CULTURAL COMPETENCY IN NURSING EDUCATION: ELIMINATING LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH DISPARITIES

by

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Abstract

Purpose: Lesbian, gay, bisexual, and transgender (LGBT) individuals face increasing health disparities linked to discrimination, social stigma, biases, and culturally incompetent health providers. LGBT cultural competence training is recommended for integration in all health professional curricula. Improving knowledge is linked to aid in eliminating LGBT health disparities. A gap exists between recommendation and the practice of educating on LGBT cultural competence. The purpose of this evidence-based change project is to initiate LGBT cultural competence education in a nursing course aimed to improve knowledge among nursing students. **Methods**: Last-term nursing students (n=10) participated in a one-group pretest-posttest educational intervention including simulation. The guiding framework was Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare Services (2007) and FIRST^{2}ACT simulation model. Instruments used for data collection included The LGBT Cultural Competency Questionnaire, simulation reflections, and program evaluations. **Results**: Results from the pre/posttest LGBT questionnaire revealed a positive improvement between the mean pretest 7.8 (48.8%) and mean posttest 15.4 (96.3%) scores with an overall group mean difference between pre and post means of 7.6 (97.4%). **Conclusion**: Students' knowledge of LGBT cultural competency improved post-educational intervention, indicating that the teaching methods used had a positive impact and further investigation is needed to assess how the intervention, when applied on a larger scale across other institutions, can improve nursing and other health professional knowledge of LGBT cultural competence. This paper will discuss the process used for the development, implementation, and evaluation of integrating LGBT cultural competency in nursing education.

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Cultural Competency in Nursing Education: Eliminating Lesbian, Gay, Bisexual, and Transgender Health Disparities

Chapter One: Introduction and Overview of the Problem of Interest

Nurses are expected to care for diverse patient populations upon graduating nursing school. Without education in understanding the various diverse populations, multiple health disparities occur. One diverse population is the Lesbian, gay, bisexual, and transgender (LGBT) population. Currently, cultural competency content is lacking in nursing curricula to equip students with the proper skill sets for providing culturally competent care for LGBT individuals (Browne, Woltman, Tumarkin, Dyer, & Buchbinder, 2008; Fenway Health Institute [FHI], National LGBT Health Education Center, 2012; Truman et al., 2011; U.S. Department of Health & Human Services [HHS], Healthy People 2020, 2013; and Winter, 2012). LGBT cultural incompetence has been linked to increased health disparities and increased medical expenditures (Browne, Woltman, Tumarkin, Dyer, & Buchbinder, 2008; FHI, National LGBT Health Education Center, 2012; Truman et al., 2011; National Conference of State Legislatures [NCSL], 2012; HHS, Healthy People 2020, 2013; and Winter, 2012). If proper LGBT cultural competency education is not addressed in nursing curricula, the already numerous LGBT health disparities will continue to grow. This paper presents an evidence-based practice change project that integrated the most up-to-date literature findings on LGBT cultural competency content in nursing education aimed at increasing LGBT cultural competency knowledge of nursing students. The background and significance sections further defines and provides the significance to the problem of LGBT cultural incompetence which leads to numerous LGBT health disparities including an increase in medical expenditures.

Background of Problem

The concept of health disparity first appeared in 1985 in a report called *Secretary's Task Force Report on Black and Minority Health* (Heckler, 1985). In 1998, President Clinton announced the goal of eliminating disparities between different racial and ethnic minority groups. The Health Care Fairness Act of 1999 was created in response to Clinton's health disparities goal. Since that time, the U.S. Department of Health and Human Services (HHS), Healthy People 2020 (2010), and Centers for Disease Control and Prevention ([CDC], 2011) have made initiatives to address health disparities between individuals tracking and reporting the research results that may impact the level of health disparities.

HHS, Healthy People 2020 (2010) is the governmental organization tasked to release 10-year national objectives in regards to literature produced for improving health statuses of different segments of the population in the United States. HHS, Healthy People 2020 (2010) has the set goal to eliminate health disparities of all individuals living in the United States. Thus, it is imperative that nursing and all other health care professionals have an understanding of health disparities and their responsibility for decreasing health disparities for all individuals.

To understand the concept of a health disparity further, a definition is supplied. HHS, Healthy People 2020 (2010) has identified a health disparity as a health disadvantage associated with social, economic, or environmental disadvantage. Unfortunately, health disparities do exist in the U.S. and there is a steady rise in health disparities due to the increase of inequalities and social injustices that can be linked to culturally incompetent providers (Truman et al., 2011).

The literature discussed above, provided the link between increasing health disparities and an increase of culturally incompetent providers. To adequately portray cultural competence, a definition is provided. Cultural Competence is identified as "a set of congruent behaviors,

attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Campinha-Bacote, 2007, p. 9). This definition provides the need for all health professionals to come together and provide unbiased care to all individuals served throughout the delivery of health care services.

Today, cultural competence has not only shown a focus on ethnicity and race, but it has moved forward to address disparities seen by the LGBT population. On May 21, 2012, current Secretary of the U.S. Department of Health and Human Services, Kathleen Sebelius, released a speech to the World Health Assembly stating, "In the past, we have come together to reduce health disparities for women, ethnic, racial and religious minorities, those with disabilities, and others who were denied access to the health care they need. Now, we need to take the next step and do the same for millions of our fellow LGBT countrymen and women" (HHS, 2012, para. 20). This speech demonstrates how the nation has changed the spotlight to focus on improving the health of the LGBT population.

Recommendations for LGBT cultural competency and curriculum reform have been made for inclusion in nursing education. Lim, Brown, and Jones (2013) discussed appropriate LGBT cultural competency to more adequately address LGBT health needs. Lim et al. concluded that nurses play a pivotal role in the elimination of LGBT health disparities and that proper LGBT-specific education and training are the first steps in achieving elimination. This expansion in nursing education provides support for the implementation of LGBT cultural competency content in nursing education.

The Ohio Board of Nursing (OBN) is the regulating body for nursing education programs in Ohio that prepare students for initial licensure as a Registered Nurse (RN) (Ohio Board of

Nursing, 2013). OBN requires that an RN curriculum consist of course content involving the application of nursing care concepts to include addressing the cultural needs of clients. The purpose and philosophy of the identified facility's nursing program discusses the need to encompass the whole person to include education focusing on cultural beliefs, customs, and habits to improve patient outcomes. Without the proper LGBT cultural knowledge, nursing professionals are unable to address the needs of LGBT individuals upon graduating nursing school.

The American Association of Colleges of Nursing ([AACN], 2008) had recommended cultural competency training be included in nursing education. Further recommendations by the AACN include educating nursing students with cultural competent material with the most relevant data sources from the best evidence to provide culturally competent care. Reviewing the most recent literature, LGBT cultural competency must be addressed for inclusion into nursing curricula to eliminate LGBT-specific health disparities.

The curriculum committee of a nursing program located in Central Ohio periodically evaluates community and employer needs to ensure graduates are adequately prepared. The committee found The Joint Commission ([TJC], 2011) requires institutions to prepare nursing professionals with proper LGBT cultural competency education. The curriculum committee identified the need to address a lack in LGBT cultural competency content within their current nursing programs. Therefore, LGBT cultural competency content was identified as an area that needed to be added to the curricular content within the nursing program.

Significance of Problem

Creating an awareness of certain population's health disparities may require a change in the culture of which one works or is employed. At New York City Health and Hospitals

Corporation Facilities, a systemic review by Browne et al. (2008) found that LGBT education was lacking in health professionals. The report identified in order to eliminate health disparities, exposure to LGBT education in medical and nursing schools in addition to continuing education is needed (Browne et al, 2008).

Each year healthcare facilities utilize the Healthcare Equality Index (HEI) Survey, conducted by the Human Rights Campaign ([HRC], 2012), to show their commitment to equitable and optimal LGBT care. The 2011 HEI results included the percentages of health professionals that were required to complete training regarding LGBT cultural needs. Less than 50% of the participants reported having received training regarding LGBT cultural needs. This outcome is alarming since TJC (2011) released criteria requiring all hospitals to demonstrate how they are specifically responding to the needs of the LGBT population.

A low level of LGBT cultural competency was confirmed throughout health care education by Winter (2012). Winter found less than 10% of the medical schools and public health programs surveyed, reported LGBT cultural training existed in their current curriculum plan. Winter linked findings from regulating and governing authorities such as the Institute of Medicine (IOM), TJC, and HHS to suggest cultural competency education to allow health care providers an opportunity to examine their own biases. As a result of this self-assessment, individuals will be better equipped to control any biases that may impact the care provided to a culturally diverse patient population. Low percentages of LGBT cultural competency in health curricula reflects inadequate education and provides the significance and need for initial and continuous LGBT cultural competency education.

A 2011 Morbidity and Mortality Weekly Report (MMWR) referred to health disparities as the differences in health outcomes between different segments of the population that reflect

social inequalities and have a negative impact on life expectancy, morbidity, and quality of life in a population segment (Truman et al., 2011). Since the 1980s, the U.S. has made substantial efforts for reducing health disparities; however, increases in health disparities related to differing cultural groups is on the rise (Truman et al, 2011). Little progress has been made towards the goal of eliminating these disparities, and in many cases the gaps have grown. The MMWR report identifies proper cultural education as the link in eliminating health disparities (Truman et al., 2011). Winter (2012) also confirmed the linking of LGBT health disparities to a lack of research and lack of health care provider knowledge. The Fenway Health Institute (FHI), National LGBT Health Education Center (2012), has suggested that the known LGBT health disparities can be addressed with increased education of health professionals.

Most recently, HHS, Healthy People 2020 (2013) has linked multiple health disparities to the LGBT population. The reported health disparities are linked to a long history of negative social stigma and discrimination for LGBT individuals (HHS, Healthy People 2020, 2013; and FHI, National LGBT Health Education Center, 2012). HHS, Healthy People, 2020 (2013) offered several examples of identified LGBT health disparities:

- LGBT youth are two to three times more likely to attempt suicide.
- LGBT youth are more likely to be homeless.
- Lesbians are less likely to get preventive services for cancer.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Lesbians and bisexual females are more likely to be overweight or obese.

- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide, and are less likely to have health insurance than heterosexual or other LGBT individuals.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.

The FHI, National LGBT Health Education Center (2012) a leader in LGBT-focused health and education, has also linked health disparities to the LGBT population and a lack of LGBT cultural competency of health professionals. Men who have sex with men (MSM), including those identified as gay and bisexual men, accounted for 64% of reported new cases of HIV, and are at high risk for other reported STDs (FHI, National LGBT Health Education Center, 2012). From 2006-2009, black MSM had a 48% increase in new HIV cases (FHI, National LGBT Health Education Center, 2012). The reported health disparities are linked to a long history of negative social stigma and discrimination for LGBT individuals (FHI, National LGBT Health Education Center, 2012). FHI, National LGBT Health Education Center (2012), has suggested that these identified health disparities can be addressed with increased education of health professionals.

Yoder-Wise (2011) believe the costs for healthcare services in the United States continue to rise at a rate greater than general inflation. The authors found in 2009, Americans spent $2.2 trillion for health care services accounting for 16.2% of gross domestic product (GDP). This accounts for $8,000 per person in the U.S. Increasing levels of LGBT health disparities are tied to the rising cost of health care, further attributing an increase in health care costs. Despite huge expenditures, major indicators such as social stigma, discrimination, biases, inadequate

education, and cultural incompetency reveal significant health disparities (as stated above) pertaining specifically to the LGBT cultural group (HHS, Healthy People 2020, 2013). The NCSL (2012) released information on the cost of health disparities stating, "disparities represent a lack of efficiency within the health care system and therefore account for unnecessary costs" (para. 1). Failing to address health disparities will result in higher medical expenditures, a less productive workforce, and an increasingly segmented nation. As such, addressing health disparities is also an imperative issue of moral and social justice. According to a 2009 study by the Joint Center for Political and Economic studies, eliminating health disparities for certain populations would have reduced medical expenditures by more than $229 billion between 2003 and 2006 (NCSL, 2012). In order to assist in reducing high medical expenditures, healthcare professionals need to understand the impact they may have on certain populations such as the LGBT.

The identified LGBT health disparities and expenditures related to these expenditures have been reported. Literature has linked LGBT cultural incompetence of health care providers to the identified LGBT health disparities and the increase cost of medical expenditures. If LGBT cultural competency is not addressed in health professional education, LGBT health disparities and medical expenditures will continue to increase. The clinical problem guiding this Evidence Based Practice (EBP) change project is the lack of LGBT cultural competency in nursing education that leads to increased levels of LGBT cultural incompetency which is believed to further increase LGBT health disparities and medical expenditures.

Question Guiding Inquiry: PICO

According to Melnyk and Fineout-Overholt (2011), a properly formulated clinical question leads to a more effective search to result in more profitable appraisal of evidence. The

PICO question format is what Melnyk and Fineout-Overholt (2011) was referring to. The format begins with identifying the (P) population, (I) intervention, (C) comparison intervention, and (O) outcome. The following question was proposed to guide this EBP change project: Will integrating LGBT cultural competency content for nursing students, improve LGBT cultural competency knowledge, ultimately having a positive impact on the LGBT health disparities?

P-Population. Nursing students of any gender, race, religion or ethnicity enrolled in a registered nursing (RN) program in Central Ohio, in their last semester, ages 18 and older were invited to participate in this evidence-based change project. This population was selected because the literature suggests a lack in health professional cultural competence increases LGBT health disparities.

I-Intervention. The intervention focused on integrating LGBT cultural competency content to nursing student curriculum following Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare Services (2007). Students were to receive cultural competence and LGBT-specific content within their routinely scheduled course work, complete LGBT specific case studies, which were the preparation work for an LGBT-specific simulation, participate in a LGBT culturally diverse patient scenario, and finally students were to receive a review of LGBT cultural competency content.

C-Comparison intervention. No comparison intervention will be used; however, a comparison will be made between pre and post knowledge tests to assess the impact of the educational intervention.

O-Outcome. The intended outcome is to improve LGBT cultural competency knowledge in nursing students. The objective is to see an increase in the mean difference between the pretest and posttest scores. The benchmark to assess if the intervention was

effective was set at the institutional level of 78%, meaning each student must have a 78% or higher to pass. A 25% between the difference in mean pretest and posttest scores was also planned. The ultimate, long-term outcome is to decrease LGBT health disparities, which is linked from literature to the improvement of LGBT cultural competency knowledge of health professionals. The measurement tool to evaluate LGBT cultural competency pre and post education is the LGBT Cultural Competency Questionnaire. The project implementer developed the tool and the content was found to be reliable and valid by submitting to a review board specializing in LGBT health. This paper and pencil self-assessment consists of 16 different questions that focus on the cultural competency and LGBT-specific content obtained from the most up-to-date literature.

Conclusion

There is compelling literature supporting the need for LGBT culturally competent health professionals to be equipped with increased knowledge aimed for improving the long-term outcome of LGBT health disparities and the consequent medical expenditures. As such, the desired outcome was to improve LGBT cultural competency levels among nursing students while meeting institutional testing benchmarks. Nursing students received cultural competency educational content with integration of an LGBT cultural competency simulation utilizing Campinha-Bacote's cultural process (2007) as the guiding framework.

Chapter Two: Review of Literature/Evidence

There is significant support that lesbian, gay, bisexual, and transgender (LGBT) cultural competency education is needed in nursing curricula to improve knowledge levels among nursing students, better preparing students to provide patient-centered culturally competent care for LGBT individuals upon graduation. As such, improving knowledge is anticipated to improve patient satisfaction, LGBT health disparities and the consequent medical expenditures. A cultural competency framework by Campinha-Bacote (2007) was found as an effective means for delivering cultural competency education among nursing students and will be used to integrate LGBT cultural competency (Abel, Silva, Desilets & Durand, 2010; Black, Soelberg, & Springer, 2008; Chen, McAdams-Jones, Tay, & Packer, 2012; Hawala-Druy and Hill, 2012; Hayward & Charrette, 2012; Durand, Abel, Silva & Desilets, 2012; Escallier, Fullerton & Messina, 2011; Fitzgerald, Cronin & Campinha-Bacote, 2009; and Young, 2009). Multiple studies were identified to increase cultural competency knowledge among nursing and health professional students that incorporated competency education utilizing Campinha-Bacote's model and pre/posttests (Abel, Silva, Desilets & Durand, 2010; Black, Soelberg, & Springer, 2008; Chen, McAdams-Jones, Tay, & Packer, 2012; Hawala-Druy and Hill, 2012; Hayward & Charrette, 2012; Durand, Abel, Silva & Desilets, 2012; Escallier, Fullerton & Messina, 2011; Fitzgerald, Cronin & Campinha-Bacote, 2009; and Young, 2009). The objective of the review of literature was to determine the best available intervention to reduce health disparities among the LGBT. Multiple studies reflected strong evidence that adding cultural competency education in existing nursing curricular was most effective. The purpose of this literature review was to locate the best methods to integrate LGBT cultural competency into nursing education.

Methodology

Database search engines utilized in this review of the literature included Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Cochrane, Google Scholar, and the Jennie King Mellon Library database system. The Transcultural C.A.R.E. Associates Web site was utilized to locate studies focused specifically on improving cultural competency knowledge levels among health professionals. Key concepts used in these search engines included LGBT, lesbian, gay, bisexual, transgender, health, disparities, education, nursing, cultural, competence, awareness, transcultural care, and Cultural Competence models. Concepts were utilized either alone or in combination of one another. Initially, concepts were searched without any limitations. Next, instances of concepts producing too many results were narrowed with year limitations, filtering the results for articles released in the past 5 years. For results producing too many articles with year limitations, full-text articles were placed as a filter to narrow the search further. Articles not pertaining specifically to cultural competency education in nursing or other health professionals were not reviewed. Articles that addressed cultural competency education in health professionals as well as LGBT education were selected. Articles that made only suggestion to include LGBT or cultural competency education and did not include methods of how to best incorporate this were not selected. Cultural competency educational that did not show outcome improvements or address the effectiveness of cultural competency education was also not selected.

After the filtering process noted above, eleven articles were considered for this review. One systematic review providing intervention recommendation and ten studies of either quasi-experimental or one-group pretest-posttest design were selected. Several key articles were found that reflect the positive impact cultural competency education has on improving student

knowledge. Key similarities among the articles were Campinha-Bacote's model, as well as the use of a pretest and posttest to evaluate cultural competency levels and knowledge acquisition pertaining to the cultural educational intervention.

Findings

Lim, Brown and Jones (2013) have addressed the need to train nursing students with LGBT specific content to address the health related needs of the LGBT population. Lim et al. completed a review of the literature on LGBT content in nursing education. The authors provided academic education and training recommendations for integrating LGBT content into nursing curricula. The use of high-fidelity simulations, case studies, nursing care plans, and clinical placements that incorporate LGBT specific content was recommended. The authors believe the use of high-fidelity patient simulations can fill the practice gap and the lack of clinical interaction between nursing students and LGBT clients. Additionally, case studies and care plans can be used in didactics and skills labs. Testing may be infused with LGBT content and current best practices in cultural sensitivity. While the article by Lim et al. is not the highest level of evidence, recommendations for future practice were given by a current review of literature and no other LGBT cultural competency educational models were found that included the recommendation and interventional strategies on how to best do so.

Black et al. (2008) completed a cultural competency project focused on developing culturally competent nursing graduates. In this project 100 nursing students were offered live class sessions and Service Learning opportunities. Black used Campinha-Bacote's cultural process (2007) as a guiding model, including the five constructs of cultural competence. An evaluation tool was utilized to measure cultural competency knowledge before and after the

educational intervention. Results indicated a statistically significant difference with a mean of 13.9 points between pre and posttest scores revealing an increase in cultural competency.

Chen et al. (2012) completed a study regarding cultural competency training. In this study 13 nursing students enhanced their cultural competence through Service Learning after cultural competency training was delivered using a quasi-experimental design. The process of cultural competence (2007) by Campinha-Bacote was also utilized as the guiding framework covering the five constructs of cultural competence. The results indicated a statistical significance with a Mann–Whitney U test ($Z = -2.51$, $p = .01$) between pre and posttest scores in the experimental group indicating an increase in cultural knowledge (Chen et al., 2012). Further discussion of the findings revealed that nursing students have a significant need for obtaining cultural knowledge throughout their curricula.

Young (2009) indicated a positive difference between pre and post scores in a study examining cultural competence before and after an educational intervention. Young examined the effectiveness of an educational intervention consisting of a two-hour PowerPoint presentation on cultural competence in nursing students. Campinha-Bacote's (2007) cultural process was utilized as a referencing framework for the study; however, all aspects of the framework were not covered in the study design and the encounter construct of the framework was not included in the project design. Although an improvement between pre and posttest scores was noted, neglecting to include all five of the cultural competency constructs may have lead to a lesser difference between pre and post-test scores (Young, 2009).

Summary of Findings

The most frequently cited cultural framework was The Process of Cultural Competence in the Delivery of Healthcare Services (2007) created by Campinha-Bacote. Several studies

were found utilizing Campinha-Bacote (2007) cultural process (Abel, Silva, Desilets & Durand, 2010; Black, Soelberg, & Springer, 2008; Chen, McAdams-Jones, Tay, & Packer, 2012; Hawala-Druy and Hill, 2012; Hayward & Charrette, 2012; Durand, Abel, Silva & Desilets, 2012; Escallier, Fullerton & Messina, 2011; Fitzgerald, Cronin & Campinha-Bacote, 2009; and Young, 2009). Pre/post tests were administered in each study to measure knowledge acquisition. Various statistical tests were performed to determine an increase between pretest and posttest scores, revealing the outcomes of cultural competency education for nursing and other health care professionals. There is a compelling amount of literature to support a practice change and guide the integration of LGBT cultural competency content in nursing education.

Limitations

Several limitations were identified when conducting the literature review. First limitation was noted when narrowing the results of the search in an attempt to only pull studies that were up-to-date and pertinent. Narrowing publication dates to include only those in the past five years may have excluded valuable studies that may have added to the review of literature. Further, narrowing the search to full-text only may also present a missed opportunity where an abstract only in one database may have been beneficial to further into and add to the literature review. As such, with the large number of results pertaining to cultural competency, it was imperative to include all of the limitations in the search methodology so only those articles most valuable are to be examined and critically analyzed for evidence.

Limitations were also found in the review of literature. There was a lack of literature within the nursing discipline to guide the best method to deliver cultural competency education to nursing and other health professionals. There were a very limited number of validated frameworks that pertained directly to educating nursing professionals. No models were found

that was specific to LGBT nursing education; however, Campinha-Bacote's cultural framework was found to improve cultural competency in nursing and other health professional students. Although simulation has been shown as an effective means to improve cultural skill, clinical placement pertaining specifically to LGBT clientele would be most beneficial so that nursing students may interact face-to-face with the LGBT and experience facial expressions and mannerisms.

Conclusion

There is compelling literature presented to guide a cultural competency intervention. An improvement in LGBT cultural knowledge among nursing students is linked to the improvement of LGBT health disparities and the consequent medical expenditures. Further review of literature provided the evidence for designing LGBT cultural competency education in nursing curricula. A strong link was presented to integrate LGBT cultural competency content within Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare Services (2007) to solve the problem of cultural incompetence and LGBT health disparities.

Multiple studies were found to provide significance and positive change in knowledge levels between pre/post test scores using Campinha-Bacote's process of cultural competence in the delivery of healthcare services (Abel, Silva, Desilets & Durand, 2010; Black, Soelberg, & Springer, 2008; Chen, McAdams-Jones, Tay, & Packer, 2012; Hawala-Druy and Hill, 2012; Hayward & Charrette, 2012; Durand, Abel, Silva & Desilets, 2012; Escallier, Fullerton & Messina, 2011; Fitzgerald, Cronin & Campinha-Bacote, 2009; and Young, 2009). The findings provide significant support for guiding and integrating LGBT content in nursing curricula.

The study by Young (2009) found a positive difference in between pretest and posttest scores, indicating a positive outcome after cultural education. However, it was determined that

the cultural encounter construct of Campinha-Bacote's (2007) cultural framework was not incorporated into the project design and therefore may have resulted in differences between pretest and posttest scores. This finding was useful as a limitation for clinical placement at the institution located in Central Ohio was identified. The institution has limited resources for clinical placement focusing on LGBT specific clientele. Lim et al. (2013) recommends utilizing high-fidelity patient simulations to fill the gap of LGBT specific clinical placements.

Chapter Three: Theory and Framework for Practice Change

Melnyk and Fineout-Overholt (2011) suggested the use of conceptual models or frameworks as a guide when starting and implementing an evidence-based practice (EBP) project. Changing practice is described to be complex and challenging and as a result, EBP models systemically guide the EBP process (Melnyk & Fineout-Overholt, 2011). Chinn and Kramer (2011) highlighted the importance of best practices to be based on evidence and linked to nursing or related theory. These nursing and related theories guide evidence-based practice (Chinn & Kramer, 2011).

The importance of utilizing a theoretical model to guide implementation of a cultural competency course was identified. Hawala-Druy and Hill (2012) stated, "It is imperative that educators link and bridge cultural self-awareness, knowledge, theory, and communication skills in teaching culturally congruent care for millennial health professionals" (p. 772). Watts, Cuellar, & O'Sullivan (2008) proclaimed that the best practice model for integrating culture competence into nursing curricula has not been established and remains a challenge for nurse faculty. As such, cultural and theoretical frameworks and models were explored. A systemic review completed by Balcazar, Saurez-Balcazar and Taylor-Ritzler (2009) identified five frameworks utilizing cultural awareness and knowledge acquisition to learn about the context of individuals served. After reviewing each of the five frameworks, the Process of Cultural Competence in the Delivery of Healthcare Services by Campinha-Bacote (2007) was selected as the guiding framework due to applicability and ease of use.

The Model for Evidence-based Practice Change, Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare Services (2007) and the FIRST^{2}ACT simulation model were utilized to support an EBP change project. These frameworks were selected with an

aim to lead a project focused on increasing nursing students' knowledge of lesbian, gay, bisexual, and transgender (LGBT) cultural competence. The purpose of this chapter is to present the overview of each framework and how each will be utilized to guide this EBP change project.

Evidence-Based Change Model

The Model for Evidence-based Practice Change includes six steps for implementing an evidence-based change into practice (Melnyk & Fineout-Overholt, 2011).

Step One: Assess the need for change in practice. Key actions involved with step one included identifying a practice problem for improvement; creating a team of stakeholders to address the problem; collection of internal data; collection of external data to evaluate the internal data by standards for comparison; and refining the problem by developing a problem/population, intervention, comparison intervention, and outcomes (PICO) question (Melnyk & Finout-Overholt, 2011).

***Organizational environment*.** The organizational environment at a nursing institution located in Central Ohio was explored to identify problems within the organization and to establish a team to more appropriately address a selected problem. The curriculum committee, when evaluating community and employer needs to ensure graduates were adequately prepared, found that The Joint Commission (TJC) (2011) required healthcare institutions to prepare nursing professionals with proper LGBT cultural competency education. A needs assessment was completed utilizing Survey Monkey. Faculty was asked to complete an anonymous and voluntary assessment focused on LGBT individuals. Questions asked, focused on the readiness to address LGBT issues and concerns in education and practice, as well inquiring if faculty believed LGBT issues were adequately addressed in nursing curriculum. Faculty that participated in this anonymous and voluntary needs assessment identified they were ready to

address LGBT issues and that they did not believe that it was covered sufficiently in nursing curriculum. Further, it was noted that the mission, vision, and values within the organization included cultural competency objectives of which were not being met.

Step Two: Locate the best evidence. Key actions involved in step two included identifying the relevant LGBT cultural and educational specific data; planning the search for relevant LGBT cultural and educational specific evidence; assessing the feasibility; and conducting an EBP search that produced the best evidence related to LGBT cultural competency in nursing education that would guide this practice change. LGBT health disparities are identified by the U.S. Department of Health and Human Services ([HHS], 2012a). A literature review produced multiple studies that used educational strategies to improve cultural awareness of diverse populations that resulted in a positive change (Abel, Silva, Desilets & Durand, 2010; Black, Soelberg, & Springer, 2008; Chen, McAdams-Jones, Tay, & Packer, 2012; Hawala-Druy and Hill, 2012; Hayward & Charrette, 2012; Durand, Abel, Silva & Desilets, 2012; Escallier, Fullerton & Messina, 2011; Fitzgerald, Cronin & Campinha-Bacote, 2009; and Young, 2009).

Step Three: Critically analyze the evidence. Key actions involved with step three involve critically appraising and judging the strength of evidence being considered; synthesizing the evidence; and assessing the feasibility, and risks and benefits associated with implementing new EBP in regards to the clinical problem (Melnyk & Finout-Overholt, 2011). All identified articles were critically appraised and judged for strength of evidence. The studies identified provided significant evidence for implementing a practice change for integrating LGBT cultural competency content within nursing education. Some risks that were identified revealed not following all constructs of Campinha-Bacote's framework lead to weaker results between the pretest and posttest.

Step Four: Design practice change. Key actions involved in step four included defining the proposed practice change; identify the resources needed; designing the evaluation methods; and designing the plan for implementation (Melnyk & Finout-Overholt, 2011). An educational intervention was selected as the intervention of choice using Campinha-Bacote's process of cultural competence in the delivery of healthcare services (2007). A detailed project management plan was created outlining how the newly designed curricular content would be integrated into the current course schedule.

Step Five: Implement and evaluate change in practice. Key actions involved with step five included implementing a practice change project by inviting RN students enrolled in a nursing program in Central Ohio. Expected costs associated with implementation of the practice change project were determined for cost effectiveness purposes. Outcome determination for improvement in LGBT cultural competence of nursing students was measured using a pretest and posttest for comparison. Data was input into an Excel spread sheet for comparing individual and group data scores. Graphs were selected to better represent data results.

Step Six: Integrate and maintain change in practice. Key actions involved with step six include sustaining change and disseminating the findings (Melnyk & Fineout-Overholt, 2011). The project management plan follows the Spreading Improvements Framework. The Spreading Improvements Framework is documented for improving spread of change results (Ogrinc et al., 2013). The spread was initiated on a smaller scale in one course within a nursing institution located in Central Ohio. If positive outcomes and findings were determined, the curriculum committee would be asked to sustain the change in the existing program. Recommendations would be made to integrate LGBT cultural competence education within the curriculum. To spread the change further, the recommendations would be presented to the

national curriculum committee to create a spirit of inquiry from stakeholders from other affiliate institutions. Finally, dissemination of results to other institutions would be planned for publication into professional journals and by professional presentation during seminars.

Cultural Competency Framework

A theoretical process is identified to guide cultural education and provide a foundation for increasing LGBT-specific cultural competency in nursing education. Chinn and Kramer (2011) highlighted best practices to be based on evidence and linked to nursing or related theory. Campinha-Bacote's process of cultural competence in the delivery of healthcare services (2007) was the theoretical process identified for the guiding framework to increase LGBT-specific cultural competency content in nursing students. This process involved becoming culturally competent through the utilization of five constructs of cultural competence. This process provides a framework to follow while integrating cultural competency training in nursing education. This was an ongoing process of "becoming" culturally competent rather than "being" culturally competent (Campinha-Bacote, 2007). The following are the five cultural constructs described by Campinha-Bacote (2007):

- "Cultural desire" involves the motivational process involved with becoming culturally competent.
- "Cultural awareness" involves exploring and reflecting of one's own cultural beliefs, practices, and biases.
- "Cultural knowledge" involves seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.

- "Cultural skill" involves completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.
- "Cultural encounters" involve cultural interactions with culturally diverse individuals.

Students were first allowed to gain the desire to become culturally competent in regards to the LGBT population by learning their role and responsibility and the relation of cultural incompetence to increasing LGBT health disparities. Next, students were allowed to create a cultural awareness by exploring and reflecting on their own cultural beliefs, practices, and biases. After exploring their belief, practices, and biases toward the LGBT population, students were presented with the cultural knowledge construct through participation in classroom-based learning. Students received the most current literature findings through the integrating of LGBT-specific practices, LGBT cultural values, and LGBT-specific health disparities. Students again reflected upon their role in becoming culturally competent to effectively identify the practices, values, and health disparities that are specific to the LGBT population. Students then explored how a knowledge deficit may lead to further increasing the identified LGBT health disparities. Students gained the cultural skill needed to complete an LGBT-specific cultural assessment by collecting LGBT-relevant cultural data and completing a LGBT culturally based assessment. Experience was gained by asking LGBT cultural questions that were specific to LGBT practices and values as well as LGBT-specific health disparities. Students then welcomed the opportunity of becoming more comfortable with asking LGBT health focused questions by enhancing their skill level in the nursing skills lab. Students were exposed to LGBT-specific cultural encounters by participating in LGBT cultural competence simulations. LGBT cultural competence simulations allowed students to experience cultural encounters with LGBT-specific culturally

diverse individuals. To lead and evaluate LGBT cultural simulations, the simulation model utilized by the educational institution acted as the guiding framework.

Simulation Framework

FIRST^{2}ACT simulation model. FIRST^{2}ACT is a theory-based simulation model currently being utilized where the project was implemented. FIRST^{2}ACT is based on "well-established theory and contemporary empirical evidence" (Buykx et al., 2011, p. 687). As such, FIRST^{2}ACT provides a theoretical model promoting the use of best practice simulation education. FIRST^{2}ACT was tested in undergraduate and graduate level nursing students leading to significant increases in knowledge (Buykx et al., 2011). FIRST^{2}ACT incorporates five different components to promote an increase in knowledge while students gain practice experience. Melnyk and Fineout-Overholt (2011) identified the need to bridge the gap between evidence and practice to encourage change. Integrating LGBT cultural competency content into nursing curricula will fill the link between evidence and practice. This attempt will initiate and establish evidence-based change in nursing education focused specifically on the LGBT population. The five components of FIRST^{2}ACT are as follows:

- Developing core knowledge (classroom based learning)
- Assessment (learning stimulus)
- Simulation
- Reflective review
- Performance feedback

All five components of FIRST^{2}ACT were incorporated into the practice change project design. Students gained new knowledge through classroom-based learning. Students received LGBT cultural competency content in the classroom setting. Students were then exposed to

LGBT culturally diverse case studies with a role-play scenario, which promoted students to complete a self-assessment of their own knowledge. Completing a self-assessment is identified as a stimulant for learning (Buykx et al., 2011). Students identified the critical aspects of LGBT cultural competency, emphasizing the importance of context (Buykx et al., 2011). Students participated in a cultural encounter experience, which is also one of the cultural constructs listed in Campinha-Bacote's (2007) cultural process. Students gained practice experience while caring for a simulated LGBT individual with a medical illness. Students then were openly engaged in reflective review by self-evaluating their performances at the conclusion of the simulation. Students received constructive feedback by peers to improve clinical performance. Students were then engaged in post-simulation performance feedback during the final element of the debriefing. For the final component, students then completed a written reflective review of their simulation experience.

Conclusion

Three frameworks were presented to guide the implementation of a practice change project. The Model for Evidence-based Practice Change was the first model being utilized to guide the EBP change process. Integrating an interventional model to provide a framework for the specific intervention, Campinha-Bacote's cultural process (2007) was presented. The FIRST^{2}ACT simulation model was identified as a framework for offering students opportunity to use the newly attained knowledge. Integrating Campinha-Bacote's cultural process (2007) with the FIRST^{2}ACT simulation model, offered a well structured designed for the intervention of the project.

Chapter Four: Pre-implementation Planning

The purpose of an evidence-based practice (EBP) change project was to integrate LGBT cultural competency content in nursing education aimed at increasing LGBT cultural knowledge in students. The ultimate outcome of the intervention was to decrease LGBT health disparities and consequent medical expenditures. LGBT cultural competency content was planned for nursing students with integration of LGBT cultural simulation allowing a LGBT culturally diverse encounter. An LGBT Cultural Competency Assessment Questionnaire was created to measure the outcomes of the intervention, seeking an improvement of LGBT cultural competency knowledge of nursing students. The purpose of this chapter is to present the collaborative project management plan that was created to ensure all objectives were met and obstacles overcome.

Project Management Plan

The project management plan used to implement the project followed the spreading improvements framework (Ogrinc et al., 2013). The spread was initiated on a smaller scale in one course within an academic institution. The spread was planned for dissemination at the organizational level and then to other institutions by publication into professional journals and by professional presentations during professional seminars. The management plan incorporated the Campinha-Bacote's Process of cultural competence in the delivery of healthcare services (2007) as a guiding framework.

Implementation steps included (a) allowing students to gain the desire to become culturally competent in regards to the LGBT population by learning their role and responsibility and the relation of cultural incompetence to increasing LGBT health disparities; (b) creating a cultural awareness by exploring and reflecting on their own cultural beliefs, practices, values and

biases; (c) exploring student beliefs, practices, and biases toward the LGBT population; (d) gaining LGBT cultural knowledge by engaging students in classroom based learning, receiving the most current literature finding on cultural competency and LGBT health disparities; (e) reflecting the nurses role in becoming culturally competent to effectively identify the common practices, values, and health disparities that are specific to the LGBT population; (f) exploring how a knowledge deficit may lead to further increasing LGBT health disparities; (g) gaining cultural skill by collecting LGBT-relevant data, completing a LGBT culturally based assessment and asking relevant questions; and (h) finally, gaining exposure to LGBT-specific cultural encounters by participating in LGBT cultural simulations.

Nursing students received LGBT cultural competency educational content based on the most up-to-date content obtained from literature with integration of an LGBT cultural competency simulation. The evidence-based change practice is designed with the integration of the model for evidence-based practice change, Campinha-Bacote's process of cultural competence in the delivery of healthcare services (2007), and the First^{2}Act Simulation Model. All three models have been identified and are based on evidence to support practice change. The LGBT Cultural Competency Questionnaire was developed by the project implementer and was planned for administration before and after the educational intervention to evaluate the knowledge gained and for determining the outcomes of the project. The data analysis plan included the transfer of data from student assessment forms into an Excel spread sheet. Excel data analysis functions were utilized to evaluate the outcome data of the project.

Organizational environment. The practice change was planned for initiation into last semester nursing course of an associate degree program located in Central Ohio. The mission, vision, and values within the institution were evaluated during the initial planning stages to

ensure alignment and integration within the cultural competency project. Cultural competency objectives were found within the institutional framework, which require the delivery of education focused on effective communication and sensitivity to diversity while delivering patient-centered care to each client. Unfortunately, LGBT curricular content did not exist, which further supported the need for this EBP change project.

Readiness for change assessment. The organizational readiness for change involves recognizing the need for change within the system (Harris, Roussel, Walters, & Dearman, 2012). This process involves identification of the antecedents (events prior to planning), consequences (events as a result of project implementation), and outcomes within and outside of the organization (sustainable results as a result of ongoing project implementation) (Harris et al., 2012). An antecedent was identified, as no identifiable LGBT content existed in the curriculum. A consequence was anticipated as improvement in knowledge of LGBT cultural competency. An outcome was anticipated as the potential to decrease LGBT health disparities. Furthermore, the curriculum committee evaluated community and employer needs to ensure graduates leave the nursing program adequately prepared and found that The Joint Commission requires healthcare institutions to prepare nursing professionals with proper LGBT cultural competency education. As such, the need to address a lack in LGBT cultural competency contents was identified.

Risk management. Several methods were identified to accomplish this project and the key to the successfulness of the project outcomes was to identify the best strategy for the environment (Harris et al., 2012). The comprehensive needs assessment involved a review of internal and external processes, mechanisms, and personnel by means of assessing the strengths, weaknesses, opportunities, and threats (SWOT analysis), and a gap analysis. After identifying

the processes and mechanisms with a SWOT analysis, gaps were determined and proper decisions were made with a plan for overcoming the problems identified. The results of the SWOT analysis identified strengths as an organizational readiness for the planned evidence-based practice change proposal; supportive literature suggesting the need to include LGBT cultural competency in nursing education; and the resources needed to deliver the educational intervention were readily available. Weaknesses were identified as the limited clinical placement for participants to gain specific LGBT cultural encounter and limited time to implement an LGBT practice change project. An opportunity was identified as the capability to use the high-fidelity patient simulator to deliver LGBT simulations. Threats were identified as the potential for conflicts and miscommunication between project team members, and a failed plan due to objectives not being achieved. To overcome the identified barriers, project management included establishing recurring and proper collaboration, communication, and coordination of the project planning and implementation phases with the members of the project team. An established timeline was created to ensure all objectives and roles and responsibilities of each team member were in place.

An anonymous needs assessment questionnaire was conducted utilizing survey monkey that revealed nursing faculty were ready to embrace a practice culture aimed at educating nursing students in regard to LGBT cultural competency. This finding aligned with external needs assessment data in a study examining the attitudes among nurse educators toward homosexuality by Sirota (2013). Sirota found that most nurse educators have the opinion that teaching LGBT cultural competency to nursing students is very important to extremely important; however, most nursing educators were found to believe they lack the knowledge, skills, and tools necessary to

properly instruct LGBT cultural competency. The educational institution did not include LGBT cultural competency education in the current curriculum.

Organizational approval. Implementation of the evidence-based change project included obtaining the proper approval from key stakeholders within the organization such as the director of nursing. The process for project approval includes obtaining an affiliation agreement and a letter of permission from the program director authorizing permission and support for project implementation. An affiliation agreement was obtained between Chatham and the institution for the planned implementation. A permission letter granting approval to implement the evidence-based change project was obtained from the Director of Nursing on April 5, 2013.

Collaboration and team development. Because leadership support is imperative to successful project implementation, the project implementer was designated as the leader of the evidence-based change project. The project implementer formed an interdisciplinary team consisting of the simulation manager and the lead faculty of the class for which the project was implemented. To assume leadership and encouragement of optimal team performance, the team was introduced to the project. Goals were created and collaborated, as well as a specified timeline for goal and outcome achievement. Advanced communication, team strategies, relationship-based care, cultural and generational sensitivity, and professionalism were all linked to improving quality and outcomes for teams and health professional improvement projects (Maragh, 2011). The specified framework for guiding the team and promotion of collaboration of team members followed the path of forming, storming, norming, performing, and adjourning (Harris et al., 2012).

Information technology. Hebda and Czar (2013) discussed the importance of utilizing information technology in project management and for improving nursing education. The use of

information technology assisted in project delivery and evaluation. The utilization of information technology provided the evaluation methods and allowed for statistical calculations to be completed using Excel. A high-fidelity patient simulator was utilized to deliver the cultural encounter construct listed as one of the five cultural constructs from Campinha-Bacote's framework. Other key information technology involved in the delivery of the project intervention includes the utilization of a computer and projector used to search for the most up-to-date literature and evidence-based practice for guiding the change. Further, information technology assisted in successful project dissemination and sustainability as the project plan included dissemination to professional journals and accreditation agencies via electronic formatting.

Materials Needed for Project

The printed materials needed included informed consents, classroom based handouts, and study scenarios with simulation pre/post prep work. One faculty member was needed to deliver the contents to students. Existing resources that were made available included the use of a classroom, the implementer's laptop, and the simulation lab including the high-fidelity patient simulator.

Plan for IRB Approval

Unfortunately, an expedited evidence-based practice proposal was submitted for Institutional Review Board (IRB) approval at two different locations. Initially a formal IRB process was not established at the institution where the project was to be implemented. Therefore, an IRB proposal was initially submitted to Chatham University's IRB committee. Once approval from Chatham's IRB was obtained, the acceptance letter was sent to the required authorities at the institution where the project was to be implemented. At that time, the project

implementer was informed of the newly established IRB process at the institution and their approval was now required. A formal IRB proposal was then submitted to the IRB board where the practice change project was planned for implementation. An expedited IRB approval letter was obtained from the IRB board where the practice change project was planned for implementation on May 5, 2013.

Plan for Project Evaluation

The purpose of the LGBT cultural competency intervention was aimed at improving student knowledge of LGBT cultural competency by integrating LGBT cultural competency content with a LGBT cultural simulation. Koskinen et al. (2009) stated "Cultural experiences can be provided to learners through diverse experiential methods in real or simulated cultural contexts" (p. 502).

Outcome description. The expected outcome of integrating LGBT cultural competency into nursing education is to improve participant knowledge. Improved LGBT cultural competency knowledge is linked to decreasing LGBT health disparities. Ultimately, patient satisfaction is also expected as a result of improving LGBT cultural competency knowledge.

Evaluation tool. Initially, the Inventory For Assessing The Process of Cultural Competence Among Healthcare Professionals- Student Version (IAPCC-SV) was proposed as a tool for measuring LGBT cultural competency; however, the tool was found to not appropriately address LGBT-specific cultural competency knowledge. Through a more detailed literature review, the process for cultural competence in the delivery of healthcare services (Campinha-Bacote, 2007) was found to be more useful for driving the practice change and for project design. Therefore, an evaluation tool, titled the LGBT Cultural Competency Questionnaire, was designed by the project implementer to evaluate the LGBT-specific content (see Appendix A).

The questionnaire was created based on the most current literature. An expert in the field of LGBT health disparities has reviewed the questionnaire and has determined content to be a valid reflection of current LGBT health disparity content. The LGBT Cultural Assessment tool consists of 16 items. Items 1-8 measure cultural competency knowledge, covering Campinha-Bacote's five cultural constructs. Items 9-16 measure LGBT health disparity knowledge. All items are multiple-choice questions consisting of one correct answer.

Data analysis plan. Hebda and Czar (2013) defined benchmarking in health care as "a disciplined and systemic application of continuous measures of defined indicators for the purpose of caparison to others" (p. 172). The practices of measuring and reporting have increased in an effort to encourage better performance and increase in the quality of care (Hebda & Czar, 2013). By comparing internal and external data, or benchmarking, the LGBT Cultural Competency Questionnaire will assist to determine if there were improvements in student scores.

To evaluate the outcomes of the practice change, data from the questionnaire was coded and transferred to an Excel spread sheet where descriptive statistical analysis was conducted. The project will be considered successful or having a positive impact if students achieve a 78% or higher score on the posttest. The benchmark of 78% was required by the institution as a passing score. In addition differences between individual and overall group pre and posttest scores was evaluated. An increase of 25% in the mean between pretest and posttest scores was considered successful, reflecting the intervention had a positive impact on increasing student knowledge.

Conclusion

The LGBT population is faced with increased health disparities that are linked to culturally incompetent providers. Multiple sources support the need for integrating LGBT cultural competency content into curricular content specifically for nursing programs (Lim,

Brown, & Jones, 2013, HHS, Healthy People 2020, 2013; and FHI, National LGBT Health Education Center, 2012). The project design was supported by evidence-based literature and follows the Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2007) framework. As such, improving knowledge levels is linked to solve the problem of cultural incompetence and LGBT health disparities (Browne, Woltman, Tumarkin, Dyer, and Buchbinder, 2008; Fenway Health Institute [FHI], National LGBT Health Education Center, 2012; Truman et al., 2011; HHS, Healthy People 2020, 2013; and Winter, 2012). Key to pre-implementation planning was the inclusion of proper team members establishing communicating and collaborating strategies to promote positive outcomes. Proper risk management strategies were utilized with a plan for overcoming the ones identified. Proper permission by the institution was granted as well as IRB approval. Materials were planned and readily available. Successful project management is guided by theory and proper steps were taken to support all identified aspects within the project to ensure positive execution of the project plan.

Chapter Five: Implementation Process and Procedures

An evidence-based practice (EBP) change project was implemented to support lesbian, gay, bisexual, and transgender (LGBT) cultural competency knowledge in nursing students. The project occurred at a private educational institution located in Central Ohio. The design of this project offered nursing students LGBT cultural competency educational content based on the most up-to-date content obtained from literature with integration of an LGBT cultural competency simulation. The project was designed with the integration of a Model for Evidence-based Practice Change, Campinha-Bacote's process of cultural competence in the delivery of healthcares Services (2007), and the FIRST^{2}ACT simulation model. All three models were identified and based on evidence to support practice change. The LGBT Cultural Competency Questionnaire was developed by the project implementer and was administered before and after the educational intervention to evaluate the knowledge gained and for determining the outcomes of the project. Data analysis included the transfer of data from student assessment forms into an Excel spread sheet. Excel data analysis functions were utilized to assist with the evaluation of the outcome data of the project.

Setting

The practice change project occurred during the last-term of an associate degree nursing program at a private educational institution located in Central Ohio. Implementation of this practice change project offered students an opportunity to engage in learning during three different environmental settings. Students were engaged in didactic or classroom-based learning, skills lab based learning, and simulation based learning.

The high-fidelity patient simulator was located in a room set up to resemble a hospital suite. The simulation suite contains a remote controlled mechanical hospital bed, heart monitor,

intravenous pumps (IV), medication dispenser filled with simulated medication and IV fluids, cabinets filled with hospital procedure supplies, bedside table, bedside dresser, call light, oxygen reservoir, sink, and seating for visitors. There was a "one-way" window allowing the facilitators to view all areas and activity occurring inside in the simulation room. A speaker and microphone located on the inside the simulation suite allows for the facilitators to continuously listen to students during the simulation. A button on the facilitator's speaker and microphone allows for the facilitators to begin speaking after pressed, allowing the facilitators to simulate communication as the patient. The high-fidelity patient simulator allowed students the capability of obtaining physiologic assessment data directly from the patient simulator, such as vital signs, capillary refill, lung sounds, bowels sounds, and urinary output.

Participants

Ten nursing students enrolled in the same course during their last-term participated in this practice change project. All students enrolled in this course (n=10) were offered the opportunity to participate in this project, regardless of gender, age, ethnicity, cultural background, or sexual orientation. Three male students and seven female students participated in this project (n=10) resulting in a response rate of 100 percent.

Project Implementation Steps

Project planning started in January 2013. The lead project implementer (PI) met with two other nursing faculty members to gain input for project implementation and planning. A readiness for change assessment revealed the need to initiate LGBT cultural competency education. Risk management procedures were initiated during project planning in an attempt to identify and address risks of a LGBT cultural competency project. As such, a comprehensive needs assessment was performed by the PI to address the strengths, weaknesses, opportunities,

and threats (SWOT analysis) of the project. Communication, collaboration, team member conflict, and neglecting to attain set objectives were identified as weaknesses or threats as a result of the SWOT analysis. Therefore, project planning incorporated a plan to overcome the identified weaknesses and threats. The plan included communication prior to each day's planned implementation process and procedures as well as communication of minutes after each implementation day. In preparation of project implementation, a letter of consent from the Director of Nursing of the institution was obtained, which authorized permission to start project implementation. In addition, expedited internal institutional review board (IRB) approval was granted on May 5, 2013. Subsequently, project implementation started immediately following obtaining IRB approval. The project implementer created a timeline and distributed to student participants and other staff assisting with project implementation. This timeline included daily processes, procedures, and objectives and served as the project's syllabus while assisting to meet planned objectives and timeframes (see Appendix B). Project implementation was delivered over a six-week timeframe. Materials needed during each implementation day were prepared and gathered prior to each day's planned process and procedures. The institution supplied the classroom space and a high-fidelity patient simulator. Other technology utilized for project implementation included the PI's laptop to create handouts for distribution of weekly content. This chapter presents, the weekly implementation processes and procedures that were followed. Discussion for each week includes a high level analysis of the events that took place, followed by a thorough discussion to allow exact replication of this intervention.

Implementation week one. Process and procedures that occurred during week one included (a) a meeting with faculty involved with project implementation; (b) revising

objectives, processes or procedures on the project timeline to reflect the feedback obtained during the meeting; and (c) creating and sending out the minutes of the meeting.

The project implementer and two other faculty members (lead faculty for the course and the simulation coordinator) met to discuss project implementation. To assume leadership and encouragement of optimal team performance, each team member discussed project implementation processes, procedures, and objectives. Objectives were discussed, revised or created and collaborated, as well as a specified timeline for goal and outcome achievement. The timeline was revised accordingly to reflect input from this meeting. Changes suggested by the project implementer included locating and including a short video to allow student participants to gain an awareness of the social stigma and discrimination experienced by the LGBT individual. After the conclusion of the meeting, the project implementer wrote up an electronic version of the minutes from the meeting and distributed electronically.

Implementation week two. Process and procedures that occurred during week two included (a) sending electronic communication to faculty of the planned process and procedures that were to occur during this week; (b) preparing and printing the project timeline, informed consent forms, and manila folders; (c) introducing student participants to the project; (d) reviewing contents of the informed consent forms with the student participants; (e) distributing and collecting folders containing informed consent forms; (f) distributing and collecting the envelopes containing the pretest; (g) delivering a conclusion of the introduction and first interaction with student participants; (h) properly securing consent forms and pretests in a locked filing cabinet; and (i) creating and sending out the minutes of the first day of project implementation with the student participants.

During week two, the project implementer sent electronic communication that included the planned objectives for this week to the faculty involved with this project. The project implementer then prepared and printed the project timeline, informed consent forms, pretest forms. The pretest, consent forms, and manila folders were each coded from 1 to 10 with the number written in the upper right corner by the project implementer. Each form was then placed into the perspective labeled folder. The project implementer arrived to the classroom early to collaborate with the lead faculty of the course. When it was time to start the introduction of the course, all students were not present. The project implementer expressed rescheduling for another scheduled class time to ensure all participants were present. In this time, 10 minutes passed and all 10 students were present. The project implementer then began executing the objectives for the first day. The project implementer began with an introduction of the project then distributed and reviewed the informed consent forms. While discussing the informed consent forms with the students, the project implementer ensured each participant was sufficiently informed and made aware of the potential risks, benefits, and steps taken to ensure confidentiality. The project implementer discussed that the pretest and posttest was voluntary and signing consent would allow the use of the results. Students were then notified that informed consent may be withdrawn at any time during project implementation. The project implementer distributed contact information to ensure each participant could be in contact should any questions, comments or concerns arise. Students were offered opportunities to ask questions and the project implementer questioned if each student understood all section contained on the informed consent form. The project implementer then stepped outside the room for a couple minutes and students were offered an opportunity to sign the informed consents and place into the manila folder. Informed consent folders were then collected by students and placed into a

stack in the front of the room. The project implementer then reentered the room and distributed the coded folders containing the pretest. The project implementer discussed again that the pretest was voluntary. The project implementer again stepped outside of the classroom to allow participants time to complete the pretest and place back into the manila folder. The lead faculty member for the course remained in the classroom to proctor the pretest. Students collected and stacked the pretest folders on a table in the front of the classroom. The project implementer reentered the classroom and delivered a summary of the project introduction, informed consent forms, pretest forms, and timeframe handouts. Participants were again offered an opportunity for comments, concerns or questions. The project implementer then left the classroom and properly secured consent forms and pretests in a locked filing cabinet. The project implementer then created and sent to faculty the minutes from project implementation with the student participants occurring this week.

Implementation week three. Process and procedures that occurred during week three included (a) sending electronic communication to faculty of the planned process and procedures that were to occur during this week; (b) preparing and printing the handouts for presentation; (c) presenting LGBT cultural competency didactic content; (d) delivering a summary of content delivered; and (e) creating and sending out the minutes of the project implementation that occurred with the student participants this week.

During week three, the project implementer sent electronic communication that included the planned objectives for this week to the faculty involved with this project. The project implementer prepared a presentation using PowerPoint. The project implementer's personal laptop was utilized to create a PowerPoint presentation with LGBT cultural competency content (see Appendix C). PPT handouts were then printed for each participant. The project

implementer discussed cultural competency content with student participants. Each of the five cultural competency constructs was discussed. Additionally, the project implementer discussed LGBT health content including LGBT health disparities. Content instruction allowed students to become culturally competent of the LGBT by following Campinha-Bacote's process of cultural competence in the delivery of healthcare services. Students were encouraged to gain the desire of becoming culturally competent of the LGBT by learning their role, responsibility, and relation cultural competence has on LGBT health disparities. Students were encouraged to create a cultural awareness by exploring and reflecting on their own cultural beliefs, practices, values, and biases of the LGBT. Students explored this process by writing down their own exploration and reflection. The LGBT cultural competency didactic presentation offered students an opportunity for gaining LGBT cultural knowledge by engaging students in classroom-based learning, receiving the most current literature finding on cultural competency and LGBT health disparities. After presenting LGBT specific knowledge, students reflected on the role that they have in becoming culturally competent in an effort to effectively identify the common practices, values, and health disparities that are specific to the LGBT population. Furthermore, factors (otherwise known as determinants of health) that lead to LGBT health disparities were discussed. The roles that student participants and other nursing professionals have in properly preventing the known health disparities were explored. The investigator and students discussed how a knowledge deficit might lead to further increasing LGBT health disparities. The project implementer then delivered a summary of the didactic presentation and offered opportunity for questions, comments or concerns. The project implementer then created and sent out an electronic format to faculty of the minutes from the second day of project implementation with the student participants.

Implementation week four. Process and procedures that occurred during week four included (a) sending electronic communication to faculty of the planned process and procedures that were to occur during this week; (b) preparing and printing the handouts and assessment forms; (c) playing a short video depicting the current social stigma, discrimination and social injustice of the LGBT; (d) discussing the video and impact of discrimination, social stigma, biases, and health policy on the LGBT; (e) discussing LGBT case studies; (f) reviewing LGBT culturally competent assessment and communication skills; (g) practicing LGBT culturally competent assessments; (h) delivering a summary of activities and content covered; and (i) creating and sending out the minutes of the project implementation that occurred with the student participants during this week.

During week four, the project implementer sent electronic communication that included the planned objectives for this week to the faculty involved with this project. The project implementer printed LGBT cultural competency and health disparity assessment forms (see Appendix D). Students viewed a short video labeled *It Could Happen to You* (Crone, 2012) depicting the social stigma, discrimination and social injustice of the LGBT. After the video, students were engaged in open discussions reflecting the social stigma, discrimination and social injustices experienced by the LGBT. Students discussed the impact these social stigma experiences may have on the LGBT population such as negative behaviors (for example: drinking, smoking, high risk sexual practices, and suicide) that may lead to LGBT health disparities. Students also discussed the impact of policy on the LGBT. Students discussed the policy changes by The Joint Commission ([TJC], 2011), which now allows the LGBT visitation rights, to be part of the decision making process for their loved ones, and regulations for LGBT cultural competency training for health professionals and other staff. Students then engaged in

an LGBT case study that also served as the prep work for the simulation (see Appendix E). Students discussed their role while caring for each of the four clients, including LGBT sensitive assessment and communication skills. Next students were engaged in LGBT health assessments. Students were paired up in groups of two and practiced LGBT sensitive and culturally appropriate assessments. Students questioned, collected, and recorded sexual preferences, sexual practices, and other health behavior data sensitive to the LGBT. The project implementer then delivered a summary of the activities and content covered during the current session to the students. After the conclusion of this session, the project implementer then created and sent out the minutes of the project implementation that occurred with the student participants during this week.

Implementation week five. Process and procedures that occurred during week five included (a) sending electronic communication to faculty of the planned process and procedures that were to occur during this week; (b) preparing and printing assessment forms; (c) Preparing the simulation lab for a high-fidelity patient simulation sensitive to the LGBT; (d) engaging students in a LGBT sensitive high-fidelity patient simulation; (e) allowing students to reflected on their simulation experience; (f) delivering a debriefing and summary of the simulation; and (g) creating and sending out the minutes of the project implementation that occurred with the student participants during this week.

During week five, the project implementer sent electronic communication that included the planned objectives for this week to the faculty involved with this project. The project implementer received immediate communication that the simulation coordinator would be unavailable during the scheduled simulation time. The project implementer immediately started communication to recruit another faculty member to assist with facilitating the simulation.

Another faculty member, proficient with the use of the high-fidelity patient simulator, agreed to assist with facilitating the simulation. The project implementer and other faculty member began collaborating the plan for simulation immediately. The agreed simulation plan was to prepare a high-fidelity simulation with a patient experiencing renal failure. The project implementer printed physical assessment forms for student use during the simulation. The faculty member assisting with this simulation prepared the simulation lab for an acute renal failure patient. Supplies were gathered and prepared to ensure students had proper items needed to care for an acute renal failure patient (see Appendix E). The project implementer contacted another staff member to act as the patient's husband. A male staff member was selected to simulate the husband of the patient in a same-sex marriage. The staff member and project implementer collaborated and discussed the roles and responsibilities of the visiting husband. The role of the husband was to sit in the visitor chair and reply to the nursing students when asked questions. The staff member was to identify that he was the patient's husband. Student preparation for this simulation included students to review the most common treatments for acute renal failure, including drug therapy and various other treatments. Students were also made aware that this simulation would be integrating the LGBT content they have learned throughout the last few weeks of this project. For purposes of the simulation in regards to this project, the project implementer focused on the "integration" of the LGBT cultural competency content while the other faculty member focused on renal failure. Students were paired into two groups of five. Each of the five students was assigned a role during the simulation. Assigned roles included a primary nurse; secondary nurse; procedure, treatment, and medication nurse; communication and documentation nurse, and an observer. The primary nurse role was responsible for leading the simulation. The secondary nurse role was to work in collaboration with the primary nurse and

ensure patient assessment was completed. The procedure, treatment and medication nurse role was responsible for ensuring all procedures, treatments, and medication orders were carried out. The communication and documentation nurse was responsible for documentation, communication and collaboration during the simulation. The communication and documentation nurse also was responsible for making any needed calls to the physician and other needed collaborative health professionals. Before the simulation began, students were instructed that they were working as a team on the intensive care step-down unit (ICU step-down) to admit a 29-year-old male patient newly diagnosed with renal failure. Each group participated in a 40-minute simulation involving a renal failure patient while incorporating LGBT cultural competency knowledge and skills. Both simulations were student driven and the facilitators gave responses only when students asked questions. Students were able to collect all other physiologic assessment data on the patient simulator, such as vital signs, capillary refill, lung sounds, bowels sounds, and urinary output.

Additionally, in both simulations the other facilitating faculty member acted as the doctor for the simulated patient and entered the simulation suite. The simulated doctor questioned the visitor of his relation to the patient. After the visitor identified that he was the husband, the doctor asked the visitor to leave the room stating, “this environment is for family of patient’s only. Could I please ask you to step out of the room while we care for the patient.” This situation exposed both student groups to current policy and regulation changes as set by TJC, requiring the LGBT the same rights as non-LGBT families.

After the simulation was completed both simulation groups engaged in a reflection on their simulation experience. Each student participant discussed their reflection of the simulation experience, discussing the pros, cons, and learning attained during their experience. The

observer in each group then discussed their reflection of the simulation, offering similar feedback, pros, cons, and learning attained. After student reflection of the simulation, the project implementer and other simulation facilitator delivered a debriefing and summary of the simulation to both simulation groups. The other simulation facilitator engaged students in feedback pertaining to the renal failure portion of the simulation. The project implementer engaged students in feedback pertaining to the integration of LGBT cultural competency content, assessment, and skills. After the conclusion of the debriefing and summary, the project implementer created and sent out the minutes to faculty of the project implementation that occurred with the student participants during this week.

Implementation week six. Process and procedures that occurred during week six included (a) sending electronic communication to faculty of the planned process and procedures that were to occur during this week; (b) preparing and printing summary handouts and posttest questionnaire forms; (c) delivering a summary and conclusion of the practice change project; (d) administering the posttest questionnaire; and (e) creating and sending out the minutes of the project implementation that occurred with the student participants during this week.

During week five, the project implementer sent electronic communication that included the planned objectives for the week to the faculty involved with this project. The project implementer prepared a summary and conclusion handout for student participates (see Appendix F). The project implementer then printed the posttest questionnaire (see Appendix A) and labeled each form from 1-10 reflecting the unique coding identifier to maintain confidentiality. At the start of class, the project implementer passed out summary and conclusion handouts to student participants and delivered a summary and conclusion of the course by reviewing the content on the handouts. Students were offered time to ask any questions they had. Next the

project implementer stepped outside the room to allow for students to begin their posttest questionnaires. The lead faculty for the course passed out student assessment forms ensuring each student received their prospective assessment form matched with their unique identifier. Students completed the posttest questionnaire, placed the forms inside the envelopes, and put the envelopes in a stack on a table in the front of the classroom. The project implementer then reentered the room and delivered concluding discussion with the students. Students presented feedback and discussion of the LGBT cultural competency project. Students were engaged in meaningful discussion, expressing their thoughts and ideas on how the project implementation could have improved. Upon completing the concluding remarks, the project implementer created and sent out the minutes of the project implementation to faculty that occurred with the student participants during this week. The project implementer secured the posttest questionnaires in a locked cabinet to preserve confidentiality of student participants.

Data collection and analysis. Data was coded and collected from student pretest and posttest questionnaires and transferred into an Excel spread sheet. Excel data analysis functions were utilized to assist with the evaluation of the outcome data from this practice change project. Descriptive statistics and differences in individual and group means between pretests and posttests were calculated. The project was considered successful or having a positive impact if each students achieved a 78% or higher score on the posttest. The benchmark of 78% was required by the institution as a passing score. In addition, a 25% increase in the overall group mean difference between pretest and posttest scores was considered successful, reflecting the intervention had a positive impact on increasing student knowledge.

Conclusion

This evidence-based change practice was designed to implement and evaluate LGBT cultural competency content in one nursing course. The Model for Evidence-Based Practice Change, Campinha-Bacote's cultural process (2007), and the First^{2}Act Simulation Model were used during the implementation of this practice change project. Collaboration with other faculty and staff members occurred throughout project implementation, allowing for project process and procedures to be carried out as planned. The practice change was spread over multiple weeks. Students were introduced to the practice change project, informed consent was obtained, and students took a voluntary pretest questionnaire. Cultural competency and LGBT health disparity knowledge was presented in a classroom-based presentation via PowerPoint. Students explored their own cultural preferences, practices, and biases toward the LGBT. Students viewed a short video depicting the social stigma, discrimination, and biases of the LGBT present in the greater society. Students gained and improved their assessment skills of the LGBT by completing a case study and practicing assessments that were sensitive to the LGBT and then engaged in simulation of a medical patient that integrated the LGBT. Students engaged in reflection, received a post-simulation debriefing, engaged in a summary and conclusion of the practice change project, took the posttest questionnaire, and offered feedback for improving the implementation of this practice change project. All forms were coded and stored in a locked filing cabinet to maintain the confidentiality of participants. The data analysis of this practice change project followed implementation and the information obtained assisted to create future suggestions and implications.

Chapter Six: Evaluation and Outcomes of the Practice Change

Analyzing data from a project's implementation can be of practical use for standardizing evidence-based practices (EBP). Interventions demonstrating outcome improvement can be utilized to promote continuous improvement of patient, institutional, and educational outcomes. Key to the success of a new practice change intervention is the accurate and unbiased collection of data to reflect evaluation of outcomes that can be utilized as a reliable and valid means for leading practice change initiatives. Practice change that is driven by data is essential to informing others of improved project outcomes. Technology, such as computers and Excel software with data analysis functions, provided efficiency, structure, and accuracy during project outcome evaluation. Students enrolled in one nursing course participated in a practice change project to improve knowledge of the lesbian, gay, bisexual, and transgender (LGBT) population. This chapter discusses the data analysis process and evaluation of outcomes that resulted from the practice change project.

Participant Demographics

Nursing students enrolled in an associate degree nursing capstone course were invited to participate in the project (n=10). All students enrolled in this course were offered the opportunity to participate in the project, regardless of gender, age, ethnicity, cultural background, or sexual orientation (n=10). No nursing students were excluded from participating in this project. A total of 10 nursing students participated in the LGBT cultural competency project for a response rate of 100 percent. Three students (30%) were male and seven (70%) were female. The age of participants ranged from 22-38 years of age, with a mean age of 28.9 years. Three of the 10 nursing students (30%) identified as "Black" or "African American"; seven of the 10 nursing students (70%) identified as "White" or "European"; and none of participants (0%) were

identified as “Spanish”, “Hispanic”, or “Latino”. None of the 10 nursing students (0%) identified themselves as LGBT. Nine of the 10 nursing students reported receiving previous education focused on cultural competency in general, but no student (0%) reported receiving previous education focused on the LGBT.

Intended Outcomes

The purpose of this EBP project was to improve student nurses’ knowledge of LGBT cultural competency through a five-week program. The main intended outcome was to increase student knowledge level of LGBT cultural competency, which would ultimately decrease health disparities within this population. There were two benchmarks used to measure the outcomes, (a) each student would score at least a 78% on the posttest and (b) a 25% increase in the overall group mean between pretest and posttest scores will occur.

Measurement Tool

Effectiveness of a measurement tool relies on the accuracy of the tool for consistently measuring what it is set out for. As such, measurement tools are evaluated in terms of validity and reliability to determine accuracy and consistency of the tool (Melynk & Fineout-Overholt, 2011). Reliability refers to the tool measuring constructs consistently each time it is used. Validity refers to the tool accurately measuring what it is said to measure. For purposes of this project, the focus was on content validity. An expert, who specializes in LGBT cultural competency reviewed the measurement tool and determined content validity of the pre/posttest questionnaire.

Pretest - Posttest Questionnaire. Based on a review of the literature that confirmed no valid or reliable tool existed, the PI developed a measurement tool. The LGBT Cultural Competency Questionnaire (see Appendix A) was developed by the PI. The questionnaire is

based on the most up-to-date cultural competency and LGBT content. An expert review of the tool determined each of the 16 multiple-choice questions to be an accurate measure of the construct of LGBT cultural competency. Each question had only one correct answer.

Project Evaluation

Data from the LGBT Cultural Competency Questionnaire (utilized as the pretest/posttest) was analyzed using the Analysis ToolPak found in Microsoft Office Excel. A comparison of pre and post individual scores (correct number of answers) and overall group mean was conducted (see Table 6.1).

Table 6.1

Comparison of Pre- and Post-test Scores

	% of Correct Answers		
Participant	Pre Correct Answers (%)	Post Correct Answers (%)	% Difference Between Pre and Post Score %
1	8 (50%)	16 (100%)	+8 (100% increase)
2	9 (56.2%)	16 (100%)	+7 (77.8)
3	6 (37.5%)	16 (100)	+10 (166.7)
4	6 (37.5%)	16 (100)	+10 (166.7)
5	11 (68.8%)	14 (87.5)	+3 (27.3)
6	6 (37.5%)	15 (93.8)	+9 (150.0)
7	6 (37.5%)	13 (81.3)	+7 (116.7)
8	8 (50.0%)	16 (100)	+8 (100.0)
9	11 (68.8%)	16 (100)	+5 (45.5)
10	7 (43.8%)	16 (100)	+9 (128.6)
Group Mean	7.8 (48.8%) Mean	15.4 (96.3%) Mean	+7.6 (97.4%) Mean

The range for participant individual pretest scores was 6-11 (37.5%-68.8%) with a group mean score of 7.8 (48.8%). The range for posttest individual scores was 13-16 (81.3%-100%) with a group mean score of 15.4 (96.3%). As such, the first outcome measure of achieving a benchmark score of 78% for all participants was successfully met. Comparing the difference

between pretest and posttest scores, all participant posttest scores positively improved with a range of 3-10 (27.3%-166.7%) and group mean difference of 7.6 (97.4%). Thus, the second outcome measure of achieving a 25% increase in the mean between pretest and posttest scores was also met.

Conclusion

Ten nursing students enrolled in an associated degree capstone course participated in an evidence-based change project offering of LGBT cultural competency education as an intervention. The result of data analysis indicates a positive difference in LGBT cultural competency knowledge of each student participant. Both intended outcome measures were met, indicating a successful project evaluation. Information technology such as Excel provided a more efficient means analyzing data.

Chapter Seven: Implications for the Future and Project Limitations

An evidence-based practice (EBP) change project was completed within a nursing course at a tertiary institution located in Central Ohio. The purpose of this project was to implement an intervention to improve LGBT cultural knowledge among nursing students with implications of reducing health disparities. The project's data analysis revealed the educational intervention was successful. As such, implications for nursing educators and other nursing professionals are presented in this chapter. The eight essentials offered by the American Association of Colleges of Nursing (AACN) were utilized as a framework for discussing implications for the future of nursing. Limitations of the project are discussed with suggestion of how to improve the practice change intervention for future implementations.

Implications for Nursing Education and Practice

Nursing scholarship encompasses the translation of theory, science, and knowledge into meaningful nursing practice while advancing the discipline of nursing and improving patient and healthcare environment outcomes. In the *Essentials of Doctoral Education for Advanced Nursing Practice,* the American Association of Colleges of Nursing (AACN) discusses eight competencies that have implication for nursing professionals prepared at all degree levels. The essentials are utilized as a framework for describing implications for future nursing education and practice as a result of the EBP change intervention.

Essential I: Scientific Underpinnings for Practice. Scientific underpinnings reflect the conceptual foundation of nursing with the emerging complexity of today's nursing practice. The discipline of nursing is multidimensional and stemming from (a) principles and laws that govern the life-process, well-being, and optimal function of human beings, sick or well; (b) patterning of human behavior in interaction with the environment in normal life events and critical life

situations; (c) nursing actions or processes by which positive changes in health status are affected; and (d) the wholeness or health of human beings recognizing that they are in continuous interaction with their environments (AACN, 2006, p.9).

Scientific underpinnings expand from natural and social sciences such as human biology, genomics, therapeutics, psychosocial, and complex organizational structures. Philosophical, ethical, and historical influences from these sciences provide the context for implication into nursing practice. As such, the integration of expanding nursing science with the expanding scientific underpinnings has lead to an immense body of knowledge, theories, and concepts that are set forth to guide nursing practice (AACN, 2006). Nursing educators will require the proper scientific underpinnings needed to translate knowledge into practice, and practice into measureable data-driven outcomes for improvement. Improving outcomes through data-driven measures as a result of evidence-based practice provides benefit to current and future nursing education and practice. Nursing educators will utilize these measures to improve patient and healthcare environment outcomes to transform nursing education providing the link between nursing education and nursing practice.

When conducting a review of literature to support improvement of LGBT cultural competency knowledge of nursing students, nursing educators explore the scientific underpinnings, frameworks, conceptual models, and theories to guide this practice. The process of cultural competence through the delivery of healthcare services (Campinha-Bacote, 2007) is identified as a practical framework for LGBT cultural competency education. Nursing educators can identify multiple studies where the utilization of this model led to an improvement between pre- and post-test scores. As such, the implication is that nursing educators may utilize the process of cultural competence through the delivery of healthcare services as a practical

framework to guide LGBT cultural competency education. The use of this guiding process provides the underpinnings needed to support an educational intervention focused on the LGBT population and subsequent outcomes improvement.

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking. Organizational leadership is critical for improving outcomes within the system. Improving nursing curricula by adding LGBT cultural competency education is aligned with nursing and health care goals. As such, nursing educators will promote a culture of excellence and improve nursing education. Improving quality of nursing education and health care environments requires the nurse to possess distinct skill sets for organizational and systems management. An adaptive leadership style is required to manage all realms of nursing education and healthcare organizations.

The implication of implementing LGBT cultural competency education within nursing curricula is that nurses will promote ethical and positive working environments that are sensitive to patient and organizational diversity of the LGBT population. By providing ethical and diverse care, the nurse will better meet the needs of patients and health care environments. Improving LGBT cultural competency knowledge has implications to improve educational and healthcare organizational systems such as: (a) communication and collaboration with the LGBT; (b) LGBT health disparities; (c) medical expenditures as a result of LGBT health disparities; (d) educational and healthcare organizational compliance, regulations, and policy; and (e) sensitivity to LGBT diversity within nursing education and healthcare organizations. Nursing educators will need to provide the leadership needed to improve nursing curricula and incorporate the needs of the LGBT population.

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice. Clinical scholarship and analytical methods for EBP has implication for nursing educators. Scholarship and research methodologies are hallmarks of doctoral nursing education. Nursing educators are given the task of improving nursing curricula. In addition, evidence-based nursing education is essential for improving curricula, which has implication on patient outcomes. Nursing educators will need to recognize the processes required for evidence-based nursing education and LGBT cultural competency. Clinical scholarship and analytical methods required for LGBT cultural competency in evidence-based nursing education includes: (a) integrating knowledge from diverse sources and across health profession disciplines; (b) utilizing information technology to analyze data and evaluate the LGBT cultural competency educational intervention; (c) collaborating with others to implement the practice change intervention and generate new knowledge; and (d) suggesting practice change, seeking professional presentation, and seeking publication in an effort to disseminate the findings from integrating and evaluating LGBT cultural competency in nursing education. The implication is that nursing educators will need to utilize scholarship and analytical methods from EBP to improve outcomes and advance nursing education and practice, such as LGBT cultural competency education.

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care. Information systems and information technology improves the accuracy and efficiency of the data analysis and evaluation of LGBT cultural competency education. Data from the LGBT Cultural Competency Questionnaire (utilized as the pretest/posttest) can be organized and analyzed using software and statistical programs to improve data analysis and evaluation, such as the Analysis ToolPak add-in program in Microsoft Office Excel. Project evaluation can be further expressed through creating a table

to better depict results interpretation, which can then be utilized for presenting outcomes to other faculty or during professional presentation and publication. The implication is that nursing educators should utilize the available technology to improve data organization, data analysis, and data evaluation.

Due to the need of improving quality and healthcare outcomes, nursing professionals have now begun to integrate information technology to improve patient health (Chism, 2013). The electronic health record (EHR) is a type of technology used to collect, input, manage, and recall patient data (Hebda & Czar, 2013). Electronic assessment forms should be revised to include the proper collection of data specific to the LGBT population. Electronic assessment forms should include a format that is culturally sensitive to the LGBT population. Through electronic notifications, healthcare professionals are made aware of potential patient needs and bundled tasks to be completed. Notifications should be revised to alert nurses and other healthcare professionals to complete a culturally sensitive LGBT health assessment and carry out specific tasks to promote the health status of the LGBT population. LGBT health disparity assessment should be incorporated into EHRs. The Centers for Disease Control and Prevention ([CDC], 2011) recommends testing for Human Immunodeficiency Virus (HIV) at least once for all individuals between the ages of 13-64 in all healthcare settings. The CDC also recommends the LGBT population and other high-risk individuals to commit to yearly or even more frequent testing for HIV and other sexually transmitted infections (STIs). Further, the CDC recommends all healthcare facilities to notify all patients that testing will be performed; however, give the option for patients to decline or defer testing. In addition, written consent for HIV testing should not be required by healthcare facilities, as general consent for medical care is considered sufficient and assent will be inferred. Further, the CDC recommends prevention counseling and

resources be supplied to all patients. As such, electronic reminders should be altered so that nurses and other healthcare professionals complete an assessment for sexual health, HIV, and STI for all patients, regardless of their gender, relationship status, or sexual orientation. The implication is that nurses and other healthcare professionals should work with EHR specialists to create assessment forms and notifications that are culturally sensitive to the LGBT population. In addition, health disparities should be integrated and sexual health assessments should be included to improve STI and HIV testing and subsequent health disparities.

Essential V: Health Care Policy for Advocacy in Health Care. Nursing educators are required to prepare nursing students with the proper skill sets needed to affect health policy and provide care that is ethical, equitable, and socially just to all individuals. Nursing educators will need to ensure a clear link between practice, research, and policy. By influencing policy, nursing leaders can promote improvement of issues such as health disparities, cultural competency, ethics, access to care, quality of care, financing, and equity and social justice in the delivery of health care (AACN, 2006).

The nursing profession is guided by standards of practice and codes of ethics to ensure care ethical and equalized quality of care is provided to all individuals. Of particular significance, the International Council for Nurses (ICN) Code of Ethics for Nurses references nursing care to be “respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status” (p. 2). The implication is that nursing educators may utilize the code of from the ICN to support the need to provide care to clients that is unbiased, socially just, and respective to aspects such as culture, gender, and sexual orientation.

Boards of nursing are an avenue for addressing policy and regulations in nursing education. The Ohio Board of Nursing (OBN) is the regulating body for nursing education programs in Ohio that prepare students for initial licensure as a Registered Nurse (RN) (Ohio Board of Nursing, 2013). OBN requires that an RN curriculum consist of course content involving the application of nursing care concepts to include addressing the cultural needs of clients. The purpose and philosophy of the facility's nursing program, where the EBP project occurred, discusses the need to encompass the whole person to include education focusing on cultural beliefs, customs, and habits to improve patient outcomes. The implication is that nursing educators and all other nursing professionals should influence policy at each state board of nursing level to encourage a policy change that specifies requirement of cultural specific language to include the LGBT.

The Joint Commission ([TJC], 2011) provides practice regulation that is specific to LGBT cultural competency education. TJC now requires all institutions to prepare all health professionals with proper LGBT cultural competency education. The Element of Performance (EP) 29 of the *Comprehensive Accreditation Manual for Hospitals (CAMH)* states, "The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression" (TJC, 2011, p. 61). The implication is that appropriate LGBT cultural competency education should be offered to nursing students and existing nursing personnel in order to properly prepare nursing professionals for current practice needs. Nursing educators can integrate current policy and procedures into case studies and patient simulations that are specific to the LGBT.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes. Collaboration promotes improvement of practice and outcomes for nurses, patients, and healthcare environments (AACN, 2006). Nursing educators may utilize collaboration, communication, and conflict management skill sets to advocate for the LGBT. Implication of these skill sets provide nursing educators with needed methods for leading collaborative interprofessional EBP changes such as integrating LGBT cultural competency change in nursing education. Effective collaboration with all stakeholders will be required to lead a practice change to implement LGBT cultural competency education in nursing curricula.

Nursing educators should communicate and collaborate with LGBT individuals and experts within the fields of cultural competency and the LGBT. The implication is that nursing educators can enhance their knowledge, understanding, and capacity within each field. The LGBT and experts within these areas can be utilized as guest speakers, providing enrichment to LGBT cultural competency education.

Nursing professionals require proper collaboration, communication, and conflict management skill sets specific to the LGBT. The implication is that nursing educators will need to ensure nursing students are offered the skill sets required for LGBT culturally competent encounters. LGBT cultural skill and LGBT cultural encounter should offer students experiential learning opportunities to improve LGBT culturally sensitive assessments and required communication, collaboration, and conflict management. The nursing skills lab and high-fidelity patient simulator provide an opportunity to improve assessment skills, encounters, communication, and collaboration sensitive to the LGBT. Nursing educators may present conflicts involving the LGBT within lectures, case studies, and simulations, to improve nursing students' conflict management skills and LGBT patient advocacy.

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health. Nurses at all levels require core competencies in the promotion of health and prevention of disease. Improving the health of the nation through patient-centered and culturally competent care is an imperative for nursing professionals. Nursing educators are required to ensure nursing students are equipped with the core competencies needed to positively impact the health of the nation. Nursing educators have the task of integrating and institutionalizing evidence-based clinical prevention methodologies to improve the health status of every individual and patient population. This process requires addressing the gaps in the care of individuals and patient populations. As such, the LGBT have become a focused population for health disparity improvement. Nurses are responsible for providing the proper patient education to prevent illness, disease, and injury. Nursing educators will need to provide nursing students with the skill sets needed to positively impact LGBT health. The implication is that nursing educators will need to include education on the following: (a) LGBT health disparities, (b) determinants of health that lead to LGBT health disparities, (c) and appropriate prevention measures and patient education skills to improve the determinants of health that lead to LGBT health disparities.

Essential VIII: Advanced Nursing Practice. Nursing educators will need to provide the knowledge and practice expertise needed to impact LGBT health. By ensuing essentials I-VII, the nursing educator will align new nursing professionals with the fundamental skill sets needed to improve the health of the LGBT. Ensuing essentials I-VII will assist nursing educators to advance nursing education and nursing practice.

Nursing specialization provides nurses with an opportunity to advance their nursing practice that is unique to specific patient populations and nursing practice. Nursing

specializations offer opportunity for improving patient-centered interventions and provides a context for influencing and developing policy related specifically to practice. Transcultural Nursing Certification (TNC) by the Transcultural Nursing Society ([TCNS], n.d.) will demonstrate the knowledge, experience, and commitment to culturally competent care. The implication of obtaining TNC is that nursing professionals will demonstrate their expertise and advance their focused nursing practice. No LGBT nursing certification or specialty was identified; however, many organizations have resources available to support LGBT health. LGBT health specialization is needed to fill this void and nursing professionals may advocate for such. Meanwhile, nursing professionals may utilize the available resources to advance their nursing practice focused on the LGBT. Many of the resources available are specific to the LGBT and are designed and marketed toward the LGBT. As such, nursing professionals can utilize the available resources for patient education opportunities.

Project Limitations

Due to course availabilities, this practice change project was implemented utilizing a small convenience sample size at a single educational institution within one nursing course. As such, an identified limitation was the small sample size utilized for this practice change project. A sample size should include a sufficient number of participants to ensure confidence that change occurred as a result of the project intervention and not by chance alone. To overcome this limitation for future education, nursing educators should consider a larger sample size. Considerations for calculating a power analysis should be taken to determine the sample size needed for minimizing findings that may have occurred due to change alone. As such, a Type I error may occur as a result of a small sample size (Melnyk & Fineout-Overholt, 2011).

Effectiveness of a measurement tool relies on the accuracy of the tool for consistently measuring what it is set out for. No reliable or valid measurement tool specific to LGBT cultural competency knowledge was found during a search. Therefore, the project implementer created the LGBT Cultural Competency Questionnaire to more accurately reflect LGBT cultural competency knowledge as a result of the most up-to-date literature found. Through an expert review, the measurement tool was found to be valid, suggesting the tool accurately measures LGBT cultural competency knowledge. Reliability on the other hand refers to the tool measuring constructs consistently each time it is used. Since this was the first time the tool was utilized, reliability could not be determined. This limitation may be overcome in the future by nursing educators utilizing the tool for assessing LGBT cultural competency.

Conclusion

Implications for future nursing practice and limitations of this practice change project were discussed. Nursing educators and other nursing professionals need to be the leaders to advance evidence-based education in nursing practice. As such, the eight essentials offered by the American Association of Colleges of Nursing (AACN) were discussed and implications of each related to LGBT cultural competency education were presented. Limitations of this practice change were presented and suggestions were made to improve this practice change for future implementations.

Chapter Eight: Final Summary and Conclusion

An evidence-based practice (EBP) change project was completed within a nursing course at a tertiary institution located in Central Ohio. The purpose of this project was to implement an intervention to improve LGBT cultural knowledge among nursing students with implications of reducing health disparities. The project's data analysis revealed the educational intervention was successful. As such, this project has implications for nursing educators and other nursing professionals. This chapter discusses the highlights of the EBP change project. The project summary presents an overview of the project by briefly describing: (a) an introduction to the problem; (b) evidence used to guide the practice change intervention; (c) pre-implementation planning and preparation; (d) implementation process and procedures; (e) findings, project evaluation, and outcomes; and (f) implications, limitations, and suggestions for future practice. A final conclusion is discussed for this practice change project.

Project Summary

Lesbian, gay, bisexual, and transgender (LGBT) individuals face increasing health disparities linked to discrimination, social stigma, biases, and culturally incompetent health providers. LGBT cultural competence training is recommended for integration in all health professional curricula. LGBT cultural incompetence has been linked to increased health disparities and increased medical expenditures. Improving knowledge is linked to aid in eliminating LGBT health disparities. A gap exists between recommendations and the practice of educating individuals on LGBT cultural competence. The purpose of this project was to implement an intervention to improve LGBT cultural knowledge among nursing students with implications for nurses and other healthcare professionals in an effort to reducing health disparities.

In a review of literature, the most frequently cited cultural framework was the Campinha-Bacote's cultural process (2007). Several studies were found utilizing Campinha-Bacote cultural framework (Abel, Silva, Desilets & Durand, 2010; and Black, Soelberg, & Springer, 2008). Cultural competency educational intervention was delivered in each study following the Campinha-Bacote framework. Pre/post tests were administered in each study to measure knowledge acquisition. Various statistical tests were performed to determine if an increase between pretest and posttest scores occurred, revealing the impact of cultural competency education for nursing and other health care professionals. There is a compelling amount of literature to support a practice change and guide LGBT cultural competency nursing education. As such, the guiding framework was Campinha-Bacote's cultural process (2007) and the FIRST^{2}ACT simulation model.

Pre-implementation planning and preparation was conducted in preparation of project implementation. A team was assembled with communication and collaboration efforts starting immediately to overcome the identified potential barrier of team conflict. Materials were gathered and prepared. The printed materials needed included informed consents, classroom based handouts, case study scenario with simulation prep work, and the pre/post test. Existing resources that were available included the use of a classroom, the implementer's laptop, and the simulation lab including the high-fidelity patient simulator. Prior to implementing this project, approval was granted by the director of nursing and the university's institutional review board (IRB).

Project implementation began in May 2013. Nursing students (n=10) in their last term participated in a one-group pretest-posttest educational intervention including a high-fidelity patient simulation. The instrument used for data collection was The LGBT Cultural Competency

Questionnaire, created by the project implementer to analyze knowledge acquisition of LGBT cultural competency. Two benchmarks were used to measure the impact of this project: (a) all students would score at least a 78% on the posttest and (b) a 25% increase in the overall group mean between pretest and posttest would occur. The evaluation of the LGBT cultural competency practice change project was deemed effective for both benchmarks were met and exceeded.

Nursing scholarship encompasses the translation of theory, science, and knowledge to advance and improve practice and outcomes for nurses, patients, and healthcare environments. The LGBT practice change project has implications for advancing the nursing profession and overall health of the nation. Improving the knowledge of nursing graduates has the potential to decrease LGBT health disparities and subsequent medical expenditures. LGBT cultural competency education has future implications for nursing educators. Limitations of this project are the small sample size and a pre- posttest tool without a determined reliability. Suggestions for future project implementation include increasing the sample size and completing repeated project implementation to determine reliability.

Conclusion

The LGBT cultural competency intervention positively impacted the knowledge and awareness of LGBT cultural needs in associate-degree nursing students. Although limitations such as a sample size and reliability of this tool was identified, the integration of LGBT cultural competency education is needed in nursing curricula to more effectively prepare nursing graduates to improve the health of the nation, and care for LGBT diverse individuals. Nursing professionals and educators should utilize these results with caution, taking the identified

limitations into consideration. Future nursing professionals will be educated with the knowledge needed to care for LGBT individuals and assist with improving health disparities of the LGBT.

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Appendix A

Pre- Posttest Questionnaire

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LGBT Cultural Competency Questionnaire:

Select the best answer

1. Campinha-Bacote (2007) describes "cultural desire" as:

a) The motivational process involved with becoming culturally competent.
b) The exploration and reflecting of one's own cultural beliefs, practices, and biases.
c) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.
d) The seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.

2. Campinha-Bacote (2007) describes "cultural awareness" as:

a) The cultural interactions with culturally diverse individuals.
b) The exploration and reflecting of one's own cultural beliefs, practices, and biases.
c) The seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.
d) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.

3. Campinha-Bacote (2007) describes "cultural knowledge" as:

a) The exploration and reflecting of one's own cultural beliefs, practices, and biases.
b) The cultural interactions with culturally diverse individuals.
c) Seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.
d) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.

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4. Campinha-Bacote (2007) describes "cultural skill" as:

a) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.
b) Cultural interactions with culturally diverse individuals.
c) Seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.
d) The motivational process involved with becoming culturally competent.

5. Campinha-Bacote (2007) describes "cultural encounters" as:

a) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.
b) Seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.
c) The motivational process involved with becoming culturally competent.
d) The cultural interactions with culturally diverse individuals.

6. Which factors are considered when becoming culturally competent?

a) Age
b) Gender
c) Sexual Orientation
d) All the Above

7. Cultural incompetence leads to health disparities in which of the following populations?

a) LGBT population
b) Non-LGBT population
c) Non-Hispanic and Latino populations
d) All the Above

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8. Becoming culturally competent of which population(s) will assist to decrease health disparities?

a) All populations
b) Lesbian, Gay, Bisexual, and Transgender (LGBT) population only
c) Hispanic population only
d) Cultural competence does not affect health disparities

9. Which population is at highest risk for Human Immunodeficiency Virus (HIV) and other Sexually Transmitted Infections (STIs)?

a) Gay Caucasian Men.
b) Gay men of color.
c) Straight Caucasian Men.
d) Straight Men of color.

10. Which population(s) is more likely to attempt suicide?

a) Non-LGBT youth
b) LGBT youth
c) Both "a" and "b" are equally likely
d) Neither "a" nor "b" are likely

11. Which population is more likely to be overweight or obese?

a) Straight men.
b) Gay and bisexual men
c) Straight women
d) Lesbian and bisexual women

12. Which population has a high prevalence of HIV/STIs, victimization, mental health issues, and suicide and is less likely to have health insurance?

a) Gay and bisexual men
b) Transgender individuals
c) Lesbian and bisexual women
d) Non-LGBT individuals

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13. Which population faces additional barriers to health because of isolation and a lack of social services and culturally competent providers?

a) Non-LGBT youth
b) Elderly Non-LGBT individuals
c) LGBT youth
d) Elderly LGBT individuals

14. Which population has the highest rates of tobacco, alcohol, and other drugs?

a) Mexican Americans
b) Non-LGBT populations
c) LGBT populations
d) Asian Americans

15. LGBT individuals face health disparities that:

a) Are similar to non-minorities
b) Are similar to all individuals in the LGBT population
c) Differ from subculture to subculture within the LGBT population
d) Are similar to all other minority populations

16. Which of the following is true regarding LGBT health disparities?

a) Lesbians experience the same health disparities as all other LGBT individuals
b) Gay and bisexual men experience the same health disparities
c) Transgender individuals experience the same health disparities as Lesbian females
d) Lesbian, gay, bisexual, and transgender individuals experience differing health disparities.

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Answer Key: LGBT Cultural Competency Questionnaire

(Items 1-8 test the knowledge of cultural competency)

Select the best answer.

1. Campinha-Bacote (2007) describes "cultural desire" as:

a) The motivational process involved with becoming culturally competent.
b) The exploration and reflecting of one's own cultural beliefs, practices, and biases.
c) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.
d) The seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.

(Answer: A) Cultural desire involves the motivational process involved with becoming culturally competent (Campinha-Bacote, 2007).

2. Campinha-Bacote (2007) describes "cultural awareness" as:

a) The cultural interactions with culturally diverse individuals.
b) The exploration and reflecting of one's own cultural beliefs, practices, and biases.
c) The seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.
d) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.

(Answer: B) Cultural awareness involves exploring and reflecting of one's own cultural beliefs, practices, and biases (Campinha-Bacote, 2007).

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3. Campinha-Bacote (2007) describes "cultural knowledge" as:

a) The exploration and reflecting of one's own cultural beliefs, practices, and biases.
b) The cultural interactions with culturally diverse individuals.
c) Seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.
d) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.

(Answer: C) Cultural knowledge involves seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities (Campinha-Bacote, 2007).

4. Campinha-Bacote (2007) describes "cultural skill" as:

a) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.
b) Cultural interactions with culturally diverse individuals.
c) Seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.
d) The motivational process involved with becoming culturally competent.

(Answer: A) Cultural skill involves completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment (Campinha-Bacote, 2007).

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5. Campinha-Bacote (2007) describes "cultural encounters" as:

a) Completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.
b) Seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.
c) The motivational process involved with becoming culturally competent.
d) The cultural interactions with culturally diverse individuals.

(Answer: D) Cultural encounters involve cultural interactions with culturally diverse individuals (Campinha-Bacote, 2007).

6. Which factors are considered when becoming culturally competent?

a) Age
b) Gender
c) Sexual Orientation
d) All the Above

(Answer: D) All factors should be considered when becoming culturally competent. Factors such as age, gender, sexual orientation, religious affiliation, ethnicity, and geographical location should be taken into consideration when becoming culturally competent (Campinha-Bacote, 2007).

7. Cultural incompetence leads to health disparities in which of the following populations?

a) LGBT population
b) Non-LGBT population
c) Non-Hispanic and Latino populations
d) All the Above

(Answer: D) All populations are affected by cultural incompetence. All groups face increased health disparities related to cultural incompetence. It is further recommended for each individual to have a cultural assessment completed no matter which group they identify with. It has been established that there are differences even within the same cultural groups: however, becoming culturally competent of all individual populations

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will assist to decrease health disparities of all Americans (HHS, Healthy People 2020, 2012).

8. Becoming culturally competent of which population(s) will assist to decrease health disparities?

a) All populations
b) LGBT population only
c) Hispanic population only
d) Cultural competence does not affect health disparities

(Answer: A) All populations are affected by cultural incompetence. All groups face increased health disparities related to cultural incompetence. It is further recommended for each individual to have a cultural assessment completed no matter which group they identify with. It has been established that there are differences even within the same cultural groups; however, becoming culturally competent of all individual populations will assist to decrease health disparities of all Americans (HHS, Healthy People 2020, 2012).

(Items 9-16 discuss commonly seen LGBT disparities)

Select the best answer.

9. Which population is at highest risk for Human Immunodeficiency Virus (HIV) and other Sexually Transmitted Infections (STIs)?

a) Gay Caucasian men.
b) Gay men of color.
c) Straight Caucasian men.
d) Straight men of color.

(Answer: B) gay men are at higher risk of HIV and other STDs, especially among communities of color (U.S. Department of Health & Human Services [HHS], Healthy People 2020, 2012)

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10. Which population(s) is more likely to attempt suicide?

a) Non-LGBT youth
b) LGBT youth
c) Both "a" and "b" are equally likely
d) Neither "a" nor "b" are likely

(Answer: B) LGBT youth are more likely to attempt suicide (HHS, Healthy People 2020, 2012)

11. Which population is more likely to be overweight or obese?

a) Straight men
b) Gay and bisexual men
c) Straight females
d) Lesbians and bisexual females

(Answer: D) Lesbians and bisexual females are more likely to be overweight or obese (HHS, Healthy People 2020, 2012).

12. Which population has a high prevalence of HIV/STIs, victimization, mental health issues, and suicide and is less likely to have health insurance?

a) Gay and bisexual men
b) Transgender individuals
c) Gay and bisexual women
d) Non-LGBT individuals

(Answer: B) Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or other LGBT individuals (HHS, Healthy People 2020, 2012).

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13. Which population faces additional barriers to health because of isolation and a lack of social services and culturally competent providers?

a) Non-LGBT youth
b) Elderly Non-LGBT individuals
c) LGBT youth
d) Elderly LGBT individuals

(Answer: D) Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers (HHS, Healthy People 2020, 2012).

14. Which population has the highest rates of tobacco, alcohol, and other drugs?

a) Mexican Americans
b) Non-LGBT populations
c) LGBT populations
d) Asian Americans

(Answer: C) LGBT populations have the highest rates of tobacco, alcohol, and other drugs (HHS, Healthy People 2020, 2012).

15. LGBT individuals face health disparities that:

a) Are similar to non-minorities
b) Are similar to all individuals in the LGBT population
c) Differ from subculture to subculture within the LGBT population
d) Are similar to all other minority populations

(Answer: C) LGBT individuals face health disparities that differ from subculture to subculture within the LGBT population. Lesbian, gay, bisexual, and transgender individuals all face health disparities that differ from one another (HHS, Healthy People 2020, 2012).

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16. Which of the following is true regarding LGBT health disparities?

a) Lesbians experience the same health disparities as all other LGBT individuals
b) Gay and bisexual men experience the same health disparities
c) Transgender individuals experience the same health disparities as Lesbian females
d) Lesbian, gay, bisexual, and transgender individuals experience differing health disparities.

(Answer: D) LGBT individuals face health disparities that differ from subculture to subculture within the LGBT population. Lesbian, gay, bisexual, and transgender individuals all face health disparities that differ from one another (HHS, Healthy People 2020, 2012).

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Appendix B

LGBT Cultural Competency Education Schedule

Week:	**LGBT Cultural Competency Education** **Activity:**	**Time Allotted:**
1	Introduction to Project Informed Consent Voluntary Pretest	5-10 min. 5-10 min. 10-15 min.
2	PowerPoint Presentation Summary	60 min. 5-10 min.
3	Video LGBT Case Studies LGBT Assessment Skill Review & Practice Summary	11 min. 30 min. 30 min. 5-10
4	LGBT Cultural Simulation (2 Groups) Reflection Debriefing & Summary	60 min. (x2) 10-15 min. 5-10 min.
5	Summary of Project Question & Answer / Feedback Voluntary Posttest Final Remarks & Final Summary	10-20 min. 10-20 min. 10-15 min. 5-10 min.

Appendix C

LGBT Cultural Competency Presentation

Zachary Nethers, MBA, MSN, RN, EMT

LGBT CULTURAL COMPETENCY

LGBT POPULATION

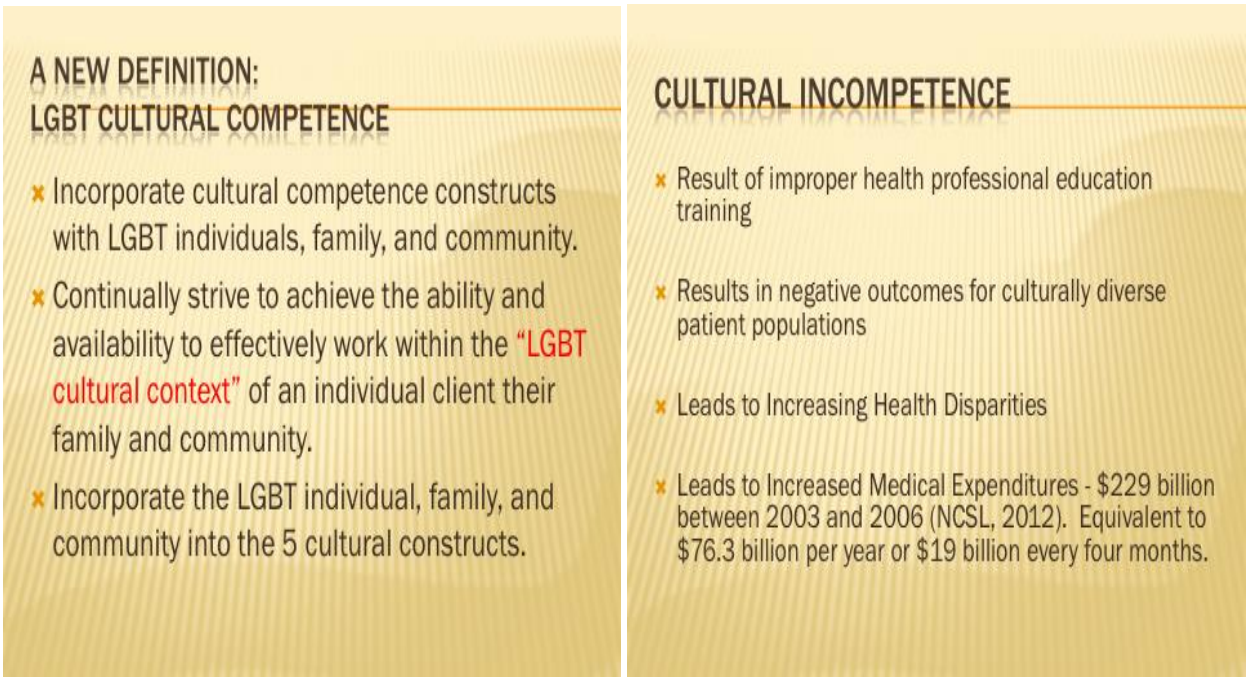
- LGBT: L=lesbian
  G=gay
  B=bisexual
  T=transgender
- 9 million or 4% of the U.S. population identify as LGBT
- 19 million or 8.2% have engaged in same-sex behavior
- 25.6 million or 11% acknowledged some same-sex attraction

CULTURAL COMPETENCE

- Associated with improving patient outcomes
- Associated with improving (decreasing) Health Disparities
- The Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2007)
- Campinha-Bacote defines cultural competence as "the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client (family, individual or community)".
- Process of *becoming culturally competent, not being culturally competent.*

THE PROCESS OF CULTURAL COMPETENCE IN THE DELIVERY OF HEALTHCARE SERVICES (CAMPINHA-BACOTE, 2007)

- 5 Constructs of Cultural Competence
- Desire
- Awareness
- Knowledge
- Skill
- Encounter



Gay Men Culturally Appropriate Educational Materials

Ten Things Gay Men Should Discuss with their Healthcare Provider

GLMA

1 Come Out to your Healthcare Provider

In order to provide you with the best care possible, your clinician should know you are gay. It should prompt him/her to ask specific questions about you and offer appropriate testing. If your provider does not seem comfortable with you as a gay man, find another provider.

2 HIV/AIDS, Safe Sex

Many men who have sex with men are at an increased risk of HIV infection, but the effectiveness of safe sex in reducing the rate of HIV infection is one of the gay community's great success stories. If you are HIV positive, you need to be in care with a good HIV provider. Safe sex is proven to reduce the risk of receiving or transmitting HIV. You should also discuss and be aware of what to do in the event that you are exposed to HIV (Post Exposure Prophylaxis)–contacting your provider IMMEDIATELY following an exposure to explore your options. If you are in a relationship where one of you is positive, you should discuss options for prevention with your provider as well.

3 Hepatitis Immunization and Screening

Men who have sex with men are at an increased risk of sexually transmitted infection with the viruses that cause the serious condition of the liver known as hepatitis. These infections can be potentially fatal, and can lead to very serious long-term issues, such as liver failure and liver cancer. Immunizations are available to prevent two of the three most serious viruses. Universal immunization for Hepatitis A Virus and Hepatitis B Virus is recommended for all men who have sex with men. Safe sex is effective at reducing the risk of viral hepatitis, and is currently the only means of prevention for the very serious Hepatitis C Virus. If you have Hepatitis C there are new, more effective treatments for that infection.

4 Fitness (Diet and Exercise)

Problems with body image are more common among gay men, and gay men are much more likely to experience an eating disorder such as bulimia or anorexia nervosa. While regular exercise is very good for your health too much of a good thing can be harmful. The use of substances such as anabolic steroids and certain supplements can be dangerous. Obesity also affects many gay men and can lead a number of health problems, including diabetes, high blood pressure, and heart disease.

5 Substance Use/Alcohol

Gay men use substances at a higher rate than the general population, and not just in larger cities. These include a number of substances ranging from amyl nitrate ("poppers"), to marijuana, ecstasy, and amphetamines. The long-term effects of many of these substances are unknown, however current wisdom suggests potentially serious consequences as we age. If your drug use is interfering with work, school or relationships, your healthcare provider can connect you to help.

6 Depression/Anxiety

Depression and anxiety appear to affect gay men at a higher rate than in the general population. The likelihood of depression or anxiety may be greater, and the problem may be more severe for those men who remain in the closet or who do not have adequate social supports. Adolescents and young adults may be at particularly high risk of suicide because of these concerns. Culturally sensitive mental health services targeted specifically at gay men may be more effective in the prevention, early detection, and treatment of these conditions.

7 STDs

Sexually transmitted diseases (STDs) occur in sexually active gay men at a high rate. These include STD infections for which effective treatment is available (syphilis, gonorrhea, chlamydia, pubic lice, and others), and for which no cure is available (HIV, Hepatitis, Human Papilloma Virus, herpes, etc). There is absolutely no doubt that safe sex reduces the risk of sexually transmitted diseases, and prevention of these infections through safe sex is key. The more partners you have in a year, the more often you should be screened. You can have an STD without symptoms, but are still able to give it to others.

8 Prostate, Testicular, and Colon Cancer

Gay men may be at risk for death by prostate, testicular, or colon cancer. Screening for these cancers occurs at different times across the life cycle, and access to screening services may be harder for gay men because of not getting culturally sensitive care. All gay men should undergo these screenings routinely as recommended for the general population.

9 Tobacco

Gay men use tobacco at much higher rates than straight men, reaching nearly 50 percent in several studies. Tobacco related health problems include lung disease and lung cancer, heart disease, high blood pressure, and a whole host of other serious problems. All gay men should be screened for and offered culturally sensitive prevention and cessation programs for tobacco use.

10 HPV (virus that causes warts and can lead to anal cancer)

Of all the sexually transmitted infections gay men are at risk for, human papilloma virus (HPV) – which cause anal and genital warts – is often thought to be little more than an unsightly inconvenience. However, these infections may play a role in the increased rates of anal cancers in gay men. Some health professionals now recommend routine screening with anal Pap Smears, similar to the test done for women to detect early cancers. Safe sex should be emphasized. Treatments for HPV do exist, but recurrences of the warts are very common, and the rate at which the infection can be spread between partners is very high.

Author: Robert J Wiss, MD AAHIVMS, Medical Director, Mission Center, Philadelphia, PA. Revised May 2012.

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Bisexual Culturally Appropriate Educational Materials

Ten Things Bisexuals Should Discuss with Their Healthcare Provider

GLMA

1 Come Out to your Healthcare Provider

In order to provide you with the best care possible, your clinician should know you are bisexual. It should prompt him/her to ask specific questions about you and offer appropriate testing. Many providers are less familiar with bisexuality and may make assumptions about your behavior. Be honest and you will get better care. Remind your provider each time you see them about who your current partners are–it may change the screening tests they offer you. If your provider does not seem comfortable with your sexual orientation, find another provider.

2 HIV/AIDS, Safe Sex

Many men who have sex with men are at an increased risk of HIV infection, but the effectiveness of safe sex in reducing the rate of HIV infection is one of the LGBT community's great success stories. If you are HIV positive, you need to be in care with a good HIV provider. Safe sex is proven to reduce the risk of receiving or transmitting HIV. You should also discuss and be aware of what to do in the event that you are exposed to HIV (Post Exposure Prophylaxis)–contacting your provider IMMEDIATELY following an exposure to explore your options. If you are in a relationship where one of you is positive, you should discuss options for prevention with your provider as well. Although women who have sex with women have lower rates of HIV, if you have sex with a gay or bi man (who have decreased rates) it is important to understand their HIV status and how to protect yourself.

3 Hepatitis Immunization and Screening

If you have sex with multiple partners (of any gender) you are at an increased risk of sexually transmitted infection with the viruses that cause the serious condition of the liver known as hepatitis. These infections can be potentially fatal, and can lead to very serious long-term issues such as liver failure and liver cancer. Immunizations are available to prevent two of the three most serious viruses. Universal immunization for Hepatitis A Virus and Hepatitis B Virus is recommended for all sexually active people. Safe sex is effective at reducing the risk of viral hepatitis, and is currently the only means of prevention for the very serious Hepatitis C Virus. If you have Hepatitis C there are new, more effective treatments for that infection.

4 Fitness (Diet and Exercise)

Problems with body image are more common among bisexuals and bisexuals are much more likely to experience an eating disorder such as bulimia or anorexia nervosa. While regular exercise is very good for your health too much of a good thing can be harmful. The use of substances such as anabolic steroids and certain supplements can be dangerous. Being overweight or obesity are problems that also affect many bisexuals. These can lead a number of health problems, including diabetes, high blood pressure, and heart disease and breast cancer.

5 Substance Use/Alcohol

Bisexuals may use substances at a higher rate than the general population, and not just in larger communities such as New York, San Francisco, and Los Angeles. These include a number of substances ranging from amyl nitrate ("poppers"), to marijuana, ecstasy, and amphetamines. The long-term effects of many of these substances are unknown, however current wisdom suggests potentially serious consequences as we age. If your drug use is interfering with work, school or relationships, your healthcare provider can connect you to help.

6 Depression/Anxiety

Depression and anxiety appear to affect bisexuals at a higher rate than in the general population. The likelihood of depression or anxiety may be greater, and the problem may be more severe for those men who remain in the closet or who do not have adequate social supports. Many bisexuals keep their orientation and sexual behavior a secret from their providers. Adolescents and young adults may be at particularly high risk of suicide because of these concerns. Culturally sensitive mental health services targeted specifically at gay men may be more effective in the prevention, early detection, and treatment of these conditions.

7 STDs

Sexually transmitted diseases (STDs) occur in sexually active bisexuals at a high rate. These include STD infections for which effective treatment is available (syphilis, gonorrhea, chlamydia, pubic lice, and others), and for which no cure is available (HIV, Hepatitis, Human Papilloma Virus, herpes, etc). There is absolutely no doubt that safe sex reduces the risk of sexually transmitted diseases, and prevention of these infections through safe sex is key. The more partners you have in a year, the more often you should be screened. You can have an STD without symptoms, but are still able to give that to others.

8 Prostate, Testicular, Breast, Cervical and Colon Cancer

Bisexuals may be at risk for death by these cancers. Screening for these cancers occurs at different times across the life cycle, and access to screening services may be harder for bisexuals because of not getting culturally sensitive care. All bisexuals should undergo these screenings routinely as recommended for the general population.

9 Tobacco

Recent studies seem to support the notion that bisexuals use tobacco at much higher rates than heterosexuals, reaching nearly 50 percent in several studies. Tobacco related health problems include lung disease and lung cancer, heart disease, high blood pressure, and a whole host of other serious problems. All gay men should be screened for and offered culturally sensitive prevention and cessation programs for tobacco use.

10 HPV (virus that causes warts and can lead to anal & cervical cancer)

Of all the sexually transmitted infections bisexuals are at risk for, human papilloma virus (HPV) – which cause anal and genital warts – is often thought to be little more than an unsightly inconvenience. However, these infections may play a role in the increased rates of anal cancers in bisexual men. Some health professionals now recommend routine screening with anal Pap Smears, similar to the test done for women to detect early cancers. Safe sex should be emphasized. Treatments for HPV do exist, but recurrences of the warts are very common, and the rate at which the infection can be spread between partners is very high. Individuals with a cervix should get routine pap smears as instructed by their clinician.

Author: Robert J Wiss, MD AAHIVMS, Medical Director, Mission Center, Philadelphia, PA. Revised May 2012.

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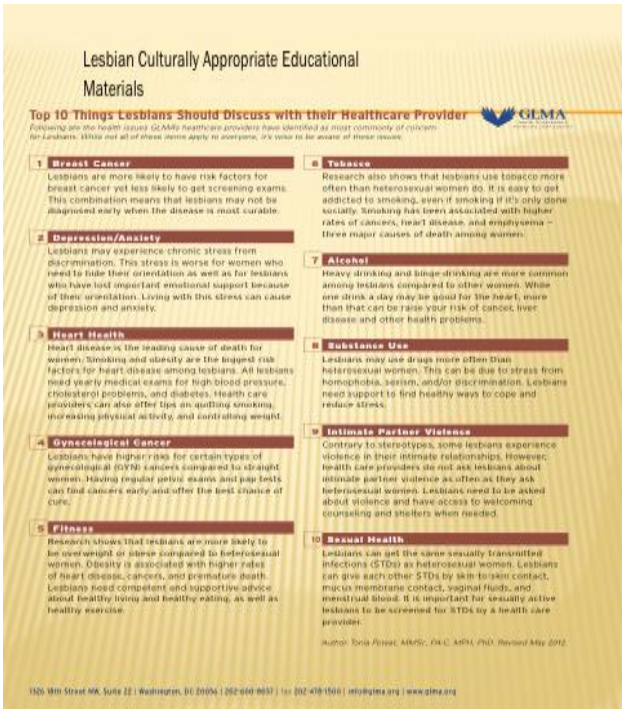

Lesbian Culturally Appropriate Educational Materials

Top 10 Things Lesbians Should Discuss with their Healthcare Provider

GLMA

1 Breast Cancer

Lesbians are more likely to have risk factors for breast cancer yet less likely to get screening exams. This combination means that lesbians may not be diagnosed early when the disease is most curable.

2 Depression/Anxiety

Lesbians may experience chronic stress from discrimination. This stress is worse for women who need to hide their orientation as well as for lesbians who have lost important emotional support because of their orientation. Living with this stress can cause depression and anxiety.

3 Heart Health

Heart disease is the leading cause of death for women. Smoking and obesity are the biggest risk factors for heart disease among lesbians. All lesbians need yearly medical exams for high blood pressure, cholesterol problems, and diabetes. Health care providers can also offer tips on quitting smoking, increasing physical activity, and controlling weight.

4 Gynecological Cancer

Lesbians have higher risks for certain types of gynecological (GYN) cancers compared to straight women. Having regular pelvic exams and pap tests can find cancers early and offer the best chance of cure.

5 Fitness

Research shows that lesbians are more likely to be overweight or obese compared to heterosexual women. Obesity is associated with higher rates of heart disease, cancers, and premature death. Lesbians need competent and supportive advice about healthy living and healthy eating, as well as healthy exercise.

6 Tobacco

Research also shows that lesbians use tobacco more often than heterosexual women do. It is easy to get addicted to smoking, even if smoking if it's only done socially. Smoking has been associated with higher rates of cancers, heart disease, and emphysema – three major causes of death among women.

7 Alcohol

Heavy drinking and binge drinking are more common among lesbians compared to other women. While one drink a day may be good for the heart, more than that can be raise your risk of cancer, liver disease and other health problems.

8 Substance Use

Lesbians may use drugs more often than heterosexual women. This can be due to stress from homophobia, sexism, and/or discrimination. Lesbians need support to find healthy ways to cope and reduce stress.

9 Intimate Partner Violence

Contrary to stereotypes, some lesbians experience violence in their intimate relationships. However, health care providers do not ask lesbians about intimate partner violence as often as they ask heterosexual women. Lesbians need to be asked about violence and have access to welcoming counseling and shelters when needed.

10 Sexual Health

Lesbians can get the same sexually transmitted infections (STDs) as heterosexual women. Lesbians can give each other STDs by skin-to-skin contact, mucus membrane contact, vaginal fluids, and menstrual blood. It is important for sexually active lesbians to be screened for STDs by a health care provider.

Author: Tonia Poteat, MAHSc, PA-C, MPH, PhD. Revised May 2012.

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Transgender Culturally Appropriate Educational Materials

Ten Things Transgender Persons Should Discuss with their Health Care Providers

1 Access to Healthcare

It is not easy to find a healthcare provider who knows how to treat transgender people. Sometimes it is difficult to find someone who will agree to treat you. Some providers may feel that there is something wrong with you because you are a transgender person. They are not correct, of course. They simply not understand all you have always been this way. Even if you do find someone who will treat you, your insurance may not pay for the treatment. Ask your provider if your costs will be covered by your insurance. If they will not, ask if they will reduce your bill so you can pay.

2 Health History

Its important for you to be able to trust your healthcare provider. Tell them about the medicines you have taken and the surgeries you may have had. If your provider knows what has happened with you in the past, he or she will be better able to give you the best treatment today.

3 Hormones

Talk with your provider about hormone treatment. If you are starting hormones for the first time, ask about the things you need to watch out for while taking these medicines. If you are a transgender woman, ask about estrogen and blood clots, swelling, high or low blood pressure and high blood sugar. If you are a transgender man, ask about the blood tests you will need to be sure your testosterone dose is safe. Be sure and take only the hormones prescribed by your provider.

4 Cardiovascular Health

Transgender persons may be at increased risk for heart attack or stroke, not only from hormone use but from cigarette smoking, overweight, high blood pressure and diabetes. Transgender women may fear that their provider may make them stop estrogen if they develop heart trouble, and so they may not report feelings such as chest pain or trouble breathing. Be sure to tell your provider if you do have these feelings.

5 Cancer

It is very rare to develop cancer due to hormone treatment, but your provider will evaluate you for this possibility when he or she sees you for check-ups. Your provider will also check for possible cancer of your sex organs, if they have not been removed. Again this is very rare but it should be checked along with the rest of your physical examination.

6 Sexually Transmitted Diseases and Safe Sex

Transgender people, particularly young transgender people, may be engaging in sexual activity. Just like anyone else, transgender people may get a sexually transmitted disease. It is very important to practice safe sex, so you will not be come infected with HIV or other sexually transmitted diseases. Ask your provider about safe sex practices.

7 Alcohol and Tobacco

Transgender persons who drink alcohol may drink too much and risk damage to the liver or other organs. Too much alcohol may also cause a person to treat themselves or other people badly, or to drive unsafely. Alcohol and hormones may be more dangerous when taken together. Many transgender people smoke cigarettes. This increases their risk of heart and lung disease, especially in persons taking hormones. Transgender persons who care about their health should not smoke, and they should drink only small amounts, if at all.

8 Depression

It is very easy for transgender persons to become sad and depressed. If our families or friends don't want to see us anymore. It is a very depressing time. Even after transition, depression can still be a problem. When someone is depressed, they cannot be happy no matter what they are doing. Depressed persons may make bad choices and may harm themselves. Please talk with your provider or your therapist about your feelings and tell him or her if you feel sad or depressed. Many good treatments are available for depression.

9 Injectable Silicone

Some transgender women want to look feminine and beautiful without having to wait for the effects of estrogen. They inject injections of silicone to give them "instant curves." The silicone sold at "pumping parties" by non-medical persons, may move around in the tissues and cause ugly scars years later. It is usually not medical grade, may be contaminated and is often injected using a shared needle. You can get hepatitis or HIV through shared needles. Silicone is dangerous and should not be used.

10 Fitness (Diet & Exercise)

Many transgender people are overweight and do not exercise. It is hard to make time for exercise if you have to work long hours. A healthy diet and a frequent exercise routine are just as important for transgender persons as for anyone else. If you are planning to have surgery, your surgeon will want to be sure you are in good physical condition to do well during and after surgery. Try to eat a healthy diet and try to exercise for at least 20 minutes three times a week.

Rebecca A. Allison, MD, Board of Directors, Gay and Lesbian Medical Association. Revised May 2012.

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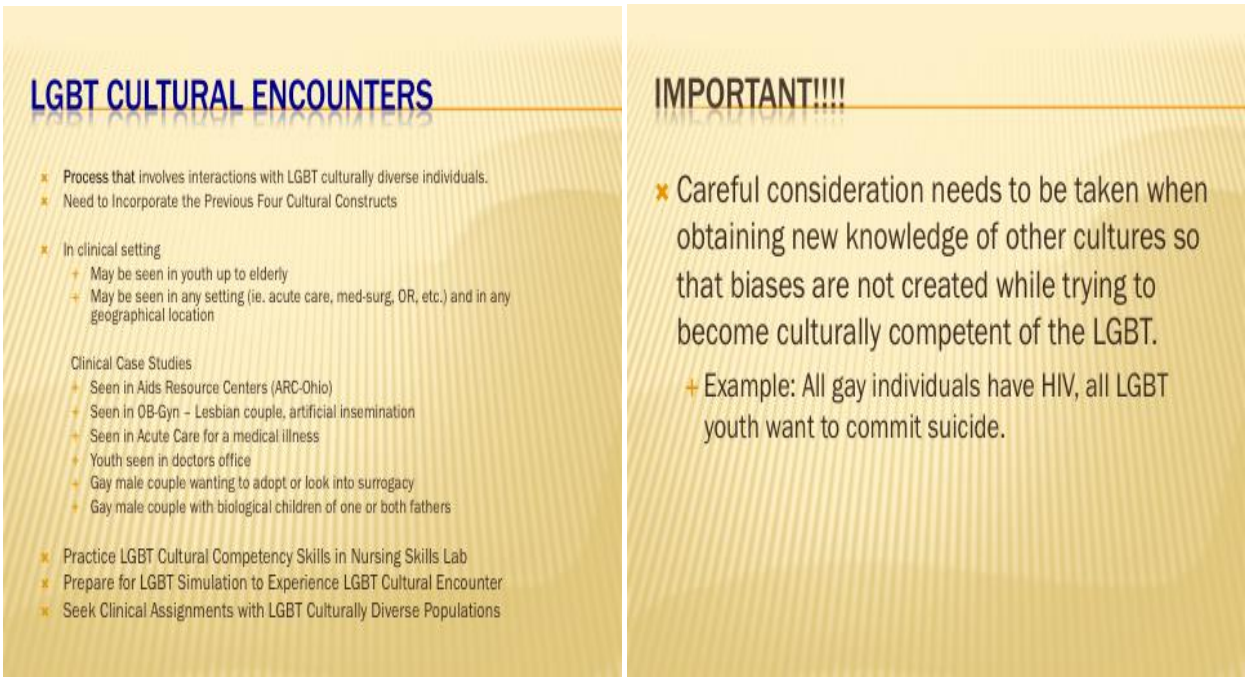

Appendix D

LGBT Cultural Competency and Disparities Assessment

Student Name: _____ Date: _____

Age:_____ Occupation & Income: _____
Current Living Arrangements: _____

Gender Identity:
Male___ Female___ Transgender___ Intersex___

Cultural/Spiritual/Linguistic Assessment:
Primary Language: _____
Family Dynamics: _____
Health Practices & Beliefs: _____
Special Cultural Communication Considerations: _____
Religious Affiliation: _____
Spiritual/Religious Practices or Needs: _____
Ethnicity: _____ Race: _____

Sexual Health Assessment:
Sexual Orientation: Straight____ / Lesbian ____ / Gay ____ / Bisexual ____ /

Sexual Practices: Male___ / Female___ / Both___ / How Often_____ /
How Many Partners_____ / Condom Use _____
Give or Receive Intercourse: _____ Give or Receive Oral Sex: _____
Intercourse (Circle Best Option): Vaginal Only / Anal Only /Both Vaginal & Anal
Condom Use: How Often: _____
History of STIs: _____ / How often & Date of Last HIV Test: _____
How Often & Date of Last STI Check-up: _____
Recent High Risk Sexual Practices: _____
Special Sexual Considerations: _____
Does the Patient Need Additional Sexual Education or Resources: _____
Sexual Function Concerns _____

Student Name: _____ Date: _____

Lesbian, Gay, Bisexual, and Transgender Health Disparities Assessment:

LGBT youth:

Suicide thoughts or attempts: _____

Living situation: _____

Family / Social Support: _____

Tobacco Use: _____ Alcohol Use: _____ Drug Use: _____

Gay and bisexual men:

Tobacco Use: _____ Alcohol Use: _____ Drug Use: _____

Sexual Orientation: Straight____ / Gay ____ / Bisexual ____ / Other ____ /

Sexual Practices: Male___ / Female___ / Both___ /
How Often_____ / How Many Partners_____
Condom Use_____
Give or Receive Anal Intercourse: _____
Give or Receive Oral Sex: _____
Condom Use: How Often: _____
History of STIs: _____ / How often & Date of Last HIV Test: _____
How Often & Date of Last STI Check-up: _____
Recent High Risk Sexual Practices: _____
Special Sexual Considerations: _____
Does the Patient Need Additional Sexual Education or Resources: _____
Sexual Function Concerns _____

Student Name: _____ Date: _____

Lesbians:

Preventative Services:

Pap Smear_____ / Mammogram_____

Activity / Exercise_____

Eating Habits_____

Tobacco Use: _____ Alcohol Use: _____ Drug Use: _____

Elderly LGBT:

Living situation: _____

Family / Social Support: _____

Tobacco Use: _____ Alcohol Use: _____ Drug Use: _____

Student Name: _____ Date: _____

Transgender:

Age: _____ Occupation & Income: _____
Health Insurance: _____
Tobacco Use: _____ Alcohol Use: _____ Drug Use: _____

Sexual Practices:
Male_____ / Female_____ / Both_____ / How Often_____
How Many Partners_____ / Condom Use _____
Give or Receive Intercourse: _____ Give or Receive Oral Sex: _____
Intercourse (Circle Best Option): Vaginal Only / Anal Only /Both Vaginal & Anal
Condom Use: How Often: _____
History of STIs: _____ / How often & Date of Last HIV Test: _____
How Often & Date of Last STI Check-up: _____
Recent High Risk Sexual Practices: _____
Special Sexual Considerations: _____
Does the Patient Need Additional Sexual Education or Resources: _____
Sexual Function Concerns _____

Mental Health:
Mental health diagnosis:_____

Suicide thoughts or attempts: _____

Living situation: _____

Family / Social Support: _____

Depression: _____ Anxiety: _____

Victimization: _____

Appendix E

LGBT Case Study and Simulation

LGBT Case Study / Simulation **Acute Renal Failure**

Name: Ryan Taylor
Age: 29
Weight: 56.8 kg
MR #: 4521

Sample History
Signs/Symptoms: Abdominal and flank pain with dark scant urine output
Allergies: NKA
Medications: Adderall, Ativan
Past & Present Medical Hx: Tonsillectomy, Gastritis, GERD, Multiple Kidney Stones
Last Oral Intake: Drank 2 alcoholic drinks before arrival. Last food > 3 days.
Events Leading Up To: Signs and symptoms started 2 days ago, progressing the last couple hours

---

Handoff Report
Situation:
The patient is a 29 year-old male who presented to the ED with complaints of abdominal pain with small amounts of dark urine.
Background:
His primary diagnosis is acute renal failure. He is awake, alert, and calm.
Assessment:
Vital signs: HR: 95, BP: 92/56, RR: 26, SpO2: 92% RA, oral temp: 98.5, Pain: 7/10.
General Appearance: Alert, oriented, calm, appears stated age, no acute distress
Neurological: Alert and oriented to person, place, situation, and time. Pupils are equal, round, reactive to light and accommodation. There are no neurological deficits identified.
Cardiovascular: Sinus Rhythm
Respiratory: Breath sounds clear to auscultation, bilaterally
Gastrointestinal: Bowel sounds are hypoactive; abdomen flat and non-distended; nauseated, without vomiting or diarrhea. Last bowel movement yesterday, normal.
Genitourinary: Urinary output 20 mL of dark amber urine in the last hour.
Extremities: Color pale, warm, and dry. Radial pulses weak bilaterally; Strong grips, pushes and pulls.
Skin: Warm, dry and pale
Recommendation:
What is your recommendation?

LGBT Case Study / Simulation Acute Renal Failure

When Students Arrive In Simulation:

Orders

Initial Orders

Insert IV: Start 0.9 Normal Saline at 200mL/hr.
Draw Labs: CBC, Basic Metabolic Panel, BUN, Creatinine
Fall Risk: Low risk
PRN Medications:
Promethazine 25 mg IVPB, given over 30 minutes, every 6 hours prn nausea
Hydromorphone 0.5-1mg every 2 hours IVP prn pain

Learning Objective

- Plans, prioritizes, implements, and evaluates nursing care provided to an LGBT individual experiencing acute renal failure

Preparation Questions

Renal:

- Discuss the pathophysiological changes that occur in acute renal failure.
- Differentiate between the causes, clinical manifestations, and diagnostic findings in pre-renal, intra-renal, and post-renal failure.
- What are the most common fluid and electrolyte disturbances?
- What are the signs and symptoms and causes that correlate with each of the identified electrolyte disturbance?
- Describe the collaborative management of a patient experiencing acute renal failure (Include: fluid administration, treatment of electrolyte imbalances, and dialysis).

LGBT Cultural Competency:

- Discuss the five constructs of cultural competency as defined by Campinha-Bacote.
- Describe the role cultural competency and each construct has while delivering patient care.
- Discuss a culturally competent LGBT patient assessment
- Discuss the common LGBT health disparities
- Describe the nurses role for improving LGBT health disparities
- Discuss current policy in the health care environment for the LGBT
- Discuss the possible determinants of health that can lead to the most common LGBT health disparities
- Discuss the patient education that nurses can provide for positively influencing health behaviors of the LGBT

LGBT Case Study / Simulation **Acute Renal Failure**

The Five Components of FIRST²ACT for Evaluating the LGBT Simulation:

Developing core knowledge (classroom based learning)
See the LGBT Cultural Competency PowerPoint for the review of

Assessment (learning stimulus)
Pre-simulation case study: Ryan Taylor. Students prepared for simulation the week before participating in simulation. Ryan Taylor is a simulated LGBT patient who identifies as a 29-year-old gay male, legally married in the District of Columbia, and has two biological kids from a previous marriage.

Simulation
Students engaged in a high-fidelity patient simulation of an LGBT individual, Ryan Taylor. Ryan has acute renal failure that is related to his chronic use of alcohol (one of the LGBT health disparities). Additionally, Ryan smokes a pack of cigarettes every day. When students assessed for possible LGBT health disparities the (facilitator) Ryan discussed that he and his husband have an open relationship with others. On the sexual assessment, students revealed that Ryan and his husband have had multiple other sexual partners within the past year without the use of condoms. Students educated on safe sex practices to prevent HIV/STI infections. Students collaboratively assessed for each of the common LGBT health disparities and made valid prevention measures. Additionally, students in each simulation group became patient advocates when the practitioner came in the room and asked the patient's husband to leave the rooms, while expressing only visitors were allowed to visit the patient.

Reflective review
Students reflected on their simulation experience, immediately after completing the simulation. Students discussed their learning and the difficulty of assessing sensitive information such as sexual practices of individuals. Students in both groups expressed that they feel more comfortable with assessing sexual practices after their simulation experience.

Performance feedback
Students received feedback from the project implementer after their reflection.

Appendix F

LGBT Cultural Competency Conclusion

Conclusion of LGBT Cultural Competency

Campinha-Bacote (2007) describes:

- **"Cultural desire" as:** the motivational process involved with becoming culturally competent.
- **"Cultural awareness" as:** exploring and reflecting of one's own cultural beliefs, practices, and biases.
- **"Cultural knowledge" as:** seeking and obtaining proper culturally diverse educational base integrating health-related belief practices; cultural values; and disease incidence and prevalence otherwise known as health disparities.
- **"Cultural skill" as:** completing a cultural assessment, collecting relevant cultural data, and completing a culturally based physical assessment.
- **"Cultural encounters" as:** cultural interactions with culturally diverse individuals.

Factors considered when becoming culturally competent:

- Age
- Gender
- Sexual Orientation
- Religious Affiliation
- Geographical Location
- Ethnicity
- ***All the Above are considered when becoming culturally competent***

Cultural incompetence leads to health disparities in the following populations:

- LGBT population
- Non-LGBT population
- Non-Hispanic and Latino populations
- ***Cultural incompetence leads to health disparities in all the above in addition to all populations***

Becoming culturally competent will assist to decrease health disparities in the population(s):

- All populations are affected by cultural incompetence. All groups face increased health disparities related to cultural incompetence. It is further recommended for each individual to have a cultural assessment completed no matter which group they identify with. It has been established that there are differences even within the same cultural groups; however, becoming culturally competent of all individual populations will assist to decrease health disparities of all Americans (HHS, Healthy People 2020, 2012).

Conclusion of LGBT Cultural Competency

Commonly seen LGBT disparities From the U.S. Department of Health & Human Services [HHS], Healthy People 2020 (2012):

- Gay men are at higher risk of HIV and other STDs, especially among communities of color
- LGBT youth are more likely to attempt suicide
- Lesbians and bisexual females are more likely to be overweight or obese
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or other LGBT individuals
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers
- LGBT populations have the highest rates of tobacco, alcohol, and other drugs
- LGBT individuals face health disparities that differ from subculture to subculture within the LGBT population. Lesbian, gay, bisexual, and transgender individuals all face health disparities that differ from one another
- LGBT individuals face health disparities that differ from subculture to subculture within the LGBT population. Lesbian, gay, bisexual, and transgender individuals all face health disparities that differ from one another