for LGBTQ communities with the purpose of creating a welcoming environment.

- Non-discrimination policy, which includes sexual orientation and gender identity, is clearly posted in patient areas.
- Staff who have completed training in LGBTQ patient care wear pins, stickers, or buttons that feature a rainbow flag or transgender flag
- Staff wear gender pronoun pins, or there is a sign indicating that patients should feel comfortable telling staff their gender pronouns.
- There is literature and/or posters in the patient waiting area that features LGBQ people and TGNC people.
- Multi-user bathrooms have signage indicating inclusive access, and/or a single user bathroom is indicated with an "all gender restroom" sign.

Literature in the patient waiting area reference issues relevant to LGBTQ communities, and/or feature a rainbow or transgender flag, affirming brochures, or stickers.

Use Affirming and Inclusive Language

In addition to visual cues that show your clinical practice is welcoming, LGBTQ patients pay close attention to the use of inclusive language. The best way to ensure staff are consistently using affirming language with patients is to encourage its use in everyday conversations, not only during clinic hours. Please refer to the chart on the next page and the glossary at the end of this guide for helpful tips on language to use and terms to avoid both in conversation and on any intake forms.

SAY THIS:	INSTEAD OF:	WHY?
They **The patient**	He, she, Mr., Mrs., Miss, Ms. or Sir, Ma'am	If you do not yet know the gender identity and gender pronouns of a patient, it is important to use gender-neutral alternatives like "the patient" or "they" rather than making an assumption of their gender. You can also simply eliminate the gendered term and not use a substitute. For example, you could say "excuse me, how may I help you?" Instead of "excuse me, sir, how may I help you?"
Folks **or** **Everyone**	Ladies and gentlemen	These are gender neutral alternatives to addressing a group of people.
Parent or guardian	Mother or father	Not every family includes a mother and/or father. Parent/Guardian are gender-neutral alternatives that convey the same meaning.
Sibling	Brother or sister	This is a gender-neutral term that applies to siblings of all genders, and would be inclusive of someone who is non-binary or gender non-conforming.
Significant Other **or** **Spouse** **or** **Partner**	Boyfriend or girlfriend or Husband or wife	Significant Other is a term that does not assume the gender of someone's romantic partner. It can also be used to refer to a romantic partner who does not identify as male or female. Similarly, spouse can be used if a couple has married.
Intersex	Hermaphrodite	Hermaphrodite is an outdated term with a negative medical history, that when used can be stigmatizing to Intersex people. Intersex is the term used by the Intersex community.
Gay or lesbian	Homosexual	The term homosexual has a negative medical history as being used as a "diagnosis," or in conjunction with "conversion therapy." Additionally, the term is often used when referring to a discomfort with gay and lesbian communities.

SAY THIS:	INSTEAD OF:	WHY?
Transgender person	"Transgendered" or "A Transgender"	Transgender is a term that should always be used as an adjective, not a noun or past state of being.
Cisgender woman or cisgender man	"A real woman" or " a normal man"	Saying "real" or "normal" implies that transgender people are abnormal, which is false and a stigmatizing way to refer to someone.
Assigned female at birth or assigned male at birth	"born female" or "born male" or "biological" gender "male bodied" or "female bodied"	Using "assigned sex at birth" accurately describes how gender is attributed to newborns. Furthermore, the "-bodied" language is often interpreted as pressure to medically transition, or can be interpreted as invalidation of someone's gender identity.
Who are your sexual partners? **or** **What are the genders of your sexual partners?**	Do you have sex with men, women or both? or Assuming the gender of someone's sexual partner(s)	This open ended, gender-neutral question will help avoid making assumptions about someone's sexual orientation or sexual behavior during a sexual history. Only asking about "men, women, or both" also can act to erase non-binary identities, and might cause a patient to not be as open with their provider.
Could your chart be under a different name? **or** **What is the name/ gender on your insurance?**	We don't have you in our records. or What's your real name/gender? Oh, I see you're actually [insert other name]	If a patient's name or gender does not match what you have in the medical record, it is best to ask respectfully about a possible additional or previous name, rather than invalidating the patient's identity or making them feel stigmatized and uncomfortable.
I apologize for using the wrong pronoun, I did not mean to disrespect you.	It's too hard for me to remember your pronoun.	If you make a mistake and use the wrong gender pronoun for someone, simply apologize and acknowledge your mistake.

Appendix K

Appendix L

Appendix M