LGBT Cultural Competence in a Southern Nevada Outpatient Mental Health Clinic

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Abstract

The lesbian, gay, bisexual, and transgender (LGBT) population has suffered discrimination, stigma, and bias within the healthcare system. The Institute of Medicine and Healthy People 2020 provide recommendations to increase LGBT cultural competency to decrease the disparities experienced by this population. This quality improvement project implements a cultural competency intervention to increase mental healthcare access to the LGBT population.

Keywords: *culturally competent care, LGBT, training, education, patient outcome, patient-centered care, cultural competence, and barriers to care*

LGBT Cultural Competence in a Southern Nevada Outpatient Mental Health Clinic

Cultural competency is accepting and respecting a person's needs, behaviors, and beliefs demonstrated through attitudes, practices, and policies (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Healthcare organizations have made efforts to improve cultural competence, patient-centered care, equitable care, and improved communication; however, the lesbian, gay, bisexual, and transgender (LGBT) patients have been overlooked in the cultural competency education (The Joint Commission, 2011). The Institute of Medicine (IOM) examined the health of the LGBT population and identified multiple health disparities (Felsenstein, 2018; Office of Disease Prevention and Health Promotion [ODPHP], 2018). Health disparities are differences in health outcomes, the presence of disease, access to and quality of health care services experienced by a specific population (National Conference of State Legislatures [NCSL], 2015). The LGBT population carries a higher burden of human immunodeficiency virus (HIV), a higher prevalence of clinical depression, anxiety, substance use, and suicide (Safer, et al., 2016). Other health disparities experienced include stigma, discrimination, and social disadvantage (Reisner, 2018). The LGBT population is considered a gender minority (National Institutes of Health [NIH], 2018). Gender minorities are people that do not conform to societal norms based on their gender identity, gender expression, sexual orientation, and it also includes lesbian, gay, bisexual, and transgender populations (NIH, 2018). Healthy People is a government organization focused on health disparities (Healthy People 2020, 2018). It creates ten-year goals to improve healthcare for all. Healthy People 2020 defines health disparities as a health difference that is linked to an environmental, social, or economic disadvantage (Healthy People 2020, 2018). There has been an absence of LGBT cultural competency education for healthcare faculty and healthcare providers (Lim, Brown, & Jones,

2013). Healthy People 2020 recommend that healthcare providers obtain cultural competency education to address the health disparities of LGBT patients (ODPHP, 2018; Boroughs, Andres Bedoya, O'Cleirigh, & Safren, 2015; Felsenstein, 2018). Doctor of nursing practice (DNP) nurses have the skills and knowledge as an educator and leader to implement change and quality improvement for better patient outcomes (Chism, 2013). This project will implement a cultural competency program for healthcare providers to better meet the mental health needs of the LGBT community in Southern Nevada.

Background

Access to healthcare is the personal use of healthcare services in a timely manner to achieve the best health outcome (Institute of Medicine [IOM], 2011). There have been two types of barriers preventing the LGBT population from having access to healthcare: personal and structural (IOM, 2011). Personal barriers to access healthcare include the beliefs, attitudes, and behaviors of the people in the healthcare system; this includes the patients and the providers. Enacted stigma is the explicit behaviors that display negative regard (IOM, 2011). According to Krehely (2009), harassment and discrimination were seen in 39% of transgender people by their healthcare provider. LGBT patients state they have been denied care by healthcare providers or received disrespectful and verbally abusive healthcare (IOM, 2011). Felt stigma is the patient's internal feeling of potentially being stigmatized. Felt stigma and enacted stigma causes the LGBT population to delay seeking care. Twenty-nine percent of the LGBT population will delay or not seek medical care due to discrimination by health care providers or the potential of it (Krehely, 2009; Reisner, 2018). As a result of not seeking healthcare or delaying health care, there are increased health disparities within this population. The LGBT patients that do visit a healthcare provider may not disclose their sexual orientation to prevent enacted stigma (IOM, 2011). Other

personal barriers can include race/ethnic status, income, employment, immigration status, and education level in addition to being an LGBT individual.

Structural barriers to healthcare occur as a result of a lack of training for providers on the healthcare needs of LGBT patients (IOM, 2011). Offering high-quality, culturally appropriate healthcare is cultural competence (IOM, 2011). Communication between the patient and provider is critical for improved health outcomes, adherence to treatment plans, and patient satisfaction (The Joint Commission, 2011). This communication is not present when culturally competent care is not provided. Healthcare providers have reported a lack of knowledge of the health risks and needs of the LGBT population (IOM, 2011). This is due to a lack of cultural competency training for healthcare providers.

Problem Statement

Lack of culturally competent care in the mental health setting has been a strong barrier for LGBT patients who are in need of treatment. Among the transgender population, 62% suffer from depression; 41% attempted suicide; 30% smoke daily; 26% abuse substances (American Medical Student Association, 2015). LGBT youth attempt suicide two to three times more than the rest of society (ODPHP, 2018). The mental health community pathologized them with diagnoses, such as, gender dysphoria which means a conflict between a person's assigned sex and the sex the person identifies with (American Psychiatric Association, 2016). As of June 2018, the World Health Organization (WHO) removed transgender as a mental illness (Simon, 2018). WHO states it causes more stigma for the transgender population and that increases the health disparities (Simon, 2018). This transition in healthcare perception of the LGBT population is now being slowly translated into healthcare settings. Cultural competency of the LGBT community is emerging as a healthcare provider priority in many healthcare settings (ODPHP,

2018).

Nevada has one of the largest LGBT populations in the country (Adams, 2016). Due to past stigma associated with healthcare treatment, the LGBT population relies on local LGBT centers to identify designated culturally sensitive healthcare providers. According to the Gay and Lesbian Community Center of Southern Nevada's directory of healthcare providers, there is only one LGBT-friendly mental health clinic in Southern Nevada (The Center, 2018). To decrease the healthcare disparities in Southern Nevada, healthcare providers need to be formally trained on cultural competence for the LGBT community (Felsenstein, 2018; ODPHP, 2018; Boroughs, Andres Bedoya, O'Cleirigh, & Safren, 2015; Radix & Maingi, 2018). Development of a culturally competent mental health care clinic may lead to increased healthcare access for the LGBT population (ODPHP, 2018).

Purpose Statement

The purpose of this quality improvement project is to increase LGBT cultural competency at an outpatient mental health clinic in Southern Nevada through the implementation of a structured cultural competency training program. The aim of this project is to increase mental healthcare access through identification as a mental health clinic that welcomes the LGBT population and evidenced by an increase in LGBT patients within a two-week post-intervention period.

Project Question

(P) In an outpatient mental health clinic (I) does cultural competency training for LGBT patients (C) in comparison to current practices (O) increase LGBT patient access to healthcare evidenced by increased appointments (T) in a two-week post-training period?

Project Objectives

In the timeframe of this DNP project, the project lead will:

1. Implement and evaluate a 4-hour cultural competency training, conducted by the Gay and Lesbian Community Center of Southern Nevada.
2. The Gay and Lesbian Community Center of Southern Nevada will notify the LGBT community and list on their healthcare directory that the outpatient mental health clinic is recognized as welcoming to the LGBT population.
3. Increase LGBT appointments by 10% within two weeks after the cultural competency training.

Significance

The LGBT population has significant health disparities due to discrimination, stigma, and victimization. The LGBT population has been fearful to identify themselves because of potential discrimination and stigma (Fredriksen-Goldsen, et al., 2014; Nama, MacPherson, Sampson, & McMillan, 2017). They delay seeking healthcare or do not seek healthcare at all because there are limited medical facilities where they feel safe and free of judgment (IOM, 2011). Conducting a cultural competency training is the beginning of more awareness of their medical needs and creating a safe place for them to receive medical care (The Joint Commission, 2011). Mental health care is critical to this population due to the trauma they endure from discrimination, stigma, and victimization (Mereish & Poteat, 2015; Becerra-Culqui, et al., 2018). Children as young as three years old that are transgender are experiencing mental health disorders related to their non-conforming gender status (Becerra-Culqui, et al., 2018). Teens are having psychosis within six months of showing signs of gender transformation (Becerra-Culqui, et al., 2018). The mental health community must be educated and prepared to manage the health of this population. As a result of the great need for safe LGBT-welcoming mental health providers, this DNP project is

needed. It is also needed because Southern Nevada has one of the largest LGBT populations in the country which translates into more mental health care needs are present.

Search Terms/Strategies

A comprehensive literature search was conducted to determine the effectiveness of cultural competence training and increasing patient access to services. The literature search was conducted using the following databases: CINHAL, Pubmed, and Proquest. The search terms used included: culturally competent care, LGBT, training, education, patient outcome, patient-centered care, cultural competence, and barriers to care. The date delimitations were from 2015 to current. The search yielded 7,905 results. After applying the inclusion criteria described below, there were only 214 articles remaining.

The inclusion criteria were English-language original systematic reviews or studies in academic, peer-reviewed journals. The articles needed to have a full-text version available to be included as well. Exclusion criteria included articles that discussed the need and importance of a cultural competence intervention only or were not healthcare related. Articles that were specific to cultural competence for the LGBT population were included. After applying the exclusion criteria, there were 10 remaining studies. The remaining articles included five mixed method studies, two quantitative research studies, one qualitative research study, one systematic review, and one integrative review.

Review of Literature

Cultural competence has been identified as a means to decrease health care disparities among the LGBT population (Nynas, 2015; Felsenstein, 2018; Choi & Kim, 2018; Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly, 2017; Orgel, 2017; Behar-Horenstein & Feng, 2017; Shattell, et al., 2017; Nama, MacPherson, Sampson, & McMillan, 2017; Gendron, et al., 2013;

May, Potia, & , 2013). However, an examination of the elements required to have an effective cultural competency training must be examined. The purpose of this literature review is to analyze studies that have conducted or analyzed cultural competency interventions and identify what strategies increased cultural competency. The cultural competency interventions will be reviewed based on the content of the training, delivery of the training, tools used to determine the effectiveness of the training, and the results of the training. In each area, themes will be sought that could be applied to this project.

The Content of the Training

The content of the cultural competency trainings that were provided in the literature was limited. Three of the ten articles did not discuss the content shared in their intervention. The consistent theme seen in the content of the culturally competent trainings were key terms and terminology. Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly (2017) conducted a mixed-method systematic review and found that most cultural competency trainings included not only key terms and terminology but also discrimination, stigma, sexuality, sexual dysfunction, LGBT-specific health, LGBT healthcare disparities, and sexual history taking. Gendron (2013) conducted a mixed methods intervention to healthcare professionals at five locations for older LGBT clients. She included LGBT symbols and facts, awareness of political, economic, social and legal issues related to the LGBT population, and assumptions related to the LGBT population in her content. Felsenstein (2018) conducted a mixed methods intervention in a primary care clinic and asked the participants about what they wanted to learn. They were interested in families and relationships, healthcare screening recommendations, health-related risk factors, LGBT terms, and the biggest situations and topics to avoid when caring for LGBT patients. She also asked if there were any questions the participants wanted to be addressed during the training and they

included language to use when questioning if the patient had surgery during his or her transition; correct gender terms to use; what guidance should be provided during transgender therapies; and how to ask about past medical history and current partners. Last, Felsenstein (2018) asked what resources would be beneficial to the clinic when working with LGBT patients a list of LGBT-friendly providers in the area or a website with additional educational modules or other. The majority of participants wanted a website with additional education. Nama, MacPherson, Sampson, & McMillan (2017) conducted a quantitative study explaining key terms and terminology for the LGBT population. May & Potia (2013) conducted a general cultural competency training and included key concepts as it relates to culture, adherence, culturally competent care, and inter-relationships related to physiotherapy; identification of own values, beliefs, and perceptions related to culture, application of socio-cultural knowledge to improve the patient-provider interactions; application of cultural competence in good practice guidelines; and considerations to make when working with diverse patients. Nynas (2015) included content that addressed general cultural competency and discussed culture and cultural differences and self-awareness. Behar-Horenstein & Feng (2017) explored the meaning of being competent and what cultural competency meant, and what was culturally insensitive communication. The content varied significantly among the studies reviewed. Key terms, terminology, and health-related LGBT issues seem to the most consistent. The lack of consistency in content leads to varying effectiveness of cultural competency trainings (Choi & Kim, 2018).

Delivery of the Training

Didactic lectures were the primary delivery of the cultural competency trainings with various interactive activities following the didactic component. The interactive activities ranged from panel discussions, case studies, interviews, small group discussions, use of multimedia, role-

playing, and simulation. Orgel (2017) stated that multi-method approaches were best because different approaches increased cultural competency more comprehensively. The use of self-reflective, self-awareness, and active learning techniques were found consistently among the studies (Nynas,2015; Felsenstein, 2018; Behar-Horenstein & Feng, 2017; Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly, 2017; Shattell, et al. ,2017; Nama, MacPherson, Sampson, & McMillan, 2017; Gendron, et al., 2013; May & Potia, 2013). All of the articles utilized multiple methods of delivery, but there is a lack of guidance as to what method is better than the other. However, active learning activities are a common theme among all of the trainings.

Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly (2017) stated that trainings lasted from one hour to 42 hours with an average of four hours or less. The average timeframe of a training was four hours or less (Felsenstein, 2018; Behar-Horenstein & Feng, 2017; Gendron, et al., 2013; May & Potia, 2013). Some exclusions were trainings that were administered in a university or school setting (Nynas, 2015; Shattell, et al., 2017; Nama, MacPherson, Sampson, & McMillan, 2017).

Results of the Training

Cultural competency consists of three categories: knowledge, attitude, and skill/behavior (Nynas, 2015; Felsenstein, 2018; Choi & Kim, 2018; Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly, 2017; Orgel, 2017; Behar-Horenstein & Feng, 2017; Shattell, et al., 2017; Nama, MacPherson, Sampson, & McMillan, 2017; Gendron, et al., 2013; May, Potia, & , 2013). All of the reviewed articles indicated an increase in knowledge as evidenced by an increase in a pre and posttests (Nynas, 2015; Felsenstein, 2018; Choi & Kim, 2018; Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly, 2017; Orgel, 2017; Behar-Horenstein & Feng, 2017; Shattell, et al., 2017; Nama, MacPherson, Sampson, & McMillan, 2017; May & Potia, 2013).

Attitude refers to removing bias by becoming more self-aware of values, beliefs, and perceptions that allows the individual to be more open to other cultures (Nynas, 2015; Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly, 2017; Orgel, 2017; Behar-Horenstein & Feng, 2017; Shattell, et al., 2017; Nama, MacPherson, Sampson, & McMillan, 2017; Gendron, et al., 2013). Attitude can be changed with the application of knowledge, but it is more sustained with panel discussions, guest speakers, or any other form of face-to-face interactions (Felsenstein, 2018; Orgel, 2017; Behar-Horenstein & Feng, 2017; Mu, et al., 2016). May & Potia (2013) states that active learning adds a new dimension to the experience of learning. Skill development was found among the studies that utilized panel discussions, self-awareness, and self-reflective activities (Nynas, 2015; Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly, 2017; Orgel, 2017; Behar-Horenstein & Feng, 2017; Shattell, et al., 2017; Nama, MacPherson, Sampson, & McMillan, 2017; Gendron, et al., 2013).

Training Practices of Local Cultural Competence Course

The facilitator of this project's educational intervention was informed of the current literature review findings and shared how she plans to implement the cultural competency training. She indicated that she identifies as LGBT (H. Reese, personal communication, January 7, 2019). She states that LGBT norms change rapidly and something that is known now could be different in the next ninety days. It is important that whoever teaches an LGBT course must be engaged in the culture to abreast of the current trends (Shattell, et al., 2017). Literature takes a while before it is published, and the climate of the LGBT community could have changed. Holly Reese, the facilitator of the educational intervention, has conducted over 500 LGBT cultural competency trainings and she works with over 70,000 people at the LGBT center (H. Reese, personal communication, January 7, 2019).

Holly starts all of her trainings with a 101 course (H. Reese, personal communication, January 7, 2019). She introduces the terminology, history, and culture. It is also during this time that she gauges where the participants' level of cultural sensitivity may be. An important point not mentioned in the literature is the ability to work with people wherever they are in their cultural competency journey. Some people believe very steadfastly their values and it can be challenging to increase self-awareness, sensitivity, and decrease bias.

After Holly has completed the 101 courses and gauged the audience, she then covers topics such as the health care challenges, statistics, language, policy, and procedures, how to overcome biases, etc. (H. Reese, personal communication, January 7, 2019). She recommends at a minimum three hours to begin to educate on this topic and if possible, have follow-up workshops to build upon what has been taught. Holly also offers consultations to modify policy and procedures regarding LGBT care and make the environment more welcoming. She will also conduct annual LGBT trainings. She provides additional resources for continued learning.

Summary of the Literature Review

The content of the studies varied but the theme of key terms and terminology and health of the LGBT population was present. Having a basic understanding of the LGBT population seems to be the first and most important foundation to build when educating on cultural competence. The other elements of culturally competency training may depend more on the setting. Active learning strategies were the main theme with the delivery of the content. If possible, have a sample of the population present to engage with the participants. The length of the training varied widely. Trainings that had two weeks or were a part of a curriculum did not have better results than the other trainings that took two to four hours. The results were strong in increasing knowledge, but attitudes and skill/behavior varied. The goal to be a culturally competent

practitioner is to be a practitioner that understands his or her own values, beliefs, and perspectives, and recognizes his or her own biases. Also, is culturally aware, sensitive, and knowledgeable about other cultures and implements care in a way that is respectful and understanding to meet the needs of that person from their cultural perspective (May & Potia, 2013).

Conclusion

LGBT cultural competence training increases LGBT patient access to care. It is very important that the training received is comprehensive and effective. Based on the literature review, there are a few themes that were present to have in a cultural competency training. Holly has a very comprehensive cultural training planned for this project that embraces those themes and provides additional follow up and support to become culturally competent. The literature for LGBT culturally competent is minimal, but what is available can be translated into practice and offer the LGBT patient quality and equitable health care.

Theoretical Framework

Historical Development of the Theory

The Donabedian model was developed by Avedis Donabedian, an Armenian physician that viewed healthcare as a system (Best & Neuhauser, 2004). He believed that people were challenged by seeing a relationship between quality and systems. When he initially wrote about his framework in 1966, his focus was on physician-patient interaction (Donabedian, 2005). His framework has three tenets: structure, process, and outcome. His model was influential in the 1970s quality assessment/quality assurance movement and the total quality management movement in the 1980s (Larson & Muller, 2002). Recently, his work has been influential with performance measurement initiatives like health plan employer data and information set (HEDIS),

computerized needs-oriented quality measurement evaluation system (CONQUEST), and ORYX which is an initiative by the Joint Commission that requires healthcare organizations to engage in performance measurements as part of the accreditation process (Larson & Muller, 2002). The relevance of the Donabedian model to nursing is the continual effort to quality patient care. Nurses spend a significant amount of time with patients and that interaction must be patient-centered for a positive outcome for the patient. The Donabedian model originally focused on the patient-provider relationship and then expanded to overall quality healthcare improvement. A major interest of the DNP nurse is QI and the Donabedian model supports QI.

Applicability of Theory to Current Practice

The Donabedian model has been used in nursing since its inception. It provides a simple yet comprehensive approach to QI. The model can be used in all nursing settings and situations where patient outcomes could be impacted. Current literature has studies of the Donabedian model being used to increase communication between healthcare providers and patients (Ralph, et al., 2017; Hursh, Salsbury, Lenhart, Doran, & Zadvinskis, 2013). Quality of life and patient satisfaction studies have utilized the Donabedian model (Mahdavi, et al., 2018). Improving patient-centered care has also been explored using the Donabedian model (Santana, et al., 2018). The Donabedian model has been used extensively for QI in patient care and serves as an ideal conceptual model for this project.

Major Tenets

The Donabedian model consists of three tenets: structure, process, and outcomes.

Structure. Structure represents the setting, staff, equipment, and organizational culture (Donabedian, 2005). It includes available resources that are vital to the success of this project. Awareness of current resources enables the project team to identify needed resources not readily

available. For example, if the equipment is outdated or there is a need for more licensed healthcare providers, these limitations must be considered when designing the DNP project. In addition, it is important to know what resources are available to create an intervention that works within that environment. This could include adequacy of the setting and/or equipment; qualifications of the healthcare providers; administrative support; and policy and protocols. The assumption is that a good setting with good instrumentalities will lead to good outcomes (Donabedian, 2005).

Process. The process is based on the belief that people are interested in applying what is considered good medical care (Donabedian, 2005). Process is important because it involves all areas of patient care particularly the interactions between the healthcare system and the patients. Bias must be considered when looking at the process of medical care. Personal perception of good medical care can differ among healthcare providers. A thorough evaluation of biases must be conducted because processes and procedures that have always been in place or stringent beliefs may hinder the intervention and outcomes. (Donabedian, 2005). This is the step where the intervention would occur. An intervention is implemented utilizing the resources identified in the structure tenant and weaved into the current process and procedures.

Outcome. Outcomes are the measure of quality (Donabedian, 2005). Did the patient have a better understanding of his or her medications? Was the patient satisfied with his or her care? Was there shared decision-making regarding care? It is important the outcome that is being measured is relevant to the study. Also, anything that might also influence the outcome must also be identified. The outcome is what validates the quality and effectiveness of medical care.

Theory Application to the DNP Project

The Donabedian model is well suited to serve as the conceptual model for this DNP

project. Its tenets will guide the implementation of the project and outlined below.

Structure

The project lead will evaluate all of the current resources available for this project. The DNP project has five domains identified for the structure tenet. S1. Co-designing the development and implementation of the LGBT educational intervention. S2. Securing the location and time of the intervention. S3. Obtaining the outcome measurement tools. S4. Assuring availability of the attendees. S5. Review of current policy and procedure for management of the LGBT population.

Process

The process relates to the educational intervention implementation. Four domains have been identified. P1. Assuring attendance of all members. P2. Utilizing the outcome measurement tool prior to the intervention. P3. Implementing the educational intervention. P4. Utilizing the outcome measurement post-intervention.

Outcomes

The outcome examines the effectiveness of the intervention to increase quality. O1. Analyze the measurement tools used before and after the intervention. O2. Obtain approval to be credentialed as an LGBT-welcoming facility. O3. Be added to the medical directory for the LGBT community.

The Donabedian conceptual framework helps to organize, plan, implement, and evaluate the DNP project. By having the domains, it creates categories for all of the activities that are necessary to complete the project. The framework takes the DNP project and breaks it down into manageable steps.

Project Design

This DNP project will use a quality improvement (QI) approach. The population of

interest are the healthcare providers and clinical staff at the project site. The desired outcomes of this project will be an increase LGBT mental healthcare access evidenced by an increase in appointments by 10% over two weeks after the intervention completion.

This quality improvement project will take place in an outpatient mental health clinic in Southern Nevada. Many of the healthcare disparities experienced by the LGBT population are related to mental health challenges and Sothern Nevada has a large population of LGBT individuals in comparison to other cities (Adams, 2016; Gay and Lesbian Medical Association, 2001). This clinic estimates that approximately 25% of its practice have clients that identify as LGBT (N. Vaugh, personal communication, Dec 2018).

An LGBT healthcare facility is a place that the LGBT population can seek care without discrimination, bias, or stigma (IOM, 2011; Krehely, 2009; Reisner, n.d.). The purpose of this project is to increase healthcare access to the LGBT population by creating an LGBT-friendly outpatient mental health clinic through LGBT cultural competency training and becoming visible in the LGBT community by being published on the Gay and Lesbian Community Center of Southern Nevada website.

Data collection for this quality improvement project will include the use of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) tool that will measure the levels of cultural competency of the participants. The data analysis will be conducted using SPSS statistical software, and a paired- samples t test. A measurement of LGBT patient appointments after the intervention will be tallied for three weeks and compared to the number of LGBT appointments prior to the intervention. Thus, the potential project variables include inaccurate notation of the number of LGBT appointments, and patients not identifying as LGBT when they actually are. Also, a change in the patient demographics could

affect the number of appointments obtained after the intervention. The data analysis will use the pre- and post-intervention scores and compare them to determine if an increase in cultural competency occurred or not. A tally of the appointments will also be kept. An increase in medical appointments by 10% after the intervention will serve as evidence of an increase in mental health care access.

Population of Interest

The population of interest includes all of the healthcare providers and clinical staff that work at the outpatient mental health clinic in Southern Nevada. This would include the two nurse practitioners, two medical assistants, and four behavioral therapists. The inclusion criteria is as follows: healthcare providers that work with patients who identify as anything other than heterosexual for their sexual orientation or chooses a gender other than their gender at birth and routinely evaluate clients at the project site. The inclusion criteria was selected to assure that the participants were individuals that have direct patient care responsibilities because they will be providing the care to the LGBT population. The exclusion criteria is: independent contractors that work at the clinic but do not provide medical care to non-heterosexual clients or non-cisgender clients. This intervention would exclude the off-site business manager and routine maintenance man.

An indirect population of interest is the LGBT population. They are the impetus for this project. The objective is to improve mental healthcare access for them. There will be no contact with this population.

Setting

The setting is an outpatient mental health clinic in Southern Nevada. The patient averages 480 patient visits a month by the nurse practitioner with additional visits by four therapists. The

clinic has been in business for two years. The project site owner is a psychiatric mental health nurse practitioner. She has two medical assistants that work full-time, and four behavioral therapists that work their own schedules which vary from full-time to part-time. She recently brought on board another psychiatric mental health nurse practitioner. The only marketing she has done for her practice is to be listed on Zocdoc. Zocdoc is a website that allows providers to get reviewed by patients, provide additional information about the provider, and allows the patient to schedule appointments through the website. Other than Zocdoc, she has grown her business through word of mouth. She is interested in an LGBT project because approximately 25% of her clients identify as LGBT and she would like to provide them with the best care. The clinic accepts all insurances. Its hours of operation are Monday – Friday with one Saturday per month for appointments. There are plans to move to a larger location and bring on more providers. Verbal permission from the project site owner was obtained for this DNP project, and she declined a formal agreement with the University.

Stakeholders

The stakeholders include the LGBT clients that seek treatment at the clinic, the owner/provider, and the healthcare providers and clinical staff of the clinic. The owner is a stakeholder because by being LGBT competent would increase business and provide a niche market that other practices may not be offering. The LGBT clients are stakeholders because they are the recipients of the care provided. The objective is to provide them quality mental healthcare in an environment that is without stigma, judgment or bias. The healthcare providers and clinical staff are the stakeholders because the intervention will enhance their practice. This means that they will have an increase in knowledge and ability that will improve the quality of care that they provide to the LGBT clients. Rapport was established through weekly telephonic communication

during the conception of this project to the present time. Throughout the project, multiple meetings have been conducted to review each section of the project and solicit feedback as it developed. The project lead will arrange follow up trainings and annual LGBT training after the intervention.

Recruitment Methods

The healthcare providers and clinical staff will be recruited by the project site owner. She will speak with each person and inform them of the intervention. It will be a mandatory and a requirement to offer mental healthcare services at the project site. Her talking points include discussing the importance of LGBT cultural competence and that every team member must be competent to provide any service to this population. She will close the clinic for half of a business day without pay and hold the intervention. She will confirm who will be participating in the intervention no later than May 30, 2019. No informed consent is required because no private patient data will be collected or assessed. The healthcare providers' and clinical staffs' data will be protected because they will not self-identify on any of the documents. There will be an identification number instead of identifiable information. There will be no advertisements or incentives provided.

Tools/Instrumentation

The tool that will be used is the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R). It was developed by Dr. Josepha Campinha-Bacote in 2002 (Transcultural C.A.R.E. Associates, 2015). The IAPCC-R measures the level of cultural competency among healthcare providers. It is a 25-item measurement tool with five domains and a four-point Likert scale (Transcultural C.A.R.E.

Associates, 2015). The five categories are awareness, desire, knowledge, skill, and encounter. The original tool that she created in 1997 had four domains (Transcultural C.A.R.E. Associates, 2015). The desired domain was added to make the currently revised version of the measurement tool. The Transcultural C.A.R.E. Associates have cited multiple studies that have confirmed the reliability of the IAPCC-R. The Cronbach alpha rating among several studies that used the tool to measure cultural competency ranged from 0.64-0.82. Construct, and content validity was validated in several studies, and face validity was determined by a review of national experts (Transcultural C.A.R.E. Associates, 2015). It takes approximately 10-15 minutes to complete, and the scores can range from 25-100. Information regarding acceptable scores for cultural competency will not be provided until the permission has been granted to use this tool. The project lead does not have the IAPCC-R and will be requesting permission. The cost to use the tool is $8 per person per administration if given face to face using pencil/paper. If used in any other format, the cost would be $20 per person per administration. The project lead has applied for grants to defray the cost of the tool, but the cost may be covered by the project if no other source of funding is identified. For this project, the participants would use two tools each because there will be a pre-intervention assessment and a post-intervention assessment. The IAPCC-R has been used frequently in cultural competency research involving nurses and nursing students (Transcultural C.A.R.E. Associates, 2015). A statistician will be sought to assist with data analysis.

Data Collection Procedures

Data collection of the pre- and post- intervention assessments will be conducted by the project lead. The administration of the IAPCC-R will be given fifteen minutes before the intervention begins and administed again after the intervention to all healthcare providers and

clinical staff in one setting. The IAPCC-R results that are collected will used to create a codebook in excel and submitted to SPSS for data analysis by the project lead and stored on a locked laptop until the final approval of the DNP project. Only the project lead will have access to the data. The data will be de-identified to ensure confidentiality. The data analysis will determine if a significant change occurred in cultural competency as a result of the intervention. The tally of new LGBT patient appointments after the intervention will be captured by the medical assistant that schedules all of the appointments. If the LGBT patient appointments after the intervention are at least 10% more than before the intervention, this is an indication that access to mental healthcare for the LGBT clients has increased. The project lead will obtain the appointment totals after two weeks post-intervention.

Intervention and Project Timeline

Pre-Intervention

Before the intervention, the site had been selected, and a site agreement was made to conduct the intervention. The DNP proposal was submitted to Touro University Nevada, and approval of the DNP project was received from the faculty. Recruitment of participants was discussed with the site owner and completed. The educational intervention was coordinated with The Gay and Lesbian Community Center of Southern Nevada. The IAPCCR-R permission requested for the tool and received. Verbal reminders will be given to all participants before the intervention.

Week 1

Week one (July 10-16) –The intervention will be conducted on July 10. The pre/post measurements will be taken during the intervention by the project lead. The educational component of the intervention will be conducted by education consultant from the Gay and

Lesbian Community Center of Southern Nevada. It will be from noon to 4 PM at the mental health clinic. A medical assistant designated by the project lead will be instructed to tally the number of LGBT appointments that were made for two weeks and compared to the two weeks before the intervention. The outpatient mental health clinic will be listed on theCenterlv.org as an LGBT-friendly provider coordinated by the education consultant from the Gay and Lesbian Community Center of Southern Nevada no later than July 13.

Week 2

Week two (July 17-23) - Data analysis will be conducted from the pre and post measurements and analyzed by the project lead. The designated medical assistant will continue to tally all new appointments identifying the referral source.

Week 3

Week three (July 24-30) - The designated medical assistant will continue to track the new appointments.

Week 4

Week four (July 31-August 6) - This is the final week for the designated medical assistant to track the new appointments. The project lead will meet with the designated medical assistant and obtain the data on August 6. The project lead will analyze the data.

Ethics/Human Subjects Protection

The Internal Review Board (IRB) determination form for Touro University Nevada will be utilized to determine if this DNP project meets criteria for IRB review. There is not an Institutional Review Board at the project site. As this is a quality improvement project, it will not fall under IRB review. The benefits of this project are increased access to mental healthcare for the LGBT patient through increased cultural competence of the staff and healthcare providers at

the project site. The participants will benefit by having increased confidence and ability to care for the LGBT patient, which could open more career opportunities. This could lead to improved patient satisfaction and a specialized skill for the participant. The risk is minimal because protected information will not be accessed, and no identifying information will be obtained. The participants will not be compensated for their time during this project. To protect privacy and confidentiality, the measurement tool will have an identification code instead of a name to protect the identity of the participants and their responses.

Plan for Analysis/Evaluation

The data analysis plan was reviewed by a statistician, Dr. Vanier. Dr. Vanier suggested a statistical procedure if I were comparing LGBT appointments to non-LGBT appointments, but that recommendation is not applicable because an examination of only LGBT appointments will be conducted. The data collected from the pre and post interventions will be used to create a codebook and analyzed in the IBM SPSS Statistics software. A paired-samples t-test will be conducted to compare the means of the pre and post interventions scores to identify if there was a significant increase in cultural competence as a result of the intervention. A paired-samples t-test is used when means are compared with the same group at two different points with the same measurement (Pallant, 2016). In other words, the set of participants in this project will have two data collection points using the same tool to determine if there is a difference. The assumption is that the dependent variable is measured at the interval level using a continuous scale. It is assumed that the two scores from the participants will be normally distributed. The variability of the group's score should be similar. The significance of the data analysis will be determined by the probability value. If the value is less than .05, then there is a significant difference between the pre and post intervention. Once a significance is determined, then the means will be compared to

see which set of scores were higher. Next, a determination of the magnitude or effect the intervention had on the differences between the means is determined by calculating the effect size. If there is an increase of appointments by 10%, this will be an indication that an increase in access to mental healthcare for the LGBT community is achieved. The appointment total will be obtained by the medical assistant designated to keep track of these appointments. The project lead will obtain the total number of appointments from the designated medical assistant two weeks after the intervention.

Implications for Nursing

Healthy People 2020 (2018) stated that an increase in cultural competence for LGBT clients would improve healthcare disparities. The World Health Organization recently retracted being transgender as a mental illness (Simon, 2018). One of the healthcare disparities is the lack of access to mental healthcare providers that are LGBT culturally competent (Dickey, Karasic, & Sharon, n.d.). Access to mental healthcare is very important to the LGBT community because they hold the highest rates of mental illness, substance abuse, and violence (IMI, 2011). The mental healthcare profession has pathologized being gay, lesbian, or transgender as evidenced by the World Health Organization labeling being gay or transgender as a mental illness (Simon, 2018). This position significantly influenced mental health providers to find ways to treat this population with an intent to cure them. The mental health providers must understand the violence, stigma, and discrimination that is faced by the LGBT community. Many LGBT patients are rejected by their family, verbally and physically abused publicly, and often lonely and isolated (Dickey, Karasic, & Sharon, n.d.).

The doctoraly-prepared nurse is considered an expert in evidence-based practice and should be aware of the health care disparities among the LGBT community. Also, he/she should

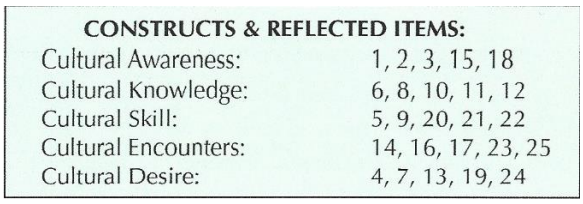
know the recommendations to improve disparities. Nurses strive to provide holistic, equitable, and quality care to all patients. Not being culturally competent hinders nurses from rendering holistic, equitable, and competent care. In some settings, nurses spend the most time with patients. This means nurses have the greatest impact on the quality of care a patient receives. To be a culturally competent nurse assures that all patients receive the best possible care with the best possible outcomes.

This DNP project anticipates that it will improve LGBT cultural competency, which will lead to the project site providing holistic, equitable, and quality care to all LGBT patients. This will improve access to mental healthcare for the LGBT patient population because they will have the ability to be seen at a clinic that will not discriminate, have bias, or stigma. This will increase business revenue at the project site. In addition, the project site will probably become well known in the LGBT community as the mental healthcare clinic to visit. Currently, there is only one mental health provider vetted by the Gay and Lesbian Community Center of Southern Nevada. Therefore, when another provider is added, the clinic will likely see an increase in patients and if they are pleased with the care received, word of mouth marketing will increase the number of patients and business revenue.

Analysis and Evaluation

Six participants provided the data to be analyzed. The data was analyzed using IBM SPSS Statistics Grad Pack 24.0 Base. The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) was used to determine if an increase in cultural competency was achieved. The IAPCC-R consists of twenty-five questions in five domains: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Transcultural C.A.R.E. Associates, 2015). The scores of each domain were entered using

the scoring key provided with the IAPCC-R (see Figure 1).



CONSTRUCTS & REFLECTED ITEMS:	
Cultural Awareness:	1, 2, 3, 15, 18
Cultural Knowledge:	6, 8, 10, 11, 12
Cultural Skill:	5, 9, 20, 21, 22
Cultural Encounters:	14, 16, 17, 23, 25
Cultural Desire:	4, 7, 13, 19, 24

Figure 1. . IAPCC-R Scoring Key

Descriptive statistics were used to evaluate the scores. To analyze the pre- and post-intervention scores, a paired-samples t-test was conducted. A paired-samples t-test is used when there is one participation group, and data is collected on two different occasions for a continuous variable (Pallant, 2016). In this project, there was a pre-/post-intervention period when data was gathered. The first assumption associated with the paired-samples t-test included an assumption that the dependent variable is continuous and not categorical. Second, it is assumed the sample is random from the population. Next, it is assumed that the difference between the two data points will be normally distributed, and the observations do not influence each other. In sample sizes greater than 30, the assumption of normality is not usually violated (Pallant, 2016). For this project, it is highly likely to be violated due to small sample size (n = 6). The last assumption is that the sample originates from populations of equal variances (Pallant, 2016).

A paired-samples t-test was conducted to evaluate the impact of an LGBT cultural competency training would have on cultural competency. The data will be reviewed within the five domains of the IAPCC-R.

Cultural awareness includes question numbers 1, 2, 3, 15, and 18. Questions 1, 3, and 18 have non-significant p values ($p < .05$) (see Table 1). A non-significant p-value means that there is not a significant difference between the means of the pre- and post-intervention scores; the null hypothesis is accepted. In other words, the cultural competency intervention did not increase the

level of cultural competency. Question number 2 was not calculated in the paired samples test for an unknown reason. Question 15 had a significant difference between the means. A significant difference means that the null hypothesis is rejected and the cultural competency levels increased as a result of the intervention. Applying the rejected null hypothesis to question 15 means cultural awareness of at least two institutional barriers that prevent cultural/ethnic groups from seeking healthcare can be significantly increased using an LGBT educational intervention.

Cultural knowledge reflected in questions 6, 8, 10, 11, and 12 yielded non-significant results, as did the questions in cultural encounters and cultural desire (see Table 1). In cultural skill, questions 5, 9, 21, and 22 did not yield significant results, but question 20 did. The significance of question 20 was that an LGBT cultural competency educational intervention could significantly increase a participant's awareness of at least two cultural assessment tools that could be used when assessing clients.

Table 2

Paired Samples Test Results

					95% Confidence Interval of the Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper	t	df	Sig. (2-tailed)
Pair 1	Awar1 - Awar1B	.33	.51	.21	-.20	.87	1.5	5	.17
Pair 3	Awar3 - Awar3B	.67	.81	.33	-.19	1.52	2.00	5	.10
Pair 4	Awar15 - Awar15B	-1.00	.89	.36	-1.93	-.06	-2.73	5	.04
Pair 5	Awar18 - Awar18B	-.20	.83	.37	-1.23	.83	-.53	4	.62
Pair 9	Desi19 - Desi19B	-.50	.54	.22	-1.07	.07	-2.23	5	.07
Pair 10	Desi24 - Desi24B	-.50	.83	.34	-1.37	.37	-1.46	5	.20

Pair 11	Know6 - Know6B	-.66	1.96	.80	-2.73	1.39	-.83	5	.44
Pair 12	Know8 - Know8B	.00	.70	.31	-.87	.87	.00	4	1.00
Pair 13	Know10 - Know10B	-.16	1.16	.47	-1.39	1.06	-.34	5	.74
Pair 14	Know11 - Know11B	.00	.63	.25	-.66	.66	.00	5	1.00
Pair 15	Know12 - Know12B	-.17	.75	.30	-.95	.62	-.54	5	.61
Pair 17	Skill9 - Skill9B	-.33	.51	.21	-.87	.20	-1.58	5	.17
Pair 18	Skill20 - Skill20B	-.67	.51	.21	-1.20	-.12	-3.16	5	.02
Pair 19	Skill21 - Skill21B	.83	1.32	.54	-.56	2.22	1.53	5	.18
Pair 20	Skill22 - Skill22B	-.67	.81	.33	-1.52	.19	-2.00	5	.10
Pair 21	Enco14 - Enco14B	-.17	.40	.17	-.59	.26	-1.00	5	.36
Pair 23	Enco17 - Enco17B	.17	.40	.16	-.26	.59	1.00	5	.36
Pair 24	Enco23 - Enco23B	-.17	1.32	.54	-1.56	1.22	-.30	5	.77
Pair 25	Enco25 - Enco25B	-.80	.83	.37	-1.83	.23	-2.13	4	.09

The IAPCC-R included a scoring key to determine the level of competence. The level of competence has four categories: culturally proficient, culturally competent, culturally aware, and culturally incompetent (see Figure 2). The individual IAPCC-R tools were calculated to determine the total score of the responses. Each participant had two IAPCC-R tools, the scores were documented in Figure 3 to reflect the level of cultural competency before and after the intervention.

LEVEL OF CULTURAL COMPETENCE:	
Culturally Proficient	91 – 100
Culturally Competent	75 – 90
Culturally Aware	51 – 74
Culturally Incompetent	25 – 50

Figure 2. Level of cultural competence

All participants had an increase in their level of cultural competency except participant number four. Participant 1 had scores that were considered culturally competent before and after the intervention. Participant 2, 3, and 4 had scores that were culturally aware before and after the intervention. Participant 5 and 6 were culturally aware before the intervention and became culturally competent after the intervention.

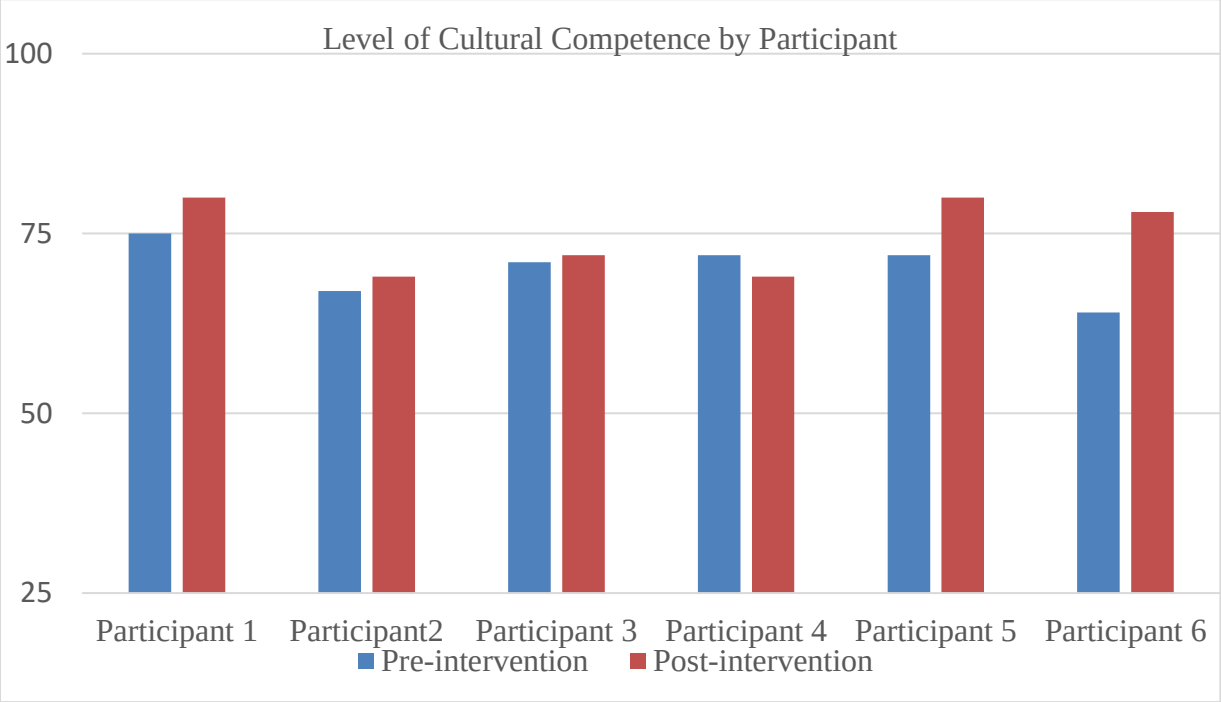


Figure 3. Level of cultural competence by participant

The number of LGBT appointments made two weeks before the intervention, and two weeks after the intervention were tallied. The number of LGBT appointments before the intervention was 6, and post-intervention was 8 (see Figure 4). The third objective of this project was to increase LGBT appointments by 10% two weeks post-intervention, and this objective was

met.

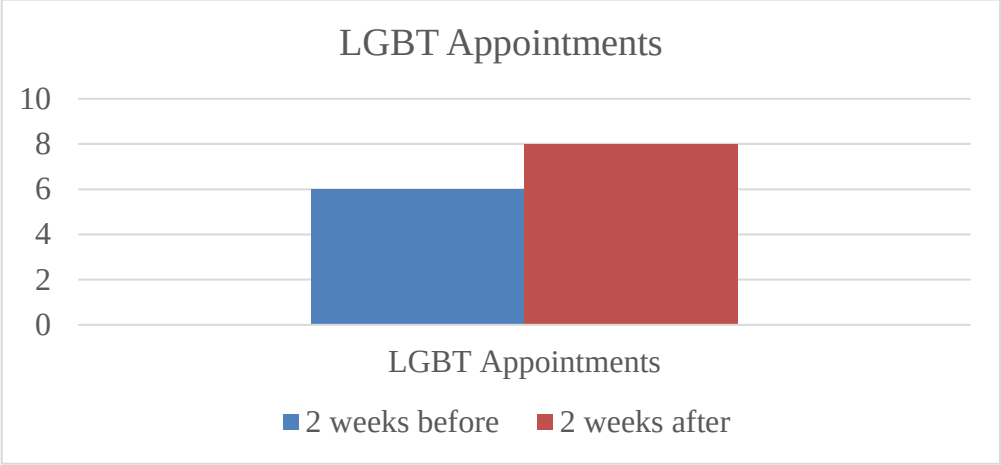


Figure 4. LGBT appointments two weeks before and after the intervention

The first objective of this project was met because a 4 hour LGBT cultural competency training conducted by the Gay and Lesbian Community Center of Southern Nevada was successfully conducted. The second objective was that the Gay and Lesbian Community Center of Southern Nevada would notify the LGBT community of the project site's cultural competency and list the project site on their website as an LGBT-welcoming mental health clinic. The project site was not listed on the website of the organization. The organization revamped their website and was building it out in sections and had not built that section of the site yet. However, the education consultant used word of mouth at the center to disseminate the news of an LGBT-welcoming mental health facility.

Discussion

Accepting people for who they are and what they believe in is cultural competency (Substance Abuse and Mental Health Services Administration, 2015). While the healthcare system has improved cultural competency of healthcare providers, the LGBT community was neglected and their needs were ignored (The Joint Commission, 2011). This is because the LGBT population has been silent in the medical community. They would delay seeking medical care or

not seek medical care at all. They would not complain or voice the discrimination they experienced in the healthcare setting. They would also lie about their sexual orientation and gender identity when seeking healthcare to avoid discrimination. Thus, no one was aware of their challenges until the Institute of Medicine (IOM) conducted a study that revealed their disparities (Institute of Medicine, 2011). LGBT cultural competency training will help to reduce the healthcare disparities among the LGBT patient population (Healthy People 2020, 2018; Institute of Medicine, 2011; The Joint Commission, 2011). An increase in cultural competence for the LGBT population would lead to better patient outcomes (Choi & Kim, 2018; Felsenstein, 2018; The Joint Commission, 2011).

The purpose of this project was to increase LGBT cultural competency by having an LGBT cultural competency training in an outpatient mental health clinic. In addition, by increasing the LGBT cultural competency would lead to increased mental healthcare access. Thus, this DNP project sought to answer the question of whether or not cultural competency training for LGBT patients in an outpatient mental health clinic would increase LGBT patient access to healthcare as evidenced by increased appointments in a two-week post-training period. Three objectives were to be met in order to provide answers to the question. The first objective was to conduct a four-hour LGBT cultural competency training. Next, the Gay and Lesbian Community Center of Southern Nevada would notify the LGBT population that the project site was LGBT-welcoming. Lastly, the number of LGBT appointments obtained at the project site would be increased by 10% within two-weeks post-intervention.

The results of this DNP project did not reveal an overall increase in LGBT cultural competency among the participants. The IAPCC-R was used to measure cultural competency. It has 25 questions and all of the questions except two did not have any significant difference from

before and after the intervention. The two questions that did have a significant difference before and after the intervention were related to an increase awareness of cultural assessment tools and at least two institutional barriers that prevented the cultural group from seeking care. This signifies that possibly the presentation was too skewed toward these questions and did not comprehensively address cultural competency. The differences between pre- and post-intervention cultural competency levels indicated that two participants became culturally competent as a result of the intervention. This means that only 33% of the participants are actually culturally competent, and the remaining four are not. It is uncertain if this is enough to improve healthcare disparities among the LGBT population. The lack of significant improvement in LGBT cultural competency is surprising. The recommendations from the literature were to conduct LGBT training and the healthcare disparites would be reduced (Felsenstein, 2018; Healthy People 2020, 2018; Institute of Medicine, 2011; The Joint Commission, 2011). The contributions this DNP project makes to the literature is there needs to be more standardization regarding how to conduct the LGBT cultural competency training to yield statistically significant improvement. The delivery of LGBT training is not consistent among the literature and there is no standard to state what is required to be taught and for what duration which leads to varied results in cultural competency (Orgel, 2017; Safer, et al., 2016).

The project did answer the question whether an outpatient mental health clinic that had an LGBT cultural competency training increase LGBT patient access to healthcare evidenced by increased appointments two weeks after the training. Although the training showed insignificant results for increased cultural competency, the LGBT appointments were increased by 10 percent within two weeks of the intervention. The increase could be due to the Gay and Lesbian Community Center of Southern Nevada promoting the project site. It could also be a reflection of

the need for mental healthcare among the LGBT population and had nothing to do with the intervention or promotion from the Gay and Lesbian Community Center of Southern Nevada. The increase in appointments is an indicator that there is increased LGBT patient access to mental healthcare.

All objectives were met to answer the question of the project. There were three objectives. The first objective was to conduct a four-hour training on LGBT cultural competency. The second was having the Gay and Lesbian Community Center of Southern Nevada promote the project site as LGBT welcoming. This was completed, but differently than anticipated. The project site was promoted verbally because the website was being upgraded. The final objective was to obtain at least a 10 percent increase in LGBT appointments within two weeks after the intervention.

Significance/Implications for Nursing

The significance of these findings to nursing relies on nurses' influence on patient care. Nurses are involved in many aspects of patient care, and it is important they are culturally competent with all people. The project site is a nurse practioner led clinical practice. Although the project site owner is a nurse and has been in practice as an advanced practice provider for over two years, her clinic ranked subpar to the level of cultural competency for LGBT patients according to the IAPCC-R tool used in this project (see Figure 2 and Figure 3). In addition, the project site owner has approxiamately 25% of her clientele from the LGBT population (N. Vaughn, personal communication, February 25, 2019). This is a reflection that although nurses try to provide the best care, cultural competency may not be present and healthcare disparites can still exist. Nursing educators should teach about LGBT culture and conduct follow up assessments to ensure cultural competency. This DNP project proves that having an educational intervention does not automatically result in competence. If nurse educators teach and assess for cultural

competency, culturally competent care will be provided. Nurse leaders should have polices regarding culturally competent care that not only includes trainings, but also addresses procedures and processes. For example, conducting a sexual history would be significantly different with an LGBT patient than a heterosexual person (Dickey, Karasic, & Sharon, n.d.). Implementing an LGBT cultural competency training is important and further dissemination and education is needed. Nurse researchers can further advance this knowledge.

Limitations

The project design is congruent with current literature. The average LGBT cultural competency trainings have ranged from one hour to a few days (Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly, 2017). Using a community advocate that understands the LGBT population in the community was a wise choice. It allowed the participants to know generalized facts, and the specific culture and needs of the people in their community. However, there were several limitations of the project.

A limitation of the project was the data recruitment. The post-intervention assessment occurred immediately after the workshop concluded. It was not advised by the statistician to conduct the post-intervention immediately after the intervention. It was recommended by the statistician to have a follow-up assessment at least a week after the intervention. The participants were not available after the intervention to meet and conduct a follow-up assessment, so the project lead conducted the post-intervention assessment immediately after the intervention concluded. Due to the timeframe completion deadlines, there was not an opportunity to assess the long-term impact of the intervention. Nor, was there time to examine qualitative perceptions from the LGBT patients. Also, the collection of the number of LGBT appointments made after the intervention could have been more specific to LGBT appointments that were directly referred

from the Gay and Lesbian Community Center of Southern Nevada instead of an all-inclusive number of LGBT appointments.

Another limitation of the project was the data collection methods. The data collection methods included using the IAPCC-R to assess cultural competency pre- and post-intervention. This tool had good validity and reliability to assess cultural competency among healthcare professionals. The other data collection method used was having a medical assistant total all LGBT appointments made for two weeks after the intervention. As previously stated, the data collection method could have been improved upon by revising the data collection criteria to LGBT clients that were referred from the Gay and Lesbian Community Center of Southern Nevada.

In addition, the small sample size of the project was a limitation. The data analysis of the project included a paired-samples t test. The paired-samples t test was conducted using SPSS and there were no difficulties conducting the test. However, due to the small sample size there were only two significant results out of 25. The small sample size of six participants could have contributed to the results; because small sample sizes decrease the power of the results. Thus, it can create errors in data analysis and results that are insignificant could actually be significant and vice versa. Projects that have 30 or more participants are more likely to have enough power for significant results (Pallant, 2016).

There was the risk of response bias because the sample was of convenience, thus creating a limitation of the project. The sample size consisted of psychiatric mental health nurse practitioner students, medical assistants, and the project site owner. There could be more variety in the sample if conducted in different outpatient mental health offices. The sample size had the resources and ability to participate but is not representative of participants that maybe could not

participate in person.

Lastly, a limitation of the project was the method used to market the announcement of the clinic. The original intent to inform the LGBT community of the project site was going to be through their website. The project site would have been listed as an LGBT-welcoming mental health clinic, but the website was being redesigned during the intervention. The project educator informed the LGBT community via word of mouth. The communication method used for the announcement of the clinic could have affected the number of appointments post-intervention. The use of a listing on a website could have proven to be more effective in informing the community than word of mouth marketing. The increase in LGBT appointments may not have been related to the intervention and do not serve as a direct correlation to increased patient access to care.

Dissemination

This DNP project will be presented for dissemination as a poster presentation with the American Psychiatric Nurses Association during the 34th Annual conference in October 2020. This project will also be presented for publication in the Journal of American Psychiatric Nurses Association. In addition, a submission for a poster presentation will be requested at the American Association of Nurse Practitioners in New Orleans June 23-28, 2020. This project will also be disseminated on The Doctor of Nursing Practice website. The Doctor of Nursing Practice organization also has an annual conference and this project will be submitted for a poster presentation for 2020.

Project Sustainability

The results of this project have led to internal changes within the project site. The intake process has been updated to be more LGBT-considerate as a result of this intervention. This

means that instead of asking gender male or female, it allows free text to include the clients to describe their gender. It is common for the LGBT community to claim both genders or none (H. Reese, personal communication, July 17, 2019) The electronic medical records system has been updated to reflect different sexual orientations and gender identities as a result of the intervention. The office staff will now inquire what pronouns are preferred by the clients. The preferred pronoun will be used in client introductions. Inquiring the preferred pronoun of a person shows consideration to individual choice to be identified as him, her, she, he, they, or them. The office waiting room has "Love is Love" mugs holding the pens as a symbol of acceptance of the LGBT community. The "Love is Love" statement derives from the Human Rights Campaign that supports LGBTQ Equality (Roberts, 2017). The project site owner has scheduled follow-up workshops with the project leader to further the knowledge of her staff. The project site will remain on the Gay and Lesbian community center of Southern Nevada's website until further notice.

Conclusion

The LGBT community has been silent in the medical community for decades and their healthcare disparities are being addressed through cultural competency education. This DNP project conducted a cultural competency educational training for the LGBT population and did not have significant results. Cultural competency was not achieved by most of the participants. The DNP project confirms the need for more research to standardize LGBT cultural competency training, the importance of having a large sample size, and adequate follow up assessments. The use of comprehensive LGBT cultural competency training and pre- and post- interventions appropriately scheduled, could result in more LGBT culturally competent healthcare providers and improve the healthcare disparities among the LGBT population.

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Appendix A

Submission for Statistician review

DNP Project: Statistics Plan Worksheet

Name: Tiffany Smith
Date: May 7, 2019

Section	Description
Project Title	LGBT Cultural Competence in a Southern Nevada Outpatient Mental Health Clinic
Project Purpose	4. Implement and evaluate a 4-hour cultural competency training, conducted by the Gay and Lesbian Community Center of Southern Nevada. 5. The Gay and Lesbian Community Center of Southern Nevada will notify the LGBT community and list on their healthcare directory that the outpatient mental health clinic is recognized as welcoming to the LGBT population. 6. Increase LGBT appointments by 10% within two weeks after the cultural competency training.
Project Question	In an outpatient mental health clinic does cultural competency training for LGBT patients in comparison to current practices increase LGBT patient access to healthcare evidenced by increased appointments in a two-week post-training period?
Project Outcomes	1. Increased cultural competency 2. Visibility to the LGBT community as a culturally competent mental health clinic by being listed on the website of the LGBT center in Southern Nevada 3. Increased appointments as a result of the listing

Project Design (general description how treatments are assigned/observational/ repeated measures of X # of people, etc.)	Quality improvement project • Intervention: one four-hour educational training regarding LGBT cultural competence • Participants: 2 nurse practitioners, 4 behavioral therapists, and 3 medical assistants • Data collection points: -a standardized tool will be used immediately before the intervention to assess the level of cultural competence -repeat the same assessment immediately after the conclusion of the intervention to determine if a significant change has occurred. -there will be a tally of the total number of appointments that were obtained as a result of being listed on the LGBT website
Population of Interest	The healthcare providers and staff at a Southern Nevada outpatient mental health clinic.
Variables	Levels of cultural competence; change in staff and providers; client population changes; insurance acceptance changes
Sample Size	2 nurse practitioners, 4 behavioral therapists, and 3 medical assistants – no chart audits required
Recruitment Methods	Mandatory meeting for the providers and staff notified verbally
Instruments/Tools (Validity/Reliability)	Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC–R) The IAPCC-R measures the level of cultural competency among healthcare providers. • 25-item measurement tool with five domains and a four-point Likert scale. The five domains are awareness, desire, knowledge, skill, and encounter. The Transcultural C.A.R.E. Associates have cited multiple studies that have confirmed reliability of the IAPCC-R. The Cronbach alpha rating among several studies that used the tool to measure cultural competency ranged from 0.64-0.82. Construct and content validity were validated in several studies and face validity was determined by a review of national experts (Transcultural C.A.R.E. Associates, 2015). It takes approximately 10-15 minutes to complete and the scores can range from 25-100.
Proposed Statistical Tests	Paired-Samples t-test- the paired-samples t-test is selected because there is one set of participants with two different data collection points (pre/post design)using the same scale.

Email completed form to your instructor and Dr Vanier- Cheryl.Vanier@tun.touro.edu
Allow Dr Vanier a minimum of 1 week to complete.

Appendix B

Approval from Statistician

Statistics Review of Project Design

C. Vanier, Ph.D., Touro University Nevada
cheryl.vanier@tun.touro.edu

I reviewed your proposed data collection and statistical analysis. Some of the text below is my effort to paraphrase your study as I understand it, while in other instances there are some recommendations for clarifying or improving the design or statistical approaches. If I get something wrong, consider whether it was a miscommunication or if you haven't completely thought through that piece of the study. Please contact me if anything is unclear.
Here's my understanding of your design: **You'll be providing training in LGBT cultural competence to staff at an outpatient mental health clinic. You will measure change in cultural competence score and in LGBT appointments after the intervention**.

- **Pre-test and Post-test: You might consider not giving participants the exact same test twice in the same day, since it's very likely that the post-test will be influenced by experience with the pre-test. That's terrific that you have a very good and validated instrument, so you don't want to mess with that. Maybe you could give the post-test a little later (you might get some guidance on this from the literature for the instrument) to help attenuate their memory. Will you be analyzing these by item, by domain, or by overall score? You have very low statistical power with 9 samples (participants), so if you don't see anything significant, it's hard to make strong statements about that.**
- **Client population changes: How many clients will you examine? Are you looking at clients before and after? How do you ascertain which patients are LGBT? If you have before/after numbers for # patients LGBT/# patients not LGBT, you will probably be analyzing this using a Fisher's exact test (a chi-square is OK if have counts over 5 in each grid of your 2x2 table).**
- **Insurance acceptance changes: You don't flesh this variable out. If count data, the same comment as for 'Client population changes' applies.**