Implementation of An Independent, Unit Specific LGBT Cultural Competency Training

A Scholarly Project

Submitted to the

Faculty of Liberty University

In partial fulfillment of

The requirements for the degree

Of Doctor of Nursing Practice

By

Kristen N. Kaiafas

Liberty University

Lynchburg, VA

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Scholarly Project Chair Approval:

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Tonia R. Kennedy, Ed.D, MSN, RN-BC, CCRN-K
Abstract

This paper describes the methodology of the implementation of an educational intervention in the emergency department (ED) setting seeking to improve the provision of culturally competent care for the Lesbian-Gay-Bisexual-Transgender (LGBT) population. The intent of the project was to improve the knowledge and skills, openness and support, and oppression awareness of ED nurses when providing care to the LGBT population. The scholarly project included an evidence-based, unit specific education intervention to improve these measurement outcomes. Analysis utilizing descriptive statistics demonstrated an increase in the mean knowledge and skills and openness and support following the education intervention. The results illustrated an insignificant change in oppression awareness post-intervention. This paper illustrates the potential effectiveness of an educational intervention to promote culturally competent care in the ED environment for the LGBT population. The results illustrated that the ED nurses were aware of the oppression that this vulnerable population faces.

Keywords: Lesbian-Gay-Bisexual-Transgender (LGBT), emergency department, emergency nursing, emergency nurses, cultural competency training, educational intervention
Dedication

I would like to dedicate this to my wonderful husband and two beautiful daughters who have provided unwavering support, encouragement, and love during the completion of all my educational journeys.
Acknowledgements

First, I want to thank God for his unconditional love and support. I am grateful for my family’s encouragement, love, and understanding as I put in the many hours required to complete this project. During the years, my husband and mother-in-law, Kathy have been instrumental in providing unwavering support and love as I pursued my many educational goals.

I am grateful for Dianne Williamson-Bunch who provided guidance, assistance, and patience to ensure the process went efficiently in the organization. To the emergency department staff and leadership, you ensured I was able to implement this project despite the pandemic and many challenges the busy ED environment faces. I am forever grateful for the privilege to work alongside you and call you family. Rosie Bennett, I am thankful that you answered your cell phone every time I had a question. You are the best!

To my colleagues in the academic setting, I am grateful for your mentorship and guidance throughout the years in my career. Karron Boyles, I am forever indebted to you for always being my cheerleader, believing in me when I was hesitant to believe in myself. Sarah Meeks and Sarah Moore you have been instrumental in the process of selecting a topic, putting together my project, and providing guidance for my degree completion. Thank you. I am thankful for my scholarly project chair, Dr. Tonia Kennedy, who demonstrated patience and reassurance throughout the completion of the project, my panic moments, and my many emails.

Lastly, I thank God for my oldest daughter Bella. Bella, thank you for helping with your sister during Daddy’s many deployments through the completion of this educational accomplishment, offering compassion when I was overwhelmed, and being one of the greatest accomplishments in my life. I love you!
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List of Abbreviations

Ally Identity Measure (AIM)

American Association of Colleges of Nursing (AACN)

Centers for Disease and Control (CDC)

Doctor of nursing practice (DNP)

“Don’t Ask, Don’t Tell” (DADT)

Electronic health record (EHR)

Emergency department (ED)

Emergency Nurses Association (ENA)

Evidence-based practice (EBP)

Institutional Review Board (IRB)

Lesbian-gay-bisexual-transgender (LGBT)

Lesbian, Gay, Bisexual, and Transgender Development of the Clinical Skills Scale (LGBT-DOCSS)

Licensed practical nurse (LPN)

Military health system (MHS)

Registered nurse (RN)

Sexual orientation and gender identity (SOGI)
SECTION ONE: INTRODUCTION

When patients present during critical situations, a culturally competent emergency department (ED) nursing staff is essential to ensure that patient-centered, respectful care is provided. Culturally competent or culturally congruent care is care that is sensitive, informed, and meaningful for the population presenting for health care services (Yoost & Crawford, 2020). One of the vulnerable populations that exist today is the lesbian-gay-bisexual-transgender (LGBT) population.

Margolies et al. (2014) noted that “most cultural competency trainings share similar goals: to bring about positive, LGBT-affirming change in the participants’ knowledge, attitude, and behavior towards LGBT patients and clients” (p. 7). One military health system’s (MHS’s) ED in the southeastern United States currently lacks LGBT training. Attempting to cover vast topics regarding the LGBT population can be overwhelming for participants attending training (Margolies et al., 2014). Thus, the purpose of this evidenced-based practice (EBP) project was to implement and evaluate an independent, unit specific LGBT cultural competency training to improve the care provided to the LGBT population presenting to the ED environment.

Background

The LGBT population serving in the military were required to follow the Department of Defense (DOD) Directive 1304.26 “Don’t Ask, Don’t Tell” (Shrader et al., 2017) until it was repealed in 2011. A service member could be barred from military service or discharged from military service for homosexual conduct or for stating that he or she is a homosexual or bisexual (Department of Defense Directive 1304.26, 1993). The repeal meant that service members could not be separated from military service under the former DADT policy. The repeal of the DADT
noted that statements about sexual orientation were no longer a bar to military service (Repeal of, 2011). The repeal of the DADT specifically states that “creation of separate bathroom facilities and living quarters based on sexual orientation is prohibited” and “it remains the policy of the Department of Defense not to ask military service members their sexual orientation” (Repeal of, 2011, p. 1).

The Office of Disease Prevention and Health Promotion’s (2019) Healthy People 2020 goal for the LGBT population is to “improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals” (para. 1). Reducing health disparities between the LGBT population and the population as a whole requires decreasing disease transmission and progression, improving mental and physical health, reducing health care costs, and improving the lifespan (Office of Disease Prevention and Health Promotion, 2019, para. 7). Strategies to improve LGBT health include collection of sexual orientation and gender identity (SOGI) data through electronic health record (EHR) documentation, effective communication with the LGBT population to provide supportive care, and an increase in medical students/staff cultural competency through training (Emergency Nurses ‘Association, 2018; Office of Disease Prevention and Health Promotion, 2019; The Joint Commission, 2011). Additional recommendations for health care organizations include changing the physical environment to be inclusive, implementing fair visitation policies, designating single-stall restrooms, avoiding assumptions about SOGI, providing forms with gender-neutral language, being familiar with resources, and staying up to date with LGBT health topics (ENA, 2018; The Joint Commission, 2011).

Both DADT policy and its repeal restrict MHSs from collecting SOGI data for service members by asking active military service members for their gender/sexual preferences. However,
the MHS provides care to military dependents and their family members, to include LGBT youth. Moreover, MHSs deliver care to the civilian population presenting for emergent complaints.

Shrader et al. (2017) noted that standardized LGBT cultural competency training does not exist within the MHS. The Department of the Army’s (2010) diversity mission states “develop and implement a strategy that contributes to mission readiness while transforming and sustaining the Army as a national leader in diversity” (p.5). Army Diversity Goal 4 reads: “Implement Diversity Training and Education Programs that Develop Socio-Cultural Competencies to Meet the Demands of the 21st Century Expeditionary Force” (Department of the Army, 2010, p. 9). Health care providers working within the ED setting for this EBP project had not received cultural competency training prior to the implementation of this project on communication techniques and health care considerations for caring for the LGBT population in the ED environment.

**Problem Statement**

According to the Centers for Disease and Control (CDC) (2016), LGBT youth are two times more likely to attempt suicide compared to the general population. The LGBT population also experiences higher substance abuse rates compared to the general population (CDC, 2016). Depression, bipolar and anxiety disorder occur at higher rates in gay and bisexual men compared to the general population (CDC, 2016). One challenge for health care providers when caring for this population is the lack of cultural competency training. Many organizations and experts have listed yearly LGBT cultural competency training as a strategy to improve care for the LGBT population (ENA, 2018, The Joint Commission, 2011; Margolies et al., 2014).

**Purpose of the Project**
The purpose of this project was to enhance the LGBT cultural competency of ED staff working in the MHS. Margolies et al. (2014) identified three common goals of LGBT cultural competency training: to increase knowledge, to increase LGBT-affirming attitude, and to increase LGBT-affirming behavior. This project leader received permission to utilize the Ally Identity Measure (AIM) tool for pre- and post-education intervention measurement of the following outcomes (Jones, et al., 2014). The first outcome was to increase ED nurses’ knowledge and skills regarding care for the LGBT population. The second measurable outcome was to increase the openness and support toward the LGBT population. The last outcome involved increasing the ED nurses’ awareness of the oppression of the LGBT population (Bristol et al., 2018; Jones et al., 2014).

**Essentials of Doctoral Education for Advanced Practice Nursing**

The EBP project supported the *Essentials of Doctoral Education for Advanced Practice Nursing* (AACN, 2006). The project sought to improve the LGBT populations patterns of interaction with the environment in critical life situations as outlined in *Essential I: Scientific Underpinnings for Practice* (AACN, 2006). The project aimed to advance communication techniques and sensitivity toward a diverse population as identified in *Essential II: Organizational and Systems Leadership in Quality Improvement and Systems Thinking* (AACN, 2006). SOGI data collection is limited in the MHS environment. Following the implementation of this project, the project leader seeks to further meet the *Doctorate of Nursing Practice Essentials* by integrating an EHR data collection point in the triage documentation to collect SOGI for all personnel presenting to the MHS excluding active and reserve military service members due to current regulations. Utilization of information technology to collect and analyze data from practice and improve programs meets *Essential III: Clinical Scholarship and*
*Analytical Methods for Evidence-Based Practice* and *Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care* (AACN, 2006).

The project leader identified the need for health advocacy for active and reserve service members and the importance of SOGI data collection in the health care environment. The collection of data for active and reserve service members can aid health providers optimize patient outcomes. Therefore, following the EBP project, the project leader will seek to advocate for the collection of SOGI data in the EHR for active and reserve military service members. This future objective aligns with *Essential V: Health Care Policy for Advocacy in Health Care* (AACN, 2006). *Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes*, *Essential VII: Clinical Prevention and Population Health for Improving the Nation’s Health*, and *Essential VIII: Advanced Nursing Practice* were supported by this project through the involvement of the multi-disciplinary team in ensuring culturally competent care is provided to this vulnerable population. This provision of culturally competent care can help to improve prevention of disease and improve health for the LGBT populations through appropriate assessment and development of therapeutic interventions (AACN, 2006).

**Clinical Question**

Will the implementation of an independent, evidence-based, ED-specific, LGBT cultural competency education with continued annual competency sustainment, improve the knowledge, skills, and attitudes toward LGBT health care in ED nurses?

**SECTION TWO: LITERATURE REVIEW**
A search was completed of electronic databases. The literature was reviewed to identify studies discussing the current best practices regarding improving the cultural competency of health care providers when caring for the LGBT population. A critical appraisal was conducted to review the studies’ strengths and limitations. To conclude, a synthesis of the literature was performed to define and clarify the problem and illustrate the significance of cultural competency training to improve the health care provided to the LGBT population.

Search Strategy

The literature review included the electronic databases Cumulative Index of Nursing and Allied Health Literature with Full Text, Academic Search Ultimate, Psychology and Behavioral Sciences Collection, and the Military and Government Collection. Keywords utilized for the search were “lesbian” or “gay” or “bisexual” or “transgender” or “queer” or “lgbt” or “lgbtq” or “lgbt+”, and “cultural competency training”, and “healthcare”. Limiters applied to the search included scholarly (peer reviewed) journals and published between 2015 and 2019. Expanders applied to the search included applying equivalent subjects. The search mode utilized was Boolean/phrase. The search returned 25 articles.

Following the removal of exact duplicates, 15 articles remained. Using the outlined search criteria, eight of the 15 articles returned were included in the review. Regarding the seven studies yielded that were not included, one was a literature review that did not employ systematic methods, two were expert opinions not related to the EBP setting, two were abstracts, and two were not applicable to the problem. The hand search method returned an additional 22 sources that were reviewed.

Critical Appraisal
The literature review included various levels of evidence. Melnyk’s level of evidence was utilized to illustrate the strength of the results measured in the studies (University of Michigan Library, 2019). In Appendix A, a table of evidence is provided illustrating the critical appraisal of the evidence. Thirty studies were critically appraised and synthesized for this literature review. There were 13 Level III-quasi-experimental studies (Bristol et al., 2018; Carabez et al., 2015; Donaldson et al., 2019; Garcia-Acosta et al., 2019; Henry, 2017; Maruca et al., 2018; Porter & Krinsky, 2014; Sawning et al., 2017; Shrader et al., 2017; Singer et al., 2019; Streed et al., 2019; Strong & Folse, 2015; Vance et al., 2016).

The critical appraisal included a Level IV-correlational design study (Nguyen & Yehia, 2015). There were three Level V (Lisy et al., 2018; Sekoni et al., 2017; Stewart & O’Reilly, 2017) and 10 Level VI studies (Acosta et al., 2019; Bidell, 2017; Chisolm-Straker et al., 2018; Donaldson & Vacha-Haase, 2016; Jones et al., 2014; Kattari & Hasche, 2016; Lim et al., 2015; Logie et al., 2019; Mendoza et al., 2015; Shetty et al., 2016). The review included two Level VII studies (ENA, 2018; The Joint Commission, 2011).

**Strengths**

There were several strengths noted in the articles reviewed. First, the 13 studies that included an educational intervention to improve the cultural competency of health care providers caring for the LGBT population illustrated improvement in at least one of the outcome measurements following the intervention (Bristol et al., 2018; Carabez et al, 2015; Donaldson et al., 2019; Garcia-Acosta et al., 2019; Henry, 2017; Maruca et al., 2018; Porter & Krinsky, 2014; Sawning et al., 2017; Shrader et al., 2017; Singer et al., 2019; Streed et al., 2019; Strong & Folse, 2015; Vance et al, 2016). Additionally, studies repeatedly found that patients were not consistently asked their gender pronoun and preferences (Acosta et al., 2019; Donaldson &
Vacha-Haase, 2016; Henry, 2017; Logie, et al., 2019; Nguyen & Yehia, 2015; Shetty et al., 2016) and training was needed to improve the provision of culturally competent care (Acosta et al, 2019; Bidell, 2017; Bristol et al., 2018; Donaldson & Vacha-Haase, 2016; ENA, 2018; The Joint Commission, 2017; Lisy et al., 2018; Lim et al., 2015; Nguyen & Yehia, 2015; Shetty et al., 2016; Sekoni et al., 2017). Selected evidence included best practice toolkits for caring for the LGBT population created by the ENA (2018), the organization that publishes professional guidelines for emergency care, and The Joint Commission (2019), a health care organization accrediting body.

**Limitations**

Several limitations existed amongst the appraised literature. First, self-reporting was utilized in most of the studies in the literature review (Acosta et al., 2019; Bidell, 2017; Bristol et al., 2018; Carabez et al, 2015; Chisolm-Straker et al., 2018; Donaldson et al., 2019; Donaldson & Vacha-Haase 2016; Henry, 2017; Jones et al., 2014; Lim et al., 2015; Logie et al., 2019; Maruca et al., 2018; Mendoza et al., 2015; Porter & Krinsky, 2014; Sawning et al., 2017; Shetty et al., 2016; Strong & Folse, 2015; Vance et al., 2016). Although self-reporting is one of the most widely used data collection tools, it does present the potential for participants’ responses to be skewed due to social desirability, or the tendency to respond in a way that is considered acceptable by others (Mateo & Foreman, 2014). Second, several studies had small sample sizes (Acosta et al., 2019; Donaldson et al., 2019; Donaldson & Vacha-Haase, 2016; Henry, 2017; Logie et al., 2019; Vance et al., 2016). One study did not include nurses among the participants (Bidell, 2017). Several studies utilized tools that were not validated (Chisolm-Straker et al., 2018; Sawning et al., 2017).
Last, the literature review failed to return any higher levels of evidence to include randomized controlled trials. One randomized controlled trial that was found in the literature review is currently being conducted and results are not yet available (Willging et al., 2016). The literature search returned vast qualitative research. Although qualitative research is considered low-level evidence, it provides crucial and beneficial information for improving patient experiences and outcomes in health care. This EBP project aimed to improve the provision of care experienced in the ED setting by the LGBT population. As Mateo and Foreman (2014) explained, qualitative studies are essential to understanding the specific population's feelings, perceptions, and beliefs to deliver culturally competent care.

Synthesis

The evaluated evidence indicated that both cultural competency training and the promotion of gender inclusive environments are the beginning steps to improving the provision of care for the LGBT population (ENA, 2018; The Joint Commission, 2019; Margioles et al., 2014). Streed et al. (2019) identified low pre-test score areas to include screening and management of sexually transmitted illnesses, substance abuse, and mental health issues in the LGBT population. According to Chisholm-Straker et al. (2018), 85.2% of emergency providers reported no formal training on provision of care for the LGBT population with 88% in the same study reporting caring for this population, and 79.2% agreeing that SOGI questions should be part of the EHR. The inclusion of checkboxes in social history was the greatest predictor of the documentation of gender/sexual preferences in one study (Nguyen & Yehia, 2015). Strong and Folse (2015) found various influences on nursing students’ attitudes toward the LGBT community. These influences included family/friends (89.7%) and the media (27.6%) (Strong & Folse, 2015).
Knowledge, Skills, and Behaviors

All the studies in the literature review that provided education illustrated significant improvement in one or more aspects of care. As identified by Sekoni et al. (2017) in their systematic review of two qualitative and 15 quantitative studies. Post education intervention outcomes included increased knowledge and skills, awareness of oppression, and openness and support (Bristol et al., 2018; Vance et al., 2016), improved knowledge (Donaldson et al., 2019; Garcia-Acosta et al., 2019; Streed et al., 2019; Strong & Folse, 2015), and improved attitudes (Strong & Folse, 2015). In one study, the number of LGBT self-disclosures and the providers’ knowledge, skills, and attitudes increased post implementation of cultural competency training (Henry, 2017). In another study, the knowledge of misconceptions, prejudice, sensitive language, and normativity regarding LGBT pregnant patients increased after an education intervention (Singer et al., 2019). Over half of the participants reported increased awareness of LGBT issues and knowledge after an intervention by Carabez et al. (2015). Following the implementation of a transgender simulation, nursing students reported an increase in affirmative practices when providing care to the LGBT population (Maruca et al., 2018). In caring for the elder LGBT population, a five-hour training workshop improved the knowledge, attitudes, and behaviors post intervention (Porter & Krinsky, 2014). In another study, 11 LGBT health training sessions were offered as an extracurricular activity for medical students. After attending at least one session, attendees were invited to participate in a pre/posttest that assessed attitudes on and knowledge of LGBT health concerns. Knowledge scores increased, and participants reported an increased awareness of the need for additional clinical skills training to provide culturally competent care for the LGBT population (Sawing et al., 2017).
Beliefs

Patients and health care providers illustrated conflicting views on asking gender and sexual preference questions. In one study, only 26% of participants reported inquiring about a patient’s sexual orientation (Shetty et al., 2016) compared to 53.8% of emergency providers reported asking about gender affirming surgeries despite presenting complaints (Chisolm-Straker et al., 2018). Patients reported it being beneficial for providers to ask gender and sexual preferences (Acosta et al., 2019; Logie et al., 2019), and LGBT training decreased providers’ assumptions toward this patient group (Streed et al., 2019). In comparison, staff reported feeling the need to treat the LGBT population the same as other patients (Donaldson & Vacha-Haase, 2016) and providers did not feel it was necessary or did not know if it was necessary to identify the patient’s sexual orientation to provide culturally competent care (Shetty et al., 2016). Maruca et al. (2018) implemented a transgender simulation to improve the beliefs and attitudes of nursing students providing care to the LGBT population and pre/post intervention scores illustrated no statistical difference.

Tools to Assess Staff Cultural Competency

Two of the research studies tested tools to assess the outcome measurements following the educational intervention. Bidell (2017) developed the Lesbian, Gay, Bisexual, and Transgender Development of the Clinical Skills Scale (LGBT-DOCSS). The sample sizes for testing the tool were large and cross-national (consisting of educators in the U.S. and the UK). Bidell (2017) utilized the terminology clinical skills versus cultural competency to illustrate a need to continuously provide training and education to ensure the provision of culturally competent care. The sample population included for testing the tool did not encompass nurses, nurse practitioners, physician assistants, allied health professionals, or clinical social workers
LGBT CULTURAL COMPETENCY TRAINING

(Bidell, 2017). The tool did illustrate that higher levels of advanced education were correlated with higher scores on the LGBT-DOCSS (Bidell, 2017).

A second research article tested the AIM tool. The test measured three factors: knowledge and skills, openness and support, and oppression awareness when caring for LGBT persons (Jones et al., 2014). The tool was used in the study conducted by Bristol et al. (2018) that was used as a guide in the completion of this EBP project. Additionally, the Bristol et al. (2018) study utilizing the AIM tool was conducted in an ED setting similar to the practice setting for the EBP project. Furthermore, the ED staff illustrated a 14.9% increase in knowledge and skills scores, a 6.5% increase in oppression and awareness scores, and 4.9% increase in openness and support scores on the AIM tool after the education intervention (Bristol et al., 2018).

Limiting Factors in the Assessment of Staff’s Cultural Competency

In two of the studies that included an educational intervention to improve the cultural competency of health care providers caring for the LGBT population, pre/post questionnaires were not matched limiting the findings (Bristol et al., 2018; Donaldson et al., 2019). Two of the methods utilized to match pre/post questionnaires discovered in the literature review included using the last four digits of the phone numbers (Singer et al., 2019) and asking participants to create an anonymous identification code (Jones et al., 2014). Another limiting factor found was a short time frame between pre/posttest and the educational intervention (Singer et al., 2019).

Education Modalities

Several modalities were utilized to present the LGBT education found in the literature. Additionally, the length of the sessions varied in each of the studies, a finding which was comparable to the systematic literature review results by Sekoni et al. (2017) that found times ranging from one hour to 42 hours. These variations included a two-hour facilitator led session
following a 30-minute online pre-education session (Bristol et al., 2018), an one-hour online educational session (Donaldson et al., 2019; Streed et al., 2019), didactic education with video presentations and shared LGBT individuals’ experiences (Henry, 2017), a one-hour education session with pre/posttest assessment (Shrader et al., 2017; Strong & Folse, 2015), and grand round training (Singer et al., 2019). A two-hour lecture combined with instructions on conducting a scripted interview and an assignment completion was utilized in increasing the knowledge of LGBT issues in baccalaureate, generic master’s, and RN to BSN programs (Carabez et al., 2015). Garcia-Acosta et al. (2019) employed problem-based learning and film-forums in the final-year of nursing school to increase the knowledge of transgender issues. Six interactive online modules taking approximately two hours were combined with one five-hour observational clinical in another study (Vance et al., 2016).

**Barriers**

Reported barriers to the provision of culturally competent care included the EHR and wristband listing the legal name/gender that conflicted with the preferred gender/name (Acosta et al., 2019). Lack of education was identified as a problem when accessing health care (ENA, 2018; Lisy et al., 2018; Stewart & O’Reilly, 2017). Mendoza et al. (2015) found that 74% of faculty and staff reported diversity and inclusion training but the training was not specific to the LGBT population. Furthermore, the estimated time for teaching LGBT health in a Bachelor of Science in Nursing program was 2.12 hours (Lim et al., 2015), indicating that even recently educated staff may lack this crucial preparation. Carabez et al. (2015) echoed the findings that recently graduated nurses may lack the knowledge and skills to provide care to the LGBT population. In the study, 85% of graduates reported nursing education did not prepare them to care for the LGBT population (Carabez et al., 2015). A history of stigmatization and
discrimination by health care providers, legal name change challenges, health insurance coverages or lack of health care coverage, and provider knowledge gaps were additional obstacles identified for the LGBT population when accessing health care (ENA, 2018). Lisy et al. (2018) identified a lack of opportunity for disclosure of SOGI, homophobia, inadequate knowledge and affirmative behaviors, heterocentric care environments, and lack of support groups and LGB appropriate information as reemerging themes in their systematic literature review.

**Discrimination and Victimization in the ED setting**

Kattari and Hasche, (2016) conducted a cross-sectional study by reviewing 5,885 responses to the 2010 National Transgender Discrimination Survey. The researchers found that individuals below the age of 35 reported the highest level of discrimination overall, with 16.1% reporting discrimination in emergency rooms, the highest frequency of harassment, with 19.8% reporting harrassment in emergency rooms, and the highest levels of victimization, with 0.7% reporting victimization in emergency rooms (Kattari & Hasche, 2016). This literature review illustrates the need for and importance of the implementation of an independent, ED specific cultural competency training to improve the ED nurses’ knowledge and skills, openness and support, and awareness of oppression when caring for the LGBT population.

**Conceptual Framework/Model**

The Iowa Model of Evidence-Based Practice was revised in 2017 (Hanrahan et al., 2019). The revision includes “the addition of a purpose statement, feedback loops, and expansion of piloting, implementation, patient engagement and sustaining change” (Hanrahan et al., 2019, p. 1). The model includes seven components and three decision points subsequently outlined (Iowa Model Collaborative et al., 2017).
Identify Triggering Issues/Opportunities

The first component of the Iowa Model is identifying triggering issues and opportunities. This component includes five triggering issues and opportunities (Iowa Model Collaborative, 2017). According to White et al. (2016), EBP requires nursing leaders to assess current practices and determine whether the current and best practices are being utilized to care for patient populations.

The LGBT population experiences disparities in health care throughout the United States. In the MHS setting for the EBP project, a knowledge-focused trigger presented in the provision of care for the LGBT population (Iowa Model Collaborative et al., 2017). Although the repeal of the DADT policy states military service members will not be asked their sexual preference, this policy does not apply to the military dependents, to include LGBT youth, and the civilians presenting for emergency care. Furthermore, the MHS recently obtained the Level III trauma status. This designation allows increased access to emergency care for civilians in need of trauma care when this MHS is the closest location. Lastly, the Healthy People 2020 goal necessitates improving the provision of care for the LGBT population (Office of Disease Prevention and Health Promotion, 2019). The recognition of lack of culturally competent training and the new Level III trauma status prompted this project leader to identify the need to implement national guidelines and standards for the provision of care for the LGBT population, while ensuring abidance by current military regulations for SOGI with active military service members.

Appraisal of the current best evidence, to include national agency guidelines (ENA, 2018; The Joint Commission, 2019), revealed that knowledge and training are required to improve the health disparities that the LGBT population face. The ENA’s position statement recommends
education and training for health care providers that include the presentation of basic definitions such as a preferred pronouns and, both the identification of and strategies for addressing health concerns that are more prevalent in this population (Riwitis, 2018). Furthermore, the ENA recommends continued quality improvement efforts aimed to maintain staff competencies and improvement of communication training efforts to create an inclusive environment (Riwitis, 2018). The current ED practice setting for this EBP project does not offer formal LGBT cultural competency training.

**State the Question or the Purpose**

The second step in the Iowa Model is to state the question (Iowa Model Collaborative et al., 2017). Utilizing the Problem Intervention Comparison Outcome (PICO) format, the purpose of the scholarly project includes the Population, ED nurses. The intervention was an independent, evidenced-based, ED specific, LGBT cultural competency education with continued annual competency sustainment training compared to no unit specific training. The expected outcome was to improve the knowledge and skills, openness and support, and oppression awareness in providing care for the LGBT population. The clinical question was, Will the implementation of an independent, evidenced-based, ED specific, LGBT cultural competency education with continued annual competency sustainment, improve the knowledge and skills, openness and support, and oppression awareness toward LGBT health care in ED nurses?

The site selected for this scholarly project was a military health organization. The goal of the installation was to provide high-quality care to all military service members, their families, and retirees, along with civilian trauma and emergency patients. Both the mission and the vision of the organization aligned with the intent of the scholarly project.
Form a Team

The team included the project leader, the committee chair, and the organization’s ED director. The project leader developed and implemented the cultural competency training, collected the data through surveys, and disseminated the findings at the conclusion of the project. The committee chair guided the project leader through the various stages of project development, implementation, and data collection. The organization’s ED director provided guidance on organizational specific requirements and policies throughout the project development and implementation.

Assemble, Appraise, and Synthesize Body of Evidence

The third step and second decision point required an analysis to determine if sufficient evidence existed. The project leader assembled, appraised, and synthesized the evidence by conducting an extensive literature review. The level of evidence matrix is provided in Appendix A.

Design and Pilot the Practice Change

The next step and decision point are to design and pilot the practice change and determine if it is appropriate to adopt into practice (Iowa Model Collaborative et al., 2017). Jones et al. (2014) found the AIM tool to be reliable and valid to assess the knowledge and skills, openness and support, and awareness of the oppression of the LGBT populations. Recruitment for participation in the training was not necessary, because the intervention was provided during the pre-allotted in-service/skills training timeframes for day/evening nursing staff. Recruitment for participation in the pre/post assessment tool was voluntary and required written consent by participants.
Integrate and Sustain the Practice Change

The second to last step of the Iowa Model is the integration and sustainment of the practice change (Iowa Model Collaborative et al., 2017). Following, the success of the study, the goal of this EBP project is to include LGBT cultural competency training in the annual requirements for ED staff. Annual updates to the training with the latest EBP practices will be made to ensure the staff receives the latest information and communication tools to provide patient-centered, culturally competent care to improve the health outcomes for this vulnerable population. Additionally, it is the project leader’s goal following the EBP project to add gender identity questions and closed-format sexual orientation questions to the EHR for military dependents, family members, and civilians.

Disseminate Results

The last step in the Iowa Model is the dissemination of results (Iowa Model Collaborative et al., 2017). The results of the project were discussed with the ED health care providers, ED leadership, and the organization’s leadership. Further dissemination includes a poster presentation to ensure EDs throughout the United States are providing this crucial education to promote inclusiveness in the ED environments, and ED staff are working to reduce the health disparities that exist for this vulnerable population.

Translation of Results

Various models exist for the guidance and support for translating the results of the scholarly project. The chosen framework for this project was the Ottawa Model of Research Use (White et al., 2016). The framework includes three phases that focus on implementation efforts. One of the framework’s strengths is the simplicity of the three steps: assess, monitor, evaluate. The framework includes primary elements at each of the three phases that are basic and relevant.
One limitation of this model is the lack of a phase or component for the sustainment of knowledge. The model concludes with an evaluation of outcomes (White et al., 2016).

The first phase of the Ottawa Model of Research is an assessment of the barriers and supports, to include evidence-based innovation, potential adopters, and the practice environment (White et al., 2016). This phase is particularly relevant to the scholarly project for several reasons. Traditionally, the MHS had embraced a “DADT” philosophy that did not support the LGBT culture. Health care providers that had been caring for the military population in the traditional military culture typically embraced established beliefs, values, and practices. The assessment of barriers and supports was essential to identify early adopters and obstacles that existed in both the development and implementation of the scholarly project.

The next phase of the Ottawa Model of Research is monitoring the intervention and degree of use (White et al., 2016). One key element relevant to the scholarly project was barrier management and follow-up. Ensuring that the barriers were identified and transformed was crucial for adoption.

The last phase was the evaluation of outcomes (White et al., 2016). This phase involved determining if the cultural competency training improved the ED interdisciplinary staff’s knowledge and skills, openness and support, and oppression awareness in caring for the LGBT population. Additionally, the dissemination of the results to other units within the organization is vital to ensure that the organization is providing unit specific cultural competency training for all staff.

Theoretical Framework
The change theory applicable to this scholarly project is the social ecological theory. This theory is best suited for the scholarly project which aimed to improve the ED health care providers’ knowledge and skills, openness and support, and oppression awareness in caring for the LGBT population because it “integrates multiple perspectives into the planning of interventions for behavior change” (White et al., 2016, p. 65). The five levels of influence considered in the planning of the project are intrapersonal, interpersonal, institutional, community, and the public policy level (Terrell, 2015; White et al., 2016). This theory was effective in making the change in the practice setting because identifying the individual beliefs, values, education level, relationships with families and the community, and current policy was vital to ensure that the education provided for the scholarly project encompassed the necessary elements to improve the knowledge and skills, openness and support, and oppression awareness of staff caring for this vulnerable population while adhering to current military regulations.

Summary

Okokon O. Udo defines cultural competency in this way:

“To be culturally competent doesn’t mean you are an authority in the values and beliefs of every culture. What it means is that you hold a deep respect for cultural differences and are eager to learn, and willing to accept, that there are many ways of viewing the world.” (as cited in The Cross-Cultural Health Care Program, 2019, para. 4).

The Joint Commission (2011), ENA (2018), and several research studies identified in the literature review illustrated the importance and benefits of implementation of cultural competency training to improve the care delivered to the LGBT community. While not every study resulted in an improvement in skills and attitudes (Donaldson et al., 2019; Maruca et al.,
2018; Sawning et al., 2017) all of the interventional studies resulted in an increase in knowledge (Bristol et al., 2018; Carabez et al, 2015; Donaldson et al., 2019; Garcia-Acosta et al., 2019; Henry, 2017; Maruca et al, 2018; Porter & Krinsky, 2014; Sawning et al., 2017; Shrader et al., 2017; Singer et al., 2019; Streed et al, 2019; Strong & Folse, 2015; Vance et al, 2016).

Furthermore, in three of the descriptive studies, patients reported wanting to be asked gender/sexual preference questions by health care staff (Acosta et al., 2019; Logie et al., 2019; Shetty et al., 2019) and health care providers reported desiring increased training regarding providing culturally competent care for the LGBT population (Donaldson & Vacha-Haase, 2016; Shetty et al., 2016). Both the ENA (2018) and The Joint Commission (2011) provide toolkits for organizations wishing to implement LGBT cultural competency training. The purpose of this project was to improve the knowledge and skills, openness and support, and awareness of oppression for health care providers caring for the LGBT population in one MHS’s ED.

**SECTION THREE: METHODOLOGY**

**Design**

This EBP project used a quasi-experimental approach to collect and analyze data. The project design utilized the Iowa Model to evaluate a practice change (Iowa Model Collaborative et al., 2017). An unmatched pre and post intervention assessment was utilized for data collection. A pre-education and post-education validated, reliable tool, the AIM tool (Jones et al., 2014), was utilized to assess and score the participants’ knowledge and skills, attitudes, and openness and awareness pre and post intervention.
Measurable Outcomes

*Difference in Pre- and Post-intervention Knowledge and Skills*

The first measurable outcome for this project was the difference between pre and post intervention knowledge and skills. Knowledge and skills were measured using the AIM tool before the educational intervention was completed, and again at the completion of the cultural competency training. The difference in pre and post intervention knowledge and skills were then analyzed using descriptive statistics, mean and standard deviation.

*Difference in Pre- and Post-intervention Attitudes*

The second measurable outcome for this project was the difference between pre and post intervention openness and support. Openness and support were measured using the AIM tool before the educational intervention was completed, and again at the completion of the cultural competency training. The difference in pre and post intervention attitudes was analyzed using descriptive statistics, mean and standard deviation.

*Difference in Pre- and Post-intervention Openness and Awareness of Oppression*

The last measurable outcome for this project was the difference between pre and post intervention awareness of oppression. Awareness of oppression was measured using the AIM tool before the educational intervention was completed, and at the completion of the cultural competency training. The difference in pre and post intervention awareness of oppression was analyzed using descriptive statistics, mean and standard deviation.

Setting

This project took place at an ED within the MHS where there is access to emergency care for active military service members, military dependents, military family members, and civilians.
experiencing emergencies. A letter of support was obtained from the organization’s leader (see Appendix D). There were approximately 65 ED nursing staff to include military nurses, civilian government service nurses, contract nurses, and military reserve nurses. Furthermore, approximately 50% of the ED staff was composed of nurses.

**Population**

Purposive sampling was utilized to recruit participants for this EBP project. Purposive sampling involved the selection of participants who would be appropriate for a study (Mateo & Foreman, 2014). Considering that ED nurses encompass a large percentage of the ED staff, it was appropriate to include this population in the study. Convenience sampling is the selection of participants based on ease of access (Mateo & Foreman, 2014). The ED nurses in the MHS that was the setting for this EBP project participate in several annual skills training sessions. The annual skills training sessions afforded the project leader the time and access to this sample of individuals to implement the EBP intervention without additional cost of staffing hours to the organization.

The sample included participants who: hold a registered nurse (RN) or licensed practice nurse (LPN) position within the EBP project setting and consented to participate in the study. Individuals were excluded from the pre/post intervention survey if they did not identify as a RN or LPN in the department or if they who chose not to participate. The target sample size was 35 individuals.

**Ethical Considerations**

The American Nurses’ Association Code of Ethics (2015) necessitates that respectful, patient-centered, culturally competent care be provided to all individuals. Therefore, this EBP
project aimed to enable health care providers to recognize the differences between the needs, beliefs, and values in the LGBT population and their personal principles, and to acquire the appropriate level of knowledge, skills, and attitudes required to provide quality, effective care for this vulnerable population. The project leader and DNP chair completed the appropriate ethical and legal training prior to the start of the project to ensure protection of human subjects. A copy of the project leader’s Collaborative Institutional Training Initiative certificate is available in Appendix B. The project leader obtained Institutional Review Board (IRB) exemption approval from Liberty University and the health care organization. Copies of the IRB approval letter are provided in Appendices J and K.

Participants were informed of the purpose of the project so that they could knowledgeably and voluntarily choose whether to participate. Consent was obtained from the health care provider participants through the completion of the data collection tool. A copy of the consent is available in Appendix E. No patient data were collected for the EBP project. The EBP project did not require any personally identifiable information from the ED nursing participants.

Data Collection

Participant demographic information was collected, including age, gender, gender assigned at birth, ethnicity, and education level. Next, the project leader obtained consent from voluntary participants and assessed the pre-intervention knowledge and skills, openness and support, and oppression awareness toward the LGBT population. Following the completion of the pre-intervention survey, the project leader conducted two, 30-minute interactive education sessions that provided the ED nurses with information on LGBT appropriate communication techniques and terminology, LGBT health concerns, and ED specific materials. Subsequent
post-intervention assessment took place at the completion of the education. The pre/post intervention surveys were completed by the participants using the paper and pencil method. The data were then entered and analyzed with Intellectus statistical software (Intellectus, 2020).

Tools

The validated AIM tool was utilized for data collection following permission approvals from the researchers (Jones et al., 2014). A copy of the tool is available in Appendix F and a copy of the permission to use is presented in Appendix G. The AIM tool uses a 5-point Likert scale with 1 = strongly disagree and 5 = strongly agree (Jones et al., 2014). The AIM tool includes 19 items that measure the knowledge and skills, oppression awareness, and openness and support for health care providers caring for the LGBT population (Jones et al., 2014). The knowledge and skills scale comprises eight items that were tallied for a total score. The oppression awareness scale consists of four items that were tallied for a total score. The openness and support scale comprises seven items that were tallied for a total score (Jones et al., 2014). The approximate time to complete the tool was less than 15 minutes both pre and post intervention.

The AIM tool has demonstrated good reliability (Cronbach’s alpha 0.76 to 0.88) and proved good convergent and discriminant validity (Jones et al., 2014). Convergent validity demonstrates how well a new instrument or tool measures the same concept as an existing tool (Grove et al., 2013). Divergent validity compares the new tool with existing instruments that measure the opposite concept (Grove et al., 2013). Jones et al. (2014) performed convergent and divergent validity testing of the AIM tool and this method is called the multitrait-multimethod. This method is utilized to examine two or more concepts of a new instrument, and the AIM tool
examined three constructs (Grove et al., 2013). The AIM tool was utilized in the ED setting by Bristol et al. (2018) in a similar study that was used as a guide for this EBP project.

**Intervention**

The intervention for this project was an evidence based, culturally appropriate education intervention. The resources that were utilized for training included the National LGBT Health Education Center (2014) video “LGBT Voices: Perspectives on Healthcare,” the interactive presentation “Providing quality care to lesbian, gay, bisexual, and transgender patients: An introduction for Staff Training,”, and the interactive presentation “Affirming LGBT People through effective communication.” The ENA guide on terminology found in the ENA (2018, p. 9-10) toolkit was provided to ED nursing staff with the first training session. A handout on the effective communication techniques (ENA, 2018, p. 14-15) identified in the ENA toolkit was provided with an interactive presentation on effective communication. An interactive presentation developed from the ENA toolkit resources on care of the LGBT patients in the emergency care setting was delivered at one training session with open group discussion (ENA, 2018). The National LGBT Health Education Center is free to access and the ENA toolkit is free for members. Permission to utilize the National LGBT Health Education Center’s presentations and the ENA’s toolkit for training were obtained and are available in Appendices H and I, respectively.

The first engagement with the ED nursing staff included a description of the project, the objectives, and goals of the project, and the rationale for the implementation of the project. At the first encounter, the project leader obtained consent from willing participants through the voluntary completion of the AIM tool for pre-intervention data collection. The first meeting
The cultural competency training was conducted in two 30-minute training sessions as detailed previously. Along with the education materials and presentations, staff were encouraged to ask questions and provide feedback regarding the evidenced-based practice recommendations to identify facilitators and barriers to the recommended practice changes. At the last meeting with staff, the project leader invited feedback and recommendations from the participants for annual cultural competency training. The last meeting included the delivery of the AIM tool for post intervention data collection. The education intervention took a total of approximately 50 - 75 minutes including open dialogue and discussion within each training session. Throughout the literature review, education interventions proved successful in improving delivery of culturally competent care to the LGBT population. Thus, this project leader presumed that implementation of an evidence-based education intervention could improve the knowledge and skills, openness and support, and oppression awareness of the ED nurses providing care within one MHS.

**Timeline**

The project took place in four phases. The framework for the project included the Ottawa Model of Research Use. The three steps of the Ottawa Model of Research Use are to assess, monitor, and evaluate. The first step, assess, aligned with the DNP program’s pre-approval phase and phase one.

During the preapproval phase, a knowledge-focused trigger was identified as prescribed by the Iowa Model. The next step included determining if the topic was a priority, forming a team, and assembling, appraising, and synthesizing the literature to determine if sufficient evidence existed to pilot a change (Iowa Model Collaborative et al., 2017). The project site letter
of support was obtained from the ED director. The pre-proposal approval was received from the DNP faculty chair to complete the preapproval phase.

Phase one included submission of the first three sections of the project, the final project proposal, and the project proposal defense. Additionally, as part of this phase, applications to Liberty University’s IRB and then the organization’s IRB were submitted. Phase one was completed upon successful defense of the scholarly project to the DNP chair.

The second step of the Ottawa Model is to monitor the intervention, which aligned with the second phase of the DNP program. Phase two was the implementation of the intervention. The intervention was implemented was May 2, 2020 through May 10, 2020. The data collection and intervention occurred as follows:

- May 2, 2020: Track 1 day/evening nurses were provided an overview of the project and consenting participants completed the AIM tool for pre-intervention data collection, Part 1 of 2 of the education was delivered.
- May 3, 2020. Track 1 day/evening nurses were provided with Part 2 of 2 of the education. The post intervention AIM tool was completed for data collection.
- May 9, 2020. Track 2 day/evening nurses were provided an overview of the project and consenting participants completed the AIM tool for pre-intervention data collection, Part 1 of 2 of the education was delivered.
- May 10, 2020. Track 2 day/evening nurses were provided with Part 2 of 2 of the education. The post intervention AIM tool was completed for data collection.
- May 11 – May 20, 2020. The data were summarized and analyzed with the assistance of the Intellectus data software.
The last step of the Ottawa Model of Research is to evaluate outcomes. This step aligned with the data collection and analysis at the conclusion of Phase 2 and the beginning of Phase 3 for the DNP program. Phase 3 included the dissemination of the results and the final scholarly project draft and editing, as well as the scholarly project defense and submission of the final project to Liberty University’s Scholarly Crossings. Lastly, dissemination to key stakeholders within the EBP project setting and Liberty University occurred during this phase.

**Feasibility Analysis**

A feasibility analysis was conducted to identify the resources, personnel, technology, and budget necessary for the project. Personnel for the project included the team leader, the scholarly project chair, the ED director at the organization, the ED nursing Officer in Charge and the two Assistant Nursing Officers in Charge. Statistical software and an editor were obtained at the expense of the project leader.

The resources and technology for the project were available within the EBP project setting and required no additional financial considerations. A computer and overhead projector for presenting the interactive presentations was available in the nursing conference room. Microsoft Excel was available to the team leader through existing personal software. The handouts and surveys were provided through means of paper distribution and required the utilization of printing software at the EBP project site.

**Data Analysis**

**Measurable Outcome 1**

The difference in knowledge and skills scores between the preintervention and postintervention was the first measurable outcome. The three identified outcomes, knowledge and skills, attitudes, and openness and awareness, identified on the AIM tool were assessed using
a 5-point Likert scale. The items are divided by each of the three outcome measures and added for a score. Descriptive statistics, mean and standard deviation, were utilized to determine if a significant difference in scores existed post-intervention.

**Measurable Outcome 2**

The difference in pre- and post-intervention openness and support scores was the second measurable outcome. The same AIM tool was utilized for all three measurable outcomes. Thus, for the second measurable outcome, descriptive statistics, mean and standard deviation were employed to evaluate changes in the ED nurses’ openness and support following the education intervention.

**Measurable Outcome 3**

The last identified measurable outcome assessed the participants’ oppression awareness for the LGBT population. This was the third scale in the AIM tool. Descriptive statistics, mean and standard deviation were utilized to assess post-intervention changes.

**Sustainability Outcomes**

Sustainability is crucial when incorporating evidence into practice. Upon success of the EBP project, the project leaders seek to incorporate the LGBT cultural competency into new hire training. Additionally, six annual skills training competencies are conducted in the EBP project setting. The project leader seeks to implement annual LGBT cultural competency training into the annual skills competencies to ensure maintenance and updates to this vital training.

**SECTION FOUR: RESULTS**

**Descriptive Statistics**

A total of 42 health care providers participated in Part 1 of the education intervention. A total of 39 health care providers participated in Part 2 of the educational intervention. Thirty-six
participants met the inclusion criteria of being an RN or LPN and completed the pre and post-intervention surveys before and following the education intervention, respectively. The results of the data analysis are outlined and described below. Frequencies and percentages for the demographic data collected are presented in Table 1 and the summary statistics of the outcome measurements are presented in Table 2.

Demographics

**Sample Size**

The education was delivered in two parts in two different sessions to provide the education intervention to two tracks of nursing staff. Pre-survey data were collected on 36 participants. Post-survey data were also collected on 36 participants.

**Age**

For the pre-intervention group (Group 1), the most frequently documented categories of age were 31 - 40 (33%) and 51+ (33%). For the post-intervention group (Group 2), the most frequently documented category of age was 31-40 (33%). Three participants did not report age in the pre-intervention group. One participant did not report age in the post-intervention group.

**Ethnicity**

For both groups, the most frequently reported ethnicity was Caucasian. Five data points were missing for ethnicity on the pre-intervention survey. Two participants did not report an ethnicity on the post-intervention survey.

**Gender**

Female was the most reported category of gender within the pre-intervention group (72%) and the post-intervention group (81%). Two participants did not complete the gender
identification on the pre-intervention survey. There were no missing data points on gender demographics on the post-intervention survey.

**Gender Assigned at Birth**

Female was the most frequently observed category of gender assigned at birth with the pre-intervention group (75%) and the post-intervention group (78%). There were two missing data points on the pre-intervention survey for gender assigned at birth. Two participants did not complete the gender assigned at birth on the post-intervention survey.

**Education level**

The most frequently reported level of education was a bachelor’s degree with the pre-intervention group (39%) and the post-intervention group (50%). Four participants did not report their education level on the pre-intervention survey. One participant did not complete the education level on the post-intervention survey.

**Table 1**

*Frequency Table for Nominal Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-intervention Group</th>
<th>Post-intervention Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30</td>
<td>2 (6%)</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>31-40</td>
<td>12 (33%)</td>
<td>12 (33%)</td>
</tr>
<tr>
<td>41-50</td>
<td>7 (19%)</td>
<td>10 (28%)</td>
</tr>
<tr>
<td>51+</td>
<td>12 (33%)</td>
<td>10 (28%)</td>
</tr>
<tr>
<td>Missing</td>
<td>3 (8%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>22 (61%)</td>
<td>25 (69%)</td>
</tr>
<tr>
<td>African American</td>
<td>2 (6%)</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>0 (0%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Multiple</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Other not listed</td>
<td>6 (17%)</td>
<td>5 (14%)</td>
</tr>
<tr>
<td>Missing</td>
<td>5 (14%)</td>
<td>2 (6%)</td>
</tr>
</tbody>
</table>
Gender
- Male 8 (22%) 7 (19%)
- Female 26 (72%) 29 (81%)
- Missing 2 (6%) 0 (0%)

Education
- Associate degree 10 (28%) 12 (33%)
- Bachelor’s Degree 14 (39%) 18 (50%)
- Graduate Degree 7 (19%) 4 (11%)
- Choose not to answer 1 (3%) 1 (3%)
- Missing 4 (11%) 1 (3%)

Gender Assigned at Birth
- Male 7 (19%) 6 (17%)
- Female 27 (75%) 28 (78%)
- Missing 2 (6%) 2 (6%)

Note. Due to rounding percentages may not equal 100.

Data Analysis

Descriptive statistics are displayed in Table 2 for the outcome measurements. The first outcome measurement included knowledge and skills. There was an increase of 6.44 percent between the pre-survey to the post-survey. The second outcome measurement included openness and support. The post-intervention results illustrated a 3.52 percent increase. The third outcome measurement included oppression awareness. This outcome illustrated a less than 1 percent increase in post-intervention survey scores.
Table 2

Mean Pretest and Posttest Data

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>n</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preintervention</td>
<td>21.78</td>
<td>8.91</td>
<td>36</td>
<td>1.48</td>
</tr>
<tr>
<td>Postintervention</td>
<td>28.22</td>
<td>7.47</td>
<td>36</td>
<td>1.24</td>
</tr>
<tr>
<td>Openness and support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preintervention</td>
<td>20.17</td>
<td>6.95</td>
<td>36</td>
<td>1.16</td>
</tr>
<tr>
<td>Postintervention</td>
<td>23.69</td>
<td>7.59</td>
<td>36</td>
<td>1.27</td>
</tr>
<tr>
<td>Oppression awareness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preintervention</td>
<td>13.28</td>
<td>3.81</td>
<td>36</td>
<td>0.64</td>
</tr>
<tr>
<td>Postintervention</td>
<td>14.14</td>
<td>4.06</td>
<td>36</td>
<td>0.68</td>
</tr>
</tbody>
</table>

SECTION FIVE: Discussion

Implication for Practice

The results of this EBP project indicate that a unit-specific culturally appropriate education intervention can lead to an increase in knowledge and skills and openness and support for ED nurses providing care to the LGBT population. Overall, the average knowledge and skills score increased by 6.44%. The average openness and support score increased by 3.52%. There was no significant difference noted in the oppression awareness scores.

The education was intended to increase the ED nurses’ knowledge and awareness regarding providing culturally competent care. The education session provided information on avoidance of assumptions and, effective communication techniques, as well as statistical data on the barriers and challenges that the LGBT population faces when accessing health care services. Open discussion and practice scenarios were incorporated in the training for the ED nurses to voice their perceptions and to reinforce the best practices.
The mean scores for knowledge and skills increased post-intervention. The ED nurses voiced an appreciation for the knowledge regarding hormone therapy treatments and surgical interventions. Application to triage decision-making was discussed and applied in the education session. The ED nurses did voice frustrations regarding the lack of SOGI data collection in the current EHR due to military regulations. Additionally, the DNP project leader discussed alternatives to ensure optimal culturally appropriate care despite these barriers. This included a verbal handoff of SOGI information collected from the patient until SOGI data collection is adopted in the MHS’s EHR.

Openness and support scores also increased post-intervention. Individuals reported appreciation of and an understanding of the necessity for the training, especially because it was the first training for many participants. Individuals reported utilizing the information the same day following the first part of the educational intervention. Participants reported feeling more comfortable with gender-affirming language and communication post-intervention.

Oppression awareness scores did not demonstrate a statistically significant difference between the preintervention and postintervention. This result may be due to many of the individuals becoming aware of the challenges presented to the LGBT population through news and media reports. Additionally, several participants reported having family members or close friends in the LGBT population and have noticed and witnessed the challenges the LGBT population experience in society and when accessing health care services. These shared experiences, coupled with the increase in knowledge and skills, and openness and support, illustrate that a unit-specific cultural competency training may benefit other EDs and organizations to improve the provision of care for this vulnerable population.
Limitations

The study had several limitations. The first barrier to implementation was the current COVID-19 pandemic. The methodology was adjusted from the original plan of five short sessions with open dialogue to two lengthier sessions due to the time needed for daily COVID-19 updates to staff in morning shift huddles. Staffing shortages were present due to individuals on quarantine. Open dialogue sessions were conducted in smaller groups than originally planned due to COVID-19 social distancing restrictions. The survey utilized self-reporting which as noted previously presents the potential for social desirability, meaning that participants may respond in a manner that is considered acceptable to others (Mateo & Foreman, 2014). Last, the pre- and post-intervention surveys were unmatched.

Sustainability

The educational intervention has the potential for sustainability. The MHS had prepared an optional continuing education session to provide LGBT cultural competency training to staff that was postponed due to COVID-19. The organization plans to conduct annual LGBT cultural competency training. Additionally, the ED educators plan to implement annual cultural competency training with the six annual skills training sessions that are currently scheduled. There is both leadership and staff buy-in to sustain the annual cultural competency training to ensure the provision of quality care for this vulnerable population. The continued barrier to the change is individual previously held beliefs and biases. However, continued training and education may help staff improve their beliefs and attitudes when providing care to the LGBT population. Allowing the staff to voice their perceptions and experiences proved beneficial in this education session, and this strategy should be continue to be used in future training sessions.
Dissemination Plan

The project leader has shared the project’s success with the ED leadership. The ED leadership has scheduled time for the project leader to present the findings of the project at the Performance Improvement Committee meeting in the next few months. The project leader will reach out to community organizations including the local ENA chapter, to disseminate the findings of the project and to discuss future project opportunities. A manuscript of this project has been written. The project leader intends to submit an article to a professional nursing journal for possible publication. The project leader seeks to present the findings at several podium presentations at regional conferences.
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https://doi.org/10.4103/efh.EfH_78_16


Adolescent Health, 60(2017), 425-430.

http://dx.doi.org/10.1016/j.jadohealth.2016.11.020

Appendix A

Evidence Table

Name: Kristen N. Kaiafas

Clinical Question: For ED Nurses, will the implementation of an LGBT independent, unit specific cultural competency training increase the ED nurses’ clinical preparedness, attitudinal awareness, and basic knowledge when providing care to the LGBT population?

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Study Purpose/Objective(s)</th>
<th>Design, Sampling Method, &amp; Subjects</th>
<th>LOE*</th>
<th>Intervention &amp; Outcomes</th>
<th>Results</th>
<th>Study Strengths &amp; Limitations</th>
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<tbody>
<tr>
<td>Acosta et al. (2019)</td>
<td>To better understand the experiences of transgender adolescents and psychiatric care providers to identify areas where existing approaches are both supportive and not supportive in meeting the LGBT population's needs.</td>
<td>Semi-structured interviews. 9 patients age 13-17 18 Unit care providers</td>
<td>Level VI- Qualitative study</td>
<td>Interview. Qualitative study.</td>
<td>Patients reported it would be beneficial to be asked about their gender preference and preferred pronouns versus health care providers expecting the patient to provide this information. The legal name in the EHR was identified as a barrier to engagement.</td>
<td>A small sample size limited to one unit in an organization. Self-reporting. Descriptive study. Reiterates study findings that transgender patients are not consistently asked their pronoun and gender preferences during intake in a supportive manner. Patients’ report stress due to EHR and wristband legal name/gender conflicting with preferred gender/name.</td>
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<td>Bidell (2017)</td>
<td>To create a reliable and valid LGBT self-assessment tool for health and mental health professionals to enhance cultural humility when caring for this population.</td>
<td>Three studies: Study 1: Development of scale items for utilization in the tool. 602 participants that included mental health and primary care medicine trainees, practitioners, and educators in the U.S. and UK. In-person and online computer surveys were distributed. Voluntary participation. Study 2: Examine internal consistency. All 602 participants from study 1 partook in the study. Test-retest reliability included 27 participants. Study 3: LGBT-DOCSS scores were compared with Level VI- Descriptive study</td>
<td>Study 1: LGBT-DOCSS was developed with three elements: clinical preparedness, attitudinal awareness, and basic knowledge. Clinical preparedness included 7 items inquiring about assessment skills and feelings of cultural competency. Attitudinal awareness consisted of 7 items and include assessment of the individual’s awareness of personal LGBT prejudice. Basic knowledge included 4 items and assessed the individual’s awareness of health disparities for the LGBT population. Study 2: Results indicated strong internal consistency. Study 3: LGBT participants and participants with higher levels of education scored higher on the LGBT-DOCSS.</td>
<td>Study 1: An 18 item LGBT-DOCSS tool was created. Study 2: The LGBT-DOCSS demonstrated strong internal consistency and reliability. Study 3: LGBT participants and participants with higher levels of education scored higher on the LGBT-DOCSS.</td>
<td>In the study, only social workers reported receiving formal LGBT training. Nurses and counselors reported no formal training. The sample sizes were large and cross-national. The test-retest involved a limited group of 27 individuals. Congruent results with previous studies supporting that advanced education provide higher scores on LGBT-DOCSS. First published tool to include transgender specific items. Overrepresentation of mental health students and clinicians. The sample population did not include nurses, nurse practitioners, physician assistants, allied health professionals.</td>
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<td>Bristol et al. (2018)</td>
<td>Evaluate the impact of cultural competency training on ED health care team members’ knowledge and attitudes toward the LGBT community.</td>
<td>Pre/Post Intervention survey design 95 pre-intervention ED staff nurse, nurse practitioners, physicians, and unit secretaries. 40 post-intervention</td>
<td>Level III- quasi-experimental</td>
<td>30-minute online pre-education session. 2-hour facilitator-led session with presentation, interactive exercises, small-group discussion, and short video presentation.</td>
<td>Post-educational intervention illustrated a 14.9% increase in Knowledge and Skills, 6.5% increase in oppression and awareness, and a 4.9% increase in openness and support.</td>
<td>Pre/post surveys were unmatched. Low post-intervention survey completion compared to pre-intervention survey completion. Self-reporting tool. Demonstrated positive impact on ED health care workers’ attitudes and knowledge when</td>
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| Carabez et al. (2015) | To increase the nursing students' knowledge of LGBT issues from the beginning to the end of the semester through diverse teaching strategies | 112/122 students from the baccalaureate, generic master’s, and RN-to-baccalaureate nursing programs  
Students completed a pre-post interview survey.  
The pre-interview survey contained 14 questions to evaluate baseline knowledge of LGBT terminology and issues. | Level III-quasi-experimental | During the Community/Public Health Nursing course  
students were assigned readings, presented a 2-hour lecture on LGBT health issues, and provided instructions on conducting a scripted interview.  
The students conducted a structured interview of 2 RNs regarding the Health Care Equality Index that ensures that LGBT Americans | 40% felt unprepared to provide nursing care to LGBT patients  
1/10 had religious values that might interfere with quality care  
70% reported comfort using the patients' preferred pronoun  
29% reported asking gender/sexual preference questions | Self-reporting  
Nursing students were required to complete the assignment (intervention)  
Students were not mandated to complete the survey as part of the course, so participation was voluntary  
This study again illustrates that even recently graduated | Caring for the LGBT population  
ALLY identity tool as a potential reliable/validated tool for EBP project  
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<td>Chisolm-Straker et al., 2018</td>
<td>To explore the knowledge, attitudes, and behaviors of emergency providers in caring for the transgender and gay men.</td>
<td>399 respondents of 654 active emergency physician participants of the American College of Emergency Physicians’ Emergency</td>
<td>Level VI- Qualitative Study</td>
<td>N/A</td>
<td>85.2% reported no formal training for caring for the transgender and gender-nonconforming population</td>
<td>Convenience sampling Voluntary completion Demographics were not obtained.</td>
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The post-interview survey contained questions regarding the intervention (assignment, lecture, and interviews of 2 RNs) effectiveness in preparing them to care for LGBT patients and to reassess their knowledge of caring for the LGBT population post intervention.

- Students completed a pre-post interview survey.
- The pre-interview survey contained 14 questions to evaluate baseline knowledge of LGBT terminology and issues.
- The post-interview survey contained questions regarding the intervention (assignment, lecture, and interviews of 2 RNs) effectiveness in preparing them to care for LGBT patients and to reassess their knowledge of caring for the LGBT population post intervention.

- receive equitable, knowledgeable, sensitive, and welcoming health care.
- 62% reported possessing the knowledge to care for the LGBT population,
- 85% said nursing education did not prepare them to care for the LGBT population
- 74% reported that the intervention increased the awareness of LGBT issues
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<td>Donaldson et al. (2019)</td>
<td>To develop an online training tool to enable VA staff to better serve older LGBT veterans.</td>
<td>Pre/Post Intervention Design. Online education tool. Pre/post training questionnaire. Recruited via email. 26 participants.</td>
<td>Level III- quasi-experimental</td>
<td>One hour online educational session. Improve the knowledge, skills, and attitudes when caring for LGB knowledge and transgender knowledge increased following the intervention. Skills and attitudes did not illustrate a</td>
<td>LGB knowledge and transgender knowledge increased following the intervention.</td>
<td>Pre/post questionnaires were not matched. Staff knowledge increased following the educational intervention.</td>
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<td>gender-nonconforming population</td>
<td>Medicine Practice-Based Research Network</td>
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<td>The survey tool was not validated. Self-reporting. It illustrates that emergency care providers are willing to provide culturally competent care but the majority lack formal training.</td>
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| Donaldson & Vacha-Haase (2016) | To assess the LGBT cultural competency of staff working in long term care facilities, identify their training needs, and develop a framework for understanding LGBT cultural competency among staff.                                 | LGB knowledge and attitudes were assessed using 22 items from the LGB Knowledge and Attitudes Scale for Heterosexuals (LGB-KASH).  
Transgender related attitudes were assessed using the 14 items from Attitudes toward transgender individuals scale (ATTIS).  
LGBT knowledge was assessed using four true/false statements.  
The Marlowe-Crowne Social Desirability Scale was utilized to measure social desirability.                                                                                                     | Level VI: Qualitative study                                                                 | Interview. Qualitative study.                                                                 | Staff reported struggling with how to be sensitive to LGBT populations. Staff felt the LGBT population should be treated the same as the rest of the residents. | Online format demonstrated difficulties for participation and compliance. |
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<td>22 Staff members from 3 different facilities ranging in age from 22 to 72 and with various training backgrounds and demographics. Data collected from focus groups of interdisciplinary staff.</td>
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<td>Participants reported assumptions that residents were heterosexual and did not consider otherwise. Some participants reported a person-centered approach to care versus the treat, everyone, the same. Areas noted for additional training to improve care to the LGBT population included using inclusive and sensitive language when talking to transgender residents. Identification that there is an increased need for staff to work through the ambivalence of providing culturally competent care to the LGBT population. The study resulted in an increased need for education provision to staff regarding caring for the LGBT population.</td>
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| ENA (2018)   | To guide the culturally safe provision of emergency nurse care to the LGBTQ community | Systematic Reviews for each of the 8 topics in the toolkit | Level VII: Expert Opinion | It provides 8 different sections to address emergency care considerations when providing health care to the LGBTQ community. | Terminology  
ED Inclusive Environment  
Health Disparities and Considerations  
Transgender Health, surgical procedures, and post-operative complications  
Pediatric and Adolescent Patients  
Behavioral Health  
Case Studies | Utilize the guidelines to develop the education session intervention for the EBP project. |
| Garcia-Acosta et al. (2019) | To evaluate the increase in knowledge of final-year nursing students | N=59 assigned to two intervention groups  
N=57 were assigned to a control group  
Intervention- specific training course on transgender issues  
Compared knowledge before after intervention | Level III: Quasi-experimental | Problem-based learning and film-forum education intervention divided into three sessions over three weeks | The reference value for knowledge pre-intervention was 0.4652.  
The intervention group post scores increased G1= 0.757 and G2=0.721.  
The control group post scores = 0.409. | Specific population: 4th year nursing students  
Small sample size  
May be applicable to small group sizes  
Did not assess attitudes  
Increased knowledge post education intervention |
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<td>Henry, A. (2017)</td>
<td>To increase health care providers’ knowledge, skills, and attitudes when caring for the LGBT population to increase LGBT self-disclosures.</td>
<td>Pre/post interventions survey. Setting: Private psychiatric practice in Delaware. All 8 staff members participated.</td>
<td>Level III- quasi-experimental</td>
<td>Didactic educational session. LGBT patient panel to share experiences. Short video presentation on LGBT experiences in health care. Outcomes: Increase knowledge, skills, and attitudes. Increase the number of LGBT self-disclosures.</td>
<td>Knowledge increased by 16%, skills by 1.24%, and attitudes by 22% post intervention. Increase the number of LGBT self-disclosures following the intervention from 2-63%.</td>
<td>The study size was small n=8. Assessed knowledge, attitudes, and behavior toward the LGBT population in health care providers pre/post intervention. Knowledge increased by 16%, skills by 1.24%, and attitudes by 22% post intervention. Increase the number of LGBT self-disclosures following the intervention from 2-63%.</td>
</tr>
<tr>
<td>Jones et al. (2014)</td>
<td>To create and validate the LGBT Ally Identity Measurement tool</td>
<td>Study 1: Instrument development and initial evaluation. 269 participants. The survey was sent via email. Study 2: Validity. 240 participants. Surveyed via email. Study 3: Convergent validity. 221 participants. Surveyed via email.</td>
<td>Level VI- Descriptive study</td>
<td>Study 1: 38 items were sent out to the participants 24 items were retained. Study 2: 24 items were sent out to the participants 19 items were retained following the 2nd study. Study 3: 19 items were sent out to participants.</td>
<td>Study 1: Demonstrated reliability and validity. Study 2: Demonstrated reliability and validity. Study 3: The Cronbach’s alpha for the full scale 19-item AIM was .88. Study 4: The full-scale reliability was r=.73.</td>
<td>To match pre/post surveys, participants were asked to make a unique, anonymous identification code. This could be utilized in the EBP project for same purpose. Limited to individuals who had access to computers and the internet.</td>
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<td>Kattari &amp; Hasche, (2016)</td>
<td>To identify potential barriers to health care for transgender and gender non-conforming individuals.</td>
<td>Secondary data analysis 2010 National Transgender Discrimination Survey (NTDS) 6,456 surveys were collected in 2009 and 2010 Participants that did not include an age were dropped from this study n= 5,885</td>
<td>Level VI- Single descriptive study</td>
<td>The survey measured discrimination, harassment, and victimization of participants</td>
<td>Individuals below the age of 35 reported the highest level of discrimination overall (22.4%) with 16.1% experienced in emergency rooms. Individuals below the age of 35 reported the highest frequency of harassment overall (26.1%) with reported 19.8% reported in emergency rooms. Individuals below the age of 35 reported the highest levels of victimization overall (2.5%) with the emergency room reported 0.7%.</td>
<td>Most individuals in study were college educated and middle class. Potential tool for pre/post intervention assessment.</td>
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<tr>
<td>Lim et al. (2015)</td>
<td>To assess the knowledge of faculty in baccalaureate nursing programs and their administrative leaders</td>
<td>A nonprobability purposive sample of nursing school administrative leaders</td>
<td>Level VI- Single descriptive study</td>
<td>The estimated time for teaching LGBT health in a BSN program was 2.12 hours.</td>
<td>Approximately 50% of faculty reported limited knowledge and suggested development</td>
<td>Nonprobability sampling methods</td>
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<td>Lisy et al. (2018)</td>
<td>To explore the cancer care experiences and unmet needs of the LGB population</td>
<td>15 studies in systematic review and meta-synthesis</td>
<td>Level V-Systematic Review of qualitative or descriptive studies</td>
<td>Systematic review</td>
<td>28 sub themes emerged and 6 overarching themes: Lack of opportunity for disclosure, the experience of homophobia, lack of knowledge of HCPs, lack of affirmative behavior, heterocentric care, lack of support groups, lack of information and patient centered care</td>
<td>The survey tool was not tested for reliability. Limited to BSN programs. Yes, it illustrates that new graduates may lack fundamental cultural competency training despite recently graduating school.</td>
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<tr>
<td>Logie et al. (2019)</td>
<td>To explore the experiences of the LGBT population when seeking health care services.</td>
<td>16 youth 21 adults Northwestern Canada territories Individual interviews with consenting persons</td>
<td>Level VI- Single descriptive study</td>
<td>Two key aspects of the place: physical access and issues of confidentiality, anonymity, and privacy Increasing ease of access to sexual health care</td>
<td>Heteronormativity and cis-normativity limited access to appropriate sexual health care within small communities. Participants recommended non-</td>
<td>Provide firsthand experiences from the LGBT population regarding specific questions to address their health concerns and ensure culturally competent care.</td>
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<td>Maruca et al. (2018)</td>
<td>To evaluate the impact of a transgender simulation on nursing students’ affirmative practice when caring for a transgender person</td>
<td>Pre/posttest design One university in Connecticut and one university in Florida A convenience sample of prelicensure BSN nursing students in the psychiatric mental health didactic and clinical course 159/170 participated but n=47 completed the pre/posttest surveys</td>
<td>Level III- Quasi-experimental study</td>
<td>LGBT content was delivered during the didactic portion of the nursing course during a lecture Students then participated in a simulated patient scenario caring for a transgender patient to establish therapeutic communicate and assess anxiety level when caring for a transgender patient The transgender simulation will enhance the attitudes and beliefs related to LGBT patients and support affirmative practice</td>
<td>Recommendations were provided for the appropriate delivery of sexual health care to the LGBT population. The Gay Affirmative Practice (GAP) scores increased post didactic education and simulation experience Practice behaviors illustrated improvement post intervention Beliefs/attitudes illustrated minimal change post intervention</td>
<td>The results illustrate that education and simulated scenarios can increase affirmative practice when providing care to the LGBT population. Beliefs and attitudes illustrated no statistical increase post intervention Large dropout rate Delay in posttest survey (1-4 weeks post intervention) GAP survey was not specific to transgender patients Multi-sites included Small sample size Convenience sampling</td>
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<td>Mendoza et al. (2015)</td>
<td>To assess diversity and inclusion in the pediatric workforce and the level of cultural competency training.</td>
<td>8 question survey was sent to 131 U.S. pediatric chairs. 49.6% response rate</td>
<td>Level VI- Single descriptive study</td>
<td>To determine diversity and inclusion training in pediatric departments</td>
<td>69% of chairs reported being successful in diversity efforts 74% reported training for faculty and staff on diversity and inclusion</td>
<td>Not limited to LGBTQ inclusion. Descriptive study. Limited sample size. Self-reporting.</td>
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<td>Nguyen &amp; Yehia (2015)</td>
<td>To determine the proportion of primary care patients who had the gender of their sexual partner documented in the EHR. To identify factors associated with documentation of the gender of sexual partners.</td>
<td>Adults (18-89 years of age) with an outpatient visit at one of the 40 primary care practices within a large health system. A total of 170, 570 charts were evaluated. Retrospective chart review using the EpicCare EHR.</td>
<td>Level IV- Case control or cohort study</td>
<td>The greatest predictor of documentation was the inclusion of checkboxes in social history.</td>
<td>45% had sexual partner gender documentation. 95.8% had opposite gender partners and 3.6% had same sex partners documented.</td>
<td>Single health system. The health system has had an adopted EHR for an increased length of time. Utilized checkbox data collection did not account for free text enter of information. Yes, the inclusion of the sexual partner gender question may improve health screenings, preventive counseling, and inclusive care. Insufficient provider training was one listed barrier to the inclusion of this data collection from patients.</td>
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<td>Porter &amp; Krinsky (2014)</td>
<td>To provide evidence regarding whether attitudes, beliefs, and intentions of elder-service providers can be positively affected as a result of attending cultural competency training on the unique challenges of sexual and gender minorities</td>
<td>N=76 Attendees of 4 Massachusetts training events Pre/posttest survey completion</td>
<td>Level III-Quasi-experimental study</td>
<td>5-hour pilot training workshop on LGBT aging developed for service providers of older adults Improve knowledge Improve attitudes Improve behavioral intentions when providing care to LGBT older adults</td>
<td>Improved knowledge, attitudes, and behavioral intentions post intervention</td>
<td>Voluntary participation Self-reporting. Echoes research that knowledge, attitudes, and behaviors can improve following an educational intervention to enhance the care provided to the LGBT community Limited to the LGBT older adult population</td>
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<td>Sawning et al. (2017)</td>
<td>To improve the attitudes and knowledge of students post LGBT health training</td>
<td>Pre/posttest design Medical students who attended at least one of the 11 education session offerings and completed both the pre/post test N=39</td>
<td>Level III-Quasi-experimental</td>
<td>11 LGBT health trainings were offered as an extracurricular, certificate program Participants had to attend a minimum of 4 sessions to be eligible for the certificate (students could substitute two modules from the Fenway Institute)</td>
<td>102 students received the LGBT health certificate (52 were medical students) Post intervention scores increased for knowledge Post intervention items for attitudes decreased in some areas—participants reported increased challenges in patient history taking for the LGBT population compared to heterosexual and cisgender patients</td>
<td>Self-reporting Convenience sampling Pre/post tests were matched by student selected identifier Students could attend 1 out of the 11 educational sessions to participate in the pre/posttest The decrease in attitudes scores for the participants post</td>
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| Sekoni et al. (2017) | To assess the effect of educational curricula and training for health care students/professional on LGBT health care issues | Systematic review  
Out of 1171 papers, 2 qualitative studies were reviewed and 15 quantitative studies | Level V-Systematic Review of qualitative or descriptive studies | Systematic review | Short-term improvement in knowledge, attitudes, and practice when providing care for the LGBT population  
Time for education ranged from 1-42 hours. | Majority of the studies were from the USA  
The methods of the studies included were weak  
Four of the studies were published prior to 1990  
Illustrated improvement in at least one area of knowledge, attitude, and/or practice post |
<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Study Purpose/Objective(s)</th>
<th>Design, Sampling Method, &amp; Subjects</th>
<th>LOE*</th>
<th>Intervention &amp; Outcomes</th>
<th>Results</th>
<th>Study Strengths &amp; Limitations</th>
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</thead>
<tbody>
<tr>
<td>Shetty et al. (2016)</td>
<td>To assess the knowledge, attitudes, and practice behaviors of oncology providers regarding LGBT health.</td>
<td>Survey via email sent to 388 providers at one organization. 108 participants.</td>
<td>Level VI- Single descriptive study</td>
<td>Identify knowledge gaps and areas in need of education to improve the care provided to LGBT population.</td>
<td>26% of participants reported inquiring about a patient’s sexual orientation. 36% reported a need for LGBT education. 94% reported feeling comfortable caring for the LGBT population.</td>
<td>Education and training intervention. Descriptive study. Low response rate. Identifies need and readiness by health care providers for LGBT cultural competency training.</td>
</tr>
<tr>
<td>Shrader et al. (2017)</td>
<td>To develop, implement, and evaluate the effectiveness of an LGBT education program for health care providers in a military health system to increase cultural awareness for the LGBT population.</td>
<td>51 individuals completed the program that included a pre/post multiple-choice questionnaire following the education program Pre-posttest design</td>
<td>Level III- quasi-experimental</td>
<td>60-minute education session.</td>
<td>Pre/post test scores increased. Providers scored best in preventative care measures. Barriers to care and pertinent health issues proved challenging for providers.</td>
<td>Small sample size. Focused on the adult LGBT military beneficiary. Yes, Similar setting to the EBP project. Similar barriers and cultural practices.</td>
</tr>
<tr>
<td>Singer et al. (2019)</td>
<td>To explore the impact of gender and sexuality awareness training on perinatal health care providers’ knowledge, attitudes, and intended behavior toward LGBTQ childbearing individuals</td>
<td>Nonrandom convenience sampling The experimental group received 40-minute training session included 99 individuals Control group included 88 individuals</td>
<td>Level III- quasi-experimental</td>
<td>Grand round training covering gender and sexuality topics</td>
<td>Improved knowledge, misconception, prejudice, sensitive language, and normativity regarding LGBTQ pregnant patients</td>
<td>To match pre/posttests participants used the last four digits of their phone numbers. Small sample size. Nonrandom assignment.</td>
</tr>
<tr>
<td>Author (year)</td>
<td>Study Purpose/Objective(s)</td>
<td>Design, Sampling Method, &amp; Subjects</td>
<td>LOE*</td>
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<td>Stewart &amp; O'Reilly</td>
<td>To explore current literature regarding knowledge, beliefs, and attitudes of nurses and midwives of health care needs of LGBTQ population</td>
<td>Participants were recruited from 7 hospitals in 2 different cities. Systematic literature review utilizing 4 databases and two researchers.</td>
<td>Level V- Systematic Review</td>
<td>Systematic Review</td>
<td>Statistically significant increase in knowledge post intervention. Results demonstrate training may decrease misconceptions. The results of the intervention demonstrated a significant effect on LGBTQ prejudice. A higher level of sensitive language utilization following LGBT training. LGBT training decreased participant assumptions toward this patient group.</td>
<td>The short time interval between pre/posttest and intervention.</td>
</tr>
<tr>
<td>Streed et al. (2019)</td>
<td>To assess resident knowledge of health care issues affecting sexual and gender</td>
<td>833 post-graduate year 1-3 residents at 120 internal medicine</td>
<td>Level III-Quasi-experimental study</td>
<td>1-hour online module addressing sexual and gender minority health</td>
<td>Residents scored lowest in pre-test areas including screening and management of</td>
<td>Pre-test scores illustrated substandard knowledge regarding sexual and gender</td>
</tr>
<tr>
<td>Author (year)</td>
<td>Study Purpose/Objective(s)</td>
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<td>LOE*</td>
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<td>minorities as well as the role of online case-based didactics to measure and improve knowledge in the diagnosis and treatment of these patients</td>
<td>residence programs in the USA</td>
<td>Level III: a quasi-experimental study</td>
<td>Increase knowledge of health care issues affecting sexual and gender minorities</td>
<td>sexually transmitted illnesses, and substance abuse and mental health issues specific to this population Post education test scores increased from ranging in 50% to 80%.</td>
<td>minority terminology, health disparities and preventive care issues, substance abuse and mental health issues, and common sexually transmitted illnesses Residents were not aware of preventive health care options for this population Convenie...</td>
</tr>
<tr>
<td>Strong &amp; Folse (2015)</td>
<td>To improve knowledge, cultural competency, and attitudes of baccalaureate nursing students regarding LGBT patient care post educational intervention</td>
<td>Utilized three instruments to assess pre/post intervention knowledge, attitudes, and cultural competency: Attitudes toward lesbians and gay mean (ATLG) scale, Lesbian, Gay Bisexual, and Transgender Health care (LGBT Health care) scale, and the LGBT Knowledge scale</td>
<td>Education sessions included terminology and definitions, LGBT health disparities, cultural competency, and transgender-specific health care. Education was provided over 1 hour to include posttest delivery</td>
<td>89.7% reported that attitudes of family or friends influenced their attitudes about the LGBT community 56.9% reported a positive or negative experience with the LGBT community 27.6% reported the media as most influential of their attitudes toward the LGBT community</td>
<td>No established tools met the study’s need; therefore, the LGBT Health care Scale and LGBT knowledge questionnaire were developed, and reliability was low. Students studying abroad completed the education intervention through Polycom technology and could have been a limiting...</td>
<td></td>
</tr>
<tr>
<td>Author (year)</td>
<td>Study Purpose/ Objective(s)</td>
<td>Design, Sampling Method, &amp; Subjects</td>
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<tr>
<td>The Joint Commission (2011)</td>
<td>To promote effective communication, cultural competency, and patient centered care for the LGBT population.</td>
<td>A convenience sample of 88 nursing students at an undergraduate university in midwestern U.S. N=58 were included due to receipt of complete responses</td>
<td>Level VII: Evidence-based clinical practice guidelines</td>
<td>Provide a toolkit for health care organizations to promote an LGBT inclusive environment</td>
<td>Change in attitudes toward the LGBT population improved post intervention Knowledge improved post intervention</td>
<td>A cross-sectional study with post-test scores obtained following the intervention Convenience sampling Self-reporting tool. Education intervention illustrated an improvement in knowledge and attitudes post survey.</td>
</tr>
<tr>
<td>Author (year)</td>
<td>Study Purpose/Objective(s)</td>
<td>Design, Sampling Method, &amp; Subjects</td>
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<tr>
<td>Vance et al. (2016)</td>
<td>To enhance pediatric trainees’ and students’ knowledge of the psychosocial and medical issues facing gender youth through a comprehensive curriculum</td>
<td>Fourth-year medical students, pediatric interns, psychiatry interns, and nurse practitioner students who were participating in their 1-month adolescent and young adult medicine rotation N= 20 Retrospective pre/posttest survey to assess knowledge/awareness measures</td>
<td>Level III: Quasi-experimental design</td>
<td>Six interactive, online modules (terminology, taking a gender history, taking a psychosocial history, performing a sensitive physical examination, and formulating an assessment, psychosocial plan, and medical plan Interactive modules took approximately 2 hours Observational experience in a multidisciplinary pediatric gender clinic One 5-hour observational clinic 90% of participants completed this observational clinical</td>
<td>Pre/post curriculum intervention knowledge and awareness scores increased from the not knowledgeable/aware (&lt;3 Likert) to the knowledgeable/aware range (&gt;3 Likert)</td>
<td>Small sample size Self-reporting Retrospective pre-post design Support the increase in knowledge and awareness by health care providers post education intervention</td>
</tr>
</tbody>
</table>
Appendix B

Citi Training

This is to certify that:

Kristen Kaiafas

Has completed the following Citi Program course:

Biomedical Research - Basic/Refresher  (Curriculum Group)
Biomedical & Health Science Researchers  (Course Learner Group)
1 - Basic Course  (Stage)

Under requirements set by:

Liberty University

Verify at www.citiprogram.org/verify?wbf089aeb-2a74-4c93-a01e-6665ca9a3ba1-24768811
## Appendix C

### Permission to Use Iowa Model

<table>
<thead>
<tr>
<th>Permission to Use The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care</th>
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<tbody>
<tr>
<td>Getting too much email? Unsubscribe</td>
</tr>
<tr>
<td>Kimberly Jordan - University of Iowa Hospitals and Clinics</td>
</tr>
<tr>
<td>From: <a href="mailto:KJord@uiowa.edu">KJord@uiowa.edu</a> (Email)</td>
</tr>
</tbody>
</table>
| Monday, January 8, 2018 4:36 PM  
| KJord, Kristan > |

You have permission as requested today, to review and/or reproduce The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care. Click the link below to open.

[The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care](mailto:KJord@uiowa.edu)

Copyright is retained by University of Iowa Hospitals and Clinics. Permission is not granted for placing on the internet.

**Citation:** Iowa Model Collaborative. (2017). Iowa model of evidence-based practice: Revisions and validation. Worldviews on Evidence-Based Nursing, 14(2), 175-182. doi:10.1111/wvn.12223

In written material, please add the following statement:

*Used/Reprinted with permission from the University of Iowa Hospitals and Clinics, copyright 2015. For permission to use or reproduce, please contact the University of Iowa Hospitals and Clinics at 319-384-9098.*

Please contact: [email protected] with questions.
Appendix D

Letter of Support from the Organization

DNP Scholarly Project

LETTER OF SUPPORT

Liberty University, Inc.
1971 University Blvd.
Lynchburg, VA 24503

RE: IRB Letter of Support
Kristen Kaisfas

Dear Institutional Review Board Chair and Members:

I am writing this letter of support for one of our colleagues, it is our intention to support Kristen Kaisfas’ DNP scholarly project (described below).

Scholarly Project Overview:

1. Project Summary:
Implementation of an independent, unit-specific Lesbian-Gay-Bisexual-Transgender (LGBT) cultural competency training for the emergency department (ED) nursing staff.

2. Objectives:
Increase the ED nurses’ knowledge and skills, openness and support, and awareness of oppression when providing emergent care to the LGBT population.

3. Background & Rationale:
This project will use the Iowa Model of Evidenced-Based Practice for Quality Improvement. It will be designed to support the provision of culturally competent care for the LGBT population presenting to one military health system Emergency Department. Until 2011, the LGBT population serving in the military were required to follow the Department of Defense Directive 1304.26 “Don’t Ask Don’t Tell Policy.” Since the repeal of this directive, one military health system’s ED has not received formal training in effective communication techniques and healthcare considerations when caring for the LGBT population and their family members in the ED environment. The Army’s Diversity Mission (2010) states “Develop and implement a strategy that contributes to mission readiness while transforming and sustaining the Army as a national leader in diversity.” The student will receive the support to deliver the education and the equipment to present the information for the project.
Appendix E

Consent Form

By completing the following survey, you are giving consent to participate in the study. You are welcome to withdraw from the study at any time.

Please do not include your name on this form (Circle one of the following):

Age: 18-30 31-40 41-50 51+
Gender: Male Female Other
Ethnicity: Caucasian African American Asian/Pacific Islander Multiracial Other
Education Level: HS or less Associate's Degree Bachelor's Degree
Graduate Degree: Chose not to answer

Ally Identity Measure

DIRECTIONS: Please take a moment to read each question and indicate the appropriate response that captures the degree to which you agree with the statement. Please answer each item as it pertains to you right now. Please try to respond to every item.

Throughout the survey, the phrase Sexual Minority is meant to be all encompassing of all sexual minority groups and individuals (for example, Gay, Lesbian, Bisexual, Transgender, Questioning, and Queer people).

All questions are on a 5 point Likert scale, ranging from Strongly Disagree (1), Disagree (2), Neither Disagree nor Agree (3), Agree (4) and Strongly Agree (5).

1. I keep myself informed through reading books and other media about various issues faced by sexual minority groups, in order to increase my awareness of their experiences. 1 2 3 4 5
2. I know about resources (for example: books, websites, support groups, etc.) for sexual minority people in my area. 1 2 3 4 5
3. I know of organizations that advocate for sexual minority issues. 1 2 3 4 5
4. If I see discrimination against a sexual minority person or group occur, I actually work to confront it. 1 2 3 4 5
5. Sexual minority adolescents experience more bullying than heterosexual adolescents. 1 2 3 4 5
6. I have taken a public stand on important issues facing sexual minority people. 1 2 3 4 5
7. I am aware of policies in my workplace and/or community that affect sexual minority groups. 1 2 3 4 5
8. I regularly engage in conversations with sexual minority people. 1 2 3 4 5
9. I try to increase my knowledge about sexual minority groups. 1 2 3 4 5
10. Sexual minority adolescents experience more depression and suicidal thoughts than heterosexual adolescents. 1 2 3 4 5
11. If requested, I know where to find religious or spiritual resources for sexual minority people. 1 2 3 4 5
12. I am aware of the various theories of sexual minority identity development. 1 2 3 4 5
13. I am open to learning about the experiences of sexual minority people from someone who identifies as an LGBTQ person. 1 2 3 4 5
14. I know about resources for families of sexual minority people (for example: PFLAG). 1 2 3 4 5
15. I have developed the skills necessary to provide support if a sexual minority person needs my help. 1 2 3 4 5
16. I have engaged in efforts to promote more widespread acceptance of sexual minority people. 1 2 3 4 5
17. I think the sexual minority groups are oppressed by society in the United States. 1 2 3 4 5
18. I think sexual minority individuals face barriers in the workplace that are not faced by heterosexuals. 1 2 3 4 5
19. I am comfortable with knowing that, in being an ally to sexual minority individuals, people may assume I am a sexual minority person. 1 2 3 4 5
Appendix F

Ally Identity Measurement (AIM) Tool

**Ally Identity Measure**

**DIRECTIONS:** Please take a moment to read each question and indicate the appropriate response that captures the degree to which you agree with the statement. Please answer each item as it pertains to you right now. Please try to respond to every item.

Throughout the survey, the phrase Sexual Minority is meant to be all encompassing of all sexual minority groups and individuals (for example, Gay, Lesbian, Bisexual, Transgender, Questioning, and Queer people).

1. I keep myself informed through reading books and other media about various issues faced by sexual minority groups, in order to increase my awareness of their experiences.
2. I know about resources (for example: books, websites, support groups, etc.) for sexual minority people in my area.
3. I know of organizations that advocate for sexual minority issues.
4. If I see discrimination against a sexual minority person or group occur, I actively work to confront it.
5. Sexual minority adolescents experience more bullying than heterosexual adolescents.
6. I have taken a public stand on important issues facing sexual minority people.
7. I am aware of policies in my workplace and/or community that affect sexual minority groups.
8. I regularly engage in conversations with sexual minority people.
9. I try to increase my knowledge about sexual minority groups.
10. Sexual minority adolescents experience more depression and suicidal thoughts than heterosexual adolescents.
11. If requested, I know where to find religious or spiritual resources for sexual minority people.
12. I am aware of the various theories of sexual minority identity development.
13. I am open to learning about the experiences of sexual minority people from someone who identifies as an LGBTQ person.
14. I know about resources for families of sexual minority people (for example: PFLAG).
15. I have developed the skills necessary to provide support if a sexual minority person needs my help.
16. I have engaged in efforts to promote more widespread acceptance of sexual minority people.
17. I think the sexual minority groups are oppressed by society in the United States.
18. I think sexual minority individuals face barriers in the workplace that are not faced by heterosexuals.
19. I am comfortable with knowing that, in being an ally to sexual minority individuals, people may assume I am a sexual minority person.

**Response Option:**

All questions are on a 5-point Likert scale, ranging from Strongly Disagree, Disagree, Neither Disagree nor Agree, Agree and Strongly Agree.

**Scoring:** Total scores range from 15 to 75. Higher scores indicate a higher ally identity level.

**Subscales:**

**Knowledge and Skills:** Add together items 1, 2, 3, 7, 11, 12, 14, 15

**Openness and Support:** Add together items 4, 6, 8, 9, 13, 16, 19

**Oppression Awareness:** Add together items 5, 10, 17, 18
Appendix G

Permission to Utilize the AIM tool

---

Re: [External] RE: Ally identity Measurement Tool follow-up

Get: Outlook for iOS

From: Jones, Kevin

Send: Monday, January 30, 2020 2:49:57 PM

Subject: [External] RE: Ally identity Measurement Tool follow-up

---

[EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content.]

Hello,

I am sorry for the delay. I have been out of the office for the last month and a half. I hope you can still utilize my survey, it sounds like a meaningful project! Attached is the survey and scoring instructions.

From: Kalafas, Kristen

Send: Tuesday, February 03, 2020 1:27:09 PM

Re: [External] RE: Ally identity Measurement Tool follow-up

---

[EXTERNAL SENDER: Only open links and attachments from known senders. DO NOT provide sensitive information.]

Mr. Jones,

I am following up in reference to my email below. I was inquiring as to whether you have had the opportunity to consider my request for permission to utilize the Ally Identity Measurement tool for my upcoming DNP project. Once again, I thank you for your consideration in this matter.

Yours,

Kristen Kalafas
Appendix H

Permission to Utilize National LGBT education training

[External] RE: [Contact Form] LGBT Health Education Center “Permission to utilize learning modules”

Flag for follow up.

Jack Bruno <[redacted]>
Mon 12/16/2019 3:41 PM
Kalafas, Kristen; LGBT Health Education Center

[EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content.]

Good morning Kristen,

Thank you for reaching out to us at the National LGBT Health Education Center. Please feel free to use any of the materials that are available on our website for free. We ask only that you do not remove our logo, and credit us for what you use. All of the slide sets from our webinar and video series and learning modules, as well as any .pdfs from our publications page are available to you for download. The only caveat being that we’re unable to allow folks to upload them into their Learning Management Systems.

Please let us know if there is any other way we can assist you.

Best,
Jack Bruno
Operations Coordinator
The Fenway Institute

Jack Bruno | Operations Coordinator – Division of Education and Training
The Fenway Institute | 125 Brookline | 1340 Boylston St. | Boston, MA 02215
Office: [redacted] | www.thefenwayinstitute.org

IMPORTANT NOTICE: Email is not a secure means of communication; therefore, confidentiality cannot be assured. Please do not use e-mail to communicate regarding any protected mental health or medical concerns. This message is intended for use solely by the person or entity to whom it is addressed and may contain privileged and confidential information that is protected under state and federal law, and any unauthorized disclosure may result in legal penalties. If you are not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying or dissemination of this information is strictly prohibited. If you have received this message in error, please notify the sender immediately to arrange for return or destruction of these documents.
Appendix I

Permission to Utilize ENA toolkit information for Education

Hi Kristen,

Based on your email your request is for fair use and for educational purposes only without fees attached. If this is the case you are free to the resource for educational purposes only.

Thank you.

Education/Content Development
EMERGENCY NURSES ASSOCIATION
930 E. Woodfield Road | Schaumburg, IL 60173
education@ena.org | www.ena.org
Appendix J
IRB Approval Liberty University

February 11, 2020

Kristen Kaiafas
Tonia Kennedy

Re: IRB Application - IRB-FY19-20-100 IMPLEMENTATION OF AN INDEPENDENT, UNIT SPECIFIC LGBT CULTURAL COMPETENCY TRAINING

Dear Kristen Kaiafas, Tonia Kennedy:

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study does not classify as human subjects research. This means you may begin your research with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research

Explanation: Your study does not classify as human subjects research because:

1. Evidence-based practice projects are considered quality improvement activities, which are not considered “research” according to 45 CFR 46.102(d).

Please note that this decision only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application’s status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office
Appendix K

IRB Approval Organization

MEMORANDUM FOR: Ms. Karfas, Kristen, Department of Emergency Medicine

SUBJECT: Evidence Based Practice (EBP) Non-Research Determination (NRD)

1. A review of your application for a NRD for your EBP Project, Implementation of an independent, unit specific LGBT cultural competency training to improve the knowledge and skills, openness and awareness, and attitudes of ED nurses was completed by the EBP Council as part of the March 2020 meeting. Based on this review, the EBP Council determined that your project is not considered research, does not study human subjects, and does not utilize protected health information, therefore your project does not require approval by the Institutional Review Board (IRB).

2. This memorandum will serve as your Non-Research Determination. If at any time during the execution of your EBP Project, there are changes made to the frame work of your study, you will immediately notify the Chair of the Evidence Based Practice Council or the Director of the Center for Nursing Science & Clinical Inquiry in writing to ensure that your project remains in within the prescribed guidelines for an EBP Project.

4. The point of contact for this memorandum is [omitted for privacy].
Appendix L

Permission to Publish AIM tool in Liberty University’s Scholarly Crossings

Hi Kristen,
Congratulations on finishing up this monumental project. Yes, you have my permission to sum it it in full to your faculty publication. Good luck in your submission to the journal.

Nikki Jones

Get Outlook for iOS

Dr. Jones,

I want to thank you again for granting me permission to utilize the AIM tool for my Doctorate of Nursing Practice Evidence-based Practice Project. As part of the graduation requirements, I have to submit my final written project to the University’s scholarly crossings that publish faculty and staff scholarly works.

I am emailing to request permission to publish the project with a copy of your emailed permission and an example of the tool in the Appendices. I also plan to submit for publication to a journal, I am aiming for the Journal of Emergency Nursing. The copy of the tool will only be submitted with my complete written project for my University. The written publication to the journal will have your tool listed and credited but a copy will not be provided to the journal. I hope this is clear. If you have any further questions prior to granting or declining this request, just let me know. Thank you again for your assistance and permission to utilize the tool for my project.

Kristen Narles