IMPLEMENTING SEXUAL ORIENTATION AND GENDER IDENTITY (SO/GI) QUESTIONS AND PROVIDING LGBTQ EDUCATION TO STAFF IN A RURAL OUTPATIENT CLINIC

by

Deni Mayliz Fitzpatrick

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ABSTRACT

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals are important members of every community. Collecting Sexual Orientation and Gender Identity (SO/GI) information and providing staff with proper LGBTQ training is essential for acknowledging LGBTQ patients health disparities and providing proper health services to patients. The purpose of the project was to implement SO/GI questions into the clinics health survey form and provide evidence-based LGBTQ education to clinic staff members. SO/GI questions were implemented into the yearly reviewed health survey form in the outpatient clinic setting. During four-week cycle clinic patients were provided with the SO/GI questions on the patient intake form and were calculated as a percentage of the total patient intake forms completed. Overall the total completed SO/GI question percentage increased over the four week cycle. Patients were accepting of answering the SO/GI questions on the health survey forms. A LGBTQ educational session was provided to staff members on LGBTQ health and terminology and the importance of obtaining SO/GI questions from patients. Staff members clinical preparedness, attitudinal awareness, and knowledge were measured pre and post the LGBTQ educational session utilizing the LBGT-DOCSS tool. Overall, the total mean score, clinical preparedness, and knowledge scores increased after the LGBTQ educational session was provided. Attitudinal awareness did not change before or after the LGBTQ educational session. Limitations included a receptionist turnover, which required reteaching receptionists about the SO/GI collection process from clinic patients. COVID-19 protocols also required that the LGBTQ educational session to be provided virtually. Part of making the outpatient clinic more LGBTQ inclusive involved adding patient brochures, education materials, and adding a viewable nondiscrimination statement to the outpatient clinic setting.

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CHAPTER.1

INTRODUCTION

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals are vital members of every community. According to the National LGBTQ Health Education Center (2020), LGBTQ populations are more likely to experience select-health risks including smoking, substance abuse, depression, anxiety, and unhealthy weight control/perception. Rural LGBTQ individuals report an increased difficulty in accessing quality healthcare compared to their heterosexual peers (Isreal, Willging, & Ley, 2016). LGBTQ individuals residing in rural regions experience high rates of healthcare inequalities than those living in urban areas (Patterson, Jabson, Jennifer, & Kamen, 2019). The inequalities that rural LGBTQ individuals face include having difficulty disclosing LGBTQ identities to providers, less access to culturally competent providers, discrimination in the healthcare setting, and avoidance of healthcare for fear of victimization (IOM, 2011; Patterson et al., 2019).

The inequalities experienced by the LGBTQ community can be attributed to a lack of cultural competencies, communication skills, and comprehensive knowledge on LGBTQ care from healthcare providers (Isreal et al., 2017; Rowe, Chye, Louise, & Crawford, 2017). Poor provider care stems from the absence of training for providers amongst all LGBTQ populations. Specifically, given the lack of appropriate training that providers are given there are health care providers that do not regularly review sexual orientation or gender identity (SO/GI) with patients and there are healthcare facilities that have not developed systems to collect structured SO/GI data from patients (CDC, 2020; Grasso et al., 2019). To understand the health needs of LGBTQ

individuals and to identify health disparities for the LGBTQ population, the U.S. Institute of Medicine, Joint Commission, Healthy People 2020, and the U.S. Department of Health and Human Services Affordable Care Act all recommend the collection of sexual orientation and gender identity (SO/GI) from patients (Rullo et al., 2018). Sexual orientation is how a person describes their emotional and sexual attraction to others and gender identity is a person's inner sense of their gender (National LGBTQIA+ Health Education Center, 2020). Having patients provide their SO/GI information allows providers to meet healthcare needs and identify any gaps in care or services across diverse populations. Without the SO/GI data and the provider training, LGBTQ patients and their health needs will not be acknowledged, the health disparities will not be attended to, and important health care services will not be provided (CDC, 2020).

Background

The LGBTQ community deals with social stigmatization and discrimination that can lead to unhealthy patient outcomes (Rowe et al., 2017). Due to societal stigmatization and discrimination the LGBTQ community can experience higher rates of mental health disorders, sexually transmitted diseases (STDs) especially Human Immunodeficiency Virus (HIV), violence, drug and alcohol abuse, isolation, poverty, and homelessness (Rowe et al., 2017; Healthy People, 2020; CDC, 2020). Specific health disparities have been identified for each group of the LGBTQ community (Healthy People, 2020; Joint Commission, 2011). The health risks and disparities present vary based on the differing groups within the LGBTQ community as well within the developmental spectrum. In order to provide comprehensive care to the LGBTQ

community, providers need to be aware of these age and group specific health disparities (Healthy People, 2020; Joint Commission, 2011).

LGBTQ Youth

LGBTQ youth are at a significant risk for depression, suicide, sexual behaviors, substance use, bullying, isolation, and rejection compared to their heterosexual peers (Hafeez et al., 2017). LGBTQ youth are two to three times more likely to attempt suicide and to be homeless (Healthy People, 2020). It has been found that LGBTQ individuals are more at risk for suicide during their adolescence and early adulthood (National LGBTQ Health Education Center, 2018). The National LGBTQ Health Education Center (2018), states that in 2015, more than 4.5 times (29.4%) as many LGB-identified high school students reported attempting suicide in the past 12 months compared to non-LGB students (6.4%) and 42.8% of youth seriously considered suicide.

LGBTQ youth have an increased risk of experiencing violence (CDC, 2020). The CDC (2020) found in 2014 there were 10% of LGBTQ students who had been threatened or injured with a weapon on school grounds (CDC, 2020). LGBTQ youth tend to feel isolated and disconnected from their peers, which can put them at risk for suicidal ideation, depression, and anxiety (Hafeez, Zeshan, Tahir, Jahan, & Naveed, 2017). LGBTQ youth may also participate in high-risk sexual behaviors, which puts them at risk of getting STDs or HIV (Hafeez et al., 2017). In 2014, young, gay, and bisexual men made up about 80% of the HIV diagnoses among all youth (CDC, 2020).

Adult Lesbian, Gay & Bisexual
Men and Women

Adult lesbians have an increased risk of developing STDs/HIV, cancers, obesity, and mental health and substance abuse disorders (CDC, 2020; Health People, 2020; SAMSHA, 2012; Joint Commission, 2011). Adult lesbians and bisexuals are less likely to go to a primary care provider and receive preventative services, such as cancer screenings, than heterosexual women (CDC, 2020; Healthy People, 2020; SAMSHA 2012). Therefore, routine screenings, such as pap smears and mammograms are not performed in order to discover breast, cervical, and other cancers (SAMSHA, 2012). Adult lesbians also have a greater chance of being physically inactive which puts them at more of a risk of becoming overweight or obese (CDC, 2020; Healthy People, 2020).

Adult bisexual women experience more mental health issues and suicidality than both lesbians and heterosexual women (APA, 2020). For example, lifetime rates of mood/anxiety disorders in adult bisexual women are 58.7% for mood disorders and 57.8% for anxiety disorders; compared to adult lesbians experiencing 44.4% for mood disorders and 40.8% for anxiety disorders (APA, 2020). Adult heterosexual women have lifetime rates of 30.5% for mood disorders and 31.3% for anxiety disorders (APA, 2020). Adult bisexual women are 21 times more likely to consider suicide compared to heterosexual women (APA, 2020). Adult bisexual women are also at more at risk than adult lesbians and heterosexual women to have an eating disorder, mood/anxiety disorder, alcohol disorder, and substance use disorder (APA, 2020).

Adult gay and bisexual men deal with both physical and mental health issues (SAMSHA, 2012). They have an increased risk of having STDs/HIV, cancers, mental health, and substance abuse disorder (SAMSHA, 2012). Adult gay men tend to be at a greater risk of getting HIV and STDs than heterosexual men because of behaviors that transmit both STDs and HIV (e.g. condom less anal sex) (CDC, 2018). CDC (2020) states that in 2017, adult and adolescent gay and bisexual men accounted for 70% (27,000) of the 38,739 new HIV diagnoses in the United States. Around 492,000 sexually active gay and bisexual men are at a high risk for contracting HIV (CDC, 2020). Adult bisexual men who are sexually active with men are also at an increased risk in contracting human papillomavirus (HPV) and anal cancer. Proper screening and safe sex education can help prevent HIV/STDs and cancers. However, access to screening services may be extremely limited due to barriers and challenges that may prevent patients from receiving culturally responsive care (Healthy People, 2020). Adult bisexual men are also more at risk then heterosexual men in having experienced physical abuse and non-consensual sex in their childhood (APA, 2020). Adult bisexual men are 24-57% more likely to experience physical violence compared to homosexual males (APA, 2020). The risk and rate of having a mood, anxiety disorder and substance disorder are similar amongst adult bisexual and gay men and both higher than heterosexual men (APA, 2020).

Transgender Individuals

Access to healthcare is even harder for transgender individuals compared to the other LGB individuals (MAP, 2019). Finding a provider that is competent to provide transgender healthcare can be challenging (MAP, 2019). Transgender individuals also have a higher risk of

experiencing STDs/HIV, violence, mental health and substance use disorders. The National Center for Transgender Equality Survey (2016) highlights that 40% of respondents had attempted suicide in their lifetime- nearly nine times the attempted suicide rate in the U.S. population of 4.6%. The HIV epidemic greatly impacted the transgender population. The percentage of HIV amongst transgender women is 14.1%, for transgender men it is 3.2%, and for transgender people overall it is 9.2% (CDC, 2019). A major barrier that prevents a transgender individual to receive healthcare is lack of health insurance. Transgender individuals are less likely to have health insurance than any other LGB or heterosexual individual (Health People, 2020; MAP, 2019).

LGBTQ Elders

A disregarded population is the LGBTQ elders (65 years and older). The elderly LGBTQ population will increase from 12.8 percent to an estimated 19 percent in 2030 (National Gay and Lesbian Task Force, 2010). They also make up close to 17% of fatal suicides in the general population (National LGBTQ Health Education Center, 2018). LGBTQ elders have a higher suicide risk because they have been a stigmatized minority and have dealt with "minority stress" the longest (National LGBTQ Health Education Center, 2018). The LGBTQ elder population are less likely to have children than straight elders, which means that they are less likely to get care from grownup children (IOM, 2011). LGBTQ elders are also at an increased risk of being socially isolated because they do not have strong family or social supports (IOM, 2011). HIV continues to impact the LGBTQ elders and there are even fewer HIV prevention programs that are available for the older adults (Joint Commission, 2011). LGBTQ elders deal with the lack of

social services that are not readily available to them (Healthy People, 2020). LGBTQ elders are more likely than their non-LGBTQ counterparts to experience social isolation because they have higher rates of living alone, but also because of the lack of unequal welcoming they encounter at senior centers, hospitals, and mental health facilities compared to non-LGBTQ individuals (National Gay and Lesbian Task Force, 2010).

Rural LGBTQ Individuals

It is not uncommon for LGBTQ individuals living in rural areas to experience increased emotional distress, lower self-esteem, increased stigmatization, discrimination, mental health, and substance use disorders, and be less likely to disclose their sexual orientation than individuals residing in a non-rural area (Farmer et al., 2016; MAP 2019). LGBTQ individuals who are living in rural areas tend to experience significant health disparities, compared to non-rural LGBTQ individuals (MAP, 2019). In a recent DPHHS (2019) report, Montanan LGBTQ members reported the following select-health risks:

> Among LGBTQ+ adults in Montana, 1 in 4 (25%) reported currently smoking cigarettes. Approximately 1 in 5 (22%) LGBTQ+ adults in Montana engaged in binge drinking and almost 1 in 10 (9%) were heavy drinkers. 42% of Montanan LGBTQ+ adults reported having ever been diagnosed with depression and 1 in 4 (25%) reported poor mental health on 14 or more of the past 30 days. Six out of every ten (63%) LGBTQ+ adults in Montana reported being overweight or having obesity, according to the self-reported body mass index scores (DPHHS, 2019).

Montana LGBTQ health disparity data provide evidence that Montana LGBTQ individuals are in need of quality and culturally competent healthcare in order to address these health disparities. However, LGBTQ individuals who live in rural areas may have less access to providers who are comfortable with or knowledgeable about the treatment of LGBTQ healthcare

(MAP, 2019). The Bonvicini (2017) article states that in a 2011 survey there were more than 33% of U.S. medical schools who had reported having zero hours of LGBTQ-specific health care content in their curriculum. The schools that had specific LGBTQ content in their curriculum found that 43.9% of their medical students were able to provide care to the LGBTQ population if they practiced sexual history taking from patients who identified as LGBTQ (Bonvicini, 2017). Medical schools have also discovered that including sexual history taking practice in the curriculum is one way that the LGBTQ population measures whether a provider is LGBTQ-friendly (Bonvicini, 2017). Therefore, poor care may stem from providers not asking about the patients SO/GI and/or the patient may withhold this information from the provider due to not feeling comfortable (MAP, 2019). The inconsistency in providers lacking LGBTQ education and not gathering the patient's SO/GI information can negativity impact an LGBTQ patient's health, because their individualized health needs are not being addressed.

Scope of Problem

Several clinic patients have identified as gay, bisexual, or transgender. However; access to providers who are familiar with psychosocial concerns are limited (B. Dagger, PMHNP, personal communications, August 6th, 2020). Evidence is anecdotal; however, patients have specifically requested caregivers; and/or referrals to providers throughout the state of Montana that are familiar with LGBTQ lifestyle concerns/issues. The outpatient clinic providers are limited; no mental health providers are available that have been formally educated in this area (B. Dagger, PMHNP, personal communications, August 6th, 2020). The clinic does not currently provide training on LGBTQ care. A clinic report from January 1st to September 11th of 2020

shows that 0.7% or 32 patients have identified as transgender male, transgender female, other, or choose not to disclose their sexual orientation information all together.

The clinic does not provide training to staff members on LGBTQ care and does not properly track the sexual orientation and gender identity (SO/GI) data of LGBTQ individuals that come into the clinic. The clinic tracks sexual orientation for all of their patients yet does not track gender identity. Therefore, the clinic does not have the accurate data to monitor the potential LGBTQ health disparities that may exist among clinic LGBTQ patients. The facility also fails to provide a LGBTQ inclusive environment. For example, the clinic does provide accessible and viewable educational materials in the waiting room. Currently, the clinic also does not have a nondiscrimination statement visibly posted along with no other LGBTQ friendly posters (B. Dagger, PMHNP, personal communications, August 6th, 2020).

Purpose Statement

The purpose of this project was to implement SO/GI questions to the outpatient clinics intake forms. By implementing SO/GI questions to the intake forms a long-term goal of this project is to be able to identify the clinics LGBTQ patient's health disparities. The short-term goal of this project was to have 100% of patients fill out the SO/GI questions within a four-week cycle. Another short-term goal of this project was to provide a 45-minute education session during a staff member meeting. The education content that was presented to the staff included LGBTQ terminology, LGBTQ health disparities, LGBTQ communication techniques, and the importance of collecting SO/GI data in the EHR system. There was an assessment of the staff member's initial clinical preparedness, attitude, and basic knowledge about providing quality

care to the LGBTQ patient. The goal was to increase staff member's clinical preparedness, attitude, and basic knowledge on LGBTQ care. The staff members clinical preparedness, attitude, and basic knowledge on LGBTQ care was measured pre and post the education session utilizing the LGBTQ-DOCSS tool. Another goal of this project was to create a welcoming clinic environment for the LGBTQ patients. Part of making the outpatient clinic more LGBTQ friendly involved adding patient brochures, education materials, and adding a viewable nondiscrimination statement to the outpatient clinic setting.

Congruence of DNP Project to Clinic's Mission and Goals

The clinic's mission and goals include servicing all patients in the area and providing appropriate, comprehensive care (B. Dagger, personal communications, August 6th, 2020). The clinic offers comprehensive medical and behavioral health for all of their patient's needs and stresses the importance of health maintenance. The clinic's mission is to improve the health status of under-served populations and provide preventative care and screening services. The clinic is dedicated to being a leader in providing and promoting quality health and wellness to its surrounding areas (Marias Healthcare, 2020). By implementing LGBTQ training amongst staff members, the clinic would continue to accomplish its mission and goals. The LGBTQ training would also allow staff members to become more comfortable and competent in the needs, management, and referrals for the LGBTQ patients (B. Dagger, personal communications, August 6th, 2020).

CHAPTER 2

REVIEW AND SYNTHESIS OF THE EVIDENCE IN THE LITERATURE

U.S. organizations such as Department of Health and Human Services, Centers for Medicare and Medicaid Services, National Academy of Medicine, and the Joint Commission have acknowledged the importance of recognizing the health disparities among the LGBTQ population (Kodadek et al., 2019). However, SO/GI information is not being routinely collected in healthcare facilities. Without this data examining and studying the health disparities of the LGBTQ population has become challenging (Kodadek et al., 2019). Furthermore, gathering SO/GI information in the EHR system has been recommended by the above organizations to identity health disparities and assist healthcare providers to make informed clinical decisions on LGBTQ care and to enhance LGBTQ patient-provider communication (Kodadek et al., 2019; Furness et al., 2020; Grasso et al., 2020; Rullo et. al, 2018).

This literature review provides information on patients' perceptions on providing SO/GI information and the strengths and limitations of implementing SO/GI questions into healthcare facilities EHR systems. The following articles include information from a meta-analysis study, a systematic review, an integrative study, three mixed method studies, one pragmatized RCT study, five quality improvement studies, and National LGBTQ guidelines. Search engines that were searched included CINHAL, PubMed, Google Scholar, CatSearch, Cochrane, PsychInfo, Institute of Medicine, FenWay Institute, and CDC.

Patient Perception on SO/GI Questions

Research indicates patients are accepting of adding SO/GI questions to routine patient intake forms (Cahill et al., 2014; Rullo et al., 2018). For example, the Rullo et al. (2018) article, a randomized study with 491 participants from three outpatient clinic, found the collection of SO/GI questions in a routine intake form were not distressing to 97% of the heterosexual and 50-year-old and older participants. This study found that 3% of patients reported being distressed, upset, or offended by questions other than SO/GI (Rullo et al., 2018). The data provided strong support for the feasibility and acceptability of the implementation of routine SO/GI information collection in an outpatient clinical setting (Rullo et al., 2018). In the Cahill et al. (2014) article they found that 78% of the 301 randomly selected ethnically diverse patients strongly agreed that SO/GI information "is important for providers to know about them." The SO/GI questions on the intake form allowed participants to accurately select their SO/GI information. The participants overwhelmingly expressed support for asking SO/GI information and understood the importance of providers' knowing about their SO/GI information (Cahill et al., 2014). Bjarnadottir et al. (2016) completed an integrative study that examined 21 studies that evaluated patient's willingness to answer questions about their SO/GI information. The Bjarnadottir et al. (2016) article found LGBTQ patients perceive information about their SO/GI as necessary to ensure comprehensive care. LGBTQ patients disclosed their SO/GI information in the clinical setting, however, they were concerned of the possible homophobic or negative reactions that they may receive from staff members.

Two-part SO/GI Question

The Pinto et al. (2019) article examined data on patients who answered at least one question on a routinely administered sociodemographic survey between Dec. 2013-Mar. 2016. The survey was completed by 14, 247 patients. The response rate for this study was 97%. Pinto et al. (2019) found that participants answered the SO (90.6%) and GI (96.1%) questions. The transgender patients in this study who had been classified as transgender in their patient chart did not self-identify as transgender, but rather selected female (22.9%), or male (15.4%) (Pinto et al., 2019). These findings give light and more validation to using a two-part gender identity question (Pinto et al., 2019). The two-part gender identity question is also recommended by the CDC (CDC, 2020). The two-part gender identity question has been studied and approved by the Center for Excellence for Transgender Health and the World Professional Association for Transgender Health (CDC, 2020; Grasso, 2018). The CDC recommends a sexual orientation question and a two-part gender identity question to be instilled in EHR systems The two-part gender identity question reviews the patients current gender identity and the patients sex listed at birth. Together this two-part gender identity question provides a clearer representation of transgender patients. In addition to collecting SO/GI information from patients it is important to have patients provide their preferred name and pronouns so their healthcare team can use the proper ones for their patient (CDC, 2020; Grasso et al., 2018).

The Maragh-Bass et al. (2017) article looked specifically at a national sample of self-reported transgender patients view on the importance of SO/GI collection. Maragh-Bass et al. (2017) found that these transgender patients felt it was more important for primary care providers

to know their GI than SO (89% vs. 57% n=101). The participants reported that medical relevance to their chief complaint and an LGBTQ-friendly environment would increase their willingness to disclose their entire SO/GI information (Maragh-Bass et al., 2017). Concise collection of SO/GI information requires an assurance of patient confidentiality, privacy to complete the questions, and consistently equal collection amongst all demographics in a clinic setting (Haider et al., 2017). Healthcare staff often assume patients will be confused or offended by SO/GI questions. This confusion is rarely the case (Grasso et al., 2018). However, staff members should be prepared to reply efficiently to patient concerns on SO/GI questions. Preparation should include why the questions are being asked, who will see the information, and how the information will be protected (Grasso et al., 2018). Patients may need help understanding the SO/GI terms. Clinics may provide patients with education materials in the waiting rooms. Staff may be trained to distribute education materials or answer the SO/GI questions directly (Grasso et al., 2018).

SO/GI Staff Training

The Cahill et al. (2014) highlights the important of providing SO/GI staff training before collecting SO/GI information from patients. Staff training should be a requirement for SO/GI data collection (Cahill et al., 2014). The training would provide staff with knowledge on how to provide culturally competent care to LGBTQ patients (Cahill et al., 2014). In the Rullo et al. (2018) article staff training was implemented before collection of SO/GI questions. The training included information on basic LGBTQ information, health disparities, LGBTQ terminology, and misconceptions about SO/GI data collection (Rullo et al., 2018). Providing a training program for frontline staff members would be beneficial if clinics are going to collect SO/GI information

from patients (Cahill et al., 2016; CDC, 2020; IOM, 2013; National LGBTQ Health Education Center, 2020). Online and in person trainings that focus on basic terminology, health disparities, and effective communication strategies are available through the National LGBTQ Health Education Center (2020). LGBTQ health leaders recommend staff training on SO/GI information in order for staff to communicate effectivity and respectfully with patients about patient SO/GI information (Cahill et al., 2016; CDC, 2020; IOM, 2013; National LGBTQ Health Education Center, 2020).

Implementation of SO/GI Questions

The Felsenstein et al. (2018) study was a QI project that incorporated three of the LGBTQ cultural competencies that were established by the Joint Commission (Felsenstein et al., 2018). The goal of the Felsenstein et al. (2018) study was to meet all three of the Joint Commission Competencies. The Joint Commission published these LGBTQ cultural competencies for healthcare settings in reaction to a 2011 report disclosed by the Institute of Medicine (IOM). The IOM report is a comprehensive review of the health findings of the LGBTQ population. The IOM report also initiated the Healthy People 2020 to establish goals to improve the health outcomes of the LGBTQ population (Felsenstein et al., 2018). The Joint Commission competencies include creating a welcoming environment that is inclusive of LGBTQ patients, facilitating disclosure of SO/GI questions on patient intake forms, and including LGBTQ patient care information in new and existing employee staff training (Felsenstein et al., 2018; IOM, 2011). All three competencies were met in the Felsenstein et al. (2018) study which took place in a midwestern primary care clinic. Competencies were met by

creating a more inclusive environment, adding SO/GI questions to the patient intake forms, and providing staff with LGBTQ education session which included a panel session. The educational session showed a statistically significant increase (p=0.033) of staff LGBTQ knowledge from pretest to posttest scores. The panel discussion showed that 72% of staff reported they were more prepared for LGBTQ patient care (Felsenstein et al., 2018).

Implementing SO/GI questions can also be done in various settings including the Emergency Department (ED). The Haider et al. (2017) article which was a mixed-methods study performed qualitative interviews to obtain patients and providers view on collecting SO/GI information and by quantitative online surveys to evaluate patients and providers readiness to provide and obtain SO/GI information specific to the ER. The Haider et al.'s (2017) quantitative results found that a small percentage (10.3%) of patients would refuse to provide SO/GI information in the ER setting compared to what the ER healthcare professionals thought (77.8%). There were 1516 patients (244 lesbian, 289 gay, 179 bisexual, and 804 heterosexual) and 429 ED health care professionals (209 physicians and 220 nurses) who participated nationally (Haider et al., 2017).

Meaningful Use EHR Incentive Program

Since 2015 the Center for Medicare and Medicaid Services (CMS) and the Office of the National Coordinators for Health Information Technology (ONC) mandated all EHR systems certified under the Meaningful Use Incentive Program to collect SO/GI information from patients at Federally Qualified Health Centers (FQHCs) (Cahill et al., 2016; Department of Health and Human Services, 2016). The CMS's new mandate to have FQHCs collect SO/GI

information was an essential step forward to improving the care for the LGBTQ population. Collecting SO/GI information is a crucial process that the U.S government has initiated to promote better understanding of LGBTQ health disparities (Cahill et al., 2016; Department of Health and Human Services, 2016). The Joint Commission and the Institute of Medicine (IOM) have both recommended the use of SO/GI questions in clinical settings (Cahill et al, 2016). The recommendation include using SO/GI information in EHR systems (Cahill et al., 2016; Department of Health and Human Services, 2016). Due to the slow change of EHR systems adding SO/GI information, LGBTQ health leaders with funding and consultation with the CDC, developed a national quality improvement initiative called *Transforming Primary Care for LGBTQ People* (Furness et al., 2020).

Implementation of SO/GI Questions in FQHCs

The Furness et al. (2020) article is a collaborative quality improvement initiative that implemented a one year *Transforming Primary Care for LGBTQ People* initiative into ten federally qualified health centers (FQHCs) that serves 441,387 patients in 123 clinical sites in 9 states. The FQHCs received coaching in creating LGBTQ-inclusive environments, collecting SO/GI information, taking risk-based sexual histories, and screening LGBTQ people for syphilis, chlamydia and gonorrhea, and HIV (Furness, 2020). The Furness et al. (2020) study used a preintervention and postintervention evaluation design in the FQHCs which were in both in urban and rural areas around the U.S. (Furness et al., 2020). The *Transforming Primary Care for LGBTQ People* initiative ended up expanding from 10 providers at 10 clinical sites to 431 providers at 79 clinical sites (Furness et al., 2020).

FQHC's that participated in the QI initiative reported an increase in culturally affirming practices including collecting patient pronoun information (42.9% increase) and identifying a LGBTQ staff navigator for patients (300% increase). Each FQHC completed a baseline and end of initiative practice assessment questionnaire (93 items) assessing the intensity of each FQHC's practice of providing culturally competent LGBTQ care (Furness et al., 2020). The Furness et al. (2020) study found nine FQHCs reported they collected SO/GI information in EHR system and the SO/GI collection increased from 13.5% to 50.8% of patients. Eight out of ten FQHC sites reported screening LGBTQ patients increased 22.3% to 34.6% for syphilis; 25.3% to 44.1% for chlamydia and gonorrhea screening; and 14.8% to 30.5% for HIV screening (Furness et al., 2020). The Furness et al. (2020) study found FQHCs that participated in this quality improvement initiative reported an improved capacity to provide culturally affirming care and target screening for LGBTQ patients.

The retrospective study Grasso et al. (2020) went on to pick 5 of the 10 FQHCs that had participated in the Furness et al., (2020) study. The purpose of the study was to assess an approach for using SO/GI information to identify potential screening disparities of LGBTQ patients within these distinct healthcare organizations (Grasso et al., 2020). Three consecutive months of EHR patient data were stratified. The Grasso et al., (2020) study found that cervical cancer screening percentages amongst bisexual and gay patients were lower than heterosexual patients. The cervical cancer screening results of bisexual and gay patients in the Grasso et al., (2020) study give validation for collecting SO/GI information in the EHR system to detect preventative and address screening disparities (Grasso et al., 2020).

Common limitations for both Grasso et al. (2020) and Furness et al. (2020) studies exist. For example, the Grasso et al. (2020) & Furness et al. (2020) studies did not have EHR functionality to use the recommended two-step method to identify and count transgender people. The two step-method consists of assessing a person's self-reported gender identity and assessing a person's assigned sex at birth (CDC, 2020; Grasso et al., 2020; Furness et al., 2020). The 2-step method provides a cross-checking ability to allow facilities to identify transgender people who currently identify as female or male (rather than transgender male or transgender female) (CDC, 2020; Grasso et al., 2020). Due to Grasso et al. (2020) & Furness et al. (2020) having a small number of patients who identified as transgender, both studies recommended collecting data longer than 3 months before definitely characterizing health disparities in services or health outcomes for the transgender population (Grasso et al., 2020).

Another limitation found in both studies was a high percentage of patients who chose not to disclose/unknown for their SO/GI information. The Furness et al. (2020) researchers do not know if the FQHCs included participants who selected "something else" or for their gender identity as "other". In order to improve SO/GI data completeness, clinics need to prioritize SO/GI staff training about patient communication on SO/GI information. Clinic's may also educate patients about why SO/GI questions are being asked and how the data can benefit their personal health (Grasso et al., 2020; The Center of Excellence for Transgender Health, 2017).

Literature Summary

U.S. organizations have acknowledged the importance of recognizing the health disparities among the LGBTQ population (Kodadek et al., 2019). Gathering SO/GI information

in the EHR system will assist in identifying health disparities and assist healthcare providers to make informed clinical decisions on LGBTQ care and to enhance LGBTQ patient-provider communication (Kodadek et al., 2019; Furness et al., 2020; Grasso et al., 2020; Rullo et. al, 2018). The research has found that LGBTQ patients perceive information about their SO/GI as necessary to ensure comprehensive care (Bjarnadottir et al., 2016). Overwhelmingly, patients expressed support for asking SO/GI information and understood the importance of providers' knowing about their SO/GI information (Cahill et al., 2014). Staff training should be a requirement for SO/GI data collection (Cahill et al., 2014). The training provides staff with knowledge on how to provide culturally competent care to LGBTQ patients (Cahill et al., 2014). Online and in person trainings that focus on basic terminology, health disparities, and effective communication strategies are available through the National LGBTQ Health Education Center (2020).

The CMS's new mandate to have FQHCs collect SO/GI information was an essential step forward to improving the care for the LGBTQ population. Collecting SO/GI information is a crucial process that the U.S government has initiated to promote better understanding of LGBTQ health disparities (Cahill et al., 2016; Department of Health and Human Services, 2016). FQHCs that participated in this quality improvement initiative reported an improved capacity to provide culturally affirming care and target screening for LGBTQ patients (Furness et al., 2020). The two SO/GI step-method consists of assessing a person's self-reported gender identity and assessing a person's assigned sex at birth (CDC, 2020; Grasso et al., 2020; Furness et al., 2020). The 2-step method provides a cross-checking ability to allow facilities to identify transgender people who

currently identify as female or male (rather than transgender male or transgender female) (CDC, 2020; Grasso et al., 2020).

Project implementation will occur in a FQHC clinic. The clinic participates in the CMS EHR Incentive Program. Therefore, adding the recommended SO/GI questions to the clinic's patient intake form will allow them to obtain appropriate data on patients SO/GI information. Implementing SO/GI questions will also allow the clinic to gain a better understanding of the LGBTQ population the clinic serves (Department of Health and Human Services, 2016). Adopting SO/GI data collection in the UDS will align with the 2015 Edition Health Information (Health IT) Certification Criteria, 2015 Edition Health Record (EHR) Definition, and the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program. Alliance of UDS SO/GI data with ONC certification criteria will also reduce an overall health reporting burden (Department of Health and Human Services, 2016). By implementing the SO/GI questions on the patient intake form, the clinic will promote culturally competent care while contributing to evaluation and reduction of health disparities common to the LGBTQ population (Department of Health and Human Services, 2016).

CHAPTER 3

SETTING AND METHODS

The Quality Improvement Model that guided my project was the Plan-Do-Study-Act (PDSA) Model. The PDSA Model is widely accessible through the Institute of Healthcare Improvement (IHI) and utilized to determine if a change leads to an improvement (IHI, 2020). IHI (2020) states that this model is the scientific method used for action-oriented learning. The PDSA Model consists of four steps; Plan, Do, Study, and Act. The change process of this project was to implement sexual orientation and gender identity (SO/GI) questions on the patient intake form. SO/GI questions on the patient intake form will allow the clinic to assess and address the health disparities of the clinic's LGBTQ population. The PDSA Model was fitting for this project. The PDSA model rapidly tests a change on a smaller scale (outpatient clinic), evaluates the change, and allows one to make adjustments to change before application on a broader scale (hospital setting) (IHI, 2020; USDHHS, 2011).

The PDSA model consists of repeated cycles. Repeated cycles provided the opportunity to make improvement of change for each cycle as they presented themselves (IHI, 2020). The collection of patient intake forms was over a four-week cycle. Percent completion of patient intake forms by patients was analyzed after each cycle. Hundred percent completion of SO/GI questions on the patient intake form during each four-week cycle was the project goal. Communication with the clinic two to four times a week determined if modifications needed to be made to obtain a consistent response from the patients on filling out the SO/GI questions (IHI, 2020). The National LGBTQ Health Education Center (2017) also recommends upon

implementation of SO/GI questions into the EHR system to pilot the change process by utilizing the PDSA Model to implement and monitor the SO/GI data collection.

Agency Description

Toole County is a rural area on Montana's northern border known as the Hi-Line. Toole County is home to 5,324 residents with a population density of 2.8 people per square mile. The town of Shelby serves as the county seat and has a population of about 3,089 residents. Toole County is also home to six other frontier communities which include: Sunburst, Sweetgrass, Kevin, Galata, Oilmont, and Ethridge. The rural clinic where this QI project is being implemented is a Federally Qualified Health Center located in Toole County. The rural clinic is the primary healthcare provider in Toole County. In 2018, the rural clinic served 5,499 patients. Of the patients served in 2018, 25% were under the age of 20 years old and 25% were over 60 years of age. In 2018, four out of five households reported that they had access to a primary care provider while 87% reported a routine check-up within the last year. Our target population for this project is the LGBTQ population of the rural clinic. A clinic report from January 1st to September 11th of 2020 showed that 0.7% or thirty-two clinic patients had identified as transgender male, transgender female, other, or chose not to disclose their sexual orientation.

Improving the health status of under-served populations and providing health maintenance and preventative care as well as treatment of illness is the rural clinic's mission. Patients can receive primary care across their lifespan. Services that are provided through this rural clinic include well child services, preventative care services, obstetrics and delivery services, contraceptive services, health screenings, oral exams, preventative dentistry, women

and men's health, and healthy kids program application assistance. Medicare, Medicaid, and many other commercial insurance carriers are accepted through the clinic. A sliding fee schedule for qualifying families is provided. The clinic accepts all patients regardless of the ability to pay. Same day appointments are also provided at the rural clinic.

There are various stakeholders involved in this project. Stakeholders involved in this project include the project site representative, the CEO of the clinic, the clinic's quality improvement representative, the staff members who attended the SO/GI educational session, the office representatives who collected the patient intake forms, and the clinic patients who filled out the SO/GI questions on the patient intake forms. The project site representative and CEO of the clinic are both essential stakeholders for this project. Together they provided clinic information and were collaborators for a successful implementation of this project in the clinic setting. The front office representatives also played a vital role in the project by being in charge of the collection process of the patient intake forms and providing patient education on SO/GI questions when needed by patients. Another important stakeholder for this project was the quality improvement representative who provided valuable patient demographic information and assisted in implementing new SO/GI questions to the patient intake form and patient portal. The quality improvement representative also was in charge of collecting the SO/GI data for the clinic's future use to obtain LGBTQ health disparities to help improve LGBTQ patient health outcomes. Lastly, the staff members who participated in the educational session were important stakeholders for this project. For example, the staff members clinical preparedness, attitude, and basic knowledge on LGBTQ care was measured pre and post the educational session utilizing the LGBTQ-DOCSS tool.

The clinic had specific facilitators and barriers for implementing this project. A facilitator for implementation of this project included having a professional relationship with the stakeholders of the clinic. This positive relationship allowed this project to be implemented successfully. Another facilitator required stakeholders to accept implementation of this project. The stakeholders saw the importance of this project for their LGBTQ patients. Due to COVID-19, my project ran into barriers during the collection process, the educational session for staff, and distribution of education materials for patients. Appendix A is a detailed SWOT analysis diagram that provides a full list of barriers and facilitators for implementation of this project in the clinic setting.

Project Design

Project purpose was implementation of SO/GI questions on the outpatient clinic intake forms and to provide a LGBTQ inclusive clinic environment. A strategy was to supply staff members with an educational session on LGBTQ health and terminology and the importance of obtaining SO/GI questions from patients to accomplish the purpose of an inclusive environment. During a four-week cycle clinic patients were provided with the SO/GI questions on the patient intake form. Patients filled out the SO/GI questions during the four-week cycle and were calculated as a percentage of the total patient intake forms completed. A short-term goal of this project included a 100% patient fill out of the SO/GI questions.

Patient intake forms were collected from all patients who filled out the patient intake form in-person before the patients' clinic appointment. The front desk employees collected the inpatient intake forms and put them in a collection bin behind the counter for a four week cycle.

Check-ins with the collection process were done twice a week to assess and provide necessary modifications to the SO/GI questions and the collection process. This monitoring ensured that patients completed the SO/GI questions. Data collection only included completed SO/GI questions that were answered. Patient identifiers were not indicated on the tracking form. Utilization of run charts were tracked weekly for the SO/GI data of the number of patients who completed the SO/GI questions on the patient intake form. As more patients continue to complete the SO/GI questions on the patient intake form, data collection will assist the clinic staff members in best understanding the healthcare issues experienced by LGBTQ clinic patients. The health of every individual depends on disclosing their SO/GI information (IOM, 2013). The implementation of SO/GI questions to the patient intake form will improve the quality of the data collected using the SO/GI questions (IOM, 2013).

Training staff members on how to interact with LGBTQ patients and the sensitives involved in collecting data on SO/GI is essential for successful implementation of SO/GI questions in the clinic setting (IOM, 2013). Therefore, another short-term goal of this project was to provide a 45-minute educational session during a clinic staff meeting. An email was sent by the project representative to all clinic staff members inviting them to attend an LGBTQ educational session. This educational session was a scheduled event on the staff's meeting agenda. The education content that was presented to the staff included LGBTQ terminology, LGBTQ health disparities, LGBTQ communication techniques, and the importance of collecting SO/GI data in the EHR system. LGBTQ educational information came from the National LGBTQ Health Education Center of the Fenway Institute. The National LGBTQ Education Center provides educational programs, resources, and consultation to health care organizations.

with the goal of optimizing quality cost effective health care for the LGBTQ population (National LGBTQ Education Center, 2020). The National LGBTQ Education Center also provides specific information on collecting sexual orientation and gender identity (National LGBTQ Education Center, 2020). After the educational session was provided to the staff members, clinical preparedness, attitude, and basic knowledge on LGBTQ care was measured pre and post utilizing the LGBTQ-DOCSS tool. The goal was to increase staff member's clinical preparedness, attitude, and basic knowledge on LGBTQ care.

The last short-term goal of this project was to create a welcoming clinic environment for the LGBTQ patients. Part of making the outpatient clinic more LGBTQ friendly involved adding patient brochures, education materials, and a viewable nondiscrimination statement to the outpatient clinic setting (IOM, 2013). A LGBTQ resource list of accessible state and national LGBTQ information was available for patient access. LGBTQ-friendly symbols such as a rainbow flag was displayed in the waiting area which immediately signals a culture of acceptance (IOM, 2011). Also, the clinic’s nondiscrimination policy statement is posted in the waiting area. The policy ensures equitable care regardless of a patient’s sexual orientation, gender identity, or expression (IOM, 2011). Posting a nondiscrimination statement in the waiting room demonstrates the clinic’s commitment to equitable care for LGBTQ patients (IOM, 2012). It is important for the clinic’s environment to support the diversity of patients served (IOM, 2011). Research has shown that LGBTQ patients survey their surroundings to determine if an environment is one in which they feel welcome and accepted. Providing a welcoming environment can set the tone for the entire healthcare encounter (IOM, 211).

A long-term goal that will not be obtained during this project is the identification of LGBTQ patient's health disparities. This goal requires SO/GI data collection over a long period of time. With the continual use of the SO/GI questions on the patient intake form, the staff members may assess what services are needed to improve healthcare for the LGBTQ population (Grasso, 2016; IOM, 2013). SO/GI information is significantly relevant to numerous aspects of LGBTQ patient's health. The clinic could incorporate structured SO/GI data collection into decision support and coding (Fenway Health, 2020). Decision support may be built into the EHR system to remind providers to do routine screenings that support the unique health needs of LGBTQ patients. For example, screenings may be done for specific STDs and cancers (Fenway Health, 2020). Another long term goal not obtained during this project involves collection of data revealing whether or not LGBTQ patients feel comfortable sharing SO/GI information. Such data may be collected through a patient satisfaction survey. The long term goal is to have LGBTQ related questions on the patient satisfaction survey to evaluate the clinic ability to provide health needs of the LGBTQ population. By evaluating patient satisfaction survey results, the clinic may improve healthcare services for the LGBTQ population (National LGBTQ cancer network, 2013).

Project Methods

Leading LGBTQ experts, such as the National Academy of Medicine, Joint Commission, and the Center of Excellence for Transgender Health at the University of California, San Francisco recommend asking patients the following SO/GI questions that are provided in Appendix C (CDC, 2020). These SO/GI questions have been recommended based on testing

with rural and urban health centers along with other studies of SO/GI data (CDC, 2020). The recommended SO/GI questions replace “Sex: male or female?” on patient intake forms, EHRs, and patient portals (CDC, 2020). Asking two questions for sexual orientation offers a clearer, more clinically relevant representation of transgender patients. For example, asking whether a patient is transgender will exclude some transgender patients who do not identity as such (e.g. a person who born a male but whose gender identity is female may check “female” rather than “transgender” on the patient form) (CDC, 2020). The gender identity question also includes options for people who have a non-binary identity (people who do not identify as male or female) (CDC, 2020).

Equally important is asking the patient what name and pronouns they prefer. Many transgender patients have insurance records and identification cards that do not accurately reflect their current name and gender identity. When staff ask for preferred pronouns and use individuals preferred pronouns and name, patient centered communication is greatly facilitated (CDC, 2020). The SO/GI questions that will be implemented into the clinic’s patient intake forms are listed in Appendix C.

Collection of SO/GI questions may be done by various methods. For example, information may be obtained through patient portals or patient intake forms. Staff members may also ask SO/GI question during the patient visit (CDC, 2020). Regardless of how the data is collected SO/GI questions should be updated regularly over time (CDC, 2020). Figure A on Appendix D shows a sample process for gathering SO/GI data in a clinical setting (CDC, 2020). For this project we will be asking patients’ SO/GI questions utilizing the patient intake form when they arrive at the clinic for an appointment. Implementation of this project will be from

December 2020- January 2021. During this time frame the project will include finalizing and implementing the SO/GI questions into the patient intake form, sending out a staff invite via email to attend a LGBTQ educational session via ZOOM, providing an LGBTQ educational session to attending staff members, and collecting SO/GI questions patients have completed in a four week cycle. The Implementation Plan for this project is provided in Appendix B.

Human Subject Protection

An exempt application was submitted and reviewed by the Institute Review Board at Montana State University of Bozeman, MT. Approval by the Institute Review Board was obtained before the project was implemented in the clinic setting. Patient interactions were not done during this project. Patient identifiers were not included during the project data collection.

LGBTQ-DOCSS

The Lesbian, Gay, Bisexual, and Transgender Development Clinical Skills Scale (LGBTQ-DOCSS) was used as a pre and post measuring tool to examine the clinical preparedness, attitudes, and basic knowledge regarding lesbian, bisexual, and transgender (LGBTQ) patients. This tool was provided to staff members who attend the LGBTQ educational session at the clinic. The LGBTQ-DOCSS tool can be used when examining LGBTQ clinical development, exploring specific staff characteristics, or when developing and testing various LGBTQ training programs and methods (Bidel et al., 2017). The LGBTQ-DOCSS utilizes a 7-point Likert scale (i.e. 1 =strongly disagree to 7= strongly agree). Bidel et al. (2017) article found LGBTQ-DOCSS overall internal consistency is α=.86. Each of the three subscales include

clinical preparedness of α=.88, Attitudinal Awareness of α=.80, and Basic Knowledge of α=.83. The internal consistency of the LGBTQ-DOCSS tools is within the 0.8-0.9 level which is considered good internal consistency (Tavakol & Dennick, 2011). Therefore, the LGBTQ-DOCSS scale is a reliable tool to measure the clinical preparedness, attitudes, and basic knowledge regarding lesbian, bisexual, and transgender (LGBTQ) patients (Bidel et al., 2017). Another essential way the LGBTQ-DOCSS may be utilized is by assisting trainees and providers self-exploration of their LGBTQ clinical preparedness, attitudinal awareness, and basic knowledge (Bidel et al., 2017). Such self-evaluations can be completed individually, within a broader training program, or with a clinical supervisor (Bidel et al., 2017). Individual self-exploration using the LGBTQ-DOCSS provides opportunities to modify exact learning objectives that can improve staff member's clinical work with LGBTQ patients (Bidel et al., 2017). The LGBTQ-DOCSS is provided in Appendix E.

Feasibility and Plan for Sustainability

The SO/GI questions that were implemented into the outpatient intake form will be sustainable and feasible for the clinic. By implementing SO/GI questions into the patient intake form it will allow the clinic to obtain and monitor the clinic's LGBTQ patient's health disparities. With the clinic knowing about their LGBTQ patient's health disparities the clinic will be able to focus on improving LGBTQ patient centered care for this population. Adding SO/GI questions to the patient intake form is affordable and at no cost to the clinic. Implementing this QI project into the clinic will allow for modifications to be made to the SO/GI question and the

collection process in order to make them even more sustainable and feasible in this clinic for the LGBTQ population.

Summary

The PDSA model guided this QI project. This QI project had short and long term goals. The short term goals included implementation of SO/GI questions to the clinic's patient intake forms, providing an LGBTQ inclusive environment, and providing an optional LGBTQ educational session to clinic staff members. The LGBTQ educational session was presented to staff via ZOOM. The LGBTQ-DOCSS was used as a pre and post measuring tool to examine the clinical preparedness, attitudes, and basic knowledge regarding lesbian, bisexual, and transgender (LGBTQ) patients. This tool was provided to staff members who attended the LGBTQ educational session at the clinic. Long term goals included identifying the clinic's LGBTQ health disparities and patient satisfaction results that are LGBTQ related. The collection of patient intake forms was over a four week cycle. Percent completion of patient intake forms by patients were analyzed after each cycle. Hundred percent completion of SO/GI questions on the patient intake form during each four week cycle was the project goal. Communication with the clinic two to four times a week helped to determine if modifications were needed to be made to obtain a consistent response from the patients on filling out the SO/GI questions (IHI, 2020). A two-part SO/GI question, preferred name question, and a pronoun question were implemented to the patient intake form. An exempt application was submitted and reviewed by the Institute Review Board at Montana State University of Bozeman, MT prior to implementation of this QI project in the clinic.

CHAPTER 4

RESULTS

The purpose of this project was to implement SO/GI questions to the outpatient clinics intake forms. The short-term goal of this project was to have 100% of patients fill out the SO/GI questions within a four-week cycle. By implementing SO/GI questions to the intake forms, a long-term goal that will not be met during this project is to identify the clinics LGBTQ patient's health disparities. Another short-term goal of this project was to provide a LGBTQ educational session to staff members. A pre and post survey was provided to staff members to assess clinical preparedness, attitude, and basic knowledge on providing quality care to LGBTQ patients by utilizing the LGBT-DOCSS tool. The last goal of this project was to create a welcoming clinic environment for the LGBTQ patients by adding patient brochures, a nondiscrimination statement, and a "Genderbread Person" teaching tool to all of the clinic patient rooms.

LGBT-DOCSS Pre/Post Survey Results

The LGBTQ educational session was provided at two clinics. The LGBTQ educational session was provided to staff members on December 15th from 1300-1400 via the ZOOM platform due to the clinic not having in person staff meetings because of COVID-19 protocols. The chief operating officer of the clinic sent out a staff reminder email one week prior of the LGBTQ educational session notifying staff members who would be attending the LGBTQ educational session to fill out the LBGT-DOCSS pre-survey. The virtual staff meeting was an optional event for staff to attend. The chief operating officer sent out the survey monkey link of

the LGBT-DOCSS survey to staff members via email. The surveys were anonymous and staff members had a week to fill out the LGBTQ pre-survey before attending the LGBTQ educational session. Staff members who attended the LGBTQ educational session had a month to complete the LGBTQ post survey. The chief operating officer (COO) sent out a reminder email right after the LGBTQ educational session was provided. The COO also sent out a reminder email one week after the LGBTQ educational session was provided, reminding staff who had attended the LGBTQ session to fill out the LGBT-DOCSS post-survey. The LGBTQ educational session that was provided to staff members included LGBTQ health and terminology information from the LGBT Health Education Center. The presentation consisted of seventeen slides and a 45-minute ZOOM presentation. There were twenty-five questions on the LGBT-DOCSS pre-survey and twenty-seven questions on the LGBT-DOCSS post-survey. The survey consisted of seven demographic questions and eighteen questions that were LGBT-DOCSS survey questions. The two questions that were added to the LGBT-DOCSS post survey were open-ended questions asking staff what they had learned from the LGBTQ educational session and what they would like to learn more about in regard to LGBTQ healthcare. There was a total of thirty-one (N=31) staff members who completed the LGBT-DOCSS pre-survey and a total of eleven (N=11) staff members who completed the LGBT-DOCSS post-survey. Of the forty-two (N=42) staff members who completed the LGBT-DOCSS pre and post survey, a 100% of staff members were between the age group of 18-65 years old, with a mean age of 35-years-old. The respondents were 88% Caucasian and 12% Native American or Alaska Natives. The staff members who responded were 83% female and 17% male. There were also 97% of staff members who identified as straight or heterosexual and a 3% of staff members who identified within the

LGBTQ population as lesbian or gay. There were two (N=2) staff members who did not complete the LGBT-DOCSS pre and post surveys completely, therefore these two staff members were not included in the data collection. The job titles of the staff members who completed the pre and post LGBT-DOCSS surveys are also listed in Table 1. The two added on questions in the LGBTQ post-survey are in Table 2. These two tables are both listed below.

Table 1. Job Titles of Staff Members Who Completed Pre and Post LGBT-DOCSS Surveys

Job Titles						
Administration	**Nurses**	**NPs**	**Pharmacy**	**Receptionists**	**MDs**	**Therapists**
6	13	4	2	11	2	2

Table 2. Two Added on Questions in the LGBTQ Post-Survey

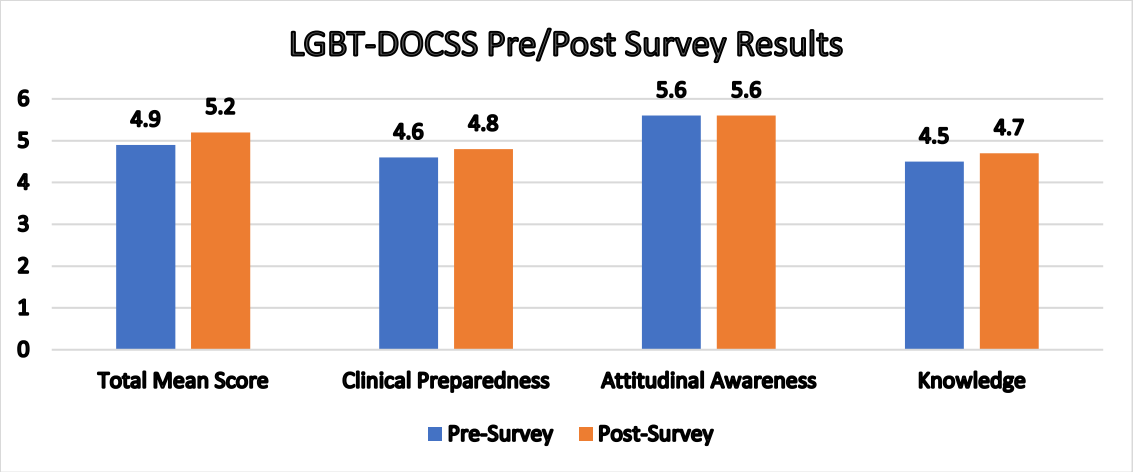
LGBT-DOCSS Post Survey Questions 26 & 27	
	Staff Responses
What was one valuable thing you learned about from this presentation?	○ Compassion ○ Life ○ How to make a patient more comfortable general trans info ○ Importance of client-centered care across all health disciplines. ○ How to take precautions when talking to patients and not assuming their gender ○ To continue to never assume gender/sexual orientation among patient population.
What was one topic you would like to learn more about in regards to LGBTQ health and communication?	○ Legal limitations ○ Hormone replacement ○ Enhancing protective factors in rural settings. ○ Any continued research to further promote positive patient outcomes is encouraged among all aspects of healthcare.

The LGBT-DOCSS survey uses a 7-point Likert scale (number 7=strongly agree, number 1= strongly disagree). The scale consists of 18 questions that ask about sexual orientation and gender identity. The survey addresses clinical preparedness in questions 4, 10, 11, 13, 14, 15, 16; attitudinal awareness in questions 3, 5, 7, 9, 12, 17, and 18; and knowledge is addressed in questions 1, 2, 6, 8. When scoring the LGBT-DOCSS surveys, all 18 questions are added to give the total raw score, then divided by 18 to equal the total mean score (Bidell, 2017). The scores can range from 18 to 126 (Bidell, 2017). Also, the sum of each subscale (clinical preparedness, attitudinal awareness, and knowledge) is added for the subscale total raw score and then divide by the number of questions in each subscale to get the subscale mean score (Bidell, 2017). The mean scores for the subscales can range from 1 to 7 (Bidell, 2017). Staff members who score higher scores on the LGBT-DOCSS in the total of all subscales show higher levels of clinical, developmental skills (Bidell, 2017).

Scores of 5 or greater on the LGBT-DOCSS surveys are informative of clinical preparedness, fundamental knowledge, and less prejudicial attitudinal awareness regarding LGBTQ patients (Bidell, 2017). There was a total of thirty-one (N=31) staff members who completed the LGBT-DOCSS pre-survey and a total of eleven (N=11) staff members who completed the LGBT-DOCSS post-survey. The staff members (N=42) total raw mean score increased from the LGBT-DOCSS survey of 4.9 to the LGBT-DOCSS post survey of 5.2. The staff members (N=42) clinical preparedness subscale mean score decreased from the LGBT-DOCSS survey of 4.6 to the LGBT-DOCSS post-survey of 4.8. The staff members (N=42) attitudinal awareness subscale mean score stayed the same from the LGBT-DOCSS pre-survey of 5.6 to the LGBT-DOCSS post-survey of 5.6. The staff members (N=42) knowledge subscale

mean score increased from 4.5 for the LGBT-DOCSS pre-survey to 4.7 for the LGBT-DOCSS post-survey. The Table 3. provides information on the results of the pre/post LGBT-DOCSS survey.

Table 3. Results of the Pre/Post LGBT-DOCSS Survey

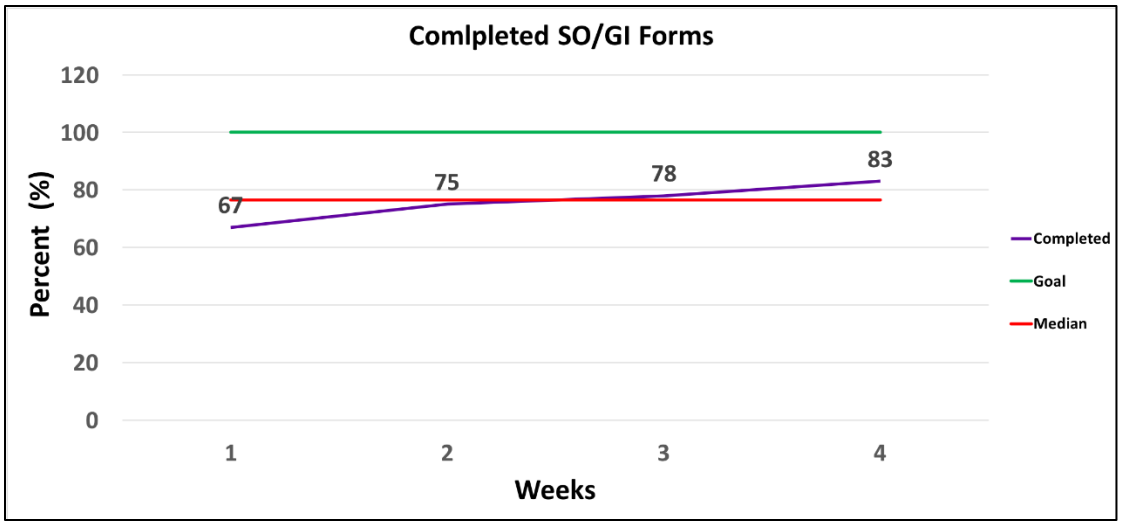


SO/GI Intake Form Results

The first PDSA cycle there were 67% of patients who filled out the SO/GI questions. There were ten (N=10) patients who filled out the SO/GI questions and five (N=5) patients who did not fill out the SO/GI questions. The SO/GI questions are on the back page of a two-page form. The first intervention that was implemented before starting the second PDSA cycle was educating all five receptionists to remind patients to fill out the front and back of the health survey forms during the check in process. The second PDSA cycle there were 75% of patents who filled out the SO/GI questions. Nine (N=9) patients who filled out the SO/GI questions and two (N=2) patients who did not fill out the SO/GI questions. The second intervention that was

implemented was to provide patients with a patient education pamphlet on the importance of answering SO/GI questions. The third PDSA cycle consisted of 78% of patients who filled out the SO/GI questions. Seven (N=7) patients who filled out the SO/GI questions and two (N=2) patients who did not fill out the SO/GI questions. The fourth PDSA cycle there were 83% of patients who filled out the SO/GI questions. Ten (N=10) patients filled out the SO/GI questions and two (N=2) patients did not fill out the SO/GI questions. Table 4. Provides information on the completed SO/GI forms.

Table 4. Information on the Completed SO/GI Forms



Summary

The results of this project found that post the LGBTQ educational session the staff members mean scores increased for the total mean scores, clinical preparedness, and knowledge. A mean score that is 5 or greater indicates that staff members are educative of clinical preparedness, fundamental knowledge, and less prejudicial attitudinal awareness

regarding LGBTQ patients. Staff members (N=42) total mean scores increased from 4.9 pre to 5.2 post. Staff members (N=42) mean score for clinical preparedness increased from 4.6 pre to 4.8 post. Staff members (N=42) mean scores for knowledge increased from 4.5 pre to 4.7. Staff members (N=42) attitudinal awareness remained the same at 5.6 pre/post. Four weekly PDSA cycles were completed to gather the percentage of SO/GI questions completed by patients. The four weekly PDSA cycles of completely filled out SO/GI questions results increased from 67% to 75% to 78% and to 83%. Receptionists started to remind patients to completely fill out their entire health survey forms front and back for the second PDSA cycle. The third PDSA cycle receptionists provided patients with a SO/GI pamphlet on the importance of asking about SO/GI questions. The outpatient clinic was also made more LGBTQ friendly by implementing a LGBTQ teaching tool called the "Genderbread Person" to all patient rooms, providing staff and providers with a LGBTQ patient resource handout, and adding a non-discrimination lobby statement that includes sexual orientation and gender identity.

CHAPTER 5

DISCUSSION

LGBTQ clinical competence is being adopted across health care facilities which is a recommended form of ethical care (Bidell, 2017). It is essential for health care organizations to develop LGBTQ clinical competence trainings and policies in order to provide LGBTQ clinical competence amongst staff members (Bidell, 2017). There are LGBTQ organizations that can help healthcare facilities incorporate these LGBTQ educational sessions into their facilities including the National LGBT Health Education Center at the Fenway Institute (Bidell, 2017). The National LGBT Health Education Center emphasizes that staff members need to achieve awareness of individual and societal LGBTQ prejudices and biases, develop appropriate clinical experience and skills to effectively treat LGBTQ patients, and gain working knowledge of LGBTQ psychosocial and health issues (Bidell, 2017).

LGBTQ Educational Session Findings

Scores that were 5 or greater on the LGBT-DOCSS survey were indicative that the staff members were informative of clinical development, have fundamental LGBTQ knowledge, and have less prejudicial attitudinal awareness for LGBTQ patients (Bidell, 2017). This QI project found that by providing staff members with an LGBTQ educational session the staff members were able to self-explore their LGBTQ clinical competencies which entailed clinical preparedness, attitudinal awareness, and basic knowledge (Bidell, 2017). The LGBT-DOCSS

scale revealed that staff members (N=42) total mean score, clinical preparedness, and basic knowledge all increased post the LGBTQ educational session.

The data showed that staff members did have increased improvements in clinical development, fundamental LGBTQ knowledge, and less prejudicial awareness for LGBTQ patients (Bidell, 2017). This increase for clinical preparedness showed that staff members learned from the LGBTQ educational session and that the staff members clinical learning experiences increased (Bidell, 2017). The increase in the mean score for knowledge showed that the staff members learned from the educational session on LGBTQ healthcare (Bidel, 2017).

The unaffected findings of the staff member's attitudinal awareness indicated that the staff members attitudinal awareness was already adequate pre the LGBTQ educational session (mean score 5 and higher), meaning that the staff members had adequate prejudicial attitudinal awareness for LGBTQ patients. Having less prejudice and bias attitudinal awareness shows that the staff members should be able to provide equal care to LGBTQ patients. The Joint Commission competencies and the Healthy People 2020 initiatives were also met during this QI project. These competencies were met by providing LGBTQ patient healthcare information during a telehealth staff training (Felsenstein et al., 2018; IOM, 2011).

SO/GI Question Findings

The short-term goal of this project was to have 100% of patients fill out the SO/GI questions within a four-week cycle. Four PDSA cycles were completed over the course of this QI project. The SO/GI questions were implemented into the patient's yearly health survey forms. The health survey form gets updated yearly when the patient checks in for their appointment.

The four weekly PDSA cycle of completely filled out SO/GI question results increased from 67% to 75% to 78% and to 83%. The receptionists ended up having to remind patients to completely fill out the health survey forms from front to back. With the receptionists reminding the patients to complete front and back of the health survey form, it increased how many patients completed the SO/GI questions for each PDSA cycle. Receptionists were also provided with SO/GI educational pamphlets and educated to give to patients who had questions about answering the SO/GI questions. The receptionists did not have any questions from patients in regards to the SO/GI questions, therefore the receptionists did not have to pass out the SO/GI pamphlets. With the increase of patients completing the SO/GI questions it was an indicator that patients were accepting of answering the SO/GI questions on the health survey forms, just as the literature had suggested (Cahill et al., 2014; Rullo et al., 2018). The recommended CDC two part gender identity and one part sexual orientation question was also utilized and implemented into the clinics health survey form permanently after this QI project was completed (CDC, 2020). The Joint Commission competencies and Healthy People 2020 initiatives were met during this QI project by facilitating disclosure of SO/GI questions into the patient health survey form (Felsenstein et al., 2018; IOM, 2011).

LGBTQ Educational Session Limitations

One of the challenges that was faced during this QI project involved the LGBTQ educational session being presented over ZOOM. By presenting the LGBTQ educational session virtually it made it challenging to collect pre and post LGBT-DOCSS surveys from the same staff members to get consistent data. The surveys were distributed via survey monkey, and it was

not possible to make sure that the same staff member responded to the pre and post survey. There was an uneven amount of pre and post surveys that were collected. There was a total of thirty-one (N=31) staff members who completed the LGBT-DOCSS pre-survey and a total of eleven (N=11) staff members who completed the LGBT-DOCSS post-survey. There was only six (N=6) staff members who filled out the post LGBT-DOCSS survey. Therefore, the clinics chief operating officer sent a reminder email one week after the LGBTQ educational session was provided to the staff who attended the session, reminding them to fill out the LGBT-DOCSS post-survey if they had filled out LGBT-DOCSS pre-survey. The LGBT-DOCSS post-survey was open for staff to complete one month post the LGBTQ educational session. The reminder email initiated five (N=5) more staff members to complete the LGBT-DOCSS post-survey, which increased the LGBT-DOCSS post data collection to a total of eleven (N=11).

With the LGBTQ educational session being presented via ZOOM it limited the opportunity for staff members to be comfortable enough to ask questions or engage in productive conversations amongst one another. There were over fifty participants who attended the one-time LGBTQ educational session. In the future, it would be beneficial for the clinic to incorporate multiple LGBTQ training sessions that involve small interactive discussion groups to enable staff members to become comfortable discussing LGBTQ health topics amongst one another.

SO/GI Question Limitations

This QI project involved working with five receptionists who provided patients with the health survey form with the SO/GI questions on it. During the data collection of the SO/GI questions the clinic was having a receptionist turnover. With the receptionist turnover it made it

challenging to get a consistent data collection for the four week PDSA cycle. The clinics receptionist turnover prompted me to increase my weekly check-ins from two to four times a week. There were two receptionists who quit working at the clinic during my QI project. The clinic was able to hire one new receptionist, who was trained on SO/GI collection, during my QI project. The check-ins during the QI project with the receptionists were to make sure that the receptionists were providing patients with the health survey forms before their appointments. The check ins with the receptionists were also to make sure that the receptionists were reminding patients to complete the health survey forms. For the first and second PDSA cycle, the QI project found that the receptionists were forgetting to remind patients to flip the health survey form over and have the patient answer all the questions on the back page. The SO/GI questions were implemented on the second page of the health survey form. For the third and fourth PDSA cycle the receptionists were reminding patients more often to complete the healthy survey form by setting reminders for themselves at their desk (sticky notes on computers and desks). They were also provided with the SO/GI pamphlets at their desks, which assisted in reminding the receptionists to have the patients complete all the questions on the health survey form. Encouraging the receptionists to remind patients to fill out the second page increased the percentage of patients completing the SO/GI questions each weekly PDSA cycle.

QI Project Strengths

This QI project allowed the clinic to maintain certification for National Committee for Quality Assurance (NCQA) recognition for a Patient Centered Medical Home (PCMH). The NCQA recognition highlights practices that follow medical evidence to deliver care and improve

its quality (National Committee for Quality Assurance, 2020). The PCMH model transforms patient care that is coordinated and delivered by emphasizing comprehensive, team-based care that places the patient at the center (National Committee for Quality Assurance, 2020). The PCMH model also leads to higher quality care at a lower cost (National Committee for Quality Assurance, 2020). This QI project provided practice improvement actions for improving care for LGBTQ patients and families that are linked to the PCMH standards. The practice actions have been adapted from LGBTQ published guides, such as the LGBTQ Health Center (National LGBTQAI+ Health Education Center, 2021). The LGBTQ practice actions that were incorporated into this clinic included adopting organizational policies prohibiting discrimination based on sexual orientation and gender identity, creating a physical environment inclusive of LGBTQ patients and families, training staff members on LGBTQ health issues, and identifying LGBTQ specific community resources and service providers (National LGBTQAI+ Health Education Center, 2021). The practice actions that were completed during this QI project were also part of meeting the Joint Commissions competencies and Healthy People 2020 initiatives for establishing quality LGBTQ healthcare.

During this QI project there was engaged leadership that demonstrated ongoing commitment to seeing this project through. When staff members have to take on a new data collection process, it can be normal to be concerned about added workload, patient questions, and staff resistance (Bidell, 2017). The staff members that were involved in the QI project (receptionists, providers, nurses, and administration) were flexible and willing to participate in this QI project. The receptionists did a great job on having the patient education brochures available in the waiting room for patients to access if they had questions about the SO/GI

questions. Although, the receptionists do feel better having the SO/GI pamphlets available in case they do have to provide proper education to patients about the SO/GI questions in the future. The lack of staff resistance allowed this QI project to be able to gather valuable LGBTQ data and for the QI project to be completed.

Feasibility and Sustainability

This QI project was found to be feasible and sustainable. The SO/GI questions that were added to the clinics health survey forms were added at no cost. The SO/GI questions that were implemented into the clinics health survey form will remain for the clinic to properly collect LGBTQ health data. The LGBTQ educational session that was provided to staff members covered evidence-based information from the National LGBTQIA+ Health Education Center. The National LGBTQAI+ Health Education Center (2021) website provides free and accessible LGBTQ learning webinars, educational programs, and publications that can continually accessed and implemented into the clinics continuing education and/or orientation process. I would recommend that the clinic continue to use staff meetings or comparable events to communicate why SO/GI questions and LGBTQ healthcare is a priority for clinic patients. I would also recommend that the clinic continue to train all staff on providing culturally responsive and inclusive services to LGBTQ patients. The clinic could initiate and incorporate online or in-person trainings that focus on basic terminology, health disparities, and effective communication strategies, which are available through the LGBTQIA+ Health Education Center website. LGBTQ training can also be provided yearly and be part of the clinic's staff orientation process or compliance trainings.

The long-term goal of this QI project is for the clinic to gather the SO/GI data, recognize LGBTQ health disparities, and provide evidence-based interventions to improve LGBTQ health outcomes. The health disparities that the LGBTQ community experience are having higher rates of mental health disorders, sexually transmitted diseases (STDs) especially Human Immunodeficiency Virus (HIV), violence, drug and alcohol abuse, isolation, poverty, and homelessness (Rowe et al., 2017; Healthy People, 2020; CDC, 2020). Collecting SO/GI data is a start to measuring, monitoring, and enhancing the stated above health disparities for the LGBTQ patients in this clinic (Rowe et al., 2017; Healthy People, 2020; CDC, 2020). In comparison, SO/GI data support the same purpose as race and ethnicity data in population health management by assisting health clinics to recognize health disparities in the LGBTQ patient population. Due to the SO/GI questions being implemented into the health survey forms at this clinic, the next step would be to have the quality improvement department begin developing summary reports for different populations based on SO/GI. The data collection can be implemented into existing population management and quality measure reports and presented to administration and at staff meetings. For example, quality measure that can be collected could be a blood pressure control measure that is classified by race, age, sexual orientation, and gender identity (National LGBTQAI+ Health Education Center, 2021).

DNP NONPF Competencies

The most relevant Nurse Practitioner Core Competencies (NONPF) that were utilized during this project include the policy competency, the independent competency, and the quality competency. The Policy Competency was accomplished in this QI project by implementing a

nondiscrimination policy in the clinic setting. The nondiscrimination policy will ensure that there is equitable care regardless of a patient's sexual orientation, gender identity, or expression. The nondiscrimination policy that was posted in the clinic waiting room demonstrates the clinic's commitment to equitable care for LGBTQ patients (NONPF, 2014). Implementation of a nondiscrimination policy that includes sexual orientation and gender identity indicates that advocation for this nondiscrimination policy has taken place and the nondiscrimination policy will initiate a safe and healthy practice environment for LGBTQ patients (NONPF, 2014).

The Independent Practice Competency and the Quality Competency were completed for this QI project by providing LGBTQ education to staff members in order for them to provide culturally sensitive LGBTQ patient care (NONPF, 2014). All clinic staff members were educated with a 45 min. LGBTQ educational presentation that included evidence-based information from the National LGBT Health Center website. The educational content that was provided to staff members included LGBTQ terminology, LGBTQ health disparities, LGBTQ communication techniques, and the importance of collecting SO/GI data in the EHR system. The goal of the QI project was to improve staff members clinical preparedness, attitude, and basic knowledge on LGBTQ care.

The Quality Competency was utilized by providing staff members with available LGBTQ evidence to continuously improve quality of LGBTQ clinical practices (NONPF, 2014). Part of making the clinic more LGBTQ friendly involved adding SO/GI brochures, LGBTQ-friendly symbols, a "Genderbread Person" teaching tool to each patient room, and a viewable nondiscrimination policy to the clinic waiting room. A Montana LGBTQ resource list of accessible state and national LGBTQ information was provided to all clinic providers to disperse

to their patients as needed. A long-term goal of this QI project includes having the clinic be able to provide high quality LGBTQ. Collecting SO/GI data, discovering LGBTQ health disparities, and providing evidence-based interventions to improve LGBTQ patient's quality of life.

Summary

The QI project was able to meet Joint Commission competencies and Healthy People 2020 initiatives by creating an inclusive LGBTQ environment, implementing SO/GI questions into the patient healthy survey form, and including LGBTQ patient care information in new and existing employee staff training (Felsenstein et al., 2018; IOM, 2011). The LGBT-DOCSS survey found that the staff members (N=42) total mean score, knowledge, and clinical preparedness increased post the LGBTQ educational session. SO/GI questions were also implemented into the clinic patient health survey form. Over a four-week PDSA cycle it was discovered that patients who had appointments and completed the SO/GI questions on the health survey form increased every week. It was supported by the fourth PDSA cycle that eight three percent of patients who were checking in for their appointments completely filled out the SO/GI questions. These findings show that the clinic patients were accepting of adding SO/GI questions to the yearly routine healthy survey form. A recommendation that resulted from this QI project included encouraging clinic administration and staff members to continue initiating LGBTQ training for staff members. The long-term goal of this QI project will be for the clinic to continue gathering SO/GI data, recognizing LGBTQ health disparities, and providing evidence-based interventions to improve the clinic's LGBTQ patient's health outcomes.

REFERENCES

American Psychiatric Association. (2020). *Mental health facts on bisexual populations*. Retrieved from www.psychiatriary.org.

Bidell, M. P. (2017). The lesbian, gay, bisexual, and transgender development of clinical skills scale (LGBTQ-DOCSS): establishing a new interdisciplinary self-assessment for health providers. *Journal of Homosexuality, 64*(10), 1432-1460.

B. Dagger. (2020, August 6th). *Personal communications*. [Personal interview].

Bonvicini, K. A. (2017). LGBTQ healthcare disparities: What progress have we made? *Patient Education and Counseling, 100*(12), 2357-2361.

Bjarnadottir, R.I., Bockting, W., & Dowding, D.W. (2017). Patient perspectives on answering questions about sexual orientation and gender identity: An integrative review. *Journal of Clinical Nursing, 26*(13-14), 1814-1833.

Cahill, S., Robbie, S., Grasso, C., King, D., Mayer, K., Baker, & Makadon, H. (2014). Do Ask, do tell: high levels of acceptability by patients of routine collection of sexual orientation and gender identity data in four diverse American community health centers. *PloS One, 9*(9), E107104.

Cahill, S. R., Baker, K., Deutsch, M. B., Keatley, J. & Makadon, H.J. (2016). Inclusion of sexual orientation and gender identity in stage 3 meaningful use guidelines: a huge step forward for LGBTQ health. *LGBTQ Health, 3*(2), 100-102.

Center for Disease Control and Prevention. (2020). *Collecting sexual orientation and gender identity information.* Retrieved from https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html.

Center for Disease Control and Prevention. (2019). *HIV and transgender communities.* Retrieved from https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf.

Center for Disease Control and Prevention. (2020). *Lesbian, gay, bisexual, and transgender health.* Retrieved from https://www.cdc.gov/LGBTQhealth/index.htm.

Center for Disease Control and Prevention. (2018). *Men who have sex with men.* Retrieved from https://www.cdc.gov/std/stats17/msm.htm.

Center of Excellence for Transgender Health University of California, San Francisco. (2017). Acknowledging gender and sex. Retrieved from https://prevention.ucsf.edu/transhealth/education/acknowledging-gender-sex.

Department of Health and Human Services (2016). Approved uniform data system changes for calendar year (PAL 2016-02). Health Resources and Services Administration, Washington, DC, 2016.

Farmer, G.W, Blosnich, J. R., Jabson, J.M., & Matthews, D.D. (2016). Gay acres: sexual orientation differences in health indicators among rural and non-rural Individuals. *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association*, *32*(3), 321-331.

Felsenstein, D. R. (2018). Enhancing lesbian, gay, bisexual, and transgender cultural competence in a midwestern primary care clinic setting. *Journal for Nurses in Professional Development, 34*(3), 1-150.

Fenway Health. (2020). Do ask, do tell. Retrieved from https://doaskdotell.org/ehr/toolkit/howtouse-2/.

Furness, B.W., Goldhammer, H. Montalvo, W., Gagnon, K., Bifulco, L., Lentine, D., & Anderson, Daren. (2020). Transforming primary care for lesbian, gay, bisexual, and transgender people: a collaborative quality improvement initiative. *Annals of Family Medicine, 18*(4), 292-302.

Grasso, C., McDowell, M. J., Goldhammer, H., & Keuroghlian, A. S. (2019). Planning and implementing sexual orientation and gender identity data collection in electronic health records. *Journal of the American Medical Informatics Association : JAMIA*, *26*(1), 66–70. https://doi.org/10.1093/jamia/ocy137.

Grasso, C., Goldhammer, H., Brown, R. J., & Furness, B.W. (2020). Using sexual orientation and gender identity data in electronic health records to assess for disparities in preventive health screening services. *International Journal of Medical Informatics (Shannon, Ireland), 142*, 104245.

Grasso, C. & Makadon, H. (2016). Do ask, do tell! collecting data on sexual orientation and gender identity in health centers. Retrieved from https://www.LGBTQiahealtheducation.org/wp-content/uploads/Collecting-SOGI-Data-Webinar-Final.pdf.

Hafeez, H., Zeshan, M., Tahir, M. A., Jahan, N., & Naveed, S. (2017). Health care disparities among lesbian, gay, bisexual, and transgender youth: a literature review. *Cureus*, *9*(4), e1184. https://doi.org/10.7759/cureus.1184.

Haider, A.H., Schneider, E. B, Kodadek, L. M, Adler, R.R, Ranjit, A. Torain, M. L., Brandyn D. (2017). Emergency Department Query for Patient-Centered Approaches to Sexual

Orientation and Gender Identity: The EQUALITY Study. *JAMA Internal Medicine, 177*(6), 819-828.

Institute of Medicine. (2013). *Collecting sexual orientation and gender identity data in electronic health records: workshop summary*. National Academies Press (US).

Institute for Healthcare Improvement. (2020). Plan-do-study-act (PDSA) worksheet. Retrieved from http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx.

Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academies Press. https://doi.org/10.17226/13128.

Israel, T., Willging, C., & Ley, D. (2016). Development and evaluation of training for rural LGBTQ mental health peer advocates. *Journal of Rural Mental Health, 40*(1), 40-62.

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: *National Center for Transgender Equality.*

Joint Commission. (2011). *Advancing effective communication, cultural competence, and patient-and family centered care for the lesbian, gay, bisexual, and transgender (LGBTQ) community- a field guide.* Retrieved from https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/LGBTQfieldguide_web_linked_verpdf.pdf?db=web&hash=FD725DC02CFE6E4F21A35EBD839BBE97.

Kodadek, L. M, Peterson, S., Shields, R. Y., German, D., Ranjit, A., Snyder, C., Haider, A.H. (2019). Collecting sexual orientation and gender identity information in the emergency department: The divide between patient and provider perspectives. *Emergency Medicine Journal*, *36*(3), 136-141.

Lindsay, Sally, Rezai, Mana, Kolne, Kendall, & Osten, Victoria. (2019). Outcomes of gender-sensitivity educational interventions for healthcare providers: A systematic review. *Health Education Journal*, *78*(8), 001789691985990-976.

Lindemann, N. (2019). What the average survey response rate? Retrieved from https://surveyanyplace.com/average-survey-response-rate/.

Marias Healthcare. (2020). *Mission statement*. Retrieved from https://mariashealth.org/.

Maragh-Bass, A.C., Torain, M., Adler, R., Ranjit, A., Schneider, E., Shields, R.Y., Haider, A. H. (2017). Is it okay to ask: transgender patient perspectives on sexual orientation and gender identity collection in healthcare. *Academic Emergency Medicine, 24*(6), 655-667.

Morris, M., Cooper, R.L., Ramesh, Aramandla, T., Mohammad, A., Thomas, A., Shinn, M., Matthews-Juarez, P. (2019). Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: A systematic review. *BMC Medical Education, 19*(1), 325-13.

Movement Advancement Project. (2019). *Where we call home-LGBTQ people in rural America*. Retrieved from https://www.LGBTQmap.org/file/LGBTQ-rural-report.pdf.

National Committee for Quality Assurance. (2020). PCMH benefits to practice, clinicians, patients. Retrieved from https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/benefits-support/benefits/.

National Gay and Lesbian Task Force. (2010). *Outing age 2010 Public policy issued affecting lesbian, gay, bisexual and transgender elders*. Retrieved from https://www.LGBTQagingcenter.org/resources/pdfs/OutingAge2010.pdf.

National LGBTQIA+ Health Education Center. (2020). *Achieving health equity for lesbian, gay, bisexual, transgender and queer (LGBTQ) people.* Retrieved from https://www.LGBTQiahealtheducation.org/resources/type/webinar/page/8/.

National LGBTQIA+ Health Education Center. (2017). *Collecting Sexual Orientation and Gender Identity (SO/GI) Data in Electronic Health Records*. Retrieved from https://www.LGBTQiahealtheducation.org/wp-content/uploads/2017/05/SOGI-Office-Hours-Update-Final.pdf.

National LGBTQIA+ Health Education Center. (2020). Ready, set, go- a guide for collecting data on sexual orientation and gender identity. Retrieved from https://www.LGBTQiahealtheducation.org/wp-content/uploads/2018/03/TFIE-47_Updates-2020-to-Ready-Set-Go-publication_6.29.20.pdf.

National LGBTQIA+ Health Education Center. (2020). Learning resources-collecting sexual orientation and gender identity data. Retrieved from https://www.LGBTQiahealtheducation.org/resources/in/collecting-sexual-orientation-and-gender-identity-data/.

National LGBT Health Education Center. (n.a.). Building patient-centered medical homes for lesbian, gay, bisexual, and transgender patients and families. Retrieved from https://www.lgbtqiahealtheducation.org/wp-content/uploads/Building-PCMH-for-LGBT-Patients-and-Families.pdf.

National Institute on Drug Abuse. (2018). *Substance Use and SUDS in LGBTQ populations* Retrieved from https://www.drugabuse.gov/drug-topics/substance-use-suds-in-LGBTQ-populations.

National LGBTQ cancer network. (2019). LGBTQ-patient-centered outcomes. Retrieved from https://cancer-network.org/wp-content/uploads/2017/02/LGBTQ-patient-centered-outcomes.pdf.

Nowaskie, D. Z., & Sowinski, J. S. (2018). Primary care providers' attitudes, practices, and knowledge in treating LGBTQ communities. *Journal of Homosexuality, 66*(13), 1927-1947.

Healthy People 2020. (2018). Lesbian, gay, bisexual, and transgender health. U.S. Department of Health and Human Services. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

NONPF. (2014). *Nurse practitioner core competencies.* Retrieved from https://cdn.ymaws.com/nonpf.site-ym.com/resource/resmgr/competencies/20170516_NPCoreCompsContentF.pdf.

Patterson, J. G, Jabson, T., Jennifer, M., & Kamen, C. (2019). Cultural competency and microaggressions in the provision of care to LGBTQ patients in rural and Appalachian Tennessee. *Patient Education and Counseling, 102*(11), 2081-2090.

Pinto, A. D., Aratangy, T., Abramovich, A., Devotta, K., Nisenbaum, R., Wang, R., & Kiran, T. (2019, January 21). Routine collection of sexual orientation and gender identity data: a mixed-methods study. *CMAJ: Canadian Medical Association Journal, 191*(3), E63+. https://link.gale.com/apps/doc/A570818851/HWRC?u=mtlib_1_1123&sid=HWRC&xid=63779f46

Rowe, D., Chye, Y.N., Louise, O. & Crawford, D. (2017). *Providers' attitudes and knowledge of lesbian, gay, bisexual, and transgender health.* Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6370394/pdf/fp-34-11-28.pdf.

Ruben, M. A, Shipherd, J.C, Topor, D., AhnAllen, C. G., Sloan, C. A, Walton, H.M., Trezza, G. R. (2017). Advancing LGBTQ health care policies and clinical care within a large academic health care system: a case study. *Journal of Homosexuality: Lesbian, Gay, Bisexual, and Transgender Clinical Competencies, Professional Training, and Ethical Care, 64*(10), 1411-1431.

Rullo, J. E., Foxen, J. L., Griffin, J. M., Geske, J.R., Gonzalez, C. A., Faubion, S. S., & Van R., M. (2018). Patient acceptance of sexual orientation and gender identity questions on

intake forms in outpatient clinics: a pragmatic randomized multisite trial. *Health Services Research*, *53*(5), 3790-3808.

SAMSHA. (2018). *2018 National Survey on drug and health: lesbian, gay, & bisexual (LGB) adults.* Retrieved from https://www.samhsa.gov/data/report/2018-nsduh-lesbian-gay-bisexual-lgb-adults.

SAMSHA. (2012). *Top health issues for LGBTQ populations*. Retrieved from https://store.samhsa.gov/product/top-health-issues-LGBTQ-populations/sma12-4684.

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

Tavakol., M. & Dennick, R. (2011). Making sense of cronbach's alpha. *International Journal of Medical Education. 2:53-55.*

United States Department of Health and Human Services: Health Resource and Services Administration. (April 2011). *Developing and implementing a QI plan.* Retrieved from www.hrsa.gov/quality/toolbox/508pdfs/developingqiplan.pdf.

William Institute. (2020). Adult LGBTQ population in the united states. Retrieved from https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBTQ-Adult-US-Pop-Jul-2020.pdf.

APPENDICES

APPENDIX A

EVIDENCE TABLE

Evidence Table

Citation	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definition	Measurement of Major Variables	Data Synthesis	Study Findings	Strength of evidence
Rowe et al. (2017)	The Process of Cultural Competence in the Delivery of Healthcare Services by Campinha-Bacote	Descriptive cross-sectional one-group design	VA Southern Nevada Healthcare System-NPs & PAs, n=45 included surveys that were completely answered, n=72 were returned n=12 unanswered questions n=14 not returned Overall response rate for completed surveys was 62.5% Participation in the project was voluntary	**IV:** survey **DV:** attitudes & knowledge of LGBTQ health with organizational policies on discrimination, visitation, staff training in LGBTQ care	General Attitudes Toward LGBTQ Nonpatients-Cronbach α 0.70-0.78 ATLG - Cronbach α 0.5 KLGBTQ- Cronbach α 0.74 GSMAP- Cronbach α 0.93- 0.94	Calculated the mean scored for each 4 measures Analysis of variance, ANOVA	Attitudes Toward Care- 51.1% (n=23) of PCPs agreed that they were competent to provide LGBTQ care, and 15.5% (N=7) disagreed Attitudes towards adequacy of medical training to address health needs of LGBTQ-29% (n=13) of PCPs agreed they were trained adequately, 51.1% disagreed (n=23)	**Level of Evidence: IV** **Strengths:** Findings showed that there is a need for additional educational and training involving LGBTQ health issues. **Limitations:** small convenience sample, lack of randomization and blinding in survey distribution, true/false participants has a 50% change of guessing,

			Duration of project was 4 months from data collection to completion of analysis and summation of results				Knowledge level response among PCPs was not found to be statistically significant- > 50% of PCPs responded currently to true/false questions about prevalence of depression, anxiety, alcohol use, substance use, STIs, physical and sexual trauma in LGBTQ , <50% correctly answered true in 2 knowledge areas of LGBTQ health, increased prevalence of tobacco use, obesity/overweight; greater risk for chronic disease	

Felsenstein (2018)	Lippitt's change theory	QI project	11 clinic staff-primary care clinic located in urban area in the midwestern region in the U.S. Stakeholders: Project leaders, project advisor, statistician, clinic director, clinic manager Computer based module and panel discussion	**IV:** staff knowledge intervention, clinic environment intervention, SO/GI intake questions intervention **DV:** enhance patients care in a primary care clinic by incorporating three LGBTQ cultural competencies **DV:** Increase staff knowledge on LGBTQ patient care by 60% on pretest to posttest scores.	Joint Commission Checklist & Assessment forms pre-post tests	Project advisor & statistician approved face validity of assessments	Module intervention showed statistically significant increase of staff LGBTQ knowledge from pretest to posttest, p=.033 Evaluation after the panel discussion showed that 72% of staff indicated they were more prepared for LGBTQ patient care.	**Level of Evidence: IV** **Strengths:** aim of the study was met, all three cultural competencies were implemented in this clinic's patient care **Weaknesses:** small sample size, clinical site for this QI project was small with a limited number of staff employees, patient population was low, results not generalizable to other healthcare settings
Rullo et al., (2018)	N/A	Two phase mixed method study – experimental /qualitative	SO/GI collected at 3 outpatient clinics between 6/29/2015-2/29/2016 in a large academic medical center	**IV:** Intake forms-routine (control)-n=273	Demographic, social and questionnaire-phase 1 & 2	SAS version 9.4, x2 tests & tests NVIVO 10 for data management	No significant differences in patient attitude between experimental and control groups (p >.0.05)	**Level of Evidence: II** **Strengths:** Collection of SOGI data as part of routine clinical patient intake process in not

			Phase 1-pramatized randomization (experimental) Phase 2- interview (qualitative) Women's health clinic, continuity care clinic, primary care clinic Participants: women, advanced age, rural population New patients at 3 sites were randomly assigned to complete either routine intake forms (control) or routine intake forms with SO/GI questions	**IV:** Intake forms with SO/GI questions (experimental) n= 218 **DV:** patient concerns about SO/GI data			Only 3% reported being distressed, upset, or offended by the SO/GI questions.	distressing to 97 percent of patients who are heterosexual, cisgender, and older than 50 years. **Limitations:** only addressed frontline SOGI data collection in an almost exclusively white, heterosexual patient population.

Grasso et al. (2020)	N/A	Retrospective study	5 FQHCs extracted three consecutive months of HER patient data on SOGI and routine screening for cervical cancer, tobaccos use, and clinical depression Jan 2017-March 2017 IRB approved-Community Health Center, inc.	**IV:** SO/GI measures, Preventative health screening measures (cervical screening, tobacco and depression screening) **DV:** disparities of LGBTQ patients	In accordance to HRSA UDS 2017 instructions Table 1, pg. 3	Chi-square and Fisher's exact test	Within each FQHC there were statistically significant associations ($p < 0.05$) between SOGI categories In all FQHCs cervical cancer screening percentage were lower among lesbian, gay patients than among bisexual and straight heterosexual patients. 3 FQHCs, cervical cancer screening percentages were lower for transgender men than for cisgender (i.e., not transgender) women.	**Level of Evidence : III** **Strengths:** first known published report of using SOGO data from EHR to detect potential disparities in healthcare services to LGBTQ patients. **Limitations:** small number of transgender patients, HER functionality caused challenges in interpretation of SOGI data
Furness et al. (2020)	PDSA framework	Collaborative Quality Improvement Initiative	1,367 FQHCS serving 441,387 patients in 123 clinical sites in 9	**IV:** Implement Practice Improvement Collaborative Project ECHO models	Practice Assessment Survey	Stata Version 15	The intervention spread from 10 clinicians in 10 clinical sites to 431 clinicians in 79 clinical sites. FQHCs reported increases in culturally affirming	**Level of Evidence: IV** **Strengths:** brought together 10 dispersed

			states. 1 year intervention. FQHC teams received coaching in creating LGBTQ-inclusive environments, collecting sexual orientation and gender identity (SOGI) data, taking risk-based sexual histories, and screening LGBTQ people for syphilis, chlamydia and gonorrhea, and HIV. We used a preintervention-postintervention evaluation design (1) create more LGBTQ-affirming practice environments to ensure inclusion and safety; (2) improve collection, capture, and reporting of SOGI in the EHR; (3) improve collection, capture, and reporting of risk-based sexual	**DV:** Percentage of HIV-unknown LGBTQ patients screened for HIV **DV:** Percentage of LGBTQ patients screened for chlamydia and gonorrhea **DV**: Percentage of LGBTQ patients screened for syphilis **DV:** Percentage of LGBTQ patients who received risk-based sexual health screening **DV:** Percentage of patients with SOGI documentation			practices, including collecting patient pronoun information (42.9% increase) and identifying LGBTQ patient liaisons (300.0% increase). Postintervention, among 9 FQHCs reporting SOGI data from electronic health records, SOGI documentation increased from 13.5% to 50.8% of patients (276.3% increase). Among 8 FQHCs reporting number of LGBTQ patients, screening of LGBTQ patients increased from 22.3% (95% CI, 4.9%-40.0%) to 34.6% (95% CI, 19.4%-48.6%) for syphilis (86.5% increase); from 25.3% (95% CI, 7.6%-43.1%) to 44.1% (95% CI, 30.2%- 58.1%) for chlamydia and gonorrhea (109.0% increase); and from 14.8% (95% CI, 3.2%-26.5%) to 30.5% (95% CI, 26.7%-34.3%) for HIV (132.4% increase)	GQHCs to participate in an intensive 1 year intervention. The project was ground breaking and focused on LGBTQ health care and included Practice Improvement Collaborative and Project ECHO. **Limitations:** QI, project so there was no comparison control group. It was not possible to infer a causal relationship between the intervention and the increase in screening

			health histories of LGBTQ patients in order to determine need, frequency, and anatomic sites for STD and HIV testing; and (4) increase the percentage of LGBTQ patients receiving appropriate STD and HIV screening					
Pinto et al., 2020	N/A	Mixed method study	St. Michael's Hospital Academic Family Health Team Large primary care organizations with 6 sites in downtown Toronto, Canada N= 15221 patients	**IV:** patient interviews & SOGI questions **DV**: patients reactions to being asked about routinely about their SO/GI	Quantitative: SO/GI survey questions on survey Qualitative: 27 structured, individual interviews	NVivo 9	Most respondents answered the sexual orientation (90.6%) and gender identity (96.1%) questions. Many patients who had been classified as transgender or gender diverse in their medical chart did not self-identity as transgender, but rather selected female (22.9%) or male (15.4%). Interview: patient expressed appreciation at the variety of options available, although some did not see their identities reflected in the options and some felt uncomfortable	**Level of evidence: IV** **Strengths:** high response rate to questions on sexual orientation and gender identity when posed to patients in a primary care setting on a routinely administered survey in the waiting room.

			Dec 2013-Mar 2016- sociodemographic survey May 2016-July 2016- patient interview Semi structured interviews with 27 patients after survey completion				answering the questions.	**Limitations:** based on the experience of a single institution in an urban setting & did not explore how patient comfort is influenced by their relationship with the patient's provider, or the sexual orientation and gender identity of their provider
Kodadek et al., 2019	N/A	Multiphase mixed methods	Baltimore and Washington, DC metropolitan area ED providers- nurses, PA, or Physicians in current ER medicine practice All participants received a $35 gift car and remuneration for their time	**IV:** exploration of differing perspectives among patient and providers concerning collection and use of SO/GI in the ED **DV:** patients and providers perception of collecting SO/GI	Semi structured interviews	Constant comparative method	Patients perceived collection of SO/GI to be important in most clinical circumstances because SO/GI is relevant to their identity and allows providers to treat the whole person	**Level of evidence: IV** **Strengths:** ED clinicians do not perceive routine collection of SO/GI to be medically relevant in most circumstances. Patients feel routine SO/GI collection allows for recognition of individual identity and

			Patients were recruited using flyers, social media, community outreach Interview were one-on-one in person, audio recorded, transcribed verbatim N= 53 patient participants and N= 26 provider participants Purposive sampling					improved therapeutic relationships in the ED **Limitations:** metropolitan area, not generalizable. Adult study, not generalizable to adolescent population. Purposively sample, may not reflect the perspectives of patients and providers generally.
Cahill et al. (2014)	N/A	Randomized survey	Study addressed 2 questions N=301 patients at 4 CHARN-affiliated CHCs	**IV:** acceptable way to ask patients about SO/GI and documenting their responses	5 min. survey 2-step method SO/GI questionnaire	Fenway Institute approved questions on survey	¾ participants from the 4 CHCs said that asking about SO registration forms is important (74% agreed that this was important vs. 25% who disagreed) 82% vs. 17% reported that asking about GI is important. Most respondents agreed	**Level of Evidence: VI** **Strengths:** study provides evidence that integrating SO/GI data collection into the meaningful use

			Inclusion: patients 18 yrs. >, and able to read and comprehensive in English	**IV:** How do patients survey responses differ based on SO/GI and other demographic variables? **DV:** better understand how a diverse group of patients will respond if SO/GI questions were asked in primary care setting			that they "understood" what the question was asking them	requirements is both acceptable and to diverse samples of patients, including heterosexuals and feasible. **Limitations:** collection occurred 2 week time frame not all health centers had the opportunity to complete a survey, no show appointments did not get surveyed
Cahill et al., (2016)	N/A	CMS Meaningful Use Guideline	N/A	**N/A**	N/A	N/A	Centers for Medicare and Medicaid Services and the Office of the National Coordinator for Health Information Technology in October 2015 require electronic health record software certified for Meaningful Use to include sexual orientation and gender identity (SO/GI) fields.	This is a critical step toward making SO/GI data collection a standard practice in clinical settings. Sexual orientation identity—whether one identifies as gay, lesbian, or bisexual—correlates with behavioral health burden, and it is important to collect these data. Providers should also collect sex assigned at birth data as well as current gender identity data. Training of clinical staff in collection and use of

								SO/GI data, education of LGBTQ patients, and SO/GI nondiscrimination policies are critical for successful implementation.
Maragh-Bass (2017)	N/A	Qualitative in-depth interview study	National sample of self-identified transgender people through a market research firm Demographic questions, survey questions, and free response comments regarding their views on SO/GI collection Inclusion: 18 yrs. >, English language proficient N=186 participants	**DV:** Evaluate patient-centered approaches for collecting SO/GI in ED	Qualitative survey	Descriptive statistics Inductive content analysis-open ended responses	Patients felt that it was more important for primary care providers to know their GI than SO (89.1% vs. 57%; $p < 0.001$); there was no difference among reported importance for ED providers to know the patients' SO versus GI. Females were more likely than males to report medical relevance to chief complaint as a facilitator to SO disclosure (89.1% vs. 80%; $p = 0.02$) and less likely to identify routine collection from all patients as a facilitator to GI disclosure (67.4% vs. 78.2%; $p = 0.09$). Qualitatively, many patients reported that medical relevance to chief complaint and an LGBTQ-friendly environment would increase willingness to disclose their SO/GI. Patients also reported need for educating providers in LGBTQ health prior to	**Level of evidence: VI** **Strengths:** Patients see the importance of providing GI more than SO to providers; nonetheless they are willing to disclose SO/GI in general.. Findings also suggest that gender differences may exist in facilitators of SO/ GI disclosure **Limitations:** less generalizable due to questions geared towards ED setting or primary care setting

							implementing routine SO/ GI collection.	
Haider et al., (2017)	N/A	exploratory, sequential, mixed-methods de-sign	Purposive sample, ED professional participants included - physicians, nurses, advanced practice clinicians 3 community and 2 academic medical centers in northeastern U.S. Semi-structured in depth, 1 on 1 interview, recruited through community outreach	Qualitative interviews were used to obtain the perspectives of patients and health care professionals on sexual orientation data collection, and a quantitative survey was used to gauge patients' and health care professionals' willingness to provide or obtain sexual orientation information	2 step SO/GI method- qualitative interviews 45 question quantitative survey	Likert scale- quantitative Atlas TI analysis- qualitative	Qualitative interviews suggested that patients were less likely to refuse to provide sexual orientation than providers expected. Nationally, 154 patients (10.3%) reported that they would refuse to provide sexual orientation; however, 333 (77.8%) of all clinicians thought patients would refuse to provide sexual orientation.	**Level of Evidence**: VI **Strengths:** Patients and healthcare professionals have discordant views on routine collection of data on sexual orientation. A minority of patients would refuse to provide sexual orientation. Implementation of a standardized, patient-centered approach for routine collection of sexual orientation data is required on a national scale to help to identify and address health disparities among lesbian, gay, and bisexual populations. **Limitations:** one region of the U.S. not generalizable

			Inclusion: 18 yrs. >, achievement of thematic saturation					
Bjarnadottir et al., 2017	N/A	Integrative review design	6 electronic databases 21 studies-qualitative synthesis Published 1985-2015, LGBTQ participants, 5 countries, 9 qualitative & 11 quantitative	studies indicated patients' willingness to respond to, and a perceived importance of, questions about sexual orientation and gender identity.	methodology proposed by Whittemore and Knafl (2005)- research checklist	Quality appraisal tools- cross sectional descriptive studies-11 question appraisal tool	This review indicates that in most cases patients are willing to answer routine questions about their sexual orientation in the healthcare setting and perceive them as important questions to ask	**Level of Evidence: II** **Strengths:** The findings of this review have implications for nurses looking to incorporate questions about sexual orientation into their routine patient assessment. The findings indicate that care providers need to be mindful of heteronormative assumptions and take steps to ensure they are knowledgeable about lesbian, gay, bisexual and transgender health

								Limitations: None of the papers identified in this review assessed differences in acceptability or willingness to respond based on different phrasing or structure of questions. Therefore, while the findings indicate a general willingness to respond to questions about sexual orientation, the specific questions to ask and how to ask them were outside the scope of this review
Ruben et al. (2017)	N/A	Meta-analysis review	38 studies **Inclusion**: Quantitative and qualitative articles, peer reviewed, number	identify the overall proportion of sexual orientation disclosure to healthcare providers, facilitators and barriers of disclosure, patient populations less likely to disclose, and the relationship between	The two authors independently extracted proportions from each study	Meta-analysis software package	Sexual orientation disclosure proportions to healthcare providers ranged from .29 to .98. The random-effects pooled estimate was .63 (95% CI: .58, .68). Disclosure compared to nondisclosure was related to more positive direct and	**Level of Evidence: I** **Strengths:** This meta-analysis is the first systematic collection of published literature on patients' verbal sexual orientation disclosure to healthcare providers and

			of patients who disclosed their SO to a healthcare provider **Exclusion:** they included disclosure about sexual behavior or practices without mention of sexual identity (e.g., studies were not included that reported patients having unprotected sex with a same-sex sexual partner) (k = 16), and did not include a rate or frequency of disclosure (k = 16)	disclosure and outcomes			indirect health outcomes including higher satisfaction, more healthcare seeking and screenings and better self-reported health and psychological wellbeing.	disclosure's relation to outcomes **Limitations:** the restriction in characteristics measured in the original studies
Brooks et al. (2017)	N/A	Systematic review	8 databases- AMED, CINAHL, Embase, MEDLINE, PsycINFO, RCNi, ScienceDirect, and Web of Science) was conducted in March 2017 Published after 2000, n=31 studies, 2442 participants final search conducted was: ((disclos* OR reveal* OR openness) AND (lgb* OR gay OR bisexual OR lesbian OR msm OR wsw OR homosex*) AND (health* OR care OR consult*)). Inclusion: > 18 y.o. who either identified as LGBTQ, had a	Understand the barriers and facilitators to SO by LGBTQ adults in healthcare settings	N/A	MMAT & Qualitative synthesis	The environment in which patients are seen should be welcoming of different SOs as well as ensuring that healthcare professional communication skills, both verbal and nonverbal, are accepting and inclusive	**Level of evidence: I** **Strengths:** first review to include participants that are both men and women as well as any sexual LGBTQ subgroups **Limitations:** participants from each study were largely homogenous, comprising mostly well-educated, white, middle-aged people, who are

			same-sex sexual relationship, or were attracted to a member of the same sex					the groups most likely to disclose their SO

KEY

Nurse Practitioners- NPs

Physician Assistants- PAs

Gender and Sexual Minority Affirmative Practice- GSMAP

Knowledge of LGBTQ patients- KLGBTQ

Physicians Attitudes Toward LGBTQ patients- ATLG

SO/GI- Sexual Orientation and Gender Identity

Federally qualified health centers- FQHCs

Extension for Community Health Outcomes-ECHO

Emergency Room-ER

Physician Assistant-PA

Years- yrs.

Mixed Methods Appraisal Tool- MMAT

APPENDIX B

SWOT ANALYSIS OF SO/GI QUESTIONS ON PATIENT INTAKE FORMS

SWOT Analysis of SO/GI Questions on Patient Intake Forms	
Strengths • Support from administration, site representative, and QI representative • Affordable evidence based intervention • LGBTQ population at clinic site • Improve knowledge, clinical skills, and attitudes of staff members on LGBTQ care. • Clinic will be able to provide more culturally competent care to LGBTQ patients, families, and the community. • Following Health People 2020 Goals, CDC recommendations, Institute of Medicine for LGBTQ healthcare	**Weaknesses** • Long term goals will not be able to be reached during the timeframe of this project. • No continuous educational session will be put into place for the clinics future use to educate staff on LGBTQ care during this project.
Opportunities • Obtain data on LGBTQ health disparities • Provide clinic the opportunity to improve health services for the LGBTQ community • Obtain patient satisfaction results specifically to the LGBTQ population • Clinic can incorporate LGBTQ health education into staff members continuing education requirements.	**Threats** • COVID-19 protocols • Staff resistance • Optional staff meeting for LGBTQ educational session • Rural clinic • Patients not filling out the SO/GI questions on patient intake form.

• Follow Meaningful Use EHR Incentive Program guidelines by appropriately collecting SO/GI information. • Piloting SO/GI questions in the clinic department could help with implementing this process in the hospital setting for the future.	• Lack of communication between staff members and patients about SO/GI questions.

APPENDIX C

PROCEDURES/IMPLEMENTATION PLAN

Procedures/Implementation Plan
November 2020 • Submission of exempt application to the IRB- MSU Bozeman **December 2020** • Meet with QI representative and finalize SO/GI Questions for patient intake forms. • Send out email invite to all clinic staff members to attend the LGBTQ and SO/GI educational session. • Provide LGBTQ and SO/GI educational session. • Provide pre/posttest at educational session to staff members who attend. **January 2020** • Implement SO/GI Questions into patient intake forms**.** • Obtain the percentage of patients who fill out the SO/GI questions over a 4 week timeframe. • Check in with front desk staff twice a week in order to make adjustments to the SO/GI collection process if needed. • Collect data in Excel with Run Charts of the SO/GI data. • Provide Clinic with inclusive LGBTQ nondiscrimination statement, LGBTQ resources list for patients, and a viewable LGBTQ symbol to the waiting room. **May 2020** • Completion and Presentation of DNP Project

APPENDIX D

SEXUAL ORIENTATION/GENDER IDENTITY

PATIENT INTAKE FORM QUESTIONS

Sexual Orientation/Gender Identity-Patient Intake Form Questions

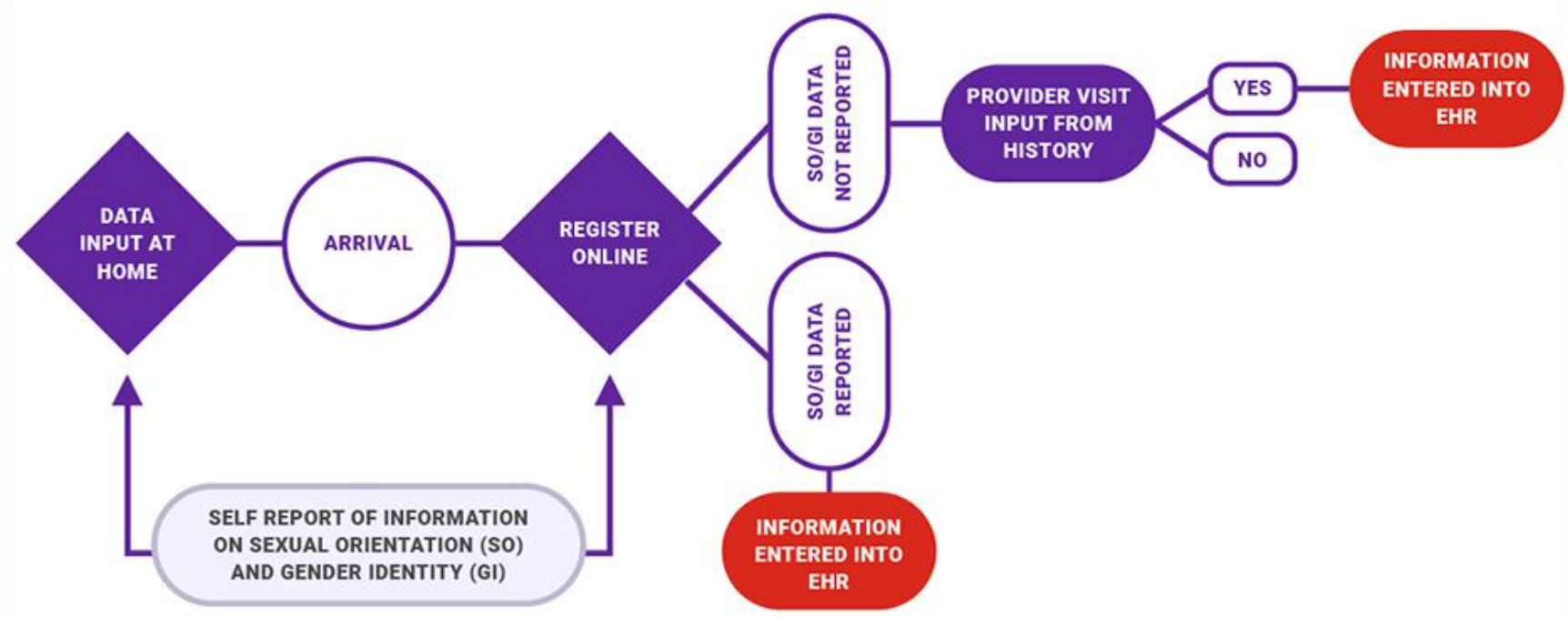
Sexual Orientation	
Do you think of yourself as:	○ Straight or heterosexual ○ Lesbian or gay ○ Bisexual ○ Queer, pansexual, and/or questioning ○ Something else; please specify: _____ ○ Don't know ○ Decline to answer
Gender Identity	
Do you think of yourself as:	○ Male ○ Female ○ Transgender man/trans, man/female-to-male (FTM) ○ Transgender woman/trans, woman/male-to-female (MTF) ○ Genderqueer/gender nonconforming neither exclusively male nor female ○ Additional gender category (or other); please specify: _____ ○ Decline to answer
What sex was originally listed on your birth certificate?	○ Male ○ Female ○ Decline to answer

Name and Pronouns	
What is your name as you would like it to appear on your health records? _____	
What are your pronouns?	○ He/him ○ She/her ○ They/them ○ Other: _____

APPENDIX E

SAMPLE PROCESS FOR COLLECTING DATA FROM PATIENTS IN CLINICAL SETTINGS

Sample Process for Collecting Data From Patients in Clinical Settings



(CDC, 2020

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APPENDIX F

LGBT DOCSS

Instructions: Items on this scale are intended to examine clinical preparedness, attitudes, and basic knowledge regarding lesbian, gay, bisexual, and transgender (LGBT) clients/patients. Please use the provided scale to rate your level of agreement or disagreement for each item. Please note, items on this scale primarily inquire about either sexual orientation (LGB = lesbian, gay, and bisexual) or gender identity (transgender). Two questions are inclusive and refer collectively to lesbian, gay, bisexual, and transgender (LGBT) clients/ patients.

1. I am aware of institutional barriers that may inhibit transgender people from using health care services.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

2. I am aware of institutional barriers that may inhibit LGB people from using health services.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

3. I think being transgender is a mental disorder.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

4. I would feel unprepared talking with a LGBT client/patient about issues related to their sexual orientation or gender identity.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

6. I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

8. I am aware of research indicating that transgender individuals experience disproportionate levels of health and mental health problems compared to cisgender individuals.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

11. I have received adequate clinical training and supervision to work with lesbian, gay, and bisexual (LGB) clients/patients

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

13. I have experience working with LGB clients/patients.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

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

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

17. People who dress opposite to their biological sex have a perversion.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

18. I would be morally uncomfortable working with a LGBT client/patient.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

Scoring Instruction for the LGBT-DOCSS

1) Reverse score all 8 questions in parentheses: (3), (4), (5), (7), (9), (12), (17), and (18). Use the reverse scoring Likert scale (1 = 7, 2 = 6, 3 = 5, 4 = 4, 5 = 3, 6 = 2, 7 = 1).

2) Calculate total LGBT-DOCSS mean score: Add all test items (using the reverse score for items in parentheses) and divide by 18.

The total LGBT-DOCSS mean score is equal to: 1 + 2 + (3) + (4) + (5) + 6 + (7) + 8 + (9) + 10 + 11 + (12) + 13 + 14 + 15 + 16 + (17) + (18) = LGBT-DOCSS Total Raw Score. Divide by 18 to obtain mean score.

3) Calculate Subscale scores: For each subscale, add up the scores of the questions listed (using the reverse score for items in parentheses) and divide by the number of questions in each subscale.

Clinical Preparedness subscale: (4) + 10 + 11 + 13 + 14 + 15 + 16 = LGBT-DOCSS Clinical Preparedness subscale Total Raw Score. Divide by 7 to obtain mean score.

Attitudes subscale: (3) + (5) + (7) + (9) + (12) + (17) + (18) = LGBT-DOCSS Attitudes subscale Total Raw Score. Divide by 7 to obtain mean score.

Knowledge: 1 + 2 + 6 + 8 = LGBT-DOCSS Knowledge subscale Total Raw Score. Divide by 4 to obtain mean score.

4) Higher scores are indicative of higher levels of clinical preparedness and rudimentary knowledge and less prejudicial attitudinal awareness regarding LGBT clients/patients. Scoring instructions are not initially provided to potential respondents and typically not provided to research participants.