QueerAlly-IDD: Supporting Intellectual Disability and Developmental Disability (ID/DD) individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+)

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Abstract

The project's purpose is to develop staff education about support strategies for ID/DD individuals who identify as LGBTQ+ in group homes to reduce adverse behavioral issues in the cohort. Studies show that the staff does not support this cohort to express their sexuality or acknowledge their sexual orientation. This study employed quality improvement measures. Data were collected from a convenience sample of the target population via post-workshop surveys adapted from the Knowledge about Homosexuality Questionnaire, pre-and-post community inclusion forms, review of agency's records and environment, and pre-and-post adverse behaviors of the cohort. Data were analyzed by content analysis, Statistical Package for the Social Sciences (SPSS) - Spearman's rho, paired-sample t-test, and Wilcoxon signed-rank test. Evolving findings show that staff education and support would reduce adverse behavioral issues among the cohort. There is a critical need to modify the agency's protocols, forms, cultural competency training, environment, and policies to emphasize the cohort's needs using interventions to diminish minority stress and improve positive psychology (PERMA model).

Keywords: LGBTQ+, LGBTQ+ health disparity, LGBTQ+ statistics, LGBTQ+ policies, LGBTQ+ sexual rights, LGBTQ+ definition, lesbian, gay, transgender, bisexual, transsexual, intersex, Queer, LGBTQ+, intellectual disabilities, developmental disabilities, group homes, sexuality, queer, minority distress, three pillars of positive psychology, PERMA.

QueerAlly-IDD: Supporting Intellectual Disability and Developmental Disability (ID/DD) individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+)

Intellectual disability is a group of conditions portrayed by limited mental function and complexity with adaptive activities such as daily living activities, social interactions, money management, daily schedules, and practices (Baines et al., 2018; Santinele, 2020; Sommarö et al., 2020. The disability could be cognitive, physical, or both (Hall et al., 2019; Khan & Leventhal, 2020). Any intellectual disability that begins before the age of 18 may be due to biological origins, such as cerebral palsy, autism, down syndrome, fetal alcohol syndrome, and non-physical issues such as the absence of stimulation and adult receptiveness. If the cognitive, physical, or both disabilities occur before age 22, the disability could be severe and lifelong (Collado, & Besoain, 2020; Girimaji et al., 2020; Katie, 2020; Khan & Leventhal, 2020).

Advanced perinatal testing and advanced screenings have made it possible for the early detection and treatment of this population (Girimaji et al., 2020; Watson, 2020). Environmental exposures such as lead have been eradicated or monitored for antenatal women and children—the ID/DD population work with expert specialists in the medical, behavioral, and other disciplines (Khan & Leventhal, 2020; Watson, 2020). There is ongoing research to support new therapeutic regimens and technologies for screening and treatments. There are currently research and treatments for fragile x, hypoxic ischemia encephalopathy, and Duchenne muscular dystrophy (Blaskowitz, 2019; Girimaji et al., 2020; Khan & Leventhal, 2020). As a result of these advanced regimens, therapies, research, diagnostic evaluations, the ID/DD population lives longer. Compared to the general population, ID/DD individuals' lifespan is lower. Medical and technological advances have increased life expectancies for people with developmental and intellectual delays (Khan & Leventhal, 2020; Watson, 2020). Compared to the general population, the average age for ID/DD individuals is 65.5 years for people versus 85.3 years (Girimaji et al., 2020; Khan & Leventhal, 2020; Reppermund et al., 2019).

The Queer community, Rainbow community, LGBTQ2+, LGBTTTQQIAA, and LGBTQ+ are diverse ways to refer to the non-heterosexual community. The LGBTQ + is an acronym to describe the lesbian, gay, bisexual, and transgender persons and those who identify as queer, questioning, transsexual, agender queer, questioning, 2/Two-Spirit, gender variant, bigender, intersex, asexual, genderqueer, pansexual, and Pangender (What Does LGBTQ+ Meaning? 2020) (See Appendix B for the description of terms).

Background

Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+)

With the increasing societal acceptance and knowledge about the LGBTQ+ population globally and nationally (Lambda Legal, 2019), many United States laws and proposed policies that may erode this cohort's confidentiality (Kamala's plan, 2019; Lambda Legal, 2019) and do not always provide comprehensive protections for the people who identify as LGBTQ+ (MAP, n.d). Due to this group's systemic discrimination and oppression, LGBTQ+ people are more likely to suffer violence, abuse, absence of support from caregivers and family (James et al., 2016), develop psychological, mental issues (Flores et al., 2018; Baldwin et al., 2017), and physiological issues (Bennett & Goodall, 2016; Williams et al., 2019).

To date, 35 states do not have anti-discrimination law protections from denying credit for the LGBTQ+ people, and only 29% of this cohort live in states that do not have hate crimes protections (Movement Advancement Project (MAP), n.d.). This cohort members also experience violence, sexual assaults and harassment, bullying, mistreatment, and lack of healthcare access (Levy & Levy, 2017; Mallory & William, 2019). Fifty-seven percent of LGBTQ+ children live in states with no discrimination protections in schools and other institutions (Wood, 2019). For instance, during Trump's administration, transgender people were banned from serving in the military (Lambda Legal, 2019; MAP, n.d.). The population is denied some of their human rights, such as confinement in solitary isolation in the jail system (Human Rights Campaign Foundation (HRCF), 2019; Lambda Legal, 2019), and exempted from religious participation (Woods, 2019). Fifty-two percent are susceptible to losing their jobs or losing their homes (Lambda Legal; 2019). In some 23 states, this cohort does not have any protections for public accommodations to protect the cohort from unfair practices such as getting services in public areas (MAP, n.d.).

Even with the mandates from regulatory bodies, the increasing incorporation of the health needs of this cohort into the healthcare professionals' primary education and training (Altneu et al., 2020; Stevens, 2020; Stokes, 2019), many LGBTQ+ people continue to encounter discrimination (Levy & Levy, 2017), stigmatization, and lack of access to quality healthcare support (HRCF, 2019; Lambda Legal, 2019 Raifman et al., 2017). Thirty-three percent of individuals who identify as LGBTQ+ may not see their healthcare providers due to fear of discrimination and mistreatment (James et al., 2016; Katie, 2020; Zeluf, 2016). While only 14 states prohibit healthcare discrimination, 21 states banned the use of transgender prohibitions to deny healthcare insurances to transgender people (MAP, n.d). Five states have religious exemptions that allow medical professionals to refuse care to LGBTQ+ people. Eighty-one percent of LGBTQ+ adolescents live in States that enable youth conversion therapies (MAP, n.d). Only nine states require proof of gender reassignment surgery, and 14 states use "X" options for birth certificates and driver's licenses (Lambda Legal, 2019; MAP, n.d; Raifman et al., 2017). Seventy-four percent of states have criminalized people with HIV+ status (Hoppe, 2017; Lambda Legal; 2019). Nine states have sexually transmitted infections and communicable disease laws used to indict people who have HIV, and five states may require people with HIV to register as sex offenders (MAP, n.d). When incarcerated, 12% of this cohort reported denial of routine health care, while 17% of transgender people reported denial of hormones (Protected and Served, n.d.).

Intellectual Disability and Developmental Disability (ID/DD)

The enactment of the American Disabilities Act (ADA) in 1990 offered protection from biases against people with disabilities; the ID/DD cohort continues to experience prejudices, mistreatment, and violence in every aspect of their life such as housing, employment, healthcare, law enforcement and violence (Pettinicchio, 2019). According to the 2010 U.S. census, 51.5 million people above 15 years of age have some disability (UNC-Chapel Hill LGBTQ Center Staff, 2017). Six million of the U.S. population have severe disabilities (James et al., 2016; UNC-Chapel Hill LGBTQ Center Staff, 2017; CDC, 2018). Depending on the severity of their disabilities, ID/DD individuals usually live with their families in the community, in 24 hours supervised group homes, or independently with weekly supervision (NCI, n.d.). People with ID/DD have more chronic illnesses than people without disabilities (Girimaji et al., 2020; Khan & Leventhal, 2020; Reppermund et al., 2019). Per CDC (2018), 38.2% of ID/DD individuals are obese, 11.5% have heart disease, 28.2 % smoke, and 16.3% have diabetes. Adding to the social determinants of health, 13% of disabled people do not have a high school degree, 59% are unemployed, 85% do not have internet access, and 34% have a household income of less than $15000, or 34% have inadequate transportation (CDC, 2018; Reppermund et al., 2019).

ID/DD individuals have several barriers, such as limited access to healthcare, unavailability of healthcare professionals and service providers, and lack of adequate data collection (CDC, 2018). Studies found that 13.7% of ID/DD individuals have problems with ambulation, 10.8% have issues concentrating or remembering, and 6.8% have difficulty with daily living activities. Also, 5.9% have a problem with hearing, 4.6% have problems with vision, and 3.7% cannot dress or bathe independently (CDC, 2018; Okoro, 2018).

Society does not always treat the ID/DD cohort the same as the public (Gil-Llario et al., 2020). Ableism, which is prejudice, and social bias against people with disabilities based on the conviction that disabled individuals' abilities are inferior, is prevalent, or disablism, which is the dismissing conduct for people with disabilities (Gappmayer, 2020; Jain, 2020). Caretakers, guardians, and families of ID/DD individuals do not consistently adhere to this cohort's ethical principles of respect, autonomy, and self-determination. ID/DD individuals have limited opportunities or are denied their rights to do business, vote, have meaningful and romantic relationships, enter into contracts, or have the right to pursue education (Gappmayer, 2020; Jain, 2020). This project will focus on the ID/DD individuals with intellectual and developmental disabilities (ID/DD) who live in group homes.

ID/DD individuals who identify as LGBTQ+

Under the American Disabilities Act (ADA), disabilities imply any mental or physical deficiency that significantly limits one or several life endeavors (Forber-Pratt, 2019). However, this definition does not include homosexuality, pedophilia, voyeurism, bisexuality, transsexualism, transvestitism, and gender identity. However, transgender people can seek protection under the American Disabilities Act (Lam et al., 2019; Rodriguez-Roldan, 2020). The NCI report did not report on the individuals who identify as LGBTQ+ (NCI, n.d.). Studies discussing LGBTQ+, ID/DD, and ID/DD individuals who identify as LGBTQ+ are different in different research areas, and the findings may not necessarily be transferable between research areas. According to James et al. (2016), LGBTQ+ individuals with disabilities experience more discrimination and oppression and are more likely to be neglected and abused in the healthcare arena.

The Human Services Research Institute (HSRI) and the National Association of State Directors of Developmental Disabilities Services (NASDDS), 46 states, the District of Columbia, and 58% of entities collaborated to aggregate data about this cohort. Different facilities, researchers, regulatory bodies like the Office of People with Developmental Delay (OPWDD), and federal, state, and local legislators use this data to create National Core Indicators (NCI) to inform strategic planning, prioritize quality improvement processes, and set priorities for the ID/DD population (NCI, n.d.; Qian et al., 2018). The NCI collects objective and subjective surveys in relationships, community, inclusion, choices, human rights, decision-making, goals, employment, service coordination, self-determination, access, welfare, safety, and Health. This information helps states and researchers to gauge important components of person-centered development, outcomes, and satisfaction. The NCI data also helps agencies and healthcare providers monitor changes in the cohort's health status, examine differences between subgroups within the cohort, monitor progress towards set goals, and scrutinize differences in care quality within healthcare facilities in different geographical areas (Bradley, 2020; Qian et al., 2018).

According to the National Core Indicators (NCI) 2018-19 data, 36% of females and 30% of males in the LGBTQ+ population have a form of disability. Also, 40% of bisexual men, 26% of gay men, and 36% of bisexual women reported disability. Seventy percent of autistic people identify as LGBTQ+ individuals (UNC-Chapel Hill LGBTQ Center Staff, 2017). Compared to 15% to 20% of the population who reported a disability or two, 36% of lesbian, 36% of bisexual women, 39% of transgender, and 40% reported more than one disability (MAP, n.d.). Seventy-three percent of individuals surveyed are 18-54 years, ranging from a mean average of 42.7 years. Of the surveyed respondents, 58% were males, 42% were female, 93% were single, and never married. Ninety-one percent have some psychiatric or behavioral problems, and they are all on 1-10 psychiatric medications (NCI, n.d.). Ninety-three percent need help to decide how to spend their free time. Fifty-one percent cited that they could not see their friends due to the lack of staff support, unavailability of transportation, and restriction about seeing their friends. Fourteen percent reported that they do not like where they live due to staff problems, and 38% want to be independent. Of the surveyed respondents, 10% want education and training for additional services, while 12% want social relationships and meeting friends. Interestingly, 93% reported that staff treats them with respect and 89% reported that staff has the proper training to meet their needs (NCI, n.d.).

According to a U.S study, disabled people who identify as LGBTQ+ are more prone than the mainstream population to experience bigotry and social stress, leading to many physiological and psychological issues (James et al. 2016; Protected and Served, n.d; Whittle & Butler, 2018). The ID/DD people that identify as LGBTQ+ people are likely to experience mood disorders such as anxiety, substance use disorders, and depression (Whittle & Butler, 2018). Forty percent of the people with disabilities who identify as LGBTQ+ reported mental health, such as suicide, bipolar, psychosis, aggressive behaviors, and depression (Hall et al., 2020; James et al., 2016; Rodriguez-Roldan, 2020).

Disabled people also have sexual needs, even though society erroneously does not think so (Botawska-Charko et al., 2018; McCann et al., 2016). ID/DD people are likely to be supported and educated if they are heterosexual instead of preferring same-sex sexuality (Zeluf, 2016). LGBTQ+ people with disabilities, especially minorities, experience more negative encounters with law enforcement and may not seek help (James et al., 2016; Protected and Served, n.d.). These individuals encounter double and triple discrimination due to their disability, ethnicity, gender identification, and sexual orientation (James et al., 2016). Twenty-eight percent of the transgender report getting arrested due to sexual identification, and 52 % of transgender ID/DD people reported uneasiness about seeking help from law enforcement (James et al., 2016.; Pettinicchio, 2019). Nine percent of individuals who identify as LGBTQ+ were twice as likely to have been in jail or prison than individuals who identify as LGBTQ+ without disabilities (Protected and Served, n.d..). McCann et al., 2016 found that 74% of people with developmental disabilities do not know about LGBTQ+ issues. Surprisingly, 70% of the ID/DD population who identify as

LGBTQ+ have negative attitudes towards individuals who identify as LGBTQ+ and have difficulty accepting their own identity as LGBTQ+ (McCann et al., 2016).

Consequently, this population may require more medical and nursing care for other health care diseases, including negative behavioral issues (Blaskowitz, 2019; Khan & Leventhal, 2020). Some of these diseases include chronic illnesses such as the dual diagnosis of physiological diseases, psychological and behavioral, and classic advanced age-related disorders (Gappmayer, 2020; McCann et al., 2016; Moreno et al., 2017; Ross, 2018).

Purpose Statement

The proposed scholarly project's purpose would use quality improvement measures to develop staff education about support strategies for ID/DD individuals who identify as LGBTQ+ in group homes to reduce behavioral issues in the cohort.

Problem Identification

Sexuality is a rudimentary human right for everybody, regardless of orientation, gender, cognitive abilities, and age (Whittle & Butler, 2018). Societal and cultural standards influence sexuality. Entrenched in the human formation of self-identity, well-being, and self-esteem is human sexuality (Brown & McCann, 2018; Hall et al., 2020; Matson, 2019). In the past decades, sexuality for the ID/DD population was restrictive and repressed, mostly ID/DD individuals who identify as LGBTQ+ (Maltais et al., 2020; Whittle & Butler, 2018). The sexual rights of the ID/DD population are considered taboo, hypersexual, or asexual (Whittle & Butler, 2018). However, with the growing acceptance of the LGBTQ+ population, many studies advocate accepting, normalizing, and supporting this population's sexual rights (Whittle & Butler, 2018). Many studies recommended integrating this socialization and normalization into practice without causing restriction to the cohort's expression of their sexuality (Maltais et al., 2020; Sommarö et al., 2020; Whittle & Butler, 2018).

Many healthcare agencies struggle with how to provide holistic care that addresses the sexual needs of these individuals. However, the needs of individuals who identify as LGBTQ+ are not always met or managed by these agencies that provide care for these individuals (Maltais et al., 2020; Medina-Rico et al., 2018; Timmeren, 2017). Inconsistent culturally congruent care and support for LGBTQ+ ID/DD individuals could contribute to patients' safety, decrease staff satisfaction and retention, and increase unnecessary emergency room and hospitalizations (Sommarö et al., 2020; Hall et al., 2020). Healthcare agencies may be charged with the violation of ID/DD individual human rights, and there are increased and frequent psychological hospitalizations of the ID/DD individuals (Blaskowitz, 2019; Hillier et al., 2019; Kim et al., 2020; Stoffelenet al., 2018).

Studies show that ID/DD individuals who identify as LGBTQ+ are less likely to be educated about their sexuality, lifestyle, or supported (Bennett & Goodall, 2016; Rodriguez-Roldan, 2020; Sommarö et al., 2020). Some of these individuals are less likely to have role models or opportunities to meet sexual partners (Bennett & Goodall, 2016). Due to cultural, societal, and personal beliefs, some staff members may not be willing to support these individuals' sexual rights (McCann et al., 2016; Zeluf, 2016).

Staff who provide care for these individuals may show discrimination, prejudice, and bias towards this cohort (McCann et al., 2016). Staff members may not have the appropriate education and support from the group homes (Maltais et al., 2020; McCann et al., 2016; Sommarö et al., 2020). Even staff who identify as LGBTQ+ may be uncomfortable acting as role models for this cohort because they may fear repercussions and discrimination from their employers and coworkers (McCann et al., 2016; Whittle & Butler, 2018). Also, the group homes' environment may not be conducive for these individuals to express their sexuality. For instance, some of these individuals depend on the staff for their transportation and community inclusion activities

(Stoffelen, 2018; Whittle & Butler, 2018) and has house rules that may not provide the privacy that they may need to express their sexuality (Stoffelen et al., 2018; Katie, 2020).

As a result of unsupported attitudes from families and caregivers of this cohort's sexual orientation (Whittle & Butler, 2018), these ID/DD individuals who identify as LGBTQ+ may not understand their lifestyles (McCann et al., 2016), may not have opportunities to meet sexual partners and satisfy sexual needs (Bennett & Goodall, 2016; Rodriguez-Roldan, 2020; Sommarö et al., 2020). These individuals may become exposed to sexual violence, commit sexual crimes, practice unprotected sex (James et al., 2016; Katie, 2020; Zeluf, 2016), or have positive role models to guide them (Brown & McCann, 2018; Stoffelenet al., 2018).

Studies show that these sexual frustrations may lead to detrimental behavioral and psychological issues such as elopement, destruction of properties, physical assaults to themselves and others, sexual assaults, depression, suicide, and distress (Blaskowitz et al., 2019; Collado & Besoain, 2020; McCann et al., 2016; Whittle & Butler, 2018). Some of these individuals will express their sexual frustrations by exhibiting an increase in objectionable behavioral and psychological issues for this cohort, such as depression, violent acts, sexual deviance, eloping, sexual violence to others, or becoming victims of sexual violence (Maltais et al., 2020; Sommarö et al., 2020; McCann et al., 2016; Whittle & Butler, 2018).

Project Question

In ID/DD individuals who identify as LGBTQ+ in a group home, does implementing a supportive strategic education protocol for the group home staff that is evidence-based and culturally competent, compared to current practice, decreased behavioral issues within five weeks?

Literature Review

Numerous disciplines have extensive studies in different settings and populations about Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+), and disabilities issues. The variables examined include psychological problems caused by the marginalization of LGBTQ+ individuals with disabilities, training for staff who support LGBTQ+ individuals with disabilities, and institutional (group homes) barriers that contribute to the lack of support for Intellectual Disability and Developmental Disability (ID/DD) individuals who identify as LGBTQ+.

Search Methods

The search started with Touro University library databases - CINAHL, PsycArticles, PsycInfo EBP database Medline, Cochrane systematic review and Google scholar for current and relevant literature using the resulting keywords search terms: *OR same-sex attract, OR learning disabil*, gay OR lesbian*, queer* OR homosexual* retard* OR intersex* OR intellectual impairment, OR support staff* OR intellectual disabil*, LGBTQ+, OR cognitive disabil* health disparity, LGBTQ+ statistics, OR queer LGBT Q+ policies, LGBTQ+ rights, OR bisexual* OR transgender OR developmental disabil* OR transex* Disabilities, Sexuality, minority distress, three pillars of positive psychology.* The search encompassed the period from 2016 to 2020 and yielded more than 200 potential papers that might match the review's aims. Boolean operators, truncation, nesting, and precision, wildcards were used to narrow the search (Ginex, 2018) using OVID, ERIC, Elsevier, SilverPlatter, and EBSCOhost systems. CINAHL was used to search for grey literature unpublished studies. More information came from citation chasing in a particular journal (Johns Hopkins Nursing Evidence-Based Practice Model, 2017).

Inclusion criteria

This literature review is saturated but not extensive due to the magnitude of available literature on disabilities and LGBTQ+. The inclusion criteria include all quantitative, qualitative, and mixed-method studies conducted globally from 2016-2021 and published in peer-reviewed journals in English that focused on support staff strategies for LGBTQ+ ID/DD individuals in all settings. Settings included anywhere the ID/DD individuals live and receive care from caretakers who are not family members. Staff members include all professional and non-professional staff that provide services for this cohort. A few older seminal studies were included to support the theoretical frameworks for this project. Eighty-eight current and valid sources were used for this literature review.

Review of Study Methods

The articles' analysis started by critically appraising the fundamental concepts of studies research questions, validity and reliability processes, sampling procedures, measurement and instrumentation, and ethical considerations (Chism, 2019; Murphy et al., 2018; Pinchbeck & Archer, 2020; Wyant, 2018). The literature sources are appraised and deemed valid and reliable due to the methodology used to conduct research examining ID/DD individuals who identify as LGBTQ+. The studies have well-written, clear, and defined research questions and independent and dependent variables. The questions contain the intended sample, action words, and the research issue (Hunt et al., 2018). The sampling method to provide a sample of participants from a homogenous population is especially important. For some research designs, subsamples may not represent the population due to the fair response rate and the oversampling, and consequently not generalizable (Creswell & Clark, 2017). Also, studies must show the protection of the participants from harm. For example, the authors must document permission from the Internal Review Board (IRB) and how confidentiality would be ensured (Creswell & Clark, 2017; Moran et al., 2020). The appropriateness of the types of statistics used for the data analysis and the type of studies. Data analysis showed saturated discussions, well-formatted tables, charts, and diagrams to illustrate descriptive and inferential statistics findings. They must establish the content validity of the research instruments for data collection. Finally, studies discussed any limitations, such as threats to external and internal validity, sampling validity, and ethical considerations (Creswell & Clark, 2017).

Review Synthesis

The literature discussed included quantitative, qualitative, and mixed-method studies. These studies include correlational, causal-comparative, retrospective, observational studies, mixed-methods comparative studies, historical, content analysis, retrospective cohort studies, phenomenological studies, integrative reviews, narrative, grounded theory, and exploratory qualitative and case studies. Additionally, the literature supports the theoretical frameworks for this project.

Globally, the connection between disabilities and sexualities is taboo (Medina-Rico et al., 2018; Santinele, 2020). ID/DD individuals who identify as LGBTQ+ are invisible when expressing their sexuality (Toft, 2020). Of all the sexual minorities, this cohort has the most restrictive barriers (Achey, 2020; Botawska-Charko et al., 2018; Medina-Rico, 2018). These individuals are usually too confused and embarrassed to explore their sexuality (Achey, 2020; Weller, n.d.). However, this cohort is having sexual intercourse (Botawska-Charko et al., 2018). By the age of 16, 24% of boys and eight percent of girls have had sexual intercourse (Weller, n.d.). Marginalized groups such as ID/DD individuals with LGBTQ+ identities have health disparities (Hall et al., 2019; NCI, n.d). Literature documents that this cohort is more marginalized than their counterparts who do not identify as LGBTQ+ in terms of access to health care (James et al., 2016), sexuality training (Bates, 2020), and sexual socialization and support (Achey, 2020; Botawska-Charko et al., 2018).

Even with the increasing acceptance of LGBTQ+ in society and extensive studies about this cohort's multidisciplinary needs, this cohort still struggled to be accepted (Protected and Served, n.d; Santinele, 2020; Stoffelen et al., 2018). There is a prevalence of stigma, bias, and discrimination associated with the combination of disability and LGBTQ+ identification (Anti-Defamation League, 2020; Dinwoodie, 2020; Toft, 2020). Society adversely portrays this cohort as almost inhuman, child-like, incapable of having or maintaining normal romantic relationships, inability to have sexual desires (Achey, 2020; Frawley & Wilson, 2016; Santinele, 2020), and inept in exercising their sexual rights (Stoffelen, 2018). This negative portrayal leads to ableism, which is the bias of and social discrimination against disabled people on the assumption that disabled people are substandard to non-disabled people and require healing from their disability (Gappmayer, 2020; Jain, 2020) and increasing stigma, misconceptions, and invisibility of the cohort (Toft, 2020). Another issue is covert and overt newgenics. Newgenics aims to promote humankind but causes barriers to the disabled population, such as restrictive group home policies to prevent sexual relationships (Eugenics to Newgenics, 2018).

This literature review focuses on the systemic barriers for disabled individuals, such as barriers to policies, supports, education, and services. This study highlights implementing an evidence-based and culturally competent supportive strategic education protocol for the group home staff to support ID/DD individuals who identify as LGBTQ+.

Evidence Gaps and Controversies

This literature review shows a myriad of limited or outdated vital issues. There are gaps regarding the exact content to add when developing policy and protocol to guide staff support for this group (Achey, 2020; Wilson & Frawley, 2016). Many agencies have limited or no protocol, limited information (Achey, 2020), inadequate training for the staff on how to support these individuals (Mcann & Brown, 2016), and inconsistent education for the ID/DD individuals who identify as LGBTQ+ population (Campbell et al., 2020; Santinele Martino 2017; Wilson & Frawley, 2016). Martino, 2020 posits a gap in understanding this cohort's intimate personal lives during unprecedented times like the covid-19 pandemic. Additional research is needed about bias and social isolation impacts the cohort and non-verbal members' needs (Bastable, 2020; Borawska-Charko, 2017; Wos et al., 2020).

When members of this cohort freely express their sexuality and are supported by their support team, there is a decrease in psychiatric problems (Achey, 2020; Chou et al., 2020) and less distress and dissonance (Dinwoodie et al., 2020). Wilson et al., 2018 stipulated that some psychological issues like depression for this cohort could be mitigated by having staff support, a partner, and active social and community inclusion. Staff should be available to individuals and make efforts to be sensitive to this cohort's needs and advocate for their autonomy and self-determination (Mcann et al., 2019). Recent studies and projects need to develop comprehensive staff training on how to provide safe sex training for the cohort (Achey, 2020). Support staff must become knowledgeable about advocating, supporting, eliminating obstacles for this cohort, and providing culturally congruent care (Nowaskie, 2020; Pereira, 2020; Salerno, 2020). There is a need for professional practice and language change when addressing this cohort (Trista, 2018). The reinforcement of a nonjudgmental attitude is essential (Achey, 2020; Nowaskie, 2020). Studies suggest that healthcare providers should be provided with culturally congruent care training to avoid health disparities (Nowaskie, 2020; Tallentire et al., 2020). The review of the literature indicates the following themes:

Theme Development

Marginalization by Support Staff and Families

Individuals with ID/DD identify as LGBTQ+ and are doubly marginalized because of their sexual orientation as LGBTQ+ (Bates, 2020; James et al., 2016; Sommarö et al., 2020) and their disabilities disease process (Bates, 2020; Lam et al., 2019; Rodriguez-Roldan, 2020; Sommarö et al., 2020). Due to their disabilities, this cohort also experiences discrimination from the mainstream LGBTQ+ community (Sommarö et al., 2020; Wilson et al., 2018) and is stigmatized by the ID/DD community (Bates, 2020; Rodriguez-Roldan, 2020) due to their lack of socialization skills and lack of finances (Stoffelen, 2018). The members of this cohort reside in group home settings or with their families (Wilson et al., 2018) and depend on others to decide their daily activities, including the dependent on others to dictate the expression of their sexuality (Achey, 2020) facilitate community participation (McDaniels & Fleming, 2018) or provide privacy to have sexual experiences (Frawley & Wilson, 2016; Stoffelen, 2018).

LGBTQ+ individuals with developmental disabilities reported that they do not feel supported by their support staff and that barriers prohibit them from expressing their sexuality (Achey, 2020). Caretakers and families may disagree that this population can consent to have sexual partnerships due to their disease process. This cohort does not have the mindset to understand the complexities of having sexual and romantic relationships (Santinele Martino, 2019). Staff erroneously thinks that individuals do not have sexual needs (Achey, 2020; Charitou et al., 2020) and may contribute to the negative attitudes and barriers that may stop them from having sexual rights (Maltais et al., 2020; Sommarö et al., 2020). Also, staff may feel that socializing this cohort to the LGBTQ+ lifestyle may be construed as promoting the lifestyle or may become the subject of discrimination themselves (Achey, 2020; Wilson & Frawley, 2016).

Individuals with ID/DD who identify as LGBTQ+ want to learn how to form and maintain healthy relationships and friendships (Bastable, 2020). According to studies, 98% of the ID/DD population show interest in sexual education (Bastable, 2020; Gil-Llario, 2020; Schaafsma et al., 2017), while 89% want to discuss their sexuality (Gil-Llario et al., 2020; Wos et al., 2020). Literature shows that this cohort's families and caretakers are not knowledgeable and competent about this population's sexuality and sexual needs (Charitou et al., 2020; Pereira, 2020). These caretakers and families may not view this cohort as sexual beings with sexual needs (Botawska-

Charko et al., 2018; McCann et al., 2016; Pereira, 2020) and incapable of romantic relationships (Charitou et al., 2020). This cohort barely receives sexuality education and are dismissed as unable to understand the concepts (Wu & Zeng, 2020; Widyaningrum & Siwi, 2018), do not have sexual needs (Achley 2020), and that the training would lead them to become promiscuous (Bolin et al., 2018; Borawska-Charko, 2017). The erroneous preconception is that the cohort is not knowledgeable about making informed decisions and consent about getting partners, safe sex, or their right to sexual expression or pleasure (Dinwoodie et al., 2020; Stoffelen, 2018). According to literature, this dismissal of this cohort's sexuality is related to staff lack of acceptance or understanding of the LGBTQ+ lifestyles (Chou et al., 2020; Robinson et al., 2020), staff personal and societal paternalistic influences that the cohort is unable to have sexual desires (Pereira, 2020; Widyaningrum & Siwi, 2018), and lack of knowledge on how to support and assist the cohort in expressing their sexuality (Achey, 2020; Bolin et al., 2018; McCann et al., 2016;). Some staff, including those who identify as LGBTQ+, may not be willing to be role models or advocates (Achey, 2020; Sommarö et al., 2020; Stoffelen et al., 2018), may be reluctant to correct colleagues due to fear of discrimination (Lund et al., 2020; Wilson & Frawley, 2016) or fear the possibility of being accused of sexual misconduct (O'Shea et al., 2020) or violation of patients' legal rights (Wilson et al., 2018). Some caretakers may have an underlying phobia, negative experiences, or implicit bias about same-sex activity and lifestyles (Bates, 2020) due to their religion, values, beliefs, or culture (Frawley & Wilson, 2016). In a study conducted this year, caregivers of ID/DD individuals with LGBTQ+ confirmed that they were not comfortable socializing or encouraging the lifestyle (Achey, 2020) or discussing the subject or the lifestyle (Bolin et al., 2018; Schaafsma, 2017). In the same study, caretakers for this cohort reported that families' or guardians' request not to socialize the cohort members into the LGBTQ+ lifestyle precludes them from socializing or supporting the cohort (Achey, 2020). Families and guardians' refusal to accept the sexuality of the

ID/DD individuals leads to further dismissal and lack of support for this cohort (Achey, 2020; McCann et al., 2016; Whittle & Butler, 2018).

Effects of marginalization: Literature documents the detrimental effects of this lack of staff support for the ID/DD individuals who identify as LGBTQ+ (Chou et al., 2020; Meyer, 2003; Pereira, 2020; Robinson et al., 2020; Tallentire, 2016). This cohort reports more fair or poor health and unmet healthcare than non-LGBTQ+ respondents and reports more social isolation (Hall et al., 2019). The adverse effect stems from the individuals experiencing minority stress (Bariola et al., 2016; Meyer, 2003; Salerno et al., 2020; Sun et al., 2020) and lack of positive psychology (Lund et al., 2020; Kern et al., 2020). Minority distress develops when this cohort cannot express their sexual rights (Lund et al., 2020; O'Shea et al., 2020). This distress may result in the dual diagnosis of ID/DD and behavior problems (Ross et al., 2020). Due to staff and organizational barriers, these individuals are uncomfortable having sexual relations in their group homes (Bates, 2020) or expressing their sexuality (Dinwoodie et al., 2020). This cohort would hide and repress their sexuality to fit the acceptable societal norms to avoid bullying, bias, discrimination (Dinwoodie et al., 20202).

This cohort's marginalization leads to individuals exhibiting mental and behavioral issues such as adverse and violent behaviors towards themselves and others (Charitou et al., 2020; Ross et al., 2020). According to the literature, 56% of LGBTQ+ teens with disabilities reported that they had considered suicide, contrasted to 27% of non-disabled LGBTQ+ teens (Horner-Johnson, 2021; Tejera et al., 2019). Since some of these individuals are nonverbal, their sexual frustration may manifest in other ways, such as depression, bipolar, body mutilation, and sexual assaults of staff, peers, and others (Charitou et al., 2020; Toft, 2020; Willging & Ramos, 2016). Other adverse behaviors may include suicide, violent acts such as biting, kicking, headbanging, destruction of properties, physical attacks on staff and families (Rodriguez-Roldan, 2020; Santinele Martino, 2020; Tallentire et al., 2016). Studies show an increased prevalence of psychiatric ER admissions and hospitalizations (Glidden, 2016; Ross et al., 2018). These frequent psychiatric and hospitalization visits may cause an increase in unnecessary treatments (McCann & Brown, 2016), exposure to hospital staff who are not familiar with the ID/DD diagnoses (Hall et al., 2019), harmful contact with law enforcement (Rodriguez-Roldan, 2020), and increase in health cost spending, decrease in family, patient, and staff satisfaction (Willging & Ramos, 2016). The institutions that serve these individuals could be liable for the lack of upholding the patients' rights and providing safe, efficient, and equitable care (James et al., 2016; Rodriguez-Roldan, 2020).

Lack of support and marginalization leads to social isolation, low self-esteem, and loneliness (McCann et al., 2019), emotional, mental, and physical abuse by strangers, family members, and support staff (Dinwoodie et al., 2020; Treacy et al., 2017). Studies show that these individuals could get indicted for sexual misconduct, such as exposing themselves in public or having sexual relations in public (Borawska-Charko, 2017; Chou et al., 2020; McCann & Brown, 2016). Also, the members of this cohort are likely to elope and have unsafe sex (McCann et al., 2019), are vulnerable to sexual exploitation and abuse (McDaniels & Fleming, 2016), sexual assault (Cessna, 2020; Hanass-Hancock et al., 2018; Wu & Zeng, 2020), contract chronic sexually transmitted diseases (Bolin et al., 2018; Treacy et al., 2017), have unplanned pregnancies (McCann et al., 2019; Wu & Zeng, 2020); and not able to sustain lasting healthy relationships (Baines et al., 2018; McCann et al., 2019).

Education of Support Staff

Studies document a lack of appropriate staff training about LGBTQ+ lifestyles (Achey, 2020; Sommarö et al., 2020; Wu & Zeng, 2020). Proper education would improve the cohort's lives (Pedani, 2016; Wu & Zeng, 2020). These studies show that support staff is not always knowledgeable about the LGBTQ+ lifestyle (Bolin et al., 2018; McCann et al., 2019) and are uncomfortable about discussing the topic (Hanass-Hancock et al., 2018; Martino & Perreault-Laird, 2019; Schaafsma, 2017; Wu & Zeng, 2020). The support staff is not educated about the intersection between disabilities diagnosis and LGBTQ+ (Santinele, 2018, 2020; Stoffelen et al., 2018) and still believe that sexual education would lead to the cohort becoming promiscuous (Borawska-Charko, 2017; Hanass-Hancock et al., 2018; Widyaningrum & Siwi, 2018). Multidisciplinary staff primary and continuing education do not always include or minimally include this population's sexual needs in the curriculum (Achey, 2020; Altneu et al., 2020; Glick et al., 2020; Joseph & Nisker, 2020; McCann & Brown, 2016; McCann et al., 2016; McNiel & Elertson, 2018; Nowaskie et al., 2020).

Studies show that even with education, the support staff is still hesitant to provide culturally sensitive care to this cohort (Dewinter et al., 2017; McCann et al., 2016; Whittle & Butler, 2018). In a 2020 study, caregivers were willing to support these individuals but did not have clear guidelines, current information, or directions on how to support the cohort (Achey, 2020). Staff reported a lack of training on support approaches for the population (Maltais et al., 2020; Sommarö et al., 2020). Literature found that education and caretakers are also crucial to challenging any negative institutional behaviors and any societal abuse (Charitou et al., 2020; McCann & Brown, 2016; Widyaningrum & Siwi, 2018).

The training design and goals are to change caretakers' conservative mentality to respect different sexualities of the ID/DD LGBTQ+ population (Bolin et al., 2018; Charitou et al., 2020). Staff education should be in-depth and incorporate adjustment in attitude about staff perceptions and feelings about the population (Altneu et al., 2020; Bolin et al., 2018), the impact of conscious and unconscious biases (Stokes, 2019), cultural awareness and beliefs, cultural knowledge, and cultural skills (Dewinter et al., 2017; Wilson et al., 2018). Staff training should be LGBTQ-specific (Fuente, 2017) and part of the staff's annual cultural competence training, including a review of policies and protocols to support the individuals (Nowaskie, 2020).

The literature also suggested incorporating positive psychology principles into caregivers' training to decrease psychological stress and maintain the individuals' welfare (Moreno et al., 2020; Sommarö et al., 2020). Staff training should also include approaches to addressing this cohort's sexual needs, the treatment for those changing their gender, signs, symptoms to monitor, and how to help the cohort adjust (Meyers, 2003; Moreno et al., 2020). A study proposed incorporating issues about consent to sexual relationships and capacity to consent (Goli et al., 2018) and addressing the staffing dilemma regarding their need to protect the individuals' rights to choose (Fisher et al., 2016) and their rights to self-determination (Mcann et al., 2019). Literature indicated that the appropriate and practical training for this cohort should include information about LGBTQ+ lifestyles, contraception, dating, sexual relationships, sexual pleasure, acceptable and unacceptable sexual conduct, and intimacy (Chrastina & Večeřová, 2020; Treacy et al., 2017; Triska, 2018; Wu & Zeng, 2020). It is essential to entrench the need for sexuality education for this cohort (Pound et al., 2017) into the policies and protocols of the agencies that service these individuals. The training's vital part is encouraging and directing staff to do personal self-reflection about their perception and values of the cohort (Altneu et al., 2020; Mayfield et al. 2017; Nowaskie, 2020; Stokes, 2020), and time allocated to discuss issues about ableism, transphobia, homophobia (Charitou et al., 2020; Wilson & Frawley, 2016). The staff competency goals include assisting the cohort in making up-to-date and educated choices about their well-being, sexuality, support, and promote their relationships (Bolin et al., 2018; Wu & Zeng, 2020).

Institutional barriers

Caretakers and families may not be aware that barriers may exist for this cohort (Sommarö et al., 2020). Studies indicated that the best practice to support this cohort has a policy that will encourage the cohort to be aware of their sexuality (The National LGBT Health Education Center (NLHEC), n.d.; Pound et al., 2017), have opportunities to meet other people socially, and get educated about their lifestyle (Moreno, 2020; Wilson et al., 2016). Staff should find resources for this population in the community to expose them to opportunities to meet other people in the cohort (Maltais et al., 2020; Sommarö et al., 2020). Agencies should provide resources such as staffing and transportation for patient-centered community inclusion activities (McDaniels & Fleming, 2018) and include opportunities to socialize individuals to meet other LGBTQ+ individuals or participate in LGBTQ+ activities (Maltais et al., 2020; Martino & Perreault-Laird, 2019).

Studies show a lack of clear policies about how staff/ caregivers could provide support (Achey, 2020; Bolin et al., 2018; Charitou et al., 2020). In recent research, staff reported that they do not have the confidence to encourage the cohort to express their sexuality (Achey, 2020) because of group homes' unrealistic and ambiguous guidelines (Charitou et al., 2020; Robinson et al., 2020; Wilson & Frawley, 2016). Staff verbalized fear of making the wrong decisions (Maguire et al., 2019) and losing their jobs (Pariseau-Legault et al., 2019). Staff reported that lack of clear directives contributes to a lack of support to the cohort due to staff fear of contravening their duty of care (Achey, 2020; Charitou et al., 2020; Robinson et al., 2020; Wilson & Frawley, 2016), or inconsistent care for the cohort (Martino & Perreault-Laird, 2019). A clear policy should include staff accountability to uphold individual rights, such as respecting and acknowledging personal pronouns preferences (Achey, 2020; Chou et al., 2020; Pound et al., 2017). Even when there are policies, staff reported a lack of knowledge (Banks, 2016) or have trouble remembering the policies' details (NLHEC), n.d.; Martino & Perreault-Laird, 2019).

The cohort is dependent on the staff for all supports and accessing services. This dependence means that staff supervises all sexual relations and contacts (Achey, 2020; Martino &

Perreault-Laird, 2019). Group homes have stringent rules about who should visit (Pariseau-Legaultet al., 2019) and keeping doors open during any visits (Ćwirynkało, 2017; Pariseau-Legault & Holmes, 2017). These restrictive regulations are hindrances when romantic partners visit the group home (Charitou et al., 2020). According to Pariseau-Legault & Holmes, 2017, inflexible rules cause this cohort to hide their sexuality and practice unsafe sex.

Agencies that provide care to this population should review all agency forms and their environment to integrate LGBTQ+ language in the admission, discharge forms, protocols (Charitou et al., 2020; Robinson et al., 2020) and creating a unique environment (Pound et al., 2017; Triska, 2018). Sex education literature and sexual paraphernalia like condoms and dental dams should be readily available or kept in a secluded place for easy access and privacy (Triska, 2018).

Project Aim

The proposed project aims to use quality improvement measures to develop staff education on support strategies for ID/DD individuals who identify as LGBTQ+ in group homes to reduce behavioral issues in the cohort.

Project Objectives

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

1. Perform content analysis of the institutions' policies and procedures, forms, and physical environment (as needed) to identify the prevalence of evidence-based words for LGBTQ+ ID/DD individuals.
2. Monitor community inclusion activities for cohort accessing LGBTQ+ friendly sites.
3. Utilize chart audits of nursing notes, medical appointments, and behavior flowsheets to monitor the rates of behavioral issues for ID/DD individuals identified as LGBTQ+ in a 5-week implementation frame.

Theoretical Frameworks

The theoretical frameworks that would guide this project are positive psychology and the minority stress model. The tenets of the positive psychology and the minority stress models would provide the consolidative framework for developing evidence-based and culturally competent strategic education protocol for the group home staff that support the ID/DD individuals who identify as LGBTQ+ (Donaldson et al., 2020; Williams et al., 2020).

Positive Psychology

Origin. For thousands of years, positive psychology concepts have existed in philosophical and religious discussions and practices (Seligman, 2020). The theory originated from other psychology theorists' works, such as Aristotle's emphasis on happiness (Seligman, 2020), Maslow's theory highlighting happiness, and Rogers's theory positing human flourishing (Srinivasan, 2015). Positive psychology is considered the "fourth wave" in psychology because of the focus on people's strengths and positivity (Seligman, 2020; Srinivasan, 2015). The theory was introduced and entrenched as an essential part of the psychology discipline in 1998 by Martin Seligman (Seligman, 2020). Seligman encouraged the psychology discipline to move away from treating only mental illness to expanding into society's improvement and people's everyday lives functioning, flourishing, and well-being (Pawelski, 2020; Seligman, 2020). Other founding contributors to the field of positive psychology are Mihaly Czikszentmihalyi, who posits the importance of the creation is more vital than the finished work (Srinivasan, 2015), and Christopher Peterson, who theorizes about the importance of well-being, hope, optimism, and character in people and society (Seligman, 2020; Srinivasan, 2015).

The major tenets of the theory

The three levels of positive psychology include group, individual, and subjective levels. The group level highlights a person's life fulfillment from the development and contribution to the community and the society (Seligman, 2018). The individual-level stresses recognizing the person's personal qualities that give the person a good life and creates a decent person (Khwaja, 2020). The subjective level emphasizes the positive experiences in a person's life that bring them happiness, joy, and satisfaction (Goodman, 2018). Positive psychology concentrates on the qualities, and positives of human life, such as joy, resilience, unique abilities, and positive foundations that support those strengths and exceptional qualities (Craig & Furman, 2018; Goodman, 2018). The theory's goal positively influences and improves people's lives by enhancing their experiences and developing their unique talents and strengths (Donaldson et al., 2020; Seligman, 2018). The theory also promotes how people use their strengths to overcome difficulties and weaknesses (Kern, 2020).

This psychology field aims to help people change their opposing viewpoints to promote the theory's concepts of well-being, flourishing, and flow (Butler & Kern, 2016; Khwaja, 2020). Flourishing is the attainment of life satisfaction through meaningful purpose, accomplishments, relationships, resilience, optimism, and self-determination (Khwaja, 2020; VanderWeele, 2019) and healthy relationships with others (Wagner et al., 2020). Flow is an enjoyable and intrinsically motivating activity that completely captures the person's attention (Tse et al., 2020). Flow enables people to derive from performing the task instead of the product (Tse et al., 2020), help people be less concerned and worried about boring and challenging life tasks, and help people's social development (Harrison, 2019). Well-being is the ability to have satisfied and meaningful social, emotional, physical, workplace, and societal experiences (Nel, 2019; Pawelski, 2020). Well-being includes handling stress, feeling well, interacting with others and the environment, having purposeful relationships, and having a life purpose (Rabbat, 2018; Seligman, 2018). Positive psychology's PERMA model measures well-being. The word PERMA is an abbreviation for Positive Emotions, Engagement, Relationships (Positive), Meaning, and

Accomplishment/Achievement (Harrison, 2019; Lai et al., 2018). The theory's major principles for this project are the three pillars of positive psychology and the PERMA model (Seligman, 2018).

The three pillars of positive psychology. The three tenets of positive psychology's pillar model are positive social institutions, character strengths, and positive subjective experiences (Rabbat, 2018; Seligman, 2020) (See Appendix B). The premises of the three pillars are "life of enjoyment," "life of engagement," and "life of affiliation" (Goodman, 2018; Tape, 2018). Life of enjoyment includes those activities and experiences that give a person joy and happiness, such as shopping, exercising, visiting friends, and eating out (Kern, 2020; Seligman, 2018). The life of engagement is the confidence, achievement, and satisfaction humans get when they dedicate themselves to a life pursuit (Kern, 2020). The life of affiliation describes the sense of belongingness and legacy that a person derives from being part of a bigger picture (Castro Baker et al., 2020; Goodman, 2018), contributing to the movement of a cause such as saving the environment (Seligman, 2020). Life affiliation also entails being a part of a more significant reason to decrease human suffering (Castro Baker et al., 2020; Donaldson et al., 2020) and achieving eudaimonic happiness (highest level of happiness that is meaningful and purposeful) (Castro Baker et al., 2020), well-being (satisfied and meaningful social, emotional, physical, workplace, and societal experiences) (Pawelski, 2020; Rabbat, 2018) and hedonic happiness (looking for pleasure, comfort, and no distress) (Tape, 2018).

PERMA Model. Positive psychology used the PERMA model to explain and define well-being (Goodman, 2018) (See Appendix C). These five phases of the PERMA model are quantifiable and explain the theory's concepts - flourishing, flow, happiness, and well-being concepts (Nel, 2019; Seligman, 2018) and how people find meaning through their lives and work, activities, hobbies, and achieve their goals, maintaining balance (Lai et al., 2018). For positive emotions, positive psychology theorists theorized that people should do more of what brings them happiness and joy in their daily lives (Seligman, 2018). For engagement, since happiness and joy do not bring well-being, people should also make sure to pursue the activities they love and bring them happiness and calmness (Lai et al., 2018). For relationships, people should also improve their relationships with others. Meaningful, positive, and healthy relationships will help people find love, form romantic relationships, and help build resilience during catastrophic events (Seligman, 2020). People seek to find meaning for their existences by looking at their impact on their work, lives, and society (Nel, 2019). For accomplishments, people seek to meet realistic goals and ambitions to give them a sense of satisfaction and pride when achieving their goals (Khwaja, 2020). The theorists posited that when people have fulfilled all the five aspects of PERMA, they will achieve well-being, flourishing, and flow (Goodman, 2018; Nel, 2019), and eudaimonic and hedonic happiness (Castro Baker et al., 2020, Tape, 2018).

Minority stress theory

Origin. The second theoretical framework to guide this project is the minority stress model, which is derived from psychological and social theoretical foundations to show how the dominant and minority values conflict with the social environment of ethnic and sexual-minority groups (Botha & Frost, 2020; Convertino et al., 2020) (See Appendix D). Most of the minority stress theory studies are about African Americans and the LGBTQ+ population (Lefevor et al., 2019; Meyer, 2003). The theory emphasizes that people belonging to sexual-minority groups or an ethnic minority group would experience more homophobic events, rejection, intolerance, stigma, and isolation than their non-minority or heterosexual counterparts (Salerno et al., 2020). Also, lack of social support, low socioeconomic status, bias, interpersonal discrimination, and discriminatory culture would lead to victimization and marginalization of the ethnic minority and sexual-minority cohort (Meyer, 2020). Studies found that bias and prejudice are common occurrences for ethnic minority and sexual-minority individuals and could damage the cohorts' well-being (Fulginiti et al., 2020; Meyer, 2003). These negative experiences could contribute to these cohorts' health disparities, reducing the life expectancy and adverse health effects (Botha & Frost, 2020; Fulginiti et al., 2020). Researchers also found that ethnic and sexual-minority groups have negative and chronic mental and physiologic distress compared to the non-minority groups (Antebi-Gruszka et al., 2020). Other disciplines such as congressional debates, legislators, court cases, social organizations, and law enforcement have successfully used the minority stress theory to highlight the adverse effects of discrimination and prejudice on ethnic minority and sexual-minority groups (Horwitz et al., 2020).

The minority stress theory provides an essential look into the effect of discrimination, heteronormativity, prejudice, rejection, and stigma among the ID/DD cohort who identify as LGBTQ+ (Anti-Defamation League, 2020; Dinwoodie, 2020; Toft, 2020). Studies show that ID/DD individuals, LGBTQ+ cohorts, and ID/DD individuals who identify as LGBTQ+ continue to experience high incidences of societal discrimination, bias, victimization across lifespan due to their sexual orientation and disease process (Protected and Served, n.d; Santinele, 2020; Stoffelen et al., 2018). Literature showed that the ID/DD population has many physical and psychological diseases, including behavioral issues that might stem from the inability to express their sexual preferences (Botha & Frost, 2020; Fulginiti et al., 2020). Likewise, the LGBTQ+ population's negative experiences have caused significant stress, leading to the cohort's physical and psychological health outcomes (Salerno et al., 2020).

The theory stipulates that individuals who belong to more than one minority group, in this instance, ID/DD individuals who identify as LGBTQ+, would have a higher incidence of experiencing adverse events (Rodríguez-Roldán, 2020). The government, religion, and institutions may enact policies that directly or inadvertently stigmatize and oppress these sexual minorities (James et al., 2016; Lambda Legal, 2019; Rodríguez-Roldán, 2020). These negative experiences may predispose ID/DD individuals who identify as LGBTQ+ to poor health and psychopathology (Horwitz et al., 2020; Meyer, 2003; 2020).

The major tenets of the theory

The minority stressors describe the stigmatization caused by social-based (negative experiences in the institutions, schools, group homes, hospitals), chronic (prejudices from the culture and the society), and unique (experiences that only the cohort experience (Meyer, 2003; Salerno et al., 2020). ID/DD individuals who identify as LGBTQ+ may experience these negative experiences from the ID/DD population and are not always accepted by the LGBTQ+ population (Fox et al., 2020). These could lead to more harmful repercussions such as suicide, adverse behavior, and unsafe sex practices (Karaiskos, 2020). According to the minority stress model, coping and social support for this cohort could counteract stress-related physiological and psychological disorders (Karaiskos, 2020).

Distal and Proximal stressors. Through studies of sexual and racial minorities, social scientists discovered that minority stress could stem from distal and proximal stressors that will eventually cause chronic illnesses for these groups (Meyer, 2003; 2020). Studies found that environmental factors drive health disparities more than genetic factors (Williams et al., 2020). According to Sun et al., 2020, distal stressors are external factors that affect the minority groups, such as victimization, discrimination, social exclusion, verbal bullying, and prejudice by society, strangers, family, friends, and law enforcers. These stressors are objective findings that affect the cohort's experiences (Lindley & Galupo, 2020).

Proximal elements are subjective and internal stressors within the minority group, such as increased vigilance about bias, anxiety, eating disorders, self-harm, and concealment of their identities (Fox et al., 2020). Proximal elements also mean the cohorts' preoccupation with the distal process's effects instead of finding strategies to solve the problems (Douglass & Conlin, 2020).

Proximal elements also entail self-discrimination of the same cohort members, acceptance and expectations of rejection, and internalized self-homophobia (Douglass & Conlin, 2020; Lindley & Galupo, 2020). Eventually, this cohort's adverse experiences will cause self-hatred, social isolation, and psychopathologies such as low self-esteem, depression, suicidal ideation, and anxiety (Douglass & Conlin, 2020). Distal and proximal factors work together to cause physical and psychological chronic illnesses (Douglass & Conlin, 2020; Lindley & Galupo, 2020).

Application to DNP Project

The positive psychology and the minority stress model principles would be combined to develop a staff education workshop including support strategies for ID/DD individuals who identify as LGBTQ+ in group homes to reduce behavioral issues in the cohort. To decrease distal and proximal factors that cause physical and psychological chronic illnesses and preclude the cohort achieve all five PERMA tenets (Douglass & Conlin, 2020; Lindley & Galupo, 2020), appropriate staff education and knowledge to support this cohort are critical (Achey, 2020; Nowaskie, 2020).

The three-pillar is a coordinating framework to develop the workshop's objectives of integration of ID/DD individuals who identify as LGBTQ+ unique virtues and the importance of supports and strengths within the agencies' practice, policies, and protocols that serve ID/DD individuals (Antebi-Gruszka et al., 2020; Brizhak et al., 2020). Staff support and flexible organization policies serve as community strengths to produce positive subjective experiences and character strengths in the cohort (Craig & Furman, 2018; Antebi-Gruszka et al., 2020). These cohorts' character strengths, such as kindness, mindfulness, gratitude, love, hope, would help this cohort achieve (Goodman, 2018; Nel, 2019) and support the cohort develop resilience, manage stressors, flourish, flow, and improve their mental and psychological well-being (Seligman, 2020).

The workshop would include promoting and emphasizing interventions such as listening, being available, advocating for the cohort, serving as a role model, and giving the cohort privacy to foster these character strengths (Craig & Furman, 2018; Brizhak et al., 2020). Examples of positive and affirming societal factors include promoting awareness of the cohort's plight and creating and supporting institutions' policies to help this cohort achieve meaningful and purposeful lives (Ghabrial & Andersen, 2020).

The staff education would also incorporate the PERMA model's use, such as meeting and forming meaningful friendships and romantic relationships with others (Craig & Furman, 2018; McGrath & Wallace, 2021). PERMA concepts would support and empower staff to advocate and provide the cohort with privacy, support, and information to freely express their sexuality (Seligman, 2020) and redesign the group homes' policies. Staff education also entails teaching staff how to help the cohort achieve the five phases of PERMA (Harrison, 2019; Lai et al., 2018).

The staff education would incorporate exercises to facilitate staff self-assessment and self-reflection about their preconceived, implicit biases, personal prejudices about the cohort, and knowledge deficits that might adversely impact their attitude and support towards the cohort (Achey, 2020; Nowaskie, 2020). The anticipation is that the outcome of these self-awareness and self-reflection exercises would produce a robust, knowledgeable, and strong support staff system to help the cohort socialize, develop coping skills and resilience to deal with the distal and proximal factors, hence managing chronic stress (Meyer, 2003; Sun et al., 2020). This reduction of stress could occur by positive social interactions within institutions that add to the character strength and subjective positive experiences of ID/DD individuals who identify as LGBTQ+ individuals to thrive and deal with their sexual orientation (Seligman, 2020; McGrath & Wallace, 2021).

Setting

With the increasing life expectancy of the developmental disability population, there is a growing demand for individualized, patient-centered care that addresses this population's sexual needs (NCI, n.d.). This project will impact the ID/DD population. ID/DD individuals are no longer institutionalized but live in Intermediate Care Facilities (ICFs) and Individualized Residential Alternative (IRAs). IRA Individualized Residential Alternatives (IRAs) are community residences that provide 24 hours of onsite staff and room and board to the ID/DD population. At the same time, Intermediate Care Facilities (ICFs) are community residences for ID/DD individuals with highly intensive medical and behavioral needs. Like IRAs, ICFs provide 24-hour support and supervised activities and therapies. Some ID/DD individuals reside at home alone or with their families or guardians and have in-home skilled and non-skilled services support services from social services agencies (NCI, n.d.).

The project site agency was founded more than 140 years ago and is one of the largest social services in NY. The agency has an annual budget of $250 million and serves more than 40,000 clients. The agency is funded by government and private donations. The agency's mission, vision, and values' overarching theme are to respect people from all backgrounds, improve practice, value honesty, and provide support and help people reach their full potential. The agency provides mental health clinics, community services, family shelters, children and adult residential services, care coordination, and intellectual and developmental services to all age groups from diverse cultures, religions, gender, sexual orientations, and socio-economic backgrounds in more than 75 locations throughout New York City and the vicinity.

The project setting would be at two residences in the agency's group homes in Brooklyn for individuals with intellectual and developmental disabilities. The agency provides services for 136 individuals in these two group homes. The age of the individuals ranges from 18 years to 92 years. Twenty-nine individuals identify as LGBTQ+. Of these 33 individuals, 15 identify as males, twelve identify as females, and six identify as non-binary or "enby." This terminology means that these individuals' gender identities do not fit the male and female binary spectrum (Kassel, 2020).

The oldest individual who identifies as LGBTQ+ is 64 years old, and the youngest is 23-year-old. These individuals have diagnoses from mild to severe intellectual and developmental disabilities. Only one of these identified individuals, a 64-year-old male, will be excluded from the study due to long-term admission in a nursing home from stroke complications. The project will concentrate only on 32 individuals.

In January 2020, the project site started using an electronic health record (EHR), PrecisionCare, for all clinical documentation, non-clinical and community inclusion flowsheets. PrecisionCare is a web-based EHR software created solely to meet the needs of Human Service providers. Documents needed for this project are in the EHR.

Population of Interest

This project's direct population of interest is all staff who directly provide care for the ID/DD individuals who identify as LGBTQ+ at the group homes. The staff includes direct support staff in two group homes where the ID/DD population identifies as LGBTQ+ live in Brooklyn. The direct population of interest would receive the workshop. The project will directly include 23 direct support professionals (DSPs). Also, 22 clinical staff (nurses, therapists (occupational, physical, behavioral, nutritionists, habilitation, social workers, and medical providers (medical doctor, psychiatrist, and nurse practitioner); and ten non-clinical staff (housekeepers, secretaries, cooks, maintenance).

The DSPs are unlicensed staff that provides direct care, physical care, and support to assist this cohort around the clock. The DSPs are responsible for transporting, cooking, and assisting with activities of daily living (ADLs) of the cohort. DSPs are responsible for ensuring that the cohort goes to medical and psychiatric appointments, comply with nutrition, medication, and therapeutic regimens. These DSPs are certified as Approved Medication Administration Personnel

(AMAP). Under the direct supervision of registered nurses, AMAPs will administer oral, topical, and subcutaneous medications to group home residents.

The clinical staff members have state licenses and have direct contact with the cohort. These staff members provide skilled care to the ID/DD population and direct the DSPs' roles as caretakers. For example, the registered nurses directly supervise the DSPs' clinical tasks, such as medication administration and clinical procedures. The non-clinical staff supports the ID/DD group home residents and the DSPs by doing unskilled tasks such as driving, cooking, laundering, and maintaining the residence. The non-clinical staff also have contact with the cohort.

By implementing this project, staff that supports the ID/DD population will be knowledgeable and prepared to support the cohort members who identify as LGBTQ +. As a result, this project will indirectly affect the Intellectual Disability and Developmental Disability (ID/DD) individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+).

Stakeholders

The key stakeholders involved with the project are the agency's executive team (chief executive officer (CEO), Chief operations officer (CEO), Nursing administrator (Nurse director), Nursing supervisors, registered nurses, Staff development educators, Human resources, Information technology staff, and residential directors. These stakeholders are interested in the quality of care, well-being, and satisfaction for the ID/DD individuals, their families/guardians, and their staff satisfaction. The collaboration with these stakeholders would help facilitate data collection, implementation, and sustainability of the project. Additionally, the partnership with an interdisciplinary team will help the project's outcome comply with the Institute of Medicine (IOM) report, *Crossing the Quality Chasm* requirements. These requirements are to deliver quality and evidenced-based care to patients with defined safety aims, timely, effective, efficient, equitable, and patient-centered (STEEEP) (Ansa et al., 2020; Murphy et al., 2018).

The nursing director and the supervisors would agree to the final protocol before dissemination. This leadership team will also help monitor and eradicate barriers that may preclude the project's implementation, compliance, and sustainability. Some of these barriers to change may include staff resistance to change, staff "partial buy-in," and lack of consistent communication (Hall & Roussell, 2016). The nursing leadership, the residential directors, and the primary nurse will also reinforce and sustain the project by ensuring that all staff members are empowered to change their practices. Additionally, these stakeholders will communicate the change outcomes and support the change by providing a staff feedback loop about the project (Hall & Roussell, 2016).

The staff development and human resources staff will help disseminate the workshop to all the targeted direct staff. The human resources and the staff development education team will also play a role in sustaining the project by including the workshop in future onboarding and annual competencies. Consistent use of the workshop will entrench the new change in the agency's policies and practice culture (Hall & Roussell, 2016). Formal permission to conduct the project at the project site or affiliation agreement between the project site and the University is unnecessary.

Interventions/project timeline

In the first week of July 2021, the DNP student will meet with the nursing director, staff development, residence leadership, and human resources to discuss the implementation plan. These key stakeholders will be reminded about the workshop's format, aim, and measures. The team will have the ability to preview the workshop before the meeting. Prior to the implementation of the workshop, a flyer about the project objectives and the post-workshop survey will be emailed to the key stakeholders.

At the end of the first week in July 2021, the workshop will be implemented. The PowerPoint will be emailed to the 23 direct support professionals (DSPs) and 22 clinical staff (nurses, therapists (occupational, physical, behavioral, nutritionists, habilitation, social workers, and medical providers (medical doctor, psychiatrist, and nurse practitioner); and ten non-clinical staff (housekeepers, secretaries, cooks, maintenance). The DNP student will email reminders to the team to complete the in-service and the online post-intervention survey in the second week of July.

The DNP student will encourage the key stakeholders to reinforce the reminders to the target group about the importance of completing the workshop. The direct target team will be encouraged to email the DNP student questions about the project's workshop and recommendations. These recommendations, concerns, and questions will be collected and documented. In the third week of July, the post-workshop surveys will be collected. The electronic survey link will be included at the end of the PowerPoint workshop. All team members who completed the training and the surveys will receive certificates of completion.

Data collection from the electronic surveys, community inclusion, and post-intervention adverse behavior incidences will start by the fourth week of July. In the first week in August, data collection and analysis will be completed and presented to the project site's key stakeholders. The results will be presented to the DNP course instructor and academic mentor by the Week 14 of DNP III.

Tools/Instrumentation

The workshop - QueerAlly-IDD

The QueerAlly-IDD workshop is designed to educate group home staff to recognize, understand, and meet the specific needs of ID/DD individuals' who identify as LGBTQ+ (See Appendices E and F). With the collaboration of the project mentor and content expert, the workshop will introduce the staff who work with this cohort to diverse ways to support the ID/DD Individuals who identify as LGBTQ+. By the end of the workshop, the learner will:

1. Recognize that it is essential to increase cultural competency

2. Recognize and affirm sexual orientation, sex, and gender diversity, and intersex status
3. Foster a safe, welcoming environment and inclusive services
4. Understand the ID/DD individuals’ sexual rights
5. Define the most significant barrier to inclusion is for this population
6. Describe how to provide support to LGBTQ+ Individuals
7. Understand What to teach – Sex Ed for People with IDD/DD
8. Commit to dynamic, ongoing change

The nursing director and the staff development team will review and approve this online workshop before the implementation.

Post-Intervention survey

This project's post-intervention tool questionnaire is adapted from the Knowledge about Homosexuality instrument to measure staff knowledge after the QueerAlly-IDD. The tool was developed by Harris, Nightengale, & Owens (Harris, 1998). The instrument measures nurses, social workers, and psychologists' Knowledge about homosexuality and sexual orientation issues. Additionally, the instrument has been used to measure other disciplines' Knowledge about LGBTQ+ (Corrêa-Ribeiro et al., 2018). For example, the instrument was used to assess special education teachers' knowledge about the LGBTQ+ population (Airton et al., 2019), physicians (Corrêa-Ribeiro et al., 2018), and nurses (Koch, 2020; Morgan, 2003). Dr. Harris was contacted, and she permitted the use of the instrument to fit the project's objectives (See Appendix G).

There are numerous instruments for measuring knowledge and attitudes about LGBTQ+. However, this Knowledge about Homosexuality Questionnaire (KHQ) instrument is specifically created to measure healthcare providers' factual knowledge instead of healthcare opinions and attitudes (Corrêa-Ribeiro et al., 2018). Koch's modified version of the instrument contains 18 items and will take five minutes to complete (See Appendix H) (Koch, 2000). The scores range from 0-18, and higher scores indicate Knowledge about the LGBTQ+ (Corrêa-Ribeiro et al., 2018). The mean scores from the original administration of the questionnaire were 16.3 (eighty-two percent correct) for a sample of healthcare professionals, with a Chronbach's alpha of .70 (Morgan, 2003). Cronbach's alpha was .70 for the sample of health care professionals, .74 for the college students, and .28 for the high school students.

Construct validity shows that the mean score was higher for health care professionals than for college students and was higher for college students than for high school students (Harris, 1998). According to the literature, the construct validity shows that people who have education about the LGBTQ+ community will score higher scores (Corrêa-Ribeiro et al., 2018; Koch, 2000). The questionnaire also produced demographic information from each staff, including age, the highest level of education, tenure at the agency, sexual orientation, sexual orientation, gender identity, and prior attendance of LGBTQ+ training.

Institute for Healthcare Improvement (IHI) Tool

For this project, a tool developed by the IHI would be utilized (See Appendix I). The project planning tool will be initiated at the beginning of the project. This tool has been tested and validated by other organizations seeking to make changes (IHI, n.d.). The tool is used to plan the project (IHI, n.d.). The form helps track the project team think analytically, track the project changes, including the Plan-Do-Study-Act (PDSA) cycles, the timeline, and the responsible person for each project's objectives (IHI, n.d.). According to IHI n.d., the PDSA will be combined within the project planning form to measure, plan, implement, test, and refine the changes.

Health Records Audit Tool

Since the cultural competency policy is on paper, a chart auditing tool will be created to review and perform a content analysis of the organization's cultural competency policy for language that specifies supporting intellectual and development delay individuals who identify as LGBTQ+ policy (See Appendix J).

The electronic health records report will generate pre-and-post adverse behavior incidences of the indirect target group. The electronic health record will also generate pre-and post-community inclusion frequency reports to LGBTQ+ friendly sites and community activities. The data would be requested in a spreadsheet that is easily exported to statistical software for analysis. Also, this report would be used to generate future performance indicators during the PDSA cycles.

Study of Interventions/Data Collection

Data collection will begin before and after the implementation of the QueerAlly-IDD workshop. The data to be collected by doing content analyses of the organization's cultural competency policy, forms, and physical environment, for language that specifies supporting intellectual and development delay individuals who identify as LGBTQ+ of the policy.

The pre-workshop percentage of adverse behavioral issues for ID/DD individuals identified as LGBTQ+ will be gathered from the agency’s electronic health record. Data from the agency's electronic health record will also yield the rate of psychiatric hospitalizations for ID/DD individuals who identify as LGBTQ+. This data will be used as a benchmark to measure against any changes in psychiatric admissions and adverse behavioral issues for the cohort after implementing the QueerAlly-IDD workshop. The information collected will only yield numbers and not identify the cohort members' information to ensure confidentiality. Collected data will be saved in a password-protected folder on a password-protected computer.

A post-intervention electronic questionnaire will be used to evaluate staff knowledge about the cohort. This questionnaire and the responses will be anonymous. It is projected that the response rate for the questionnaire will be greater than 90% since it will be readily available immediately following the workshop. The questionnaire will collect demographic data about the respondents. These data include age, the highest level of education, tenure at the agency, sexual orientation, gender identity, and prior attendance of LGBTQ+ training. Additionally, the questionnaire will collect data about the staff knowledge of the cohort (See Appendix H).

Ethics/Human Subjects Protection

The project site does not have an Internal Review Board and does not require IRB oversight and permission to complete the project. According to the Project Team Determination Form, the project has been reviewed. According to the Touro University Nevada (TUN) policy, this quality improvement project will not require an IRB review since this project is not about finding new knowledge. Additionally, the online Human Subject Research course (CITI) has been completed.

The proposed project aims to use quality improvement measures to develop staff education on support strategies for ID/DD individuals who identify as LGBTQ+ in group homes to reduce behavioral issues in the cohort. There will not be direct contact with the participants or group home ID/DD individuals who identify as LGBTQ +. Data collection will be through electronic health records and post-implementation surveys.

Due to the nature of this project, strict confidentiality and HIPAA guidelines will be maintained. Electronic health records will be maintained by ensuring that data collected will not have any personal health information. All data will have random numbers to identify the members of the cohort. All data collected will be kept secured in a password and encrypted, protected file. All information will be coded with non-identifying numbers. All personal health information (PHI) will be removed. All patient information will be key-coded. No records will be stored or removed from the practice site. When sharing results, no patient or staff identifiers would be used.

Training of staff will be through the nursing education department as a staff development activity. The workshop will be online for all shifts. Online training allows the staff to access the training at their convenience. Likewise, the post-intervention questionnaires will be anonymous and administered through electronic means. There will be no risk to the participants for completing the anonymous and voluntary questionnaire. The participants will be assured that no identifying information of the participants will be included. The participants will not receive any compensation for completing the surveys. There will not be any collection or tracking of participants' email or computer Internet Protocol (IP) addresses.

Measures/ Plan for Analysis

The Statistical Package for the Social Sciences (SPSS) Statistics will be used to analyze the three data sets collected. In addition, staff assessment of learning and use of new support protocols will be analyzed using data collected from community inclusion reports from the agency's archives. The assumption is that the variance between the data to be collected is homogenous, and the sample is more than 30 records, with interval data. The distributions and the parameters are available.

The paired-student T-tests will be used to compare the pre-and post-community inclusion frequency to LGBTQ+ friendly community activities and sites by staff for the ID/DD individuals who identify as LGBTQ+ after the workshop. The parametric test will be used to see if the differences between the frequency to the pre-workshop community inclusion sites are statistically significant compared to the post-workshop community inclusion sites. Community inclusion is a mandated document where staff document outside activities by individuals who live in group homes certified by the Office of People with Developmental Delay (OPWDD) in New York state (NCI, n.d.).

Also, the Statistical Package for the Social Sciences (SPSS) Statistics will be used to analyze all the descriptive data of post-workshop participants' demographic data and their knowledge of LGBTQ+. Likewise, there will be the utilization of content analysis of the frequency of LGBTQ + related information and staff support for the cohort is mentioned in the cultural competency workshop, policies, forms, physical environment, and family/individual handouts/materials; and the organization's cultural competency policy for language that specifies supporting intellectual and development delay individuals who identify as LGBTQ+.

The non-parametric tests of Wil will be used to analyze the workshop's significance and analyze the change frequency of adverse behavioral issues before and after staff development (Pallant, 2013). Again, the assumption is that the data are not normally distributed and homogenous. So, using parametric testing could lead to incorrect conclusions. The data collected will be nominal, and the independent variables are non-metric (Pallant, 2013).

The data analysis will be presented in graphs, charts, and tables appropriate for the information generated. Also, a narrative form of the investigation will be added about the project objectives. A statistics worksheet was completed and submitted for review. A Touro statistician will be consulted to review the statistical analysis.

Analysis of Results

Data analysis for this project were performed using the Statistical Package for the Social Sciences (SPSS). The data evaluation was derived from the content analysis, post-workshop survey, community inclusion, and pre-and post-workshop behavioral incidences. Content analysis of the agency's environment and forms were conducted (see Table 1). Demographics characteristics of the post-workshop survey respondents were aggregated (see Table 2). Data from the survey questions were presented (see Table 3). Also, there was an analysis of pre-and-post workshop data (see Figure 4). Finally, pre-and-post adverse behavior of the ID/DD individuals who identify as LGBTQ+ were compared (see Figure 5).

Content Analysis

The agency's environment, documents, policies, and workshop were analyzed and reviewed. Reviewed documents include the agency's cultural competency workshop (PowerPoint handouts) forms (admission, intake, nursing assessment, community inclusion, triage form, medical appointment form), policies (cultural competency policy, medication administration; nursing assessment, community inclusion), and family and individual hand-outs and materials. Only 0.05% (12 Lines) in the cultural competency workshop and 0.15% (18 lines) in the cultural competency policy mentioned the LGBTQ+ phrases.

These lines did not indicate how staff could support the cohort or explain any of the LGBTQ+ terminologies. Also, only 0.42% (5 lines) of the agency forms mentioned some LGBTQ+ terminologies. The five lines did not mention protocols for collecting information on the cohort. In addition, none of the agency forms mentioned or provided opportunities for LGBTQ+ pronouns. The reviewed policies only mentioned LGBTQ+ in eight lines (0.03%). Also, there were no LGBTQ+-related illustrations, pictures, or LGBTQ+-friendly materials displayed in the agency. The content analysis did not reveal any LGBTQ+ illustrations, posters, information in the environment.

Table 1

Content analysis

Material	Estimated Lines	Lines with LGBTQ+ content	Estimated Illustrations (%)	Illustrations with LGBTQ+ content (%)
Cultural competency workshop – PowerPoint, handouts	24, 450	12 (0.05%)	60	0
Forms – Admission, Intake, Nursing Assessment, Community inclusion, Triage form, medical form	12, 000	5 (0.042%)	0	0
Physical environment	20	0	30	0
Cultural competency policy	12,000	18 (0.15%)	0	0
Family and individual hand-outs and materials	2000	0	20	0
Policies – Medication Administration; Nursing Assessment, Community inclusion	28,000	8 (0.03%)	0	0

Note. LGBTQ+ = lesbian, gay, bisexual, transgender, queer, questioning+

Demographics Characteristics: Survey Respondents

Data from the post-Workshop yielded demographic characteristics and respondents' knowledge about homosexuality (see Table 2). Twenty-five people completed the workshop and the survey. The participation met the project's projection of 23-30 random participants from the staff who provide care to ID/DD individuals who identify as LGBTQ+. SPSS analysis showed positive and negative clustering of scores. Derived statistics are non-parametric descriptive statistics, so median (Md) and inter-quartile range (IQR) will be used to report this data with the assumption of lack of normal distribution and skewness of data (Pallant, 2013) (see appendix L).

The respondents consisted of 16 (64%) females, 3 (12%) other, and 6 (24%) males (Md 2, IQR: 1.50 and 2). Years at the agency ranged from less than two years to more than ten years. Eight participants have been at the agency for more than ten years, and 6 (24%) have been at the agency for less than two years. Five respondents, 5 (20%), have been at the agency for less than ten years, and 3 (12%) have worked for less than five years. Three participants, 3 (12%), have been at the agency for less than three years (Md 4, IQR: 2 and 5).

The age of the respondents ranged between 18–65+ years. Most of the respondents are between ages 55-64 (n=13, 52%), 65+ (n=3, 12%), 35-44 (n=5, 20%), and ages 45-54 (n=1, 12%) (Md 4, IQR: 1.50 and 4). The educational level of the respondents ranged from 10 (40%) hold a Bachelor's degree, 6 (24%) reported having a Master’s degree, 4 (12%) reported attaining Doctorate, and 3 (12%) reported having some college, 2 (8%) reported Associate degree and 1 (4%) reported Technical/trade school. None of the respondents reported High School/GED as their highest level of education (Md 5, IQR: 4.50 and 6).

Regarding sexual orientation, 7(68%) reported heterosexual, 4 (16%) identified as homosexual, 3 (12%) identified as bisexual, and 1 (4%) identified as other (Md 1, IQR: 1and 2). The participants were equally divided about the question of ever having had a class or course in which homosexuality was presented as part of the curriculum. Thirteen participants (52%) reported having had a homosexuality class, while 12 (48%) reported never had a homosexuality class (Md 2, IQR: 1and 2).

Table 2

Post-Workshop Demographics (N=25)

Demographic Data	Number of Respondents (N)	Percentage (%)
Gender		
Female	16	64
Male	6	24
Other	3	12
Age Range		
18-34	5	20
35-44	3	12
45-54	1	4
55-64	13	52
65+	2	12
Highest Level of Education		
High school/GED	0	0
Technical/trade school	1	4
Some college	3	12
Associates Degree	2	8
Bachelor's Degree	10	40
Master’s degree	6	24
Doctorate Degree	3	12
Sexual Orientation		
Heterosexual	17	68
Homosexual	4	16
Bisexual	3	12
Asexual	0	0
Pansexual	0	0
Other	1	4
Class or course in which homosexuality is part of the curriculum?		
Yes	13	52
No	12	48
Tenure at the agency		
< 2-years	6	24
< 3-years	3	12
< 5-years	3	12
< 10-years	5	20
> 10-years	8	32

Knowledge About Homosexuality Survey

The post-workshop survey includes 19 questions to evaluate the staff's knowledge about LGBTQ+. The most correctly answered questions are the questions about coming out and bisexuality (see Table 3). The most incorrectly answered question is the cultural-historical intolerance towards homosexuality.

For question one, if a child who engages in homosexual behaviors will become a homosexual adult. A significant percentage of the participants responded true, 18 (72%), 3 (12%) responded false, and 4 (16%) did not know the answer (M=2.04, SD= .5). For question two, there is a good chance of changing homosexual people into heterosexuals. A significant percentage of participants did not agree; 2 (8%) answered true, and 2 (8%) did not know (M=2, SD = - .4).

For question three, most homosexuals want to be members of the opposite sex. Twenty-three (92%) responded disagreed, and 2 (8%) responded true to the question. Since the data is not normally distributed, the median and not the mean will be reported (Md=2, IQR=2, 2) (Pallant, 2013).

For question four, some church denominations oppose legal and social discrimination against homosexual men and women, 21 (84%) responded true, while 1 (4%) responded not true, and 3 (12%) did not know (Md=1, IQR=1, 1). For question five, sexual orientation is established at an early age; 16 (64%) of the respondents replied true, 7 (28%) responded false, and 2 (8%) did not know (Md =1, IQR = 1, 2). For question six, homosexuality is an illness according to the American Psychological Association (APA), 7 (28%) participants agreed that while 16 (64%) responded false, and 2(8%) did not know (Md=2, IOR=1, 2).

For question seven, most of the respondents, 18 (72%), do not believe that homosexual males are more likely to seduce young men than heterosexual males are likely to seduce young girls, while 4 (16%) agrees with the statement, and 3 (12%) did not know (M =2; SD=.5).

For question eight, gay men are more likely to be victims of violent crime than the public; 19 (76%) agreed with the statement, 4 (16%) did not agree, and 2 (8%) did not know (Md=1, IQR = 1, 1).

For question nine, most homosexuals were seduced in adolescence by a person of the same sex, usually several years older, 12 (48%) responded that the statement was false, 7 (28%) did not know, and 6 (24%) believe the statement to be correct (Md=1.5; IQR: 2, 2). For question ten, a person becomes a homosexual (develops a homosexual orientation) because they choose to do so, 16 (64%) responded that the question is wrong, 8 (32%) replied that the statement is accurate, and 1 (4%) did not know (Md = 2; IQR: 1, 2).

For question 11, homosexuality does not occur among animals (other than human beings), 13 (52%) responded that the statement is false, 5 (20%) answered that it is accurate, and 7 (28%) did not know the answer (M=2, SD=.7).

The question 12, culture intolerance of homosexuals and perception as “sick” or as “sinners,” only 5 (20%) got the question correct. Many of the respondents, 20 (80%), got the question wrong (M= 1.2; SD =.4).

For question 13, hostility towards homosexuals by heterosexual males more than heterosexual females, 18 (72%) responded that it is true, 2 (8%) answered that it is false, and 5 (20%) did not know (M-1.2; SD =.8). For questions 14 and 15 about the meaning of “coming out” and bisexuality, respondents overwhelmingly answered true, 24 (96%) and 25 (100%), respectively.

Questions 16 – 19 of the survey were included to ascertain participants' specific knowledge about intellectually disabled and developmentally delayed (ID/DD) individuals who identify as LGBTQ+. For question 16, 2 (8%) respondents did not think that ID/DD individuals can identify as LGBTQ+, and 2 (8%) did not know (M=1.24; SD=.5). For question 17, one respondent (4%) did not think that ID/DD individuals can have sex. However, 18 (96%) responded that individuals with ID/DD identify as Lesbian, Gay, Bisexual, Transgender, Queer, and questioning (LGBTQ+) can have sex (M=1.08; SD =.4). For question 18, 7 (28%) did not believe that ID/DD individuals can change their biological sex with medications, while 15 (60%) believe they could. Four participants (12%) did not know the answer (M=1.52; SD=.7). For question 19, ID/DD individuals who identify as LGBTQ+ could go to LGBTQ+ events. Only 1 (4%) did not think the cohort could go to LGBTQ+ events (M=2; SD =.4).

The relationship between the highest level of education, age, and participants' participation in a previous course with homosexuality in the curriculum and questions 16-19 was investigated using a non-parametric test, Spearman's rho. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity, and homoscedasticity (Pallant, 2013) (see Appendix L).

There are strong, correlation between the level of education and questions 16-19 about if ID/DD individuals can identify as LGBTQ+; have sex, take medication to change gender and go to LGBTQ+ events. For question 16, rho=.05, n=25, p < .001. For question 17, rho=.2, n=25, p < .001. For question 18, $r = -.2$, $n = 25$, $p < .001$, and question 19, $r = .12$, $n = 25$, $p < .001$.

Moderate to strong correlation also exist for staff who took formal LGBTQ+ class and questions 16-19. For question 16, r=.2, n=25, p < .001. For question 17, r=-.2, n=25, p < .001. For question 18, r=.14, n=25, p < .001. Question 19, r=-.2, p < .001. Strong relationship exists for age and questions 16-19. For question 16, r=-0.5, n=25, p < .00. For question 17, r=.32, n=25, p < .001, question 18, r=.3 n=25, p < .001, and for question 19, r=.14 n=25, p < .001.

Table 3

Survey Frequencies and Percentages for the Knowledge about Sexuality Survey: Knowledge about LGBTQ+ (N=25)

Survey Question Number and Question	Percentage and Frequency of Answers			
	True	False	Don't Know	Answer True (T), False (F)
1. A child who engages in homosexual behaviors will become a homosexual adult.	3 (12%)	18(72%)	4 (16%)	F
2. There is a good chance of changing homosexual people into heterosexuals.	2 (8%)	21 (84%)	2 (8%)	F
3. Most homosexuals want to be members of the opposite sex.	2 (8%)	23 (92%)	0 (0%)	F
4. Some church denominations oppose legal and social discrimination against homosexual men and women.	21 (84%)	1 (4%)	3 (12%)	T
5. Sexual orientation is established at an early age.	16 (64%)	7 (28%)	2 (8%)	T
6. According to the American Psychological Association, homosexuality is an illness.	7 (28%)	16 (64%)	2 (8%)	F
7. Homosexual males are more likely to seduce young men than heterosexual males are likely to seduce young girls.	4 (16%)	18 (72%)	3 (12%)	F
8. Gay men are more likely to be victims of violent crime than the general public.	19 (76%)	4 (16%)	2(8%)	T
9. A majority of homosexuals were seduced in adolescence by a person of the same sex, usually several years older.	6 (24%)	12 (48%)	7 (28%)	F
10. A person becomes a homosexual (develops a homosexual orientation) because he/she chooses to do so.	8 (32%)	16 (64%)	1 (4%)	F

11. Homosexuality does not occur among animals (other than human beings).	5 (20%)	13 (52%)	7 (28%)	F
12. Almost every culture has evidenced widespread intolerance toward homosexuals, viewing them as "sick" or "sinners."	20 (80%)	5 (20%)	0 (0%)	F
13. Heterosexual men tend to express more hostile attitudes toward homosexuals than do heterosexual women.	18 (72%)	2 (8%)	5 (20%)	T
14. . "Coming out" is a term that homosexuals use for publicly acknowledging their homosexuality.	24 (96%)	1 (4%)	0 (0%)	T
15. Bisexuality may be characterized by sexual behaviors and responses to both sexes.	25 (100%)	0 (0%)	0 (0%)	T
16. Individuals who have Intellectual Disability and Developmental Disability (ID/DD) can identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+).	21 (84%)	2 (8%)	2 (8%)	T
17. Individuals who have Intellectual Disability and Developmental Disability (ID/DD) who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+) can have sex.	24 (96%)	1 (4%)	0 (0%)	T
18. Individuals who have Intellectual Disability and Developmental Disability (ID/DD) and want to change their biological sex can take medications to change to the opposite sex.	15 (60%)	7 (28%)	3 (12%)	T
19. Individuals who have Intellectual Disability and Developmental Disability (ID/DD) who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+) cannot go to LGBTQ+ events	1 (4%)	22 (88%)	2 (8%)	F

Community Inclusion

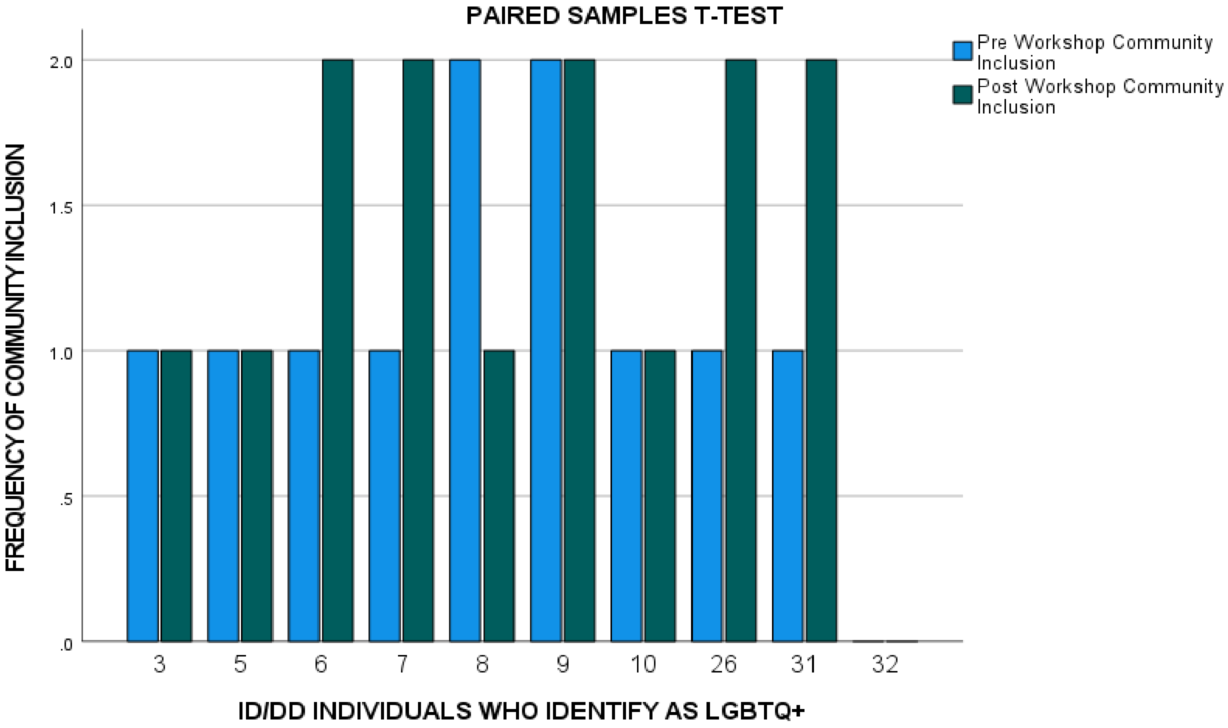
To ascertain staff participants' knowledge and willingness to support the cohort, one month of pre-workshop and post-workshop of random 32 community inclusion samples were reviewed for visits to LGBTQ+ establishments such as clubs, bars, community settings, LGBTQ+ events, and shops. The paired-sample t-test was used to compare the pre-and post-workshop community inclusion frequency to LGBTQ+ friendly community activities and sites by staff for the ID/DD individuals who identify as LGBTQ+. Pre-workshop data showed minimal community inclusion of LGBTQ+ sites. Documentation showed that limited time (10-15 minutes) was spent at these LGBTQ+ sites. No anecdotal documentation exists about the experience or the satisfaction of the ID/DD individual's visits to the LGBTQ+ sites.

This parametric test is appropriate because the dependent variable is measured at an interval ratio using a continuous scale. The scores are derived using a random sample from the population. Other observations or measurements do not influence the measurement. Also, there is a normal population distribution and a sample size of more than 30 observations (Pallant, 2013).
A paired-sample t-test was conducted to compare the mean scores for the same data group on two separate occasions; the workshop's impact on staff's support and facilitating of individuals attending community inclusion to LGBTQ+ friendly sites (see figure 4).

Statistical Package for the Social Sciences (SPSS) showed that there was a statistically significant difference in the increase in going to LGBTQ+ community inclusion-friendly sites from pre-workshop (M=.38, SD =.609) to post-workshop (M=.69, SD=.780), P<.001 (two-tailed). The mean increase in the LGBTQ+ community inclusion was -.312, with a 95% confidence interval ranging from -.545 to -.080. The eta squared statistic (0.20) indicated a small effect (Pallant, 2013).

Figure 4

Pre-and-Post Workshop community inclusion to LGBTQ+ friendly sites



Adverse Behavioral Issues

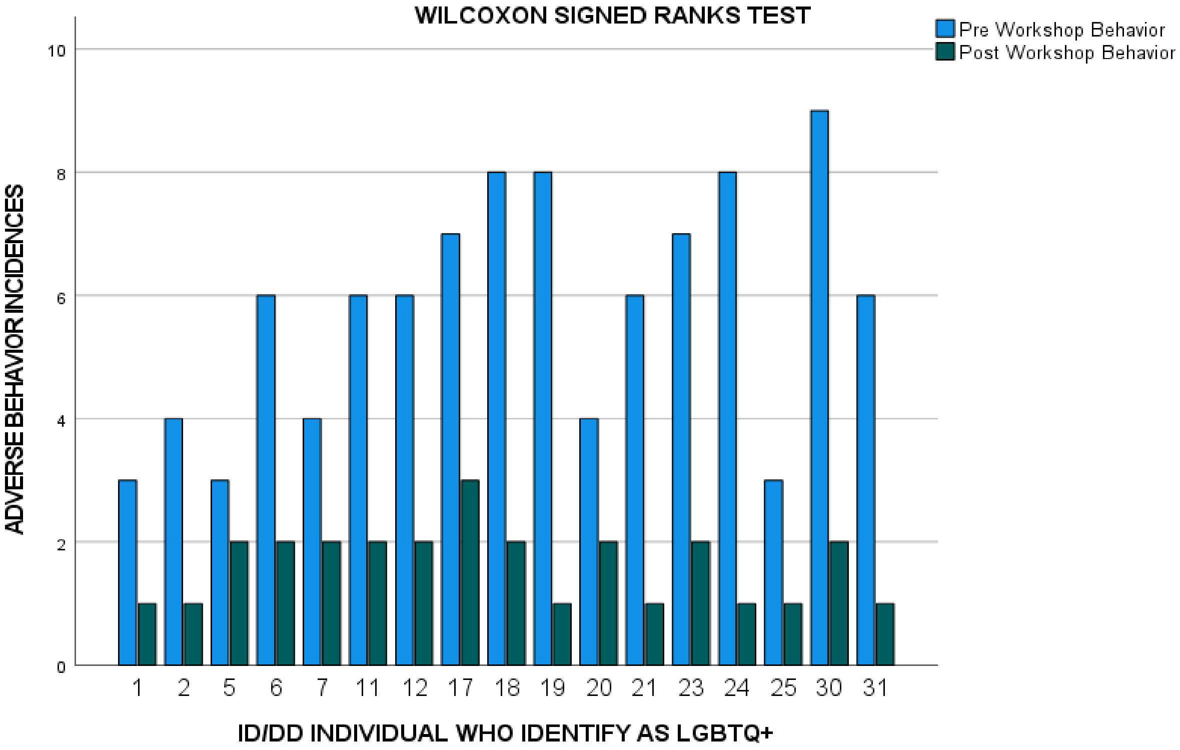
The Wilcoxon signed-rank test was used to analyze the workshop's significance and the change frequency of adverse behavioral issues pre-and-post workshop (see Figure 5). This non-parametric test was appropriate because the assumption is that even with a sample size of 32, the data was not normally distributed and homogenous. Using a sample paired t-test would yield an error (Pallant, 2013).

The data collection for one month was obtained from all 32 individuals regarding any behavior documentation, emergency services activation, and any psychiatric hospitalizations for behaviors that threaten the individual or others. These behaviors include physical aggression towards objects or people, self-injury, elopement, prostitution, sexually inappropriate behaviors, offending behaviors such as public masturbation, feces smearing, and stealing. Pre-workshop data showed that the frequency of adverse behavior among the ID/DD individuals who identify as LGBTQ+ is high. These adverse behaviors range from minor incidents such as throwing food on the floor or punching the walls to more severe behaviors such as elopement and self-injurious behaviors.

A Wilcoxon signed-rank test showed a z = -4.718, p < .001 (2-tailed). The means that the difference in adverse behaviors among the cohort pre-and-post workshop is statistically significant. Also, with a large effect size (r=.83), this statistical difference was due to the intervention workshop. The median score on the adverse behavior per month for ID/DD individuals who identify as LGBTQ+ decreased from pre-workshop (Md=4) to post-workshop (Md=1).

Figure 5

Pre-and-Post Workshop adverse behavior frequency



Discussion of Findings

Medical and technological advances have increased life expectancies for people with developmental and intellectual delays. Many agencies provide quality care for these chronic illnesses but struggle to provide holistic care that addresses these individuals' sexual needs (Simpson et al., 2016). However, the needs of intellectually disabled and developmental disorder individuals (ID/DD) who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+) are not always met or addressed by these agencies (Collado & Besoain, 2020).

The controversies with this problem are that caretakers and families might disagree that this population can give sexual consent, understand the complexities of having sex or having sexual partnerships due to their disabilities (Campbell et al., 2020; Santinele Martino, 2019). Studies show this cohort may exhibit adverse behavioral and psychological issues due to sexual frustrations stemming from this breach in service (Hall et al., 2020). These behaviors could lead to unnecessary hospitalizations, breach of staff and ID/DD individuals' safety, decreased staff and cohort satisfaction, minority stress (Blaskowitz et al., 2019; Goodman, 2018; Hall et al., 2020).

This DNP project aims to use quality improvement measures to develop staff education on support strategies for ID/DD individuals who identify as LGBTQ+ in group homes to reduce behavioral issues in the cohort. Three objectives were met for this project in a 5-week implementation frame. First, perform a content analysis of the institutions' policies and procedures, forms, and physical environment (as needed) to identify the prevalence of evidence-based words for LGBTQ+ ID/DD individuals. Second, monitor community inclusion activities for cohort accessing LGBTQ+ friendly sites. Third, use chart audits of nursing notes, medical appointments, and behavior flowsheets to monitor the rates of behavioral issues for ID/DD individuals identified as LGBTQ+.

The results of the data analysis met the objectives of this DNP project and supported the literature findings. This DNP project sought to answer if staff education on support strategies for the ID/DD individuals who identify as LGBTQ+ would decrease behavioral issues among the cohort. Aggregated data showed a statistically significant decrease in the adverse behaviors exhibited by ID/DD individuals who identify as LGBTQ+ after the workshop compared to pre-workshop behaviors. This statistical difference had a significant effect, $r = .83$, indicating the decrease in adverse behaviors among the cohort post-workshop due to the QueerAlly-IDD Workshop, $z = -4.718$, $p < .001$ The median score on the adverse behaviors decreased from pre-workshop to post-workshop.

This analysis supported the literature view that staff education and support would reduce adverse behavioral issues among the cohort. The educated staff has more resources and attitudes to advocate and minimize outside bias (Hall et al., 2020; James et al., 2016; Rodriguez-Roldan, 2020). This result also supports literature findings that sexual frustrations lead to this population's adverse behavior and psychological issues (Hall et al., 2020). The lack of support from staff may lead to these negative experiences predispose ID/DD individuals who identify as LGBTQ+ to poor health and psychopathology, minority stress, and a decrease in PERMA (well-being) (Fulginiti et al., 2020; Horwitz et al., 2020; Meyer, 2003; 2020).

Additionally, the literature showed that staff education with support strategies decreases minority stress and the distal and proximal factors that may cause the cohort's physical and psychological chronic illnesses (Meyer, 2003; 2020). Therefore, any changes in the rates of adverse behavior in the cohort could indicate that the staff is cognizant and knows how to support and facilitates sexual expression for the cohort (McCann et al., 2016).

The QueerAlly-IDD Workshop was developed to use evidence-based information to educate staff to recognize, understand and meet the specific needs of ID/DD individuals who identify as LGBTQ+. The workshop encouraged staff to self-reflect on their prejudices, provided staff with resources on how to teach the cohort about sex education and where to access community resources. Analysis of the post-workshop survey showed that respondents have a statistically significant amount of information about the cohort after the workshop. Most of the respondents answered correctly about LGBTQ+ terminology questions 14 and 15. However, most respondents did not correctly answer question 12, cultural-historical intolerance towards homosexuality.

This data analysis result supports the literature findings that staff might socialize this cohort to the lifestyle. The staff might be judged as promoting the lifestyle or become the subject of discrimination themselves (Campbell et al., 2020). This myth is supported by data analysis of question 12 about cultural intolerance of homosexuals and perception as “sick” or as “sinners,” Only 5 (20%) of respondents answered this question correctly as false. Most of the respondents, 20 (80%), responded to the question incorrectly. Literature theorizes that staff does not provide or provide minimal and inconsistent sex education for the ID/DD population (Santinele Martino, 2017). Staff may think that the individuals do not have sexual needs and may contribute to the negative attitudes and barriers that may stop them from having sexual rights (Wilson & Frawley, 2016).

For questions 22 – 25 of the survey, about specific knowledge about ID/DD individuals who identify as LGBTQ+, data analysis showed that respondents who had higher education and previous education about homosexuality scored higher, especially with the questions about ID/DD individuals identifying as LGBTQ+, having sex, changing their biological sex, and going to LGBTQ+ events. This statistically moderate to strong correlation between education and knowledge about support for the cohort validates the literature that the staff who support ID/DD need adequate training (Mcann & Brown, 2016). Conversely, the DNP post-workshop data also show that age and gender did not affect the knowledge of homosexuality. These statistical analysis results show that staff education and knowledge on how to support the cohort is the key to decreasing adverse behavior instead of other variables such as age and gender.

Community inclusion data analysis showed that the workshop implementation had a small effect, eta squared statistic (0.20), on the staff support to accompany the cohort members to LGBTQ+-friendly sites compared to pre-workshop activities. This small effect could be due to the limited time between the implementation of the workshop and the collection of post-workshop community inclusion data. However, the pre-workshop (M=.38, SD =.609) to post-workshop (M=.69, SD=.780), P<.001 (two-tailed) showed that that community inclusion to LGBTQ+ increased.

This increase in the means of pre-and-post -workshop is significant and supports the earlier data. With the increase in education and knowledge about the cohort, the staff is willing to provide more support for the cohort. Studies show that staff support, advocacy, and elimination of obstacles for this cohort and providing culturally congruent care to the cohort members would facilitate the availability and access to LGBTQ+ resources (Nowaskie, 2020; Pereira, 2020; Salerno, 2020).

These results support the literature stance that implementing evidence-based training for staff who support the cohort would help create an environment conducive to expressing their sexuality without any restrictions (Dinwoodie et al., 2020; Treacy et al., 2017). The support allows the cohort to find meaning through their lives, work, activities, hobbies and achieve their goals (Lai et al., 2018). Educated staff will increase the support for this cohort and assist the cohort members in accomplishing the five PERMA (Positive Emotions, Engagement, Relationships (Positive), Meaning, and Accomplishment/Achievement) phases (Seligman, 2018). Achieving PERMA will increase, promoting, and supporting the resilience of the cohort to flourish and live quality and meaningful lives and attaining well-being, flourishing, and flow, and eudaimonic and hedonic happiness (Castro Baker et al., 2020, Goodman, 2018; Harrison, 2019; Lai et al., 2018; Nel, 2019; Tape, 2018).

Finally, data analysis showed that the agency's environment, documents, policies, and cultural competency workshop did not contain a significant amount of words, symbols, pictures for words, or any phrase related to the care and support of the LGBTQ+ cohort. This analysis supports the literature assertions that gaps exist in the lack of clear protocols on and support for staff on how to care for ID/DD individuals who identify as LGBTQ+ (Wilson & Frawley, 2016). Also, studies support the findings that there are gaps regarding the exact content to add when developing policy and protocol to guide staff support for this group (Achey, 2020; Wilson & Frawley, 2016).

These gaps in policies, documents, and training contribute to the lack of support for staff and staff ambivalence about supporting the cohort. Lack of LGBTQ+ terms in policies would contribute to staff ambivalence and lack of support (Hall et al., 2020; James et al., 2016; Rodriguez-Roldan, 2020). An unwelcoming environment encourages intolerance, discrimination, and bias to the cohort from staff and other stakeholders (Brigham and Women’s Faulkner Hospital (BWFH), 2016). Also, an unwelcoming environment may increase minority stress and decreased PERMA in the cohort resulting in increased adverse behaviors and chronic illnesses (Dinwoodie et al., 2020; Meyer, 2020 Wilson & Frawley, 2016).

Overall, the purpose and the objectives of this quality improvement DNP project were met. Statistical analysis and data results support the literature findings that staff education about support strategies for ID/DD individuals who identify as LGBTQ+ in group homes would reduce behavioral issues in the cohort. Within the 5-week implementation frame, an evidence-based educational culturally competent workshop was designed to educate group homes staff to recognize, understand and meet the specific needs of the ID/DD individuals who identify as LGBTQ+ with the post-workshop survey. Also, content analysis of the institutions' policies and procedures, forms, and physical environment revealed the limited incidences of evidence-based words for LGBTQ+ ID/DD individuals. Furthermore, the analysis of community inclusion activities for cohort accessing LGBTQ+ friendly sites increased post-workshop, indicating an increase in staff knowledge about the cohort. Finally, chart audits of nursing notes, medical appointments, and behavior flowsheets showed a decrease in the rates of behavioral issues for ID/DD individuals identified as LGBTQ+. Per statistical analysis, this statistically significant decrease could be attributed to the staff knowledge acquired from the post-QueerAlly-I/DD workshop.

Significance/Implications for Nursing

The problem of not addressing the sexual needs of the ID/DD individuals will affect the cohort's quality of care and violate the cohort's ethical, legal, and human rights (Chism, 2019; IHI, 2018). According to Donabedian's framework, this cohort is not receiving quality care. The project's site was violating three of the Donabedian's seven attributes that define the quality of care as:

1. Acceptability: conformity to patient preferences regarding accessibility, the patient-practitioner relation, the amenities, the effects of care, and the cost of care.
2. Legitimacy: conformity to social preferences concerning all the above.
3. Equity: fairness in the distribution of care and its effects on health.

(Donabedian, 1990, Abstract).

The benefits of this project would help the agency to have a safer work environment for the staff and the cohort, help staff build stronger relationships with their colleagues and with the cohort, help the agency recruit and retain qualified staff, and help the agency sustain financially. The anticipation is that the agency's potential return on investment (ROI) will be immense due to this quality improvement project.

Staffing

Many agencies incur costs to hire and train qualified and competent registered nurses; however, these agencies cannot retain these nurses (Wilson et al., 2020). Many nurses will stay from a week to less than three months and then resign due to a hazardous working environment or be dismissed for unsafe practices (Apelgren et al., 2018). Studies show that this lack of retention is unsafe, not patient-centered, ineffective, inequitable, and inefficient (Mafuba et al., 2015; Nursing Solutions Inc. (NSI), 2020). The increase in nurse turnover causes a decrease in the quality of care received by the ID/DD population due to a lack of consistent professional providers (Lewis et al., 2019; Marufu et al., 2021). Also, this increase in nurse turnover is not cost-effective. Many agencies incur exorbitant costs to hire and train these nurses (Marufu et al., 2021; NSI, 2020).

However, with the increase in turnover, these agencies will not recoup the investment spent training the nurses (Lahana et al., 2017; NSI, 2020). This lack of retention would contribute to a lack of safety and satisfaction for patients and staff (Mafuba et al., 2015). According to the literature, the average cost of turnover for a registered nurse (RN) ranges from $37,700 to $58,400 (NSI, 2020). Institutions lose $5.2 million to $8.1 million due to RN turnover, and each percent change in RN turnover costs or saves a hospital an additional $373,200 (NSI, 2020). This benefit-cost ratio is measured by the projected benefit of the present value divided by the current value of cost (Cullen et al., 2017).

Data showed that the project decreased unnecessary psychiatric admissions and visits and frequent hospitalizations. These findings align with the literature that staff support and education decrease adverse behavioral issues in this cohort (Wilson & Frawley, 2016). With the decrease in negative behaviors, agencies would have the opportunity to recruit and retain experienced and qualified staff who would not be afraid of getting harmed (Hall et al., 2020). The cost saving is from the decrease in frequent onboarding, hiring of temporary staff, unproductive staff days, and workplace injury costs (Wilson et al., 2018). A reduction in turnover rates for ID/DD specialty nurses will decrease untoward events in the ID/DD cohort and increase patient and staff satisfaction (Mafuba et al., 2015; Nursing Solutions Inc. (NSI), 2020). It is crucial to evaluate outcome measures by linking the results to the organization's mission and values and conducting a cost analysis to report the return on investment (ROI). The ROI will help gain support and buy-in from the organization's key stakeholders (Cullen et al., 2017).

Regulatory bodies

Since the agencies may not adhere to the staffing ratio due to lack of retention, these agencies may become subject to scrutiny by federal and state regulating bodies such as the Centers for Medicare and Medicaid Services (CMS), the State Board of Nursing (and the New York State regulatory body, The New York State Office for People with Developmental Disabilities (OPWDD) (Marufu et al., 2021). Additionally, this violation gap leads to a lack of staff support and the breach of regulatory institutions' mandates, such as CMS, The Joint Commission, and OPWDD. The agency may receive negative citations and lose funding for not providing quality care to the cohort (CMS, 2017; NSI, 2020).

At the federal level, the Centers for Medicare, and Medicaid Services (CMS) regulation, 42 Code of Federal Regulations (42CFR 482.23(b)), requires hospitals certified to participate in Medicare to "have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed" (American Nurses Association (ANA), 2019, para. 5). At the state level, the New York State Board of Nursing (NYBON) requires some form of disclosure and public reporting about Registered Nurse staffing (Office of the Profession, 2018). At the local level, the NYBON and the New York State Office for People with Developmental Disability (OPWDD) require social service agencies to have registered nurses available 24 hours, 7-days a week to supervise unlicensed direct support staff who are authorized to perform registered nurse (RN) functions by the New York State Board of Nursing (Office of the Professions, 2018).

However, with the implementation of this project, increased patient and staff satisfaction and decreased sentinel and never-events would translate into increased reimbursement from Centers of Medicaid and Medicare Services and other payors. The agency will efficiently compete and sustain itself in the healthcare arena (Press Ganey, 2016). Likewise, the agency would meet the quadruple aim of healthcare - to enhance the patient experience, improve population health, reduce costs, and improve the work-life of health care providers, including clinicians and staff (CMS, 2017).

Finally, the anticipation is that this project would help agencies that support this cohort identify problems that would affect quality, cost-effective, safe, timely, effective, efficient, and patient-centered care (Chism, 2019). The data from this project will be used to explain and support the agency's quality improvement projects, sustainability and procure the buy-in of different stakeholders about the importance and urgency for any needed changes (Porter-O'Grady & Malloch, 2018). The project would also help the agency to "…measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care" (CMS, 2017, para. 2).

Revised cultural competency training

The project will help the agency's staff development and human resources develop comprehensive, evidence-based training and awareness programs for all agency staff. Studies suggest that healthcare providers should be provided with culturally congruent care training to help improve health disparities (Nowaskie, 2020; Tallentire et al., 2020). The revised training needs to incorporate comprehensive staff training on LGBTQ+ meanings, how to provide safe sex training and sexual rights for the cohort, respect for gender expression and identity, how to recognize and affirm the sexual orientation, sex, gender diversity, and intersex status of the cohort, and acknowledgment of personal bias about the cohort. The reinforcement of a nonjudgmental attitude must be included in the training (Achey, 2020; Nowaskie, 2020).

Additionally, the project will help the agency to identify the organization's cultural competence training needs in such areas as "(a) improving service delivery to culturally diverse populations; (b) identifying cross-cultural strengths that currently exist within an organization, system, or network of professionals; and (c) focusing on beneficial training topics for providers of services" (Mason, 1995, p. 8). Part of the education should be used to measure behavioral staff changes and reinforce the need for professional practice and language change when addressing this cohort (Filej et al., 2016; Trista, 2018).

Supportive environment

The project's content analysis results identified limited support for staff, LGBTQ+ language, and illustrations within the agency's forms and environment (see Table 1). Literature suggests that the best way to solve this problem is by developing a comprehensive policy and procedure to guide and support the staff as they render care to the cohort (Achey, 2020; NLHEC, n.d.; Wilson & Frawley, 2016). This LGBTQ+ inclusive policy should be enforced throughout the agency (NLHEC, n.d.). The policy should include a philosophy to support the agency's mission and vision about holistic, inclusive, and accepting people regardless of their sexual orientation, and to respect people from all backgrounds, improve practice, value honesty, and provide support and help people reach their full potential (Project site Intranet; Wilson, 2018). Also, the policy should include language that stresses intolerance for LGBTQ+ discrimination, advocates for diversity, and non-harassment (McCann et al., 2016; NLHEC, n.d.).

Literature documents that the staff may be unsure about the sexual rights and training for the cohort (Wilson & Frawley, 2016; Wilson, 2018). This lack of knowledge contributes to inadequate support and bias. This project provides information on how the agency can revise the policy to address giving and obtaining consent, age of consent, sexual education for the cohort, use of bedrooms for sexual relations, contraception use, and information for LGBTQ+ resources and friendly sites for community inclusion activities (McCann et al., 2016). Additionally, the metrics from this project can support the agency's initiative during the modification of the environment to become more welcoming to the cohort. The environment should include LGBTQ+ illustrations and LGBTQ+-related information handouts for the cohort and their families (NLHEC, n.d.). Literature suggests having LGBTQ+ rainbow stickers, flags, or decals on ID badges, staff stations, and around the agency to show support and acceptance to the cohort (BWFH, 2016).

Furthermore, the project aligns with the Institute of Medicine (IOM) report on LGBTQ+ health issues and research gaps, the vital recommendations in Healthy People 2020, and the Joint Commission's LGBTQ+ Field Guide, and the federal government's implementation of the Patient Protection and Affordable Care Act (BWFH, 2016). The project would reinforce the agency's efforts in collecting information on sexual orientation and gender identity to reduce LGBTQ+ health disparities. The agency should list LGBTQ+ health and transgender care among their services (BWFH, 2016). Also, the Agency's forms should include LGBTQ+ terminology and opportunities to ask about sexual orientations and gender identity as part of the medical and sexual history. Forms should also have options to document names and pronouns. These changes would help the staff to comply with the wishes of the cohort. The forms should not contain gender-neutral terminologies such as "father/mother," " husband/wife," "family history." Instead, forms should have "parent(s)," "partner(s)," "blood relatives." Also, forms should be gender-neutral (images without human shape) illustrations (NLHEC, n.d.).

Limitations

This DNP project has some limitations, which are uncontrollable factors that affect the study (Creswell & Clark, 2017). This project is limited to only one agency in New York City that services Intellectual Disability and Developmental Disability (ID/DD) individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+). The convenience sample size is limited to 25 and 32 indirect participants. With these small samples, the study findings may not be generalized to other agencies with a bigger or smaller population of direct and indirect participants in other locations. Also, the convenience sample for the direct participants is a limitation to this project because it could lead to sampling bias. The participants were selected due to their accessibility and availability. As a result, some population members may not be adequately represented by the sample, such as staff who were not available due to sickness or vacation (Creswell & Clark, 2017). Further studies need to use a large, random sample size of direct and indirect populations.

The assumption was that 23-30 staff members would respond to the survey after the workshop. In the first week of implementation, only ten staff members responded. The sensitivity of the study's questions, staff time constraints, unavailability, and difficulty locating the embedded survey link in the presentation could have contributed to the low response rate (Nkurumah et al., 2018). In the second week, with the collaboration and consultation with the agency's IT team, the survey link was moved out of the presentation. A button was created at the website directing the respondents to click the button for the survey link. Subsequently, 25 staff members completed the workshop and responded to the post-workshop survey.

Due to the limited period between the implementation of the workshop and the data collection, data compiled from the post-workshop community inclusion may not have yielded complete information. The project took place within five weeks at a single New York City agency.

Aggregated data showed the small effect of the workshop on the staff's willingness to start taking the cohort members to LGBTQ+ friendly sites. The project was limited because there was no investigation of the long-term effects of education on staff attitudes towards the cohort. Also, data collected from community inclusion and frequency of adverse behaviors may be affected by the limited duration of the post-workshop data collection and the small sample size of the direct participants. The assumption is that there would have been a more significant effect of the intervention on the frequency of LGBTQ+ friendly sites during community inclusion.

Finally, the survey questions prohibited the ability to perform a comprehensive analysis of the results. Survey questions did not include specific questions about lesbians, transgender people, asexuals, pansexuals, and intersex. Only one question mentions bisexuality. The inclusion of these other particular groups could have helped ascertain thorough responses from the participants. Future studies should revise the survey to include questions about the different sexual minorities under the umbrella of LGBTQ+.

Dissemination

According to Tymkow, "the translation and dissemination of clinical knowledge is the core of clinical scholarship" (2017, p. 66). The AACN (2015) asserts that the DNP student demonstrates clinical scholarship by focusing on improved outcomes, blending nursing scholarship with the eight AACN DNP Essentials. The nursing scholarship defines those professional actions that methodically contribute to the improvement of nursing, research, and teaching (AACN, 2015; Chism, 2019; Trautman, 2019). These activities are peer-reviewed, innovative, documented, essential to the nursing profession, and could be duplicated or expanded. The nursing scholarship is committed to social relevance and scientific advancement by incorporation of ideas from nursing and other disciplines to support the nursing profession's principles through the discovery, exploration, explication, and integration and contribution to new research, applications of these discoveries into clinical practice, and the promotion of nursing education (Ahmed, 2018; Curtis et al., 2017; Moran et al. 2019; Wolf, 2015). The DNP nurse's scholarship creates new knowledge through practice change improvement, translation of data, and quality improvement methods that may be transferable to other situations (Moran et al., 2019). The DNP nurses collaborate within and outside the nursing discipline to merge the research concepts from the practice and science fields to positively impact health (AACN, 2015; Chism, 2019).

The project's findings will be disseminated through different venues such as a policy paper, poster, podium presentations, interprofessional education, and peer-reviewed publications (Ahmed, 2018; Chism, 2019; Dols et al., 2017). The manuscript of this project will be submitted for publication to the International Journal of Nursing in intellectual and developmental disabilities and the American Journal on Intellectual and Developmental Disabilities (AJIDD) for publication. In addition, the project will be submitted to the doctoral project repository at the Doctor of Nursing Practice website. Finally, the project will be submitted for poster presentation at the Developmental Disabilities Nurses Association 2022 conference in San Antonio, Texas, and the Sigma 33rd International Nursing Research Congress, 21-25 July 2022 in Edinburgh, Scotland.

The results of this project will be disseminated by collaborating with the interdisciplinary team to provide scholarship to the nursing profession in Intellectual Disability and Developmental Disability (ID/DD) nursing specialties (Hall & Roussell, 2016; Moran et al., 2019). The project site will adopt the Queer Ally-IDD workshop to revise their current cultural competency workshop, modify their environment, policies, and forms. It is anticipated that other agencies will use the workshop to train and support their staff. Additionally, the project finding will be used as quality indicators benchmarks for the agency's quality improvement initiatives and evaluations (Moran et al., 2019). The project’s objectives and question variables support the Centers of Medicare and Medicaid (CMS) and the goals of the Institute of Medicine (IOM) for safe, timely, efficient, equitable, and patient-centered care (Chism, 2019). It is crucial to evaluate outcome measures by linking the results to the organization's mission and values and doing a cost analysis to report the return on investment (ROI). The ROI is a vital key performance indicator (KPI) used to determine the profitability of spending. The ROI for this project will help gain the support and buy-in from the organization's key stakeholders (Cullen et al., 2017).

Sustainability

Implementing evidence-based findings requires knowledge of change processes, team building, creativity, innovation, and collaborative skills. Before implementation, consideration, and assessment of the organizational readiness to change, culture, communication channels, systems, assessing potential staff, and institutional barriers to the evidence-based practice (EBP) and structure are instrumental in the project's success and sustainability (Hall & Roussell, 2016). Sustaining the change involves monitoring the compliance, feasibility, and the need to standardize the improvement (Institute for Healthcare Improvement (IHI), 2018). Assessment of the effect on the organizational workload and an ongoing timeline and monitoring is essential to help revise and monitor any barriers (Hall & Roussell, 2016).

Before implementing this quality improvement project at the project site, consideration, and assessment of the organizational readiness to change, culture, communication channels, systems, assessing potential staff, and institutional barriers to the change and structure are instrumental in the project's success and sustainability (Hall & Roussell, 2016; IHI, 2018). Getting the organization ready for the implementation involves collaboration, support, and the entire team's buy-in, champion, formal and informal leaders, and stakeholders (IHI, 2018).

For sustainability, the agency will utilize the Institute for Healthcare Improvement (IHI) Project Planning Tool (see Appendix I) to monitor ongoing and concluded measurables and any identified variances. The agency should continue data collection and contrast with benchmarks results revealed by the project's analysis to determine the change's effectiveness. It is imperative to sustain the change and monitor ongoing improvements by assigning ownership, responsibilities, and accountability of the new change (IHI, 2018). The IHI tool will also help monitor communication about the change, team support, and required training for team members (Hall & Roussell, 2016). Key stakeholders should continue to assess compliance with frequent monitoring, support, train staff about the importance of the change, and communicate the impact of the change and the ROI to senior leadership and the board of directors (IHI, 2018).

Conclusion

With the increasingly complex healthcare system, global pandemic, rising healthcare costs, there is an ongoing demand for quality healthcare that is safe, timely, efficient, equitable, and patient-centered (Ansa et al., 2020). The pragmatic DNP-prepared nurse leader must use organizational and leadership skills to ensure quality care for the best patient outcomes (Chism, 2019; Moran et al., 2019). DNP nurse leaders must ensure the development of culturally applicable healthcare systems by using clinical knowledge and expertise, patients' values, evidence-based research findings to ensure quality, culturally congruent, cost-effective, theory-based interventions and practices (Chism, 2019; Starkweather et al., 2019).

Medical and technological advances have increased life expectancies for people with developmental and intellectual delays (Wilson & Frawley, 2016). Many agencies provide quality care for these chronic illnesses but struggle to provide holistic care that addresses these individuals' sexual needs. Inconsistent culturally congruent care and support for the LGBTQ+ ID/DD individuals contributed to minority stress and decreased PERMA (well-being).

This DNP project sought to answer if staff education on support strategies for the ID/DD individuals who identify as LGBTQ+ would decrease behavioral issues among the cohort. The data analysis of this quality improvement measure supported the literature stance that in ID/DD individuals who identify as LGBTQ+ in a group home, implementing a supportive strategic education protocol for the group home staff that is evidence-based and culturally competent, compared to current practice, will decrease behavioral issues for the cohort.

The recommendation is that social services agencies that service and support the ID/DD population who identify as LGBTQ+ should revise the cultural competency workshops for staff. Also, these agencies should modify their environments, policies, and forms to include evidence-based information about the cohort to focus on details about the sexual needs of the ID/DD population who identify as LGBTQ+. Finally, agencies should use the project’s interventions to minimize minority stress and improve the cohort's positive psychology (PERMA model). These modifications should follow the goals and objectives of the QueerAlly-IDD workshop of recognizing, understanding, and meeting the cohort's specific needs.

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Appendices

Appendix A. LGBTQ TERMS AND DEFINITIONS

Since terminology is so fluid and identity labels mean different things to different people, this list simply aims to serve as a resource and guide. By no means can every definition perfectly describe every individual's experience with an identity.

BIOLOGICAL SEX/ASSIGNED SEX: A medical label used to categorize people according to their chromosomes, hormones, genitalia, and secondary sex characteristics (breasts, body hair, etc.) and usually assigned at birth as "male" or "female" by a doctor, though there are many variations outside of that socially constructed binary (i.e., intersex).

CISGENDER: Term used to describe an individual whose assigned biological sex aligns with their expected binary gender identity. Considered to be the opposite of "transgender." *Example*: A person whose sex assigned at birth is "female" and identifies their gender as girl or woman.

CROSSDRESSER: A person who enjoys dressing in clothing typically associated with the other of the two socially sanctioned genders but who have no intent to live full-time as the other gender. The older term "transvestite" is considered derogatory by many in the United States.

DRAG: The theatrical act of dressing in gendered clothing and adopting gendered behaviors as part of a performance (usually clothing and behaviors not typically associated with your own gender identity. It can be done for entertainment, as parody, or to make a political statement. Does not indicate the performer's sexual orientation or gender identity.

GENDER: A socially constructed identity centering around notions of "masculinity," "femininity," and "androgyny," which includes aspects of identity and expression.

GENDER EXPRESSION: The way an individual conveys (or is perceived as conveying) their gender, including their choices in clothing, hairstyles, mannerisms, communication patterns, social roles, etc.

GENDER IDENTITY: A person's understanding of themselves in gendered categories such as woman, man, boy, girl, transgender, genderqueer, etc. This understanding is how an individual feels inside and believes themself to be.

GENDER DYSPHORIA (FORMERLY REFERRED TO AS GENDER IDENTITY DISORDER): A diagnostic label included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to describe when a person identifies as a different gender than the one they were assigned based on their birth sex. This diagnosis is usually required so a trans person can receive hormone replacement therapy, sex affirmation surgery, and revised gender and sex markers on their identification.

GENDERQUEER: An identity label sometimes claimed by people whose gender identity does not fit into the culturally accepted man/woman binary. It may be characterized by the desire to challenge gender roles and expression norms, "play" with gender, and express fluid gender identity.

INTERSEX: Term to describe a person whose sex assigned at birth does not neatly fit into the socially accepted binary of "male" or "female" because they have genitalia, hormone production levels, and chromosomal makeups that are ambiguous or non-binary.

MTF/M2F/MTF AND FTM/F2M/FTM: Terms used to indicate the direction of a trans person's transition and identification change. Usually means male-to-female, male-toward-female, female-to-male, or female-toward-male.

PASSING: describes if a trans person can live convincingly and publicly as the gender they identify.

PRE-, POST AND NON-OPERATIVE (OR –OP): Terms used to describe a transgender or transsexual person’s intentions or status regarding sex affirmation surgeries.

QUEER: An umbrella identity term used by people who do not conform to norms of heterosexuality and the gender binary. A reclaimed slur is often used with a political connotation.

SEXUAL ORIENTATION: The aspect of an individual’s identity determines their sexual/erotic drives, desires, and fantasies.

SEX AFFIRMATION SURGERY (COMMONLY REFERRED TO AS SEX REASSIGNMENT SURGERY OR GENDER CONFIRMATION SURGERY): Surgeries to change the sex characteristics of one’s body, including genitals and secondary sex characteristics. Often misunderstood as being a single surgery that makes all body modifications, but the reality is that there is no “*one*” surgery or procedure.

TRANSGENDER OR TRANS: An identity label used to describe a person whose gender identity does not align with the socially expected one according to their sex assigned at birth and often used as an umbrella term to include people who transgress gender norms, including crossdressers, genderqueer people, trans women, trans men, bigender or polygender people, etc.

TRANS MAN (OR TRANSGENDER MAN OR TRANSEXUAL MAN): A person who has transitioned their identity from woman to man, and sometimes their body from female to male.

TRANS WOMAN (OR TRANSGENDER WOMAN OR TRANSEXUAL WOMAN): A person who has transitioned their identity from man to woman, and sometimes their body from male to female.

TRANSITION: The process of changing one's sex or gender, socially (e.g., changing one's name, clothing, makeup, hair, pronouns) and medically (e.g., hormones and surgery).

TRANSEXUAL: A person who usually experiences a strong and persistent feeling that their body and assigned sex are at odds with their gender identity. These individuals often (but not always) desire to change their bodies to reduce this dysphoria. Since this term comes from the medical establishment, many people choose not to identify with it.

TWO-SPIRIT: Identity label used within many American Indian and Canadian First Nations indigenous groups to describe an individual that possesses both "masculine" *and* "feminine" spirits. Coined by contemporary LGBT Native Americans to describe themselves and the traditional roles they are reclaiming.

ZE/HIR: Gender-neutral pronouns. Can be used similarly to she/her, he/him, or they/them.

OPPRESSION: The systematic subjugation of a group of people by another group with access to social power, which benefits one group over the other and is maintained by social beliefs and practices.

PRIVILEGE: A "system of advantage" that gives people from more powerful social groups access to resources and opportunities that are denied to others (and usually gained at their expense) simply because of the groups they belong to (Goodman, 2001; Johnson, 2001; Wildman & Davis, 1996, 2000).

PREJUDICE: To hold an adverse opinion or belief without just ground before acquiring specific knowledge, often against people or groups of people who are perceived as being "different" or having "different values."

DISCRIMINATION: When prejudiced feelings or beliefs move into the realm of behavior, people are denied equal treatment. It can be conscious and deliberate, or it can be unconscious and unintentional.

SEXISM: The cultural, institutional, and individual beliefs and practices that privilege men and masculinity, subordinate women and femininity, and denigrate values and practices associated with women.

HETEROSEXISM: The cultural, institutional, and individual beliefs and practices that assume heterosexuality is the only natural, standard, and acceptable sexual orientation. The assumption is that LGBQ identities are inferior to, or less authentic than, heterosexual identities.

ASEXUAL: An identity label sometimes claimed by people who do not experience sexual attraction. This identity differs from celibacy or abstinence, which are often used as an umbrella term to encompass aromantic, demisexual, grey-A, heteroromantic, homoromantic, etc.

PANSEXUAL: An identity label sometimes claimed by people who experience sexual attraction across the spectrums of gender identity, biological sex, and sexual orientation.

HOMOPHOBIA: Negative attitudes and feelings, ranging from aversion to hatred toward people who identify as or are perceived to be LGBQ. It can be present in religious institutions, the education system, and the law, and internally in individuals who may or may not identify within the LGBTQIA community.

TRANSPHOBIA: Negative attitudes and feelings, ranging from aversion to hatred, toward people who identify as or are perceived to be trans. It can be present in religious institutions, the education system, and the law, and internally in individuals who may or may not identify within the trans community.

CISSEXISM The cultural, institutional, and individual beliefs and practices that assume cisgender is the only natural, standard, and acceptable gender identity. The belief that transgender identities are inferior to, or less authentic than, cisgender identities.

HETEROSEXUAL: Originally a medical term to describe a person who experiences sexual attraction to people on the "opposite" side of the sex and gender binaries. The time came into existence in the 1890s solely to be used in opposition to the term "homosexual."

HOMOSEXUAL: Originally a medical term to describe a person who experiences sexual attraction to people on the same side of the sex and gender binaries. Because of its pathological connotation, many LGBQ people today do not identify with it.

LESBIAN: An identity label sometimes claimed by woman-identified people who form their primary romantic and sexual relationships with other woman-identified people.

BISEXUAL: An identity label sometimes claimed by people who are sexually attracted to two (or more) sexes or genders, not necessarily equally or simultaneously.

GAY: An identity label sometimes claimed by man-identified people who form their primary romantic and sexual relationships with other man-identified people.

FAAB OR AFAB: Abbreviation for "female assigned at birth" or "assigned female at birth."

MAAB OR AMAB: Abbreviation for "male assigned at birth" or "assigned male at birth."

POLYAMOROUS: An identity label sometimes claimed by individuals who recognize their ability to be in multiple loving and honest sexual and/or romantic relationships simultaneously.

HETERONORMATIVITY: The outright or underlying assumption that all people are heterosexual.

CISNORMATIVITY: The outright or underlying assumption that all people are cisgender.

ROMANTIC ATTRACTION: The aspect of an individual's identity determines who they focus on their romantic feelings and desires.

ALLY: A person that actively combats homophobia, queerphobia, transphobia, heterosexism, and cissexism in their day-to-day life.

OUT: To be openly identified as LGBTQ to certain people and in specific spaces. Outing someone without their consent is not only invasive but also can put that individual in danger.

BINARY: Term to describe an assumed duality. Usually about the socially constructed gender binary of man/woman and sex binary of male/female.

AGGRESSIVE (AG): An identity label claimed by some African Americans and Latin@ masculine of center lesbians. Some use “stud” as a synonym.

SAME GENDER LOVING (SGL): A term sometimes used by Black women who love women and Black men who love men. They emerged in the 1990s to provide African American and Black communities with an alternative way to discuss their identity outside of white-centric terminology.

QPOC/ QTPOC: Abbreviation for “queer people of color” or “queer and trans people of color.”

MASCULINE OF CENTER: Term coined by B. Cole of the Brown Boi Project to describe a queer or lesbian female assigned at birth with a more masculine gender expression. It can be used as an umbrella term of sorts to include identities such as butch, stud, aggressive (ag), dom, mach@, boi, tomboy, transmasculine, etc.

UNDOCUQUEER: Identity label claimed by some individuals in the United States who are both queer and undocumented to show that those two aspects of their identity are intersectional and inseparable.

DOWN LOW (DL): A term originating from the African American community to describe a man who usually identifies as heterosexual and has sex with men, often secretly.

BUTCH: A person, often—but not always—a lesbian or queer-identified woman, who identifies strongly with "masculinity." It has been used historically in a derogatory manner.

FEMME: A person, often—but not always—a lesbian or queer-identified woman, who identifies strongly with "femininity."

TRANSMASCULINE: A trans person whose gender expression is primarily "masculine." Often includes trans, transgender and transexual men.

TRANSFEMININE: A trans person whose gender expression is primarily "feminine." Often includes trans, transgender and transexual women.

LGBTQ Terms and Definitions - lgbtq. https://lgbtq.multicultural.ufl.edu/programs/speakersbureau/lgbtq-terms-definitions/

Appendix B. Pillars of positive psychology

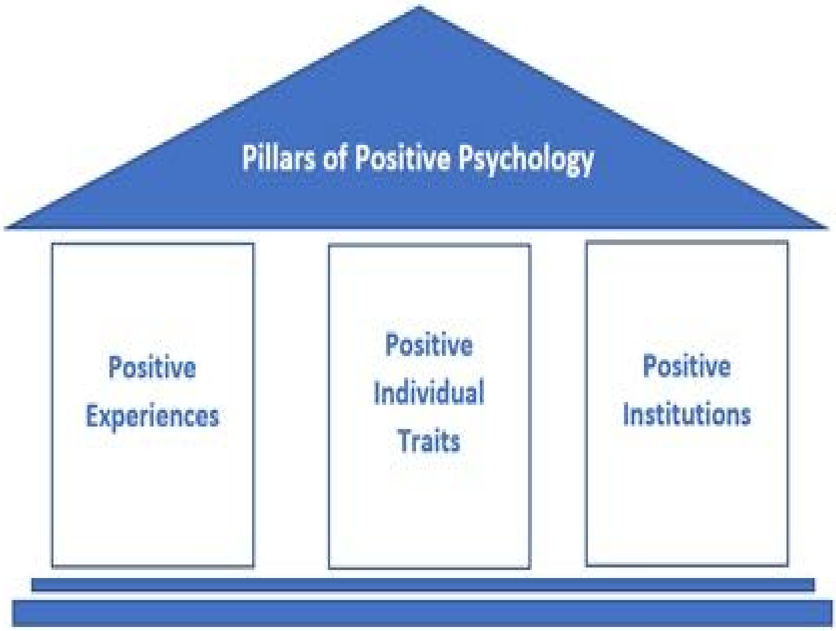


Figure 1 The pillars of positive psychology adapted from connect.ashp.org

Appendix C. PERMA Model

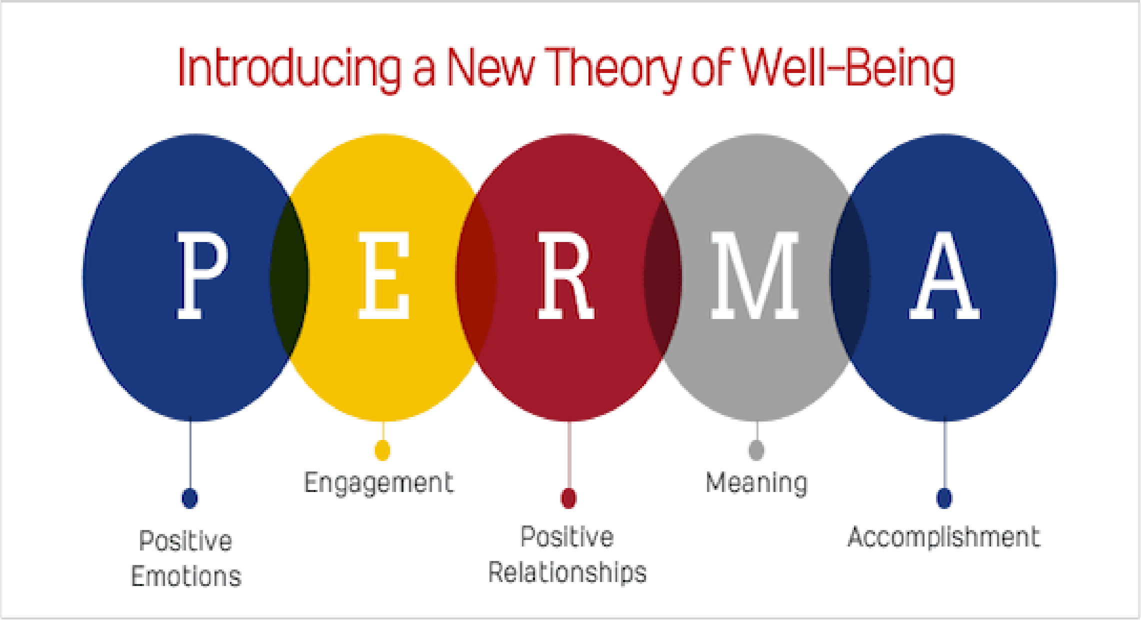


Figure 2 PERMA Model adapted from authentichappiness.sas.upenn.edu

Appendix D. Minority stress processes

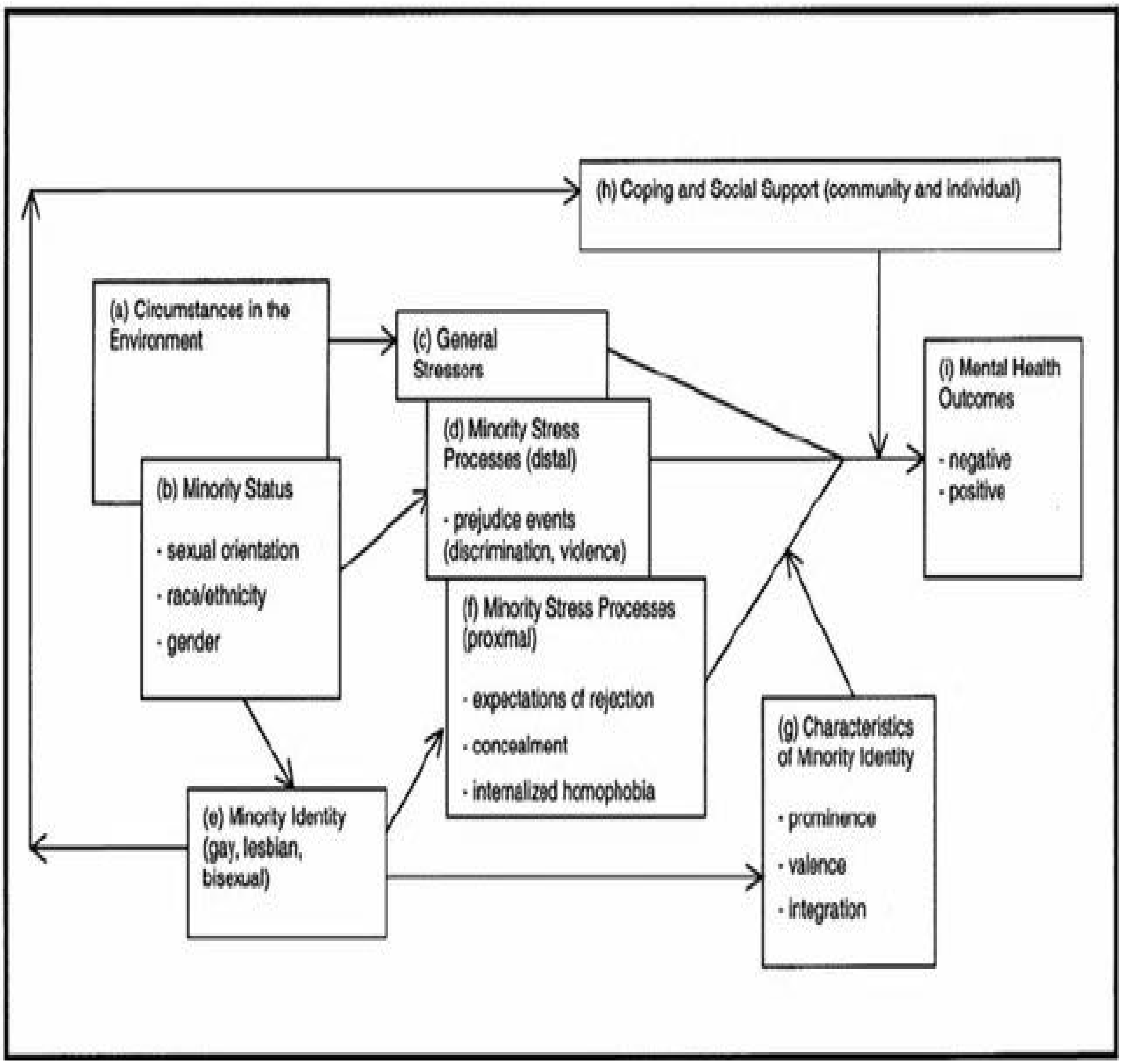


FIGURE 3 Minority stress processes in lesbian, gay, and bisexual populations. Meyer (2003).

Appendix E. QueerAlly-IDD Workshop

QueerAlly-IDD Workshop

Supporting the Intellectual and Developmental Disabilities (ID/DD) individuals who identify as LGBTQ+

July 2021 | Online

Goal

The QueerAlly-IDD workshop is designed to educate group home staff to recognize, understand, and meet the specific needs of ID/DD individuals' who identify as Lesbian Gay, Bisexual, Transgender, Queer or Questioning.

Post Workshop Survey

An anonymous 25-question questionnaire at the end of the workshop will help in assessing your knowledge about the LGBTQ+ population.

Confidentiality is assured on all sources of information given. Your feedback is greatly appreciated.

Survey Link

Objectives

- Recognize that it is important to increase cultural competency
- Recognize and affirm sexual orientation, sex, and gender diversity and intersex status
- Foster a safe, welcoming environment and inclusive services
- Understand the ID/DD individuals sexual rights
- Define the biggest barrier to inclusion is for this population
- Describe how to provide support to LGBTQ+ Individuals
- Understand What to teach – Sex Ed for People with IDD/DD
- Make a commitment to dynamic, ongoing change

Highlights

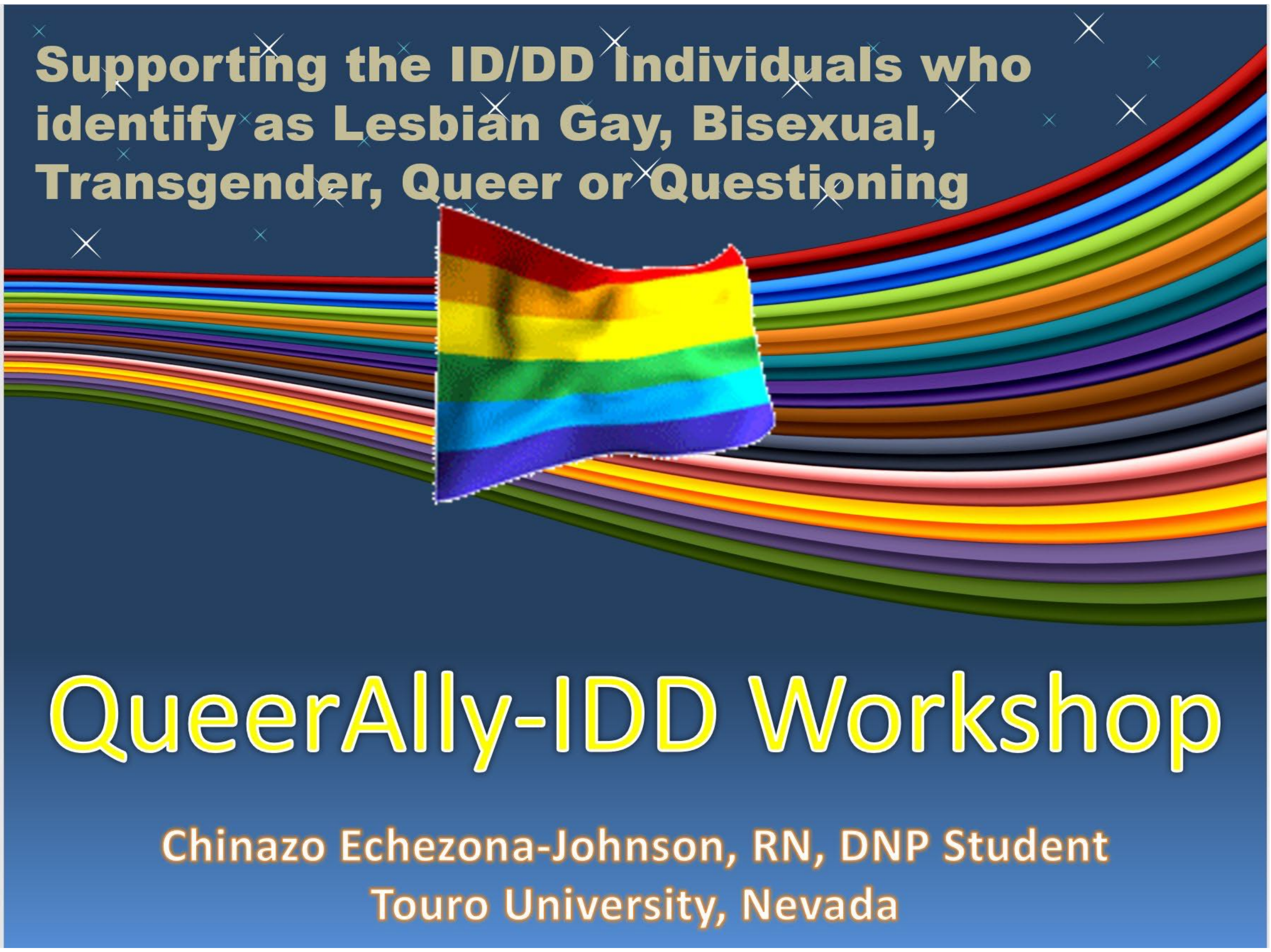
What to teach – Sex Ed for People with IDD/DD

CONTACT INFORMATION

CHINAZO ECHEZONA-JOHNSON, Touro University Nevada

✉ cechezon@student.touro.edu

Appendix F. QueerAlly-IDD Workshop



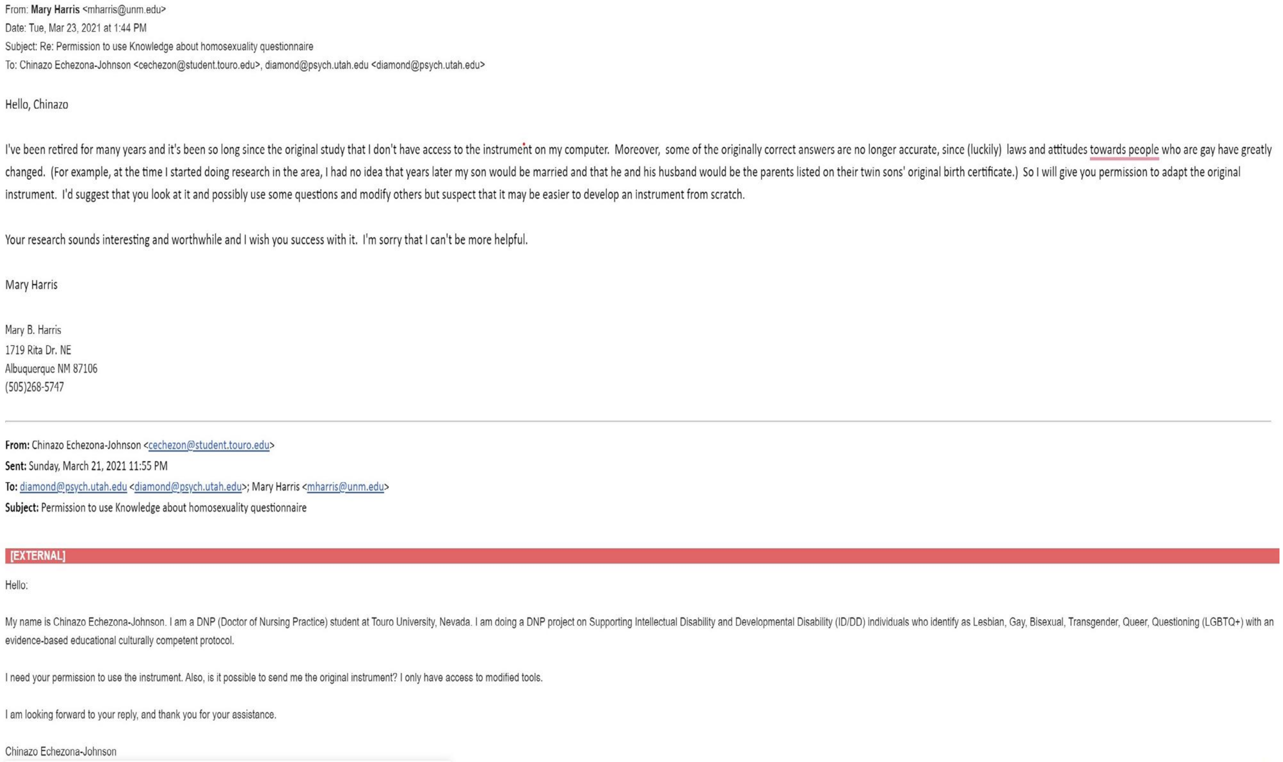
Supporting the ID/DD Individuals who identify as Lesbian Gay, Bisexual, Transgender, Queer or Questioning

QueerAlly-IDD Workshop

Chinazo Echezona-Johnson, RN, DNP Student
Touro University, Nevada

Available at: http://www.inspiringteacherrn.com/449906649

Appendix G. Permission to use Knowledge about Homosexuality Instrument



From: **Mary Harris** <mharris@unm.edu>
Date: Tue, Mar 23, 2021 at 1:44 PM
Subject: Re: Permission to use Knowledge about homosexuality questionnaire
To: Chinazo Echezona-Johnson <cechezon@student.touro.edu>, diamond@psych.utah.edu <diamond@psych.utah.edu>

Hello, Chinazo

I've been retired for many years and it's been so long since the original study that I don't have access to the instrument on my computer. Moreover, some of the originally correct answers are no longer accurate, since (luckily) laws and attitudes towards people who are gay have greatly changed. (For example, at the time I started doing research in the area, I had no idea that years later my son would be married and that he and his husband would be the parents listed on their twin sons' original birth certificate.) So I will give you permission to adapt the original instrument. I'd suggest that you look at it and possibly use some questions and modify others but suspect that it may be easier to develop an instrument from scratch.

Your research sounds interesting and worthwhile and I wish you success with it. I'm sorry that I can't be more helpful.

Mary Harris

Mary B. Harris
1719 Rita Dr. NE
Albuquerque NM 87106
(505)268-5747

From: Chinazo Echezona-Johnson <cechezon@student.touro.edu>
Sent: Sunday, March 21, 2021 11:55 PM
To: diamond@psych.utah.edu <diamond@psych.utah.edu>; Mary Harris <mharris@unm.edu>
Subject: Permission to use Knowledge about homosexuality questionnaire

[EXTERNAL]

Hello:

My name is Chinazo Echezona-Johnson. I am a DNP (Doctor of Nursing Practice) student at Touro University, Nevada. I am doing a DNP project on Supporting Intellectual Disability and Developmental Disability (ID/DD) individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+) with an evidence-based educational culturally competent protocol.

I need your permission to use the instrument. Also, is it possible to send me the original instrument? I only have access to modified tools.

I am looking forward to your reply, and thank you for your assistance.

Chinazo Echezona-Johnson

Appendix H. Answers for the Knowledge about Homosexuality Questionnaire

Survey Link:

https://docs.google.com/forms/d/e/1FAIpQLSegFDa4PeB6A7xXTpEIc1__kwCAKM2KFunTQwUmO54v-8l7BQ/viewform?usp=pp_url

1. A child who engages in homosexual behaviors will become a homosexualadult.
   A. True **B. False** C. Don't Know

2. There is a good chance of changing homosexual people into heterosexuals.
   A. True **B. False** C. Don't Know

3. Most homosexuals want to be members of the opposite sex.
   A. True **B. False** C. Don't Know

4. Some church denominations oppose legal and social discrimination against homosexual men and women.
   A. True B. False C. Don't Know

5. Sexual orientation is established at an early age.
   A. True B. False C. Don't Know

6. According to the American Psychological Association, homosexuality is anillness.
   A. True **B. False** C. Don't Know

7. Homosexual males are more likely to seduce young men than heterosexualmales are likely to seduce young girls.
   A. True **B. False** C. Don't Know

8. Gay men are more likely to be victims of violent crime than the public.
   A. True B. False C. Don't Know

9. A majority of homosexuals were seduced in adolescence by a person of thesame sex, usually several years older.
   A. True **B. False** C. Don't Know

10. A person becomes a homosexual (develops a homosexual orientation)because he/she chooses to do so.
    A. True **B. False** C. Don't Know

11. Homosexuality does not occur among animals (other than human beings).
    A. True **B. False** C. Don't Know

12. Intellectual Disability and Developmental Disability (ID/DD) individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+)

A. True B. False C. Don't Know

13. Individual who have Intellectual Disability and Developmental Disability (ID/DD) can identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+) can have sex

A. True B. False C. Don't Know

12. Almost every culture has evidenced widespread intolerancetoward homosexuals, viewing them as "sick" or as "sinners".
    A. True **B. False** C. Don't Know

13. Heterosexual men tend to express more hostile attitudes toward homosexuals than do heterosexual women.
    A. True B. False C. Don't Know

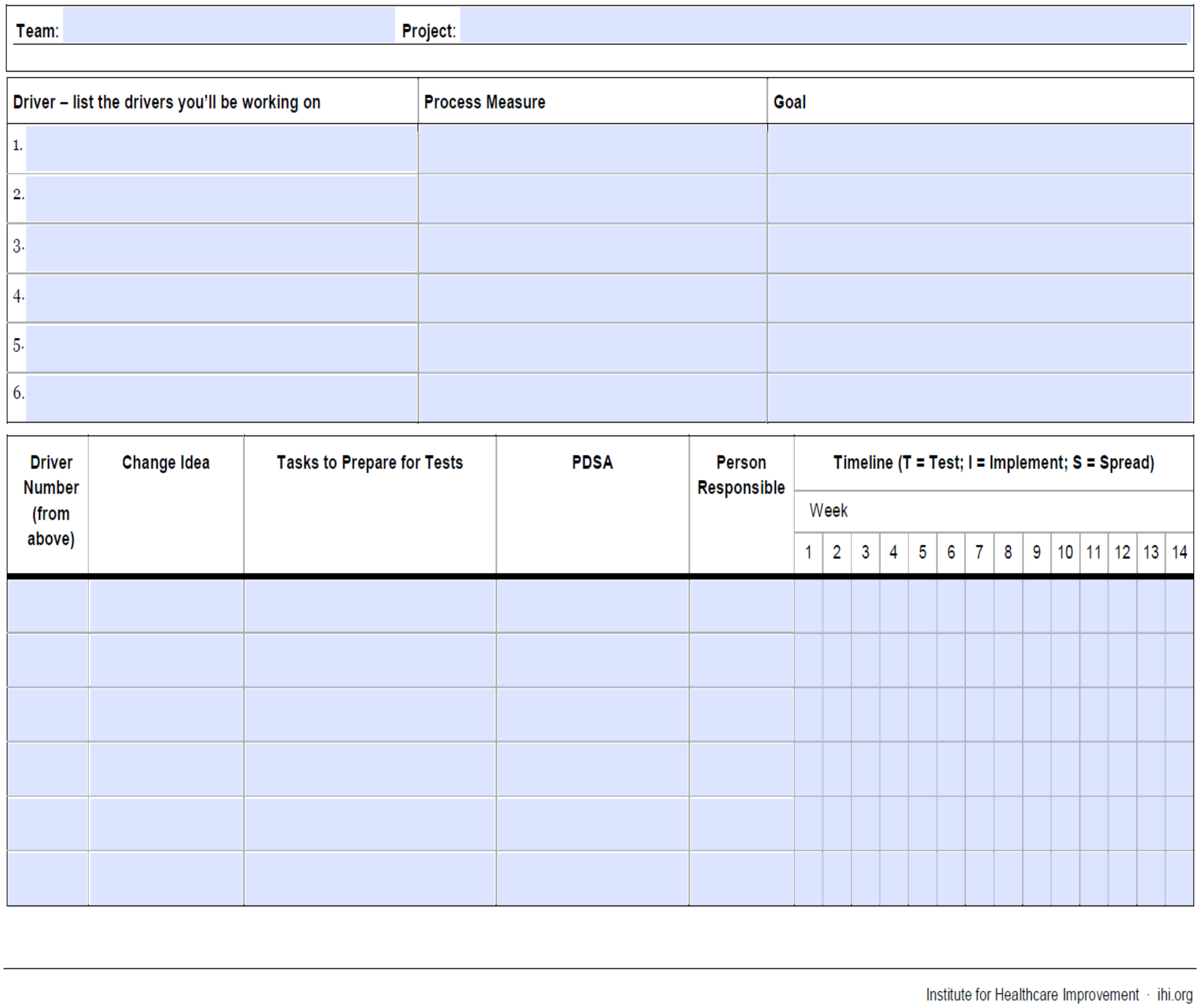
14. "Coming out" is a term that homosexuals use for publicly acknowledgingtheir homosexuality.
    A. True B. False C. Don't Know

15. Bisexuality may be characterized by sexual behaviors and/or responses toboth sexes.
    A. True B. False C. Don't Know

18. Individual who have Intellectual Disability and Developmental Disability (ID/DD) and want to change their biological sex can take medications to change to the opposite sex

A. True B. False C. Don't Know

Appendix I. Institute for Healthcare Improvement (IHI) Project Planning Tool



Team:

Project:

Driver – list the drivers you'll be working on	Process Measure	Goal
1.		
2.		
3.		
4.		
5.		
6.		

Driver Number (from above)	Change Idea	Tasks to Prepare for Tests	PDSA	Person Responsible	Timeline (T = Test; I = Implement; S = Spread)													
					Week													
					1	2	3	4	5	6	7	8	9	10	11	12	13	14

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Appendix J. Health Record Audit Tool

Practice Site	Date of Audit	Auditor

Items	Cultural competency policy	Community inclusion
# LGBTQ mentioned		
# Sentences to support LGBTQ+ individuals		
# LGBTQ + community friendly places, events		
Totals		

Appendix K. Data Analysis with Wilcoxon Signed Rank Test and Paired-Samples T-Test

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum	Percentiles 25th	Percentiles 50th (Median)	Percentiles 75th
Prewkshop Pre Workshop Behavior	**32**	**4.19**	**2.681**	**0**	**9**	**2.00**	**4.00**	**6.00**
Postwrkshop Post Workshop Behavior	**32**	**.88**	**.942**	**0**	**3**	**.00**	**1.00**	**2.00**

Ranks

		N	Mean Rank	Sum of Ranks
Postwrkshop Post Workshop Behavior - Prewkshop Pre	Negative Ranks	**29**[a]	**15.00**	**435.00**
	Positive Ranks	**0**[b]	**.00**	**.00**
	Ties	**3**[c]		

Workshop Behavior	Total	**32**		

a. Postwrkshop Post Workshop Behavior < Prewkshop Pre Workshop Behavior

b. Postwrkshop Post Workshop Behavior > Prewkshop Pre Workshop Behavior

c. Postwrkshop Post Workshop Behavior = Prewkshop Pre Workshop Behavior

Test Statistics[a]

	Postwrkshop Post Workshop Behavior - Prewkshop Pre Workshop Behavior
Z	**-4.718[b]**
Asymp. Sig. (2-tailed)	**<.001**

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	PrewkshopCominc Pre Workshop Community Inclusion	**.38**	**32**	**.609**	**.108**
	PostwkshopCominc Post Workshop Community Inclusion	**.69**	**32**	**.780**	**.138**

Paired Samples Correlations

		N	Correlation	Significance One-Sided p	Significance Two-Sided p
Pair 1	PrewkshopCominc Pre Workshop Community Inclusion & PostwkshopCominc Post Workshop Community Inclusion	**32**	**.594**	**<.001**	**<.001**

Paired Samples Test

		Paired Differences					t	df	Significance	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	95% Confidence Interval of the Difference Upper			One-Sided p	Two-Sided p
Pair 1	PrewkshopCominc Pre Workshop Community Inclusion - PostwkshopCominc Post Workshop Community Inclusion	**-.312**	**.644**	**.114**	**-.545**	**-.080**	**-2.743**	**31**	**.005**	**.010**

Paired Samples Effect Sizes

			Standardizer^{a}	Point Estimate	95% Confidence Interval Lower	95% Confidence Interval Upper
		Cohen's d	**.644**	**-.485**	**-.848**	**-.115**

Pair 1	PrewkshopCominc Pre Workshop Community Inclusion - PostwkshopCominc Post Workshop Community Inclusion	Hedges' correction	**.652**	**-.479**	**-.838**	**-.113**

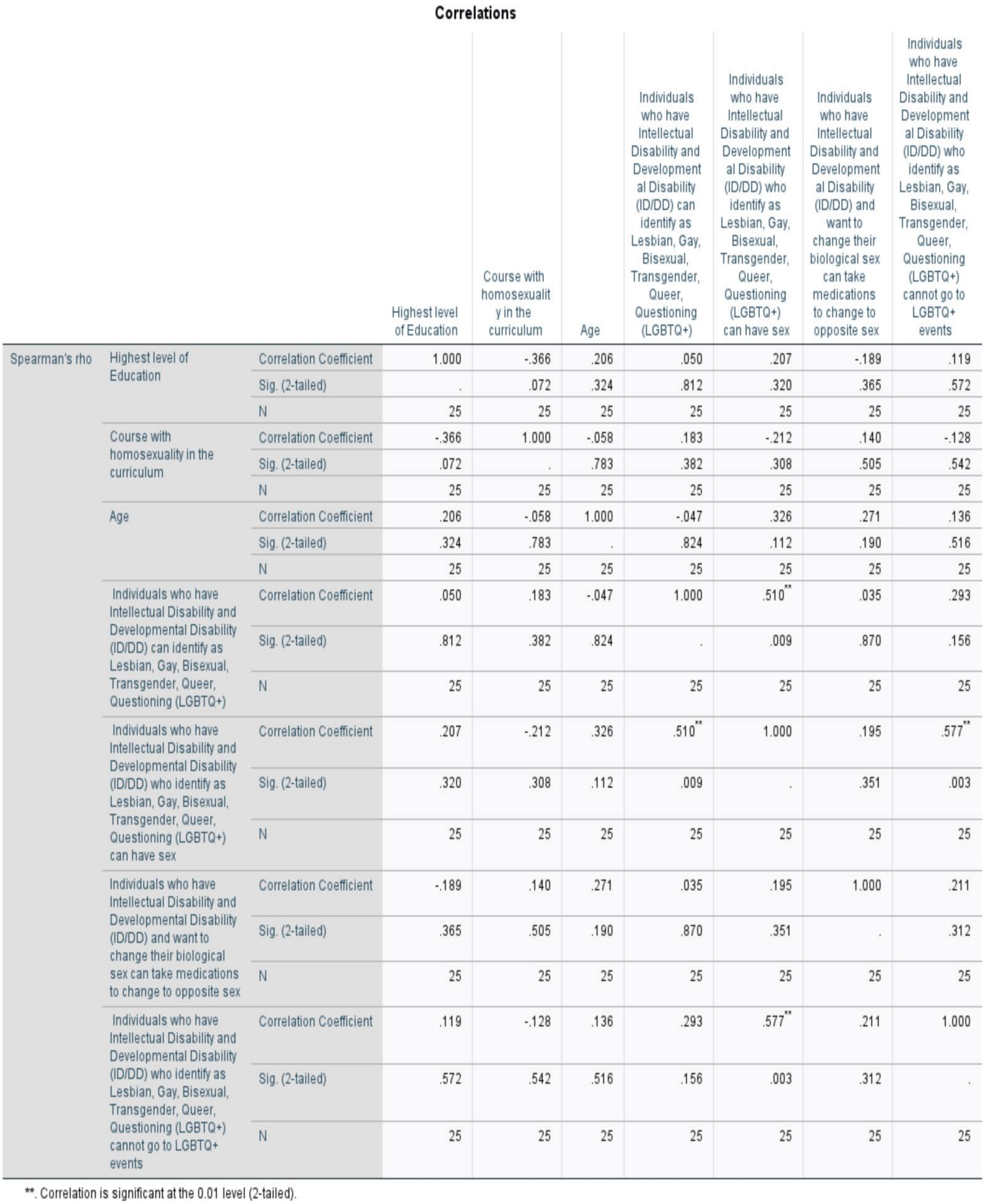
a. The denominator used in estimating the effect sizes.
Cohen's d uses the sample standard deviation of the mean difference.
Hedges' correction uses the sample standard deviation of the mean difference, plus a correction factor.

Appendix L. Demographic Data Analysis with Frequency distribution and correlations

Statistics

		Years Worked at the organization	Gender	Highest level of Education	Course with homosexuality in the curriculum	Sexual orientation	Age
N	Valid	25	25	25	25	25	25
	Missing	0	0	0	0	0	0
Mean		3.28	1.88	5.00	1.52	1.60	2.96
Median		4.00	2.00	5.00	2.00	1.00	4.00
Mode		5	2	5	2	1	4
Std. Deviation		1.568	.600	1.258	.510	1.155	1.457
Skewness		-.295	.032	-.682	-.085	2.647	-.189
Std. Error of Skewness		.464	.464	.464	.464	.464	.464
Kurtosis		-1.494	.022	.215	-2.174	8.286	-1.558
Std. Error of Kurtosis		.902	.902	.902	.902	.902	.902
Range		4	2	5	1	5	4
Percentiles	25	2.00	1.50	4.50	1.00	1.00	1.50
	50	4.00	2.00	5.00	2.00	1.00	4.00
	75	5.00	2.00	6.00	2.00	2.00	4.00

Nonparametric Correlations



Correlations

			Highest level of Education	Course with homosexuality in the curriculum	Age	Individuals who have Intellectual Disability and Developmental Disability (ID/DD) can identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+)	Individuals who have Intellectual Disability and Developmental Disability (ID/DD) who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+) can have sex	Individuals who have Intellectual Disability and Developmental Disability (ID/DD) and want to change their biological sex can take medications to change to opposite sex	Individuals who have Intellectual Disability and Developmental Disability (ID/DD) who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+) cannot go to LGBTQ+ events
Spearman's rho	Highest level of Education	Correlation Coefficient	1.000	-.366	.206	.050	.207	-.189	.119
		Sig. (2-tailed)	.	.072	.324	.812	.320	.365	.572
		N	25	25	25	25	25	25	25
	Course with homosexuality in the curriculum	Correlation Coefficient	-.366	1.000	-.058	.183	-.212	.140	-.128
		Sig. (2-tailed)	.072	.	.783	.382	.308	.505	.542
		N	25	25	25	25	25	25	25
	Age	Correlation Coefficient	.206	-.058	1.000	-.047	.326	.271	.136
		Sig. (2-tailed)	.324	.783	.	.824	.112	.190	.516
		N	25	25	25	25	25	25	25
	Individuals who have Intellectual Disability and Developmental Disability (ID/DD) can identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+)	Correlation Coefficient	.050	.183	-.047	1.000	.510**	.035	.293
		Sig. (2-tailed)	.812	.382	.824	.	.009	.870	.156
		N	25	25	25	25	25	25	25
	Individuals who have Intellectual Disability and Developmental Disability (ID/DD) who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+) can have sex	Correlation Coefficient	.207	-.212	.326	.510**	1.000	.195	.577**
		Sig. (2-tailed)	.320	.308	.112	.009	.	.351	.003
		N	25	25	25	25	25	25	25
	Individuals who have Intellectual Disability and Developmental Disability (ID/DD) and want to change their biological sex can take medications to change to opposite sex	Correlation Coefficient	-.189	.140	.271	.035	.195	1.000	.211
		Sig. (2-tailed)	.365	.505	.190	.870	.351	.	.312
		N	25	25	25	25	25	25	25
	Individuals who have Intellectual Disability and Developmental Disability (ID/DD) who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+) cannot go to LGBTQ+ events	Correlation Coefficient	.119	-.128	.136	.293	.577**	.211	1.000
		Sig. (2-tailed)	.572	.542	.516	.156	.003	.312	.
		N	25	25	25	25	25	25	25

**. Correlation is significant at the 0.01 level (2-tailed).

DNP Project: Statistics Plan Worksheet

Please provide a brief description of each section. Attach supporting documents (instruments) to the end of this form as appendices.

Name: CHINAZO ECHEZONA-JOHNSON
Date: March 23, 2021

Section	Description
Project Title	QueerAlly-IDD: Supporting Intellectual Disability and Developmental Disability (ID/DD) individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning (LGBTQ+)
Project Purpose	The proposed scholarly project's purpose would use quality improvement measures to develop staff education about support strategies for ID/DD individuals who identify as LGBTQ+ in group homes to reduce behavioral issues in the cohort.
Project Question	In ID/DD individuals who identify as LGBTQ+ in a group home, does implementing a supportive strategic education protocol for the group home staff that is evidence-based and culturally competent, compared to current practice, decreased behavioral issues within a five-week time frame?
Project Design (general description of how treatments are assigned/observational/repeated measures of X # of people, etc.)	**Quality Improvement Project** Data collection and analysis will entail doing a content analysis to: 1. Review the organization's cultural competency policy, forms, and physical environment, for language that specifies supporting intellectual and development delay individuals who identify as LGBTQ + of the policy. Data will be analyzed using descriptive analysis of the number of times LGBTQ + related information and staff support for the cohort is mentioned in the workshop's policies, form, physical environment, and materials. 2. Evaluate staff knowledge – Data analysis will use the descriptive to measure the means difference in staff knowledge about support services for ID/DD individuals who identify as LGBTQ+ measure of pre-and post-community inclusion to LGBTQ +-friendly community activities and sites for the cohort.

	3. Monitor the rates of behavioral issues within the implementation frame. Data from the agency's electronic health record -nursing notes, medical appointments, and behavior flowsheets - will yield the pre-and post-workshop implementation of the percentage of adverse behavioral issues for ID/DD individuals identified as LGBTQ+.
Population of Interest	All agency staff who have direct contact with ID/DD individuals who identify as LGBTQ+ at the group homes will be educated about the protocol.
Variables	• Independent Variable(s) –Supportive strategic education protocol • Dependent Variable(s) – Decrease behavioral issues among the ID/DD individuals who identify as LGBTQ+ in group homes • Dependent Variable (s) – Staff knowledge about the support for the cohort • Relevant Constant(s)- Not applicable
Sample Size	23 population of interest; 32 electronic health records of the indirect population
Recruitment Methods	**A convenience sample of all agency staff.** Review of archived records, electronic health records, and environment.
Instruments/Tools (Validity/Reliability)	• **Health Records Audit Tool for data collection and mining from** the cultural competency policy, organization's cultural competency policy, forms, environment, community inclusion,pre-and-post adverse behavior incidences of the indirect target group. Content analysis of archival data. • **The QueerAlly-IDD workshop** is designed to educate group home staff to recognize, understand, and meet the specific needs of ID/DD individuals' who identify as LGBTQ+. • **The post-intervention tool questionnaire** is adapted from the Knowledge about Homosexuality instrument to measure staff knowledge after the QueerAlly-IDD. Reliability & Validity -Mean scores from the original administration of the questionnaire were 16.3 (eighty-two percent correct) for a sample of healthcare professionals, with a Chronbach's alpha of .70. Permission was obtained from the developer to use the instrument.

	• **Institute for Healthcare Improvement (IHI) Tool** - The project planning tool will be initiated at the beginning of the project. This tool has been tested and validated by other organizations seeking to make changes. The tool is used to plan the project.
Proposed Descriptive Statistics and Statistical Test(s)	**The Statistical Package for the Social Sciences (SPSS)** will analyze the three data sets collected. • **Parametric tests of the paired-student T-tests** will compare the pre-and post-community inclusion frequency to LGBTQ+ friendly community activities and sites • **Descriptive and Secondary analysis – Post-workshop survey** data of post-workshop participants' demographic data and their knowledge of LGBTQ+. • **Non-parametric tests of Wilcoxon signed-rank test and Spearman's Rho** will be used to analyze the workshop's significance and the change frequency of adverse behavioral issues before and after staff development. • **Content analysis** of the agency's cultural competency workshop, policies, forms, physical environment, and family/individual hand-outs/materials; and the organization's cultural competency policy for language that specifies supporting intellectual and development delay individuals who identify as LGBTQ+.

After your instructor has approved the draft, email your completed form to your instructor and Dr. Murukutla- Manognya.Murukutla@tun.touro.edu

Allow Dr. Murukutla a minimum of 1 week to send feedback. If you have not received at least acknowledgment of receipt within one week, you should follow up to make sure the email came through.