LGBTQ CULTURAL COMPETENCY IN A RURAL SETTING

by

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A DNP Project Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements

For the Degree of

DOCTOR OF NURSING PRACTICE

In the Graduate College

THE UNIVERSITY OF ARIZONA

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THE UNIVERSITY OF ARIZONA
GRADUATE COLLEGE

As members of the DNP Project Committee, we certify that we have read the DNP project prepared by *Catherine Dockery-Jackson*, titled *LGBTQ Cultural Competency in a Rural Setting* and recommend that it be accepted as fulfilling the DNP project requirement for the Degree of Doctor of Nursing Practice.

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Final approval and acceptance of this DNP project is contingent upon the candidate's submission of the final copies of the DNP project to the Graduate College.

I hereby certify that I have read this DNP project prepared under my direction and recommend that it be accepted as fulfilling the DNP project requirement.

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ABSTRACT

Background: The lesbian, gay, bisexual, transgender, and queer (LGBTQ) population is a diverse community of gender and sexual minorities that experiences mental health disparities such as increased prevalence of anxiety, depression, suicide, drug and alcohol abuse and dependence (Healthy People 2020, 2018). In rural America, mental health disparities among LGBTQ individuals can be attributed to geographic barriers, limited healthcare providers (HCP), stigma, and limited culturally competent HCPs (Rosenkrantz, Black, Abreu, Aleshire, & Fallin-Bennett, 2017). LGBTQ cultural competency (CC) programs are a response to LGBTQ health disparities and attempt to improve knowledge, beliefs, behaviors, and effect organizational policies.

Methods: This quality improvement project used a descriptive quantitative design to address the knowledge, beliefs, and behaviors towards the LGBTQ population among rural HCPs employed at an organization with a mandatory LBGTQ cultural competency program. A convenience sample of staff (n= 51) at a behavioral health center were emailed surveys including demographic information, the Gay Affirmative Practice (GAP) scale, and a basic knowledge survey.

Results: Response rate of fully completed surveys was 13.7%. Registered nurses (RN) accounted for 45% of respondents however response rate per profession was highest among social workers (75%). GAP results provided a mean belief score of 67.2 (SD 6.32) and behavior score of 58.5 (SD 7.29). The mean score for the knowledge survey was 56% overall with a range of 50.

Conclusion: Those that attended CC101 had higher GAP and knowledge scores compared to those that did not attend. Overall respondents reported higher GAP belief scores than behavior scores and relatively low knowledge scores. Future cultural competency training should focus on

how HCPs can display affirmative behaviors towards LGBTQ and increase general LGBTQ knowledge.

INTRODUCTION

Background Knowledge

Approximately 3.5% of Americans identify as lesbian, gay, or bisexual and an additional 0.3% identify as transgender (Hafeez, Zeshan, Tahir, Jahan, & Naveed, 2017). Collectively this population is referred to as LGBTQ with the Q (queer) representing an umbrella term for all sexual and gender minorities including those that do not identify as lesbian, gay, bisexual, or transgender. The LGBTQ community is a diverse community of gender and sexual minorities with members worldwide of different faiths, nationalities, ages, socioeconomic standings, and ethnicities.

Discrimination against LGBTQ individuals has been associated with high rates of anxiety, depression, suicide, drug and alcohol abuse and dependency (Healthy People 2020, 2018). In acknowledgment of health disparities among LGBTQ individuals, Healthy People 2020 included the improvement of the health, safety, and well-being of LGBTQ individuals as a goal (2018). Collectively this community faces violence, discrimination, social stigma and denial of civil rights leading to health disparities (Healthy People 2020, 2018). These health disparities can be intensified based on location. Like all individuals living in rural America, rural LGBTQ individuals face geographic barriers and limited healthcare providers (HCP); however, stigma and limited culturally competent HCPs create further health disparities (Rosenkrantz, Black, Abreu, Aleshire, & Fallin-Bennett, 2017). An online survey found a majority of rural LGBTQ individuals experienced anticipated stigma (concern for possible future discrimination), internalized stigma (devaluation of self-based on identify) and enacted stigma (actual instances of discrimination) (Whitehead, Shaver, & Stephenson, 2016). Anticipated and enacted stigmas

were significantly associated with lower self-reported health scores in the rural transgender population (Whitehead et al., 2016). If the culture of a rural community is homophobic, an LGBTQ individual may conceal their sexual or gender identity. One study found lesbian and bisexual women that do not openly disclose their sexual orientation had a significant increase of suicide ideation or suicide attempts compared to heterosexual women (Koh & Ross, 2006).

Local Problem

This project focused on evaluating the impact of a current program at a mental health center in rural central Arizona. According to the Movement Advancement Project (MAP) (2018), 4% or 211,983 of Arizona adults identify as LGBTQ with 27% of the LGBTQ population raising children. Only five cities (Flagstaff, Phoenix, Sedona, Tempe, & Tucson) have ordinances prohibiting discrimination based on gender identity or sexual orientation in private employment, housing, and public accommodations (MAP, 2018). In addition to being a state with limited legal protection for LGBTQ, Arizona is slightly higher than the national average when it comes to adolescent depression, suicidal adults, as well as adult drug and alcohol abuse (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). These mental health concerns and limited legal protection for LGBTQ are intensified in the LGBTQ community when HCPs have limited LGBTQ cultural competency. In a national survey of LGBTQ physicians, 65% experienced other HCPs using disparaging comments regarding their LGBTQ patients and 34% witnessed discriminatory care of LGBTQ patients (Bonvicini, 2017).

The problem of limited LGBTQ culturally competent HCP is significant in healthcare. HCPs have been reported to feel incompetent in delivering care to LGBTQ patients and frustrated in lack of training received to properly counsel LGBTQ patients (Knight, Shoveller,

Carson, & Contreras-Whitney, 2014; Sabin, Riskind, & Nosek, 2015). As HCPs, nurse practitioners (NP) are likely to encounter LGBTQ patients, sometimes unknowingly. As part of required competencies, the National Organization of Nurse Practitioner Faculties (NONPF) (2006) states all NPs should be able to deliver culturally-sensitive care. This extends to the LGBTQ population which many NPs express they are inadequately prepared to deliver care to (Dorsen & Van Devanter, 2016). To be a holistic practitioner, an NP must be aware of how every aspect of a person's identity impacts their overall health.

Purpose

The purpose of this DNP project was to perform an impact evaluation to determine if a current LGBTQ cultural competency training among HCPs in a rural Arizonan crisis stabilization unit is effective in achieving its goals. The Center for Disease Control (CDC) (2015) distinguishes cultural competence from cultural knowledge, sensitivity, and awareness with action or structural change. It is not enough for a HCP to have knowledge of LG BTQ patients to be culturally competent. True cultural competence is the culmination of behaviors, beliefs, and policies in a system that allows for effective work in cross-cultural situations (CDC, 2015). A culturally competent HCP would be able to function effectively among others composed of complex patterns of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of gender, sexuality, race, ethnicity, and religion (Shen, 2015).

According to the Agency for Healthcare Research and Quality (AHRQ) (2014), stakeholder participation is needed to provide relevant and useful research. For this project, stakeholders included LGBTQ patients, their families, and HCPs such as NPs, physicians,

emergency medical technicians, nurses, behavioral health technicians, case managers, and social workers. LGBTQ patients and their families will benefit from improved LGBTQ cultural competency of HCP's. For HCP's, being culturally competent is a component of evidence-based practice (Boroughs, Andres Bedoya, O'Cleirigh, & Safren, 2015).

LGBTQ cultural competency programs are being initiated by many companies and organization. While it is more accepted to be LGBTQ, there still exists an increased risk for violence against this minority group. According to the CDC (2010), 46% of bisexual women have been raped compared to 17% of heterosexual women and 13% of lesbians. In the transgender community, 47% are sexually assaulted at some point in their lifetime with those of American Indian, middle eastern, or African American decent most likely to be assaulted (James et al., 2016). The Federal Bureau of Investigation (2016) reports a 5% increase in hate crimes between 2015 and 2016 with a 2% increase on crimes based on sexual orientation bias and a 9% increase based on gender identity bias. These statistics show that now more than ever HCP need to be aware of the violence and stigma their LGBTQ patients face and provide culturally competent care. HCP training provides an opportunity to examine beliefs and behaviors towards the LGBTQ population as well as increase knowledge of the population (Bonvicini, 2017). Although deep-seated beliefs are difficult to change completely, cultural competency training has been shown to modify beliefs to be more inclusive and change behaviors such as improved sexual history taking (Sekoni et al., 2017).

Study Question

Among rural Arizona HCPs, does having attended the current LGBTQ cultural competency program have a significant impact on their beliefs and behaviors towards and knowledge of the LGBTQ community?

THEORETICAL FRAMEWORK AND SYNTHESIS OF EVIDENCE

Theoretical Framework

The theoretical framework that guided this DNP project was the Theory of Culture Care Diversity and Universality Perspective (CCDUP) by Madeleine Leininger (Leininger, 2007). CCDUP is uniquely suited to this DNP project as it is a nursing theory primarily directed at culture care within the domain of nursing inquiry (Leininger, 2007). The founding principle of CCDUP is providing culturally congruent care that promotes health, healing, and well-being within a culture (Leininger, 2007). CCDUP is holistic as it incorporates various dimensions of an individual such as social factors of religion, politics, economics, cultural history, life span, values, and kinships; and geo-environmental factors that can influence the culture care (Leininger, 2007). CCDUP is important in guiding this project because if HCPs have better knowledge and positive beliefs towards the complex LGBTQ subculture they will be better prepared to provide culturally congruent care to promote health, healing, and well-being.

Four major principles come from CCDUP. The first principle states within all cultures both similarities and differences can be found, it is the nurse's job to discover components of care that are culturally universal (Eldridge, 2014). Nelson (2006) states common constructs among cultures include respect, concern, attention, assistance, listening, physical presence, and connectedness. The next principle is the importance of nursing to recognize the multitude of

ways that culture can impact healthcare outcomes (Eldridge, 2014). For HCPs, it means understanding how being a gender or sexual minority can be stressful and can affect an LGBTQ patient's health. Third, it is important to be aware of the differences and similarities between professional and folk care as these may be a source of problems or benefits (Eldridge, 2014). Lastly, culturally congruent care is needed for well-being and health (Eldridge, 2014). This can be a complex process as LGBTQ patients may identify as part of several cultural groups. To assure that culturally congruent care is given the HCP should work with the patient to identify what culturally congruent care is for them.

CCDUP joins concepts from both nursing and anthropology (Eldridge, 2014). Five central concepts of this theory are culture, worldview, environmental context, care and health (Albuquerque et al., 2016). Learned behaviors and shared values that are passed from one generation to the next compose the concept of culture (Albuquerque et al., 2016). Worldview addresses how an individual perceives events around them, their lives, and the world as a whole (Albuquerque et al., 2016). Environmental context is the sum of all knowledge and experiences that give meaning to life and contribute to social interactions, physical, emotional and cultural dimensions of an individual (Albuquerque et al., 2016). Care and health are culturally defined and based subjectively and objectively on values, beliefs, and standard of living (Albuquerque et al., 2016).

These concepts were used in this project to look at how the HCP's culture, worldview, and environmental context may differ from LGBTQ patients. Gathering basic demographic information on HCPs and comparing it to their beliefs about and behaviors towards LGBTQ patients will inform if mandatory cultural competency is having an impact on LGBTQ patients

care and health. In order to provide culturally congruent care to others, HCPs must first have an understanding of their own beliefs and how they may differ from those outside their culture. This project asked primarily cisgender, meaning their gender identity and expression aligns with their assigned sex at birth, heterosexuals HCPs in a rural/medically underserved setting to explore their beliefs and behaviors towards LGBTQ patients and determine if these beliefs and behaviors were affected by mandatory cultural competency training.

Cultural competency is defined as a skill set that allows the individual to act in a culturally appropriate way with a particular culture thereby demonstrating sensitivity to cultural differences and similarities (Dootson, 2000). In practicing cultural competency, HCPs are able to assess their own feelings regarding a culture and increase awareness within their profession of prejudice and intolerance that may exist (Dootson, 2000). Madeleine Leininger's theory provides a framework to explore how LGBTQ cultural competency can be improved in HCP.

Concepts

In understanding why being a gender and/or sexual minority is a risk factor for patients it is important for HCPs to understand the concepts of sexual orientation, gender, and minority stress theory. Sexual orientation is the component of personal identity that includes who a person is physically, romantically, and/or emotionally attracted to; this may include being attracted to men, women, both, neither, or androgynous individuals (American Psychological Association [APA], 2015). Patients may identity their sexual identity as heterosexual (attracted to the opposite gender), gay (an umbrella term for being attracted to the same sex), lesbian (women attracted to women), bisexual (attracted to both men and women), and asexual (lacking attraction to any gender).

Gender can be broken down into three components of body, identity, and expression (Gender Spectrum, 2017). Gender based on the body (genital, sex chromosomes, hormones, & reproductive structures) refers to sex assigned at birth, either male or female (Gender Spectrum, 2017). The binary concept of male or female fails to include children that are born intersex. Intersex occurs in roughly 1% of births when a child is born with chromosomes, hormones, genitalia and/or other sex characteristics that do not exclusively meet medical standards of male or female (Gender Spectrum, 2017). Gender identity is an internal process of how one views themselves as either male, female, or an alternative gender (gender queer, gender nonconforming, or gender neutral) (APA, 2015). Individuals whose gender identity does not align with their sex assigned at birth are transgender (APA, 2015). Gender Expression is how an individual presents their gender to the world around them through choices in clothing and behaviors (APA, 2015). The majority of people are cisgender while gender minorities include those who are transgender or gender nonconforming (APA, 2015).

Minority stress theory is frequently used to account for the elevated rates of depression, anxiety, and suicide attempts among LGBTQ individuals in comparison to heterosexuals. Minority stress theory hypothesizes that there are stressors specific to minorities (such as LGBTQ) that lead to risky behaviors and poor health outcomes (Gonzalez, Gallego, & Bockting, 2017). These stressors are a result of stigmatization a person faces as a minority that underlies all social and cultural structures (Pitoňák, 2017). Many minority groups face stress due to prejudice, discrimination, and rejection however sexual and gender minorities face additional stress due to concealment of gender or sexual identity and internalized homophobia or transphobia (Pitoňák, 2017).

Language is a powerful tool for HCPs, as the word selection used can either alienate LGBTQ patients or show that the HCP to be an ally. In understanding the concepts of gender and sexual orientation a HCP is able to use more inclusive language. Understanding the minority stress theory helps HCPs to understand why LGBTQ patients are at risk for poor health outcomes.

Synthesis of Evidence

Individuals that identify as LGBTQ experience higher rates of substance abuse, mental illness, higher cancer rates with worse outcomes due to late detection, increased rates of sexually transmitted diseases, suicide, and trauma (Sawning et al., 2017). One reason this is believed to be true is due to limited LGBTQ cultural competency training among HCP and real or perceived biases and discrimination towards LGBTQ patients (Sawing et al., 2017). This has led to more mandatory LGBTQ cultural competency training courses at both urban and rural health organizations. What is unknown is what topics should be addressed by these programs and how effective they are in increasing LGBTQ cultural competence among HCP.

To gain a better understanding of effectiveness of LGBTQ cultural competency training programs and the topics that need to be addressed, several literature searches were conducted using PubMed, PsycINfo, Cumulative Index of Nursing and Allied Health Literature (CINAHL), and Scopus. The following key words were used: cultural competency, LGBTQ, rural and disparities. Related terms were used for LGBTQ such as gay, lesbian, bisexual, transgender, queer, homosexual, sexual minorities, and gender minorities. Inclusion criteria for articles included: published within the last ten years, English language, full text, academic journals, and human species. These searches yielded a total of 288 results. Articles that were not related

closely to LGBTQ cultural competency training or rural LGBTQ population were excluded. Ten articles were retained that applied to the project's purpose (Table 1).

TABLE 1. *Literature review.*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
Crisp, C. (2006). The Gay Affirmative Practice scale (GAP): a new measure for assessing cultural competence with gay and lesbian clients. *Social Work*, *51*(2), 115-126. doi:sw/51.2.115	Can a scale be developed that would assess attitudes/ practices against gays/ lesbians & examine the relationship between this scale & social workers' attitudes in general towards gays/lesbians	Mixed-method	(n=488) Randomly selected direct practitioners that were members of either NASW or APA 74%= women 86%= heterosexual 92%= white 49%= master's degree 59%= work in mental health	Stage 1: literature review on gay affirmative practices yielding 372 items Stage 2: Experts on gay affirmative practice rated & ranked items. Yielding 80 items representing belief & behavior domains. Stage 3: 3,000 members of NASW & APA sent by mail: test scale (GAP), Attitudes towards lesbians &Gay men scale (ATLG), Heterosexual Attitudes towards homosexual scale (HATH), Marlowe-Crowne Social Desirability scale (SDS), & request of 20 demographic items.	Initial 80-item GAP Internal consistency reliability: Cronbach's alpha 0.93 for belief domain & 0.95 for behavior domain. 15 items in each domain retained for final version Final version overall Cronbach's alpha of 0.95 Validity: correlation btwn belief domain scores of GAP & HATH 0.624 (p=.000) Correlation btwn behavior domain & ATLG 0.466 (p=.000) Analyses suggests GAP measures gay affirmative practice
Gendron, T., Maddux, S., Krinsky, L., White, J., Lockeman, K., Metcalfe, Y., & Aggarwal, S. (2013). Cultural competence training for healthcare professionals working with LGBT older	Does on-site workforce training within community-based facilities & statewide healthcare organizations/association increase awareness of unique issues r/t LGBT community;	Quasi-experimental nonequivalent-groups pretest posttest design	(n=199) healthcare professionals working with the aging from 5 sites in Richmond, VA area Caucasian = 46%, African Amer. =48% 40-49yr= 25%, 50-59yr= 25%	(n=158) Participants completed a questionnaire pre & post training. Four evaluators attended a minimum of 2 training sessions assessing delivery of	Pre-test/Posttest: Awareness: pre- M=.52 SD= .5 post- M= .93 SD=.26 p<.001 (not demonstrated at every site) Comfort caring for: pre- M=4.41, SD= .98 post- M=4.62, SD=.77,

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
adults. *Educational Gerontology*, *39*(6), 454-463. doi:10.1080/03601277.2012.701114	development of cultural competence & sensitivity towards aging LGBT population; increase ability to interact comfortably with members of the aging LGBT community; better define awareness of political, social, & economic issues that are unique to LGBT community; & increased awareness of legal issues regarding LGBT individuals & couples.		Female= 83% High school= 37%, Bachelors= 23%	training, degree of fidelity & variability in program implementation utilizing a rubric and descriptive notes. Semi- structured interviews with participants	Reported consistent instructional method $p<.001$ (not demonstrated at every site) Would recommend program: 90-100% Field observation: Symbols, LGBT facts, assumptions, & barriers to inclusion covered completely by trainers in all observed session. Skill development covered completely in 60% of session & partially covered in 40% Reported consistent instructional method btwn sessions and btwn trainers. All participants seemed most engaged by interactive group activities & least by didactic. 6 Participants & 3 stakeholders interviewed. Themes: underscoring importance of providing compassionate, knowledgeable care.

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
					Positive feedback on film portion of training. With the exception of one not finding the members of the film representative of population. In groups some personalities dominated the discussion. Stakeholders stated program was beneficial to staff & plan to implement new LGBT relevant policy.
Kano, M., Silva-Banuelos, A. R., Sturm, R., & Willging, C. E. (2016). Stakeholders' recommendations to improve patient-centered "LGBTQ" primary care in rural and multicultural practices. *J Am Board Fam Med, 29*(1), 156-160. doi:10.3122/jabfm.2016.01.150205	What are the experiences of LGBTQ persons in rural, understudied, minority communities in receiving primary care and how can they be improved?	Qualitative	(n=32) participated in 4 town hall dialogues Ages= 16-75 yrs (n=175) participated in New Mexico Sexual & Gender Diversity Summit were town hall findings discussed, after which additional gaps in LGBTQ care identified.	Two researchers moderated each town hall, asking open-ended questions focused on perceptions of LGBTQ primary care in the community, comfort in seeking services, cultural appropriateness of care/services, service gaps, and how to improve. Digitally recorded& transcribed dialogues. Imported into NVivo 10 qualitative data analysis software	Health care gaps for seven populations: LGBTQ youth, elders, American Indians, Latinos/Latinas (native & immigrant), transgender persons, bisexual people & all LGBTQ rural residents. Realistic action steps to immediately improve care: 1. Create a safe, welcoming environment. 2. Develop culturally competent medical staff.

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
				Issues presented to summit where attendees identify additional health care gaps and suggestions on how to address them.	3. Update medical training
Klotzbaugh, R., & Glover, E. (2016). A lesbian, gay, bisexual and transgender dedicated inpatient psychiatric unit in rural New England: A descriptive analysis in demographics, service utilization and needs. *Journal of Clinical Nursing*, *25*(23/24), 3570-3576. doi:10.1111/jocn.13253	What is the demographic data of patients admitted to LGBTQ-specific inpatient psychiatric program in rural New England	Descriptive correlational study	(n=456) patient records admitted to a rural New England inpatient psychiatric clinic Lesbian= 6.8%, Gay= 8.1%, hetero= 60.4% Age 36-55yrs= 34.4% Female= 58.6% Urban= 31.9%, small rural=27.6% Substance abuse= 40.1%, Mood disorder= 28.9%	Electronic health records for one yr reviewed using SPSS. Chi-square analysis used to examine relation btwn drug use & sexual orientation & regional description.	Significant difference in proportion of heterosexuals that abuse alcohol p=.042 Heterosexuals more likely to abuse heroin p=.017 No difference in sexual orientation when it came to tobacco, marijuana, or synthetics (meth, bath salts, ketamine) use. Significant difference in patients from isolated small rural town areas that abuse alcohol p=.008 Small rural towns & isolated small rural towns more likely to abuse synthetics compared to either urban or micropolitan p=.004

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
Lee, M. G., & Quam, J. K. (2013). Comparing Supports for LGBT aging in rural versus urban areas. *Journal of Gerontological Social Work, 56*(2), 112-126. doi:10.1080/01634372.2012.747580	How do geographic differences of rural vs urban in the aging LGBT community impact self-reported outness, acceptance of sexual identity, social and familial support, & household income?	Secondary analysis	(n=690) LGBT sample from MetLife Mature Market Institute's study (MMMI) Rural= 172 Urban= 518 Age= 45-64 yrs White: rural- 78.6% urban- 67.2% Male: rural- 53.8% urban-68.6% Gay: rural- 31.8% urban- 61.7% Lesbian: rural-31.4% urban-25% Bisexual: rural- 37.5% urban- 13.1% In a relationship: rural-65.2% urban- 55.6%	Utilized MMMI information & compared rural & urban LGBT level of outness, importance of LGBT identity, familial support, number of friends, & income levels using one-way ANOVA. Fisher's LSD method used for questions that produced a statistically significant overall difference Chi-square analyses used to test significant differences btwn rural & urban on question of who they were guarded about their LGBT identity & household asset levels.	Level of outness: rural moderately lower than urban (ANOVA: $p<.001$, Fisher's LSD: SD= 1.493 rural SD= 1.273 urban Importance of LGBT identity: rural moderately lower than urban (ANOVA $p=.037$) Familial & Social Support: Biological family support significant at $p=.024$. Post-hoc did not detect significant difference. Number of close friends significant at $p<.001$ however post-hoc did not detect significant difference Most guarded about identity: $p<.05$ with respect to siblings, closest friends, acquaintances, neighbors, coworkers, & people at the place of worship. Differences in income: $p<.001$ Post-hoc Fisher's LSD found rural reported lower

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
					income SD=.805 than urban SD= 1.127
Maragh-Bass, A. C., Torain, M., Adler, R., Ranjit, A., Schneider, E., Shields, R. Y., … Haider, A. H. (2017). Is it okay to ask: Transgender patient perspectives on sexual orientation and gender identity collection in healthcare. *Academic Emergency Medicine*, *24*(6), 655-667. doi:10.1111/acem.13182	Self-identified females and males may differ in preferred disclosure methods and patients may perceive more importance for Sexual orientation (SO)/Gender Identity (GI) disclosures in primary vs ED care.	Mixed-method	(n=101) 86%= some college >80%= did not have regular access to HCP ID as male=54.5% White= 58.4% Mean age=37 yrs	Quantitative survey assessed with chi-square and STAT 14.0 qualitative survey coded by 2 coders then Cohen's kappa used to quantify inter-rater agreement	Endorse importance of PCP knowing GI compared to ED:56%vs 26% p=.000 PCP should know their GI compared to ED: 89% vs 65% p=.000 Importance for PCP knowing SO of all patients compared to ED: 44% vs 22% p=.000 Females were more likely than males to disclose their SO when told why it is relevant to their Healthcare:89% vs. 80% (p=0.02) Females were more likely than males to endorse confidentiality as a facilitator to SO collection (p=0.10). Males were more likely to prefer disclosing SO electronically at a kiosk (p=0.03) Females were more willing to dis-

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
					close to a registrar compared to males (p=0.003) Qualitative themes: 1) personal factors, 2) environmental factors, 3) contextual/interpersonal factors, and 4) political/population-level factors Good reliability was achieved between coders (ƙ=0.71; 95% confidence interval [95%CI]=0.60–0.82)
Nama, N., MacPherson, P., Sampson, M., & McMillan, H. J. (2017). Medical students' perception of lesbian, gay, bisexual, and transgender (LGBT) discrimination in their learning environment and their self-reported comfort level for caring for LGBT patients: a survey study. *Medical Education Online*, *22*(1), 1368850. http://doi.org/10.1080/	Aim: (1) determine medical students comfort level and knowledge working with colleagues and caring for patients who identify as LGBT; (2) determine if medical students have witnessed or perceived any bias against LGBT persons from fellow medical students, residents, allied health staff (e.g. nurses, physiotherapists) and/or staff physicians.	Descriptive	(n=103) Medical students at University of Ottawa Female= 58.3% Heterosexual= 63.1% 1st yr= 33%	Survey groups divided btwn LGBTQ & cis-gender heterosexuals. Analyzed with SAS Fisher's exact test used to compare 2 groups Wilcoxon signed-rank-t-test used to compare attitudes towards LGB vs transgender issues	Disclosed their LGBT status to other students= 51.4% Reason for concealment: No one's business= 48.6%; concern for stereotype= 45.9%; concern for being discriminated against= 37.8% Witnessed heterosexism= 31.1%; fellow students source= 87.5% Witnessed discrimination against

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
10872981.2017.1368850					LGBT= 14.6%; fellow students source= 73.3% LGBT students witnessed/exposed to heterosexism more (OR=8.2, 95% CI; 2.93-23.5, p<.001) & anti-LGBT discrimination (OR = 6.6, 95%CI:1.71–30.3, p = 0.002) LGBT in comparison to hetero students expressed less fair treatment of transgender students (p<.001), lower agreement with medical students speaking positively of LGB (p=.04) or transgender (p=.008) Agreed strongly that LGBT colleagues are subjected to negative comments/jokes (p<.001), rumors (p=.02), bullying (p=.006) Students indicated transgender students were treated less fairly

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
					in comparison to LGB (p<.001) Confident in defining gay terms= 99% Only 21.4% able to define 2 spirited 75.7% agreed with offering additional education around LGBT issues
Sawning, S., Steinbock, S., Croley, R., Combs, R., Shaw, A., & Ganzel, T. (2017). A first step in addressing medical education curriculum gaps in lesbian-, gay-, bisexual-, and transgender-related content: The University of Louisville Lesbian, Gay, Bisexual, and Transgender Health Certificate Program. *Education for Health: Change in Learning & Practice (Medknow Publications & Media Pvt. Ltd.)*, *30*(2), 108-115. doi:10.4103/efh.EfH_78_16	Does the University of Louisville LGBT Health Certificate Program increase medical students' LGBT health knowledge and some general attitudes?	Pretest-post-test design	(n=39) Medical student who attended at least 1 session & completed both pre/post surveys 1st yr=56%, 2nd yr= 26% Attended 4/11 session= 53%, 5 or more= 28%	-11 item knowledge survey (completed pre &post) -16 item attitude survey	Pre-mean= 6.90 (SD= 1.41) post-mean=8.46 (SD=1.33) P<.001 Pre-percentage agreement= 74%, post-percentage agreement= 90% p=.019 Believed transgender identities natural pre=77%, post= 85% p=.037 Conducting LGB hx more challenging that heterosexual pre-mean =2.44, post-mean= 2.97, p=.018

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
Walinsky, D., & Whitcomb, D. (2010). Using the ACA competencies for counseling with transgender clients to increase rural transgender well-being. *Journal of LGBT Issues in Counseling*, *4*(3-4), 160-175. doi:10.1080/15538605.2010.524840	What is the well-being among members of a rural transgender support group?	Qualitative	(n=6) focus group 3=transgender: 2= MTF 1=FTM 5=heterosexual 100%= white (n=1) individual interview	120 min focus group 45 min individual interview Digital recordings analyzed by comparing content across transcripts of group and interview. Date coding performed leading to themes.	Themes: vocational experiences in which work experiences impacted perceptions of well-being, personal growth and coming out in which participants described choices r/t coming out in relation to well-being, acceptance was discussed in terms of how well-being was influenced by internal acceptance of self-and acceptance from others, and identity in which participants shared thoughts on gender identity and its impact on relationships and community.
White Hughto, J., Clark, K., Altice, F., Reisner, S. Kershaw, T., & Panchankis, J. (2017). Improving correctional healthcare providers' ability to care for transgender patients: Development and evaluation of a theory-driven cultural	Aim of study to adapt a transgender cultural & clinical competence intervention & open field-test the intervention with healthcare providers working in correctional settings.	Longitudinal design	Sample: 58 healthcare providers (18 yrs or older, fluent in English, working in a correctional institution, identify as healthcare provider) participated in training. -40 completed baseline survey	(n=34) Baseline demographics, training/experience, workplace characteristics, willingness to provide gender-affirming care, transgender knowledge, attitudes, and beliefs (TKAB) scale, Transgender clinical	-Demonstrated feasibility, acceptability, & preliminary efficacy of a novel transgender cultural/ clinical competence intervention for correctional healthcare providers.

TABLE 1 – *Continued*

Author / Article	Hypothesis Research Question	Design	Sample (N) Setting	Data Collection (Instruments/tools)	Findings
and clinical competence intervention. *Social Science & Medicine 195*, 159-169. doi:10.1016/j.socscimed.2017.10.004			-34 completed immediate follow-up survey -28 completed 3-month follow-up survey -9 completed semi-structured recorded interview Setting: correctional facilities in Connecticut & Massachusetts	competence (TCC) scale, self-efficacy scale, subjective norm scale, & survey on feasibility/acceptability of intervention (n=9) 1 on 1, in depth interviews lasting 15-20 mins conducted by 1st author. Interviews audio-recorded & transcribed verbatim. Participants given a gift card as compensation. SAS version 9.4 used for quantitative analyses	-Willingness to provide gender-affirming care: T0-T1= 0.76, T0-T2= 0.66 -Transgender Cultural competence: T0-T1=0.23, T0-T2= 0.32 -General health knowledge: T0-T1=0.24, T0-T2=0.23 -Medical gender affirmation knowledge: T0-T1= 0.72, T0-T2=0.35 (Cohen's *d* used for T0-T1 comparison; Hedges' *g* used for T0-T2 comparison) Qualitative: Open-ended survey question (n=34) & in-depth exit interview (n=9) found intervention curriculum to be highly acceptable. Found role-playing, discussions, & ability to ask questions useful components of intervention. Most found the format/length acceptable. 2 participants indicated it should be longer. 1 indicated it was too much information. A few reported wanting more medical content r/t hormones and mental health therapies.

Kano, Silva-Banuelos, Sturm, and Willging (2016) identified healthcare gaps in seven populations including LGBTQ youth, elders, American Indians, Latinos/Latinas (native & immigrant), transgender persons, bisexual people and all LGBTQ rural residents. Immediate steps to improve these healthcare gaps included creating a safe/welcoming environment, develop culturally competent medical staff, and update medical training (Kano et al., 2016). To develop culturally competent medical staff, it is recommended training include how to be an LGBTQ ally, enhancement of understanding of anti-LGBTQ stigma/phobias and microaggressions, invite local LGBTQ community members to discuss their experience, use of relevant terminology, risk factors, sexual history taking, and use of respectful, direct open-ended questions (Kano et al., 2016).

LGBTQ cultural competency programs can increase participants' knowledge of LGBTQ issues (Gendron et al., 2013; Sawning et al., 2017; White Hughto et al., 2017). They are feasible, and acceptable to participants (Gendron et al., 2013; White Hughto et al., 2017). Programs can gather institutional support by working with supervisors (White Hughto et al., 2017). Organizational support facilitates recruitment of participants and ensures that supervisors attend the training (White-Hughto et al., 2017). The teaching style of the cultural competency course can have effects on how engaged participants are in the course. Gendron et al. (2013) found participants were more engaged during interactive small group activities (that involved brainteasers and role-playing) than the didactic portion of the course. A majority of participants in the Gendron et al. (2013) study had a positive view of a documentary featuring aging LGBT individuals in the Boston area, which personalized the issue of LGBT cultural competency of the aging population. Providing a list of local and national LGBTQ resources during training can

strengthen the intervention as it fills in any gap the HCP has in seeking additional information and to provide referrals for LGBTQ patients (Gendron et al., 2013).

Gendron et al. (2013) study included five sites and while overall there was an increase of LGBT awareness and comfort of caring for LGBT this was not demonstrated at two sites. This speaks to the need for programs to be modified for the site and participant population. Participants of the competency programs enter with various knowledge levels of LGBTQ knowledge in regard to terminology, healthcare disparities, and healthcare needs. While there is yet to be a standardized mandatory format of LGBTQ cultural competency programs this may be a benefit as it can allow instructors to tailor the education to where participants are currently in their knowledge.

To offer culturally competent care a HCP must know the cultural identities of a patient. Due to a history of discrimination, disclosure can be a difficult topic for some LGBTQ individuals. Maragh-Bass et al. (2017) found LGBTQ individuals were more likely to see it important to disclose LGBTQ identity to a primary care provider then an emergency provider. Explaining how sexual orientation was relevant to care was more likely to encourage LGBTQ patients to disclose their sexual orientation or gender identity (Maragh-Bass et al., 2017). Fear of disclosure is not a new concern for the LGBTQ population. Among medical students, approximately half did not disclose their LGBTQ identity to other classmates with reasons including fear of discrimination or stereotyping (Nama, MacPherson, Sampson, & McMillan, 2017).

Rural LGBTQ cultural competency programs should incorporate knowledge that is specific to the rural population. Lee and Quam (2013) found rural LGBTQ individuals are less

likely to disclose their sexual orientation or gender identity than urban LGBTQ individuals. Walinsky and Whitcomb (2010) found rural transgender individuals may face difficulties in obtaining a job or feeling safe in the workplace to disclose gender identity. Types of substances abused also differ with location. Small rural towns and isolated small rural towns have a higher rate of abusing synthetics (methamphetamines, bath salts, or ketamine) compared to either urban or micropolitan areas (Klotzbaugh & Glover, 2016).

A weakness of cultural competency programs is a lack of self-reflection that can create a gap between theoretical knowledge and lived experience of patients (Heyes & Thachuk, 2015). To improve this gap and create this clinical skill, cultural competency programs should focus more on active role-playing, problem-based, narrative approaches to medicine and cultural competency (Heyes & Thachuk, 2015). In practicing cultural competency, HCPs can assess their own feelings regarding a culture and increase awareness within their profession of prejudice and intolerance that may exist (Dootson, 2000). Sawning et al. (2017) found a higher post-test score in belief that transgender identity was natural. This offers evidence that given education some individuals may alter their beliefs. However, despite training HCPs are at times unable to keep biases in check and may be rigid in rule-abiding behavior such as filling out forms that lack space for non-heteronormative answers (Heyes & Thachuk, 2015). Often deep-seated beliefs about LGBTQ individuals are not changed by training programs and can be difficult to assess in a posttest (Gendron et al., 2013). LGBTQ cultural competences can be optional at institutions creating a discrepancy in care between providers that do attend and do not practice culturally competent care.

This literature review yielded findings that LGBTQ cultural competency can increase knowledge and influence behaviors regarding the healthcare of LGBTQ individuals (Gendron et al., 2013; Sawning et al., 2017; White Hughto et al., 2017). However, programs are more successful when they account for the current knowledge and beliefs of participants, the specific population seen and their risk factors, and are engaging, interactive programs that help cross the barrier between theoretical knowledge and applied practice. While rural LGBTQ populations have been studied, each rural community has its' own unique culture that may influence acceptance and outness of LGBTQ patients with HCP and their social community. There is a gap in literature about rural HCPs beliefs and knowledge of LGBTQ cultural competency. Such a gap is indicative of a need for future research to aid in the evidence for LGBTQ cultural competency programs in rural areas.

METHODS

Design

This DNP project was a quality improvement project that used a descriptive quantitative design to describe the knowledge, beliefs, and behaviors towards the LGBTQ population among rural HCPs that are required to take a LGBTQ cultural competency program. A descriptive quantitative design is appropriate in measuring behaviors or conditions as they are without attempting to change them (Hopkins, 2000). As an impact evaluation project this DNP project did not attempt to change the HCP's knowledge, behaviors, or beliefs. Instead this project measured how effective the mandatory cultural competency training is on producing HCPs that are culturally competent about LGBTQ individuals. As a descriptive study only associations were made between the variables of the current cultural competency program and HCP's

knowledge, beliefs, and behaviors towards LGBTQ individuals. This means this project was not able to make a direct correlation between the HCP's LGBTQ cultural competency and the current cultural competency program.

Setting

This project was conducted in one location of a non-profit community mental health organization in Yavapai County, Arizona. Health Choice Integrated Care (HCIC) covers physical and behavioral health services for Arizona Health Care Cost Containment System (AHCCCS) (Arizona's Medicaid program) members in Mohave, Coconino, Apache, Navajo, Gila, and Yavapai counties (Health Choice Integrated Care, 2015). As an organization that takes AHCCS patients the site is subject to HCIC polices. As part of HCIC's cultural competency plan, focus has been put on training HCPs on the unique needs of LGBTQ members (Figueroa, 2015). To meet compliancy for HCIC all new employees and existing staff at the site are required to take *Cultural Competency 101: Embracing Diversity* (CC 101) which briefly addresses LGBTQ needs (Figueroa, 2015). *Cultural Competency 200: Gender and Sexual Minorities* (CC 200) is at this point optional under HCIC policy (Figueroa, 2015).

The project site serves as a crisis stabilization unit accepting walk-in and referred patients. Outpatient services include bridge appointments for those enrolled with the organization that has missed an appointment and need to obtain medication refills. There are 10 reclining chairs available for patients admitted to the 23-hour observation unit. On the inpatient side there are eight available subacute beds with two rooms being single occupant rooms and three rooms being double occupancy.

The site is located centrally in Arizona with major cities one hour and a half south and north. The population of the town the site is located in is 1,004 people per square mile (United States Census Bureau, 2017a) however the county it services has a population of 26 per square miles (United States Census Bureau, 2017b). Under the urban-rural classification system rural areas have population densities less than 500 people per square mile with open countryside, and there are places with fewer than 2,500 people (USDA, 2017). This qualifies the site as serving the rural central Arizona population.

Participants

Participants of this project included the staff of the center that interacts with patients and provide health care. This included behavioral health technicians (BHT), social workers/case managers, registered nurses (RN), nurse practitioners (NP), paramedics, crisis counselors, and physicians. This was a convenience sample. All staff at the site that interacts with patients were invited by email to anonymously fill out a demographics questionnaire, a Gay Affirmative Practice (GAP) scale, and a basic knowledge survey. All employees have a company email address that is used to communicate frequently between staff, making it necessary for staff to check this email address routinely. A cover letter (Appendix A) addressing the purpose of the project was sent along with a link to surveys using Qualtrics. The cover letter identified the project and indicated that participation was completely voluntary, not affecting or influencing employment status. No monetary incentive was given for completing the study. There was no penalty for withdrawing at any point during the project. After one week a reminder letter was sent thanking those that had participated and informing those that had not of the upcoming deadline to participate if desired.

Data Collection

The first data collected was on the organization as a whole. The organizations policies and procedures related to LGBTQ patients were reviewed. As true cultural competency is also reflected in organizations policies (CDC, 2015), a review of current policies provided an insight into the organizations overall LGBTQ cultural competency. Policies that were searched include policies addressing LGBTQ considerations such as (but not limited to) trainings, zero/no tolerance discrimination, etc.

Participants were asked to complete three items. The first form asked basic demographic questions (Appendix B) which included age range, gender identity, sexual orientation, and job title. Additionally, as the organization offers a mandatory CC 101 and elective advanced CC 200, participants were asked which course(s) they completed and approximately how long ago it was completed.

The next item was the GAP scale (Appendix C). The GAP scale consists of 30-items divided into the domains of belief and behavior (Crisp, 2006). As cultural competency expands beyond knowledge, the GAP scale can be used to measure attitudes and behaviors of individuals. The GAP scale has been rigorously tested and found to be reliable and valid in assessing gay affirmative practice (Crisp, 2006). It has been made available for public use at no cost. Items 1-15 assess participants beliefs and asks them to rate their response as either strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree (Crisp, 2006). In scoring this section, participants are given a ‘5’ for strongly agree, ‘4’ for agree, ‘3’ for neither agree nor disagree, ‘2’ for disagree, and ‘1’ for strongly disagree (Crisp, 2006). Items 16-30 assess participants’ behaviors towards LGBTQ patients and ask them to respond with always, usually, sometimes,

rarely, or never (Crisp, 2006). In scoring this section, participants are given a ‘5’ for Always, ‘4’ for Usually, ‘3’ for Sometimes, ‘2’ for Rarely, and ‘1’ for Never (Crisp, 2006). The highest score possible in each section was 75 and the lowest 15; higher scores reflect more affirmative practices with LGBTQ patients (Crisp, 2006). Responses were grouped into four ranges with 61 to 75 indicating those with strong affirmative beliefs and behaviors, score of 46 to 60 indicating moderately affirmative beliefs and behaviors, 31 to 45 showing negative beliefs and behaviors, and 15 to 30 reveling strongly negative beliefs and behaviors towards LGBTQ individuals.

As the cultural competency course provides basic LGBTQ knowledge a 12-item survey was given to determine if after the course participants could answer basic questions (Appendix D). Questions focused on terminology and health disparities of LGBTQ individuals, additionally reflection questions were asked to offer staff to add input for improvement of cultural competency. Along with the GAP scale this survey was used to inform on if the current LGBTQ cultural competency course was meeting its goal of improving HCP’s LGBTQ cultural competency. The participants were given two weeks to complete the requested surveys. After one week a reminder letter with survey links was sent via email.

Plans for Data Analysis

The obtained results were entered into Statistical Package for the Social Sciences (SPSS) statistical software program and reviewed. Correlational analyses of the GAP scale findings and the demographic information were performed to determine if any group had statistical significant differences. Compared groups included gender, age range, profession, number of courses taken, and time range since last course was taken. The results are displayed in bar graphs and tables. Upon completion of data analysis recommendations for improvement of the current LGBTQ

cultural competency program were made. Dissemination of the findings and recommendations were made available to the clinic with an executive summary.

Ethical Considerations

In research with human subjects, the ethical principles of respect for persons, beneficence, and justice must be considered. Addressing these principals ensures that all participants are treated in a safe, fair, and ethical manner.

Respect for Persons

Respect of person includes both treating people as autonomous agents and recognizing those with diminished autonomy need more protection (U.S. Department of Health & Human Services [USDHHS], 1979). Individuals in this study will be treated as autonomous beings, able to make their own decision on participating in study. They will not be pressured or coerced to participate. The cover letter and attachments of the demographics, GAP tool, and survey will clearly state that in filling out the information the person is giving consent to use the information in the study. They will have the right to ask questions about the study or withdraw or withhold information (Polit & Beck, 2017). As the participants in this study are autonomous adults no extra measures will be taken as might with those with diminished autonomy.

Beneficence

Beneficence ensures that not only are a person's decisions respected but they are protected from harm and their well-being is secure (USDHHS, 1979). The two general rules under this principle are do not harm and maximize possible benefits and minimize possible harms (USDHHS, 1979). In this study no physical harm is expected to come from participating in the study. Psychological harm is not and expected outcome but may be possible for those with

strong feelings against LGBTQ. To protect against this all answers will be confidential and it will be the person's choice to complete the survey are not. The possible benefits include having an understanding of the current cultural competency program and how it may be improved upon to better serve the LGBTQ community in the area.

Justice

To address the principle of justice, all participants will be treated equally and have equal privacy during the study (Polit & Beck, 2017). Even those that refuse to participate by responding to the email will be treated with equality and fairness (USDHH, 1979). The pre-arranged agreement to ensure confidentiality in all responds. In going through Qualtrics information returned to the researcher will be anonymous, further ensuring confidentiality.

RESULTS

Surveys were sent to 17 RNs, four social workers, three NPs, two psychiatrists, 12 paramedics, nine BHTs, and four crisis counselors for a total of 51 participants. Of 51 surveys sent, 11 were started and seven completed fully for a response rate of 13.7%. One participant only filled out demographic information, one participant did not complete the behavior section of the GAP as well as one of the knowledge questions, one participant did not answer four of the knowledge questions, and one participant did not include their role as well as not responding to four of the knowledge questions. Due to the limited data received partially competed survey answers will be included in analysis.

All respondents identified as cisgender and three identified themselves as LGBTQ (Table 2). RNs accounted for 45% of the respondents however among professional roles the response rate was highest among social workers at 75% (Table 3). Age among respondents varied

however no one identified themselves as less than 21 years of age (Figure 1). A majority of the respondents had last taken the CC 101 course nine months to a year ago (Figure 2). Only one respondent replied the mandatory training prepared them to work with LGBTQ patients (Figure 3).

TABLE 2. *Gender and sexual orientation.*

	Cisgender Female	Cisgender Male	Total
Heterosexual Female	7	0	7
Heterosexual Male	0	1	1
Lesbian	1	0	1
Bisexual	2	0	2
Total	10	1	11

TABLE 3. *Response rates by role.*

	Responded	Total Invited	Response Rate
Crisis Counselor	0	4	0%
Physician	0	2	0%
RN	5	17	29%
NP	1	3	33%
Social Worker	3	4	75%
BHT	1	9	11%
Paramedic	0	12	0%
Total	10	51	19%

*One missing role result

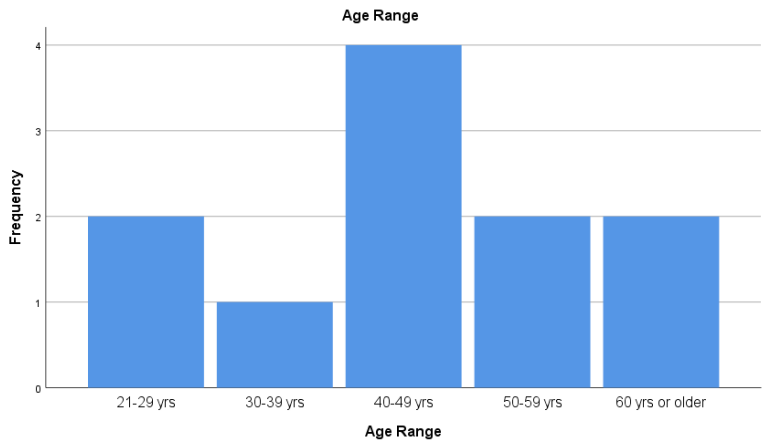

FIGURE 1. Age range.

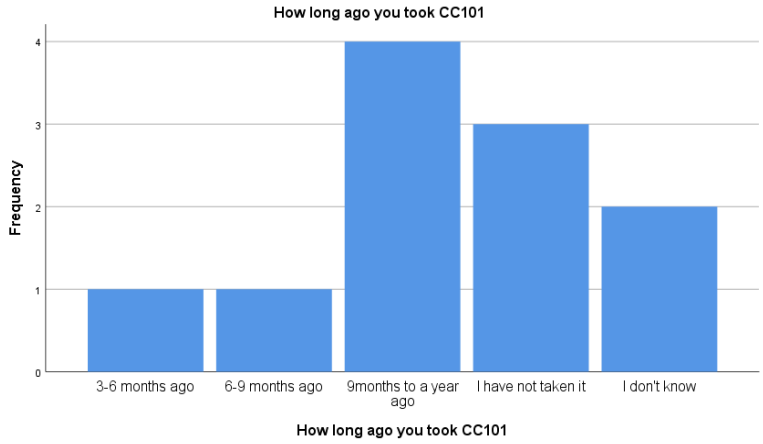

FIGURE 2. Last took CC 101.

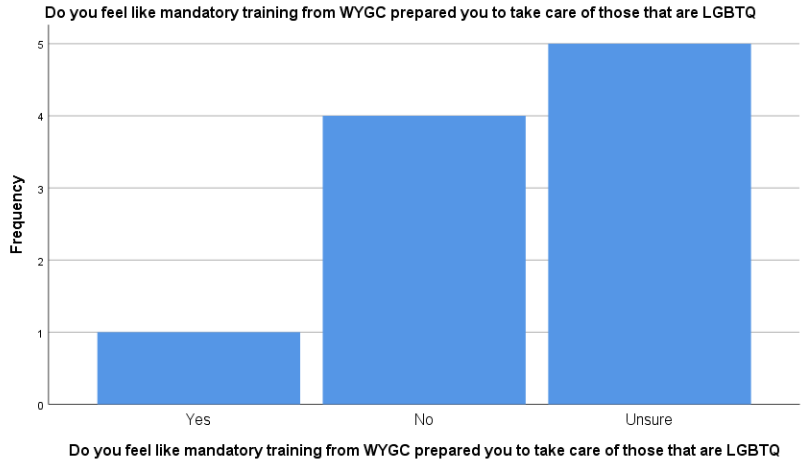

FIGURE 3. Did the training prepare you?

On both the GAP belief and behavior surveys the highest possible score is 75 and the lowest 15, with the higher score indicating more affirmative practices with LGBTQ patients (Crisp, 2006). The mean result of the belief score was 67.2 (SD 6.32) and 58.5 (SD 7.29) for the behavior score. One participant had a GAP belief score of 75 however the highest GAP behavior score was 69. The lowest GAP belief score was 57 and the lowest behavior score was 50. The groups that had the highest GAP belief score were heterosexual male (74), social workers (73), those 40-49 years old (72), those that took the CC101 nine months to a year ago (69.6), and those

that have not taken CC200 (67.2). The groups that had the lowest belief scores were heterosexual females (64.8), BHT (57), both those 21-29 years of age and those 60 years or older (64.5), those that took CC101 three to six months ago (59), and those that were unsure if they had taken CC200 (67). The groups that had the highest GAP behavior score were heterosexual male (62), social worker (64.6), those 50-59 years of age (65), those that took CC101 six to nine months ago (69), and those that have not taken CC200 (59.3). The groups with the lowest GAP behavior score were lesbian (51), BHT (55), those 30-39 years of age (50), those that have not taken CC101 (52.6), and those that are unsure if they have taken CC200 (57) (Table 4).

TABLE 4. *GAP results.*

Groups	N	GAP Belief Score-mean	N	GAP Behavior Score-mean
Sexual Orientation				
Heterosexual Female	6	64.8	5	58.6
Heterosexual Male	1	74	1	62
Lesbian	1	66	1	51
Bisexual	2	71.5	2	60.5
Role				
RN	4	67	3	57.3
NP	1	63	1	56
Social Work	3	73	3	64.6
BHT	1	57	1	55
Age Range				
21-29 yrs	2	64.5	2	61
30-39 yrs	1	65	1	50
40-49 yrs	3	72.3	3	61
50-59 yrs	2	66	1	65
60 yrs or older	2	64.5	2	53.5
Time since CC101				
3-6 month	1	59	-	-
6-9 months	1	68	1	69
9month- 1 yr	3	69.6	3	61.6
Not taken	3	66	3	52.6
Unsure if taken	2	69	2	57.5
Taken CC200				
Yes	1	-	1	-
No	7	67.2	6	59.3
Unsure if taken	3	67	3	57

On the knowledge section there were two questions that everyone correctly answered (questions eight and nine). One question addressed how to respect gender variance and the other inquired about the risk between concealing sexual identity and suicidal behavior. No respondent correctly identified the percentage of Arizona adults that identify as LGBTQ and instead overestimated the population. One respondent out of ten correctly identified the concept of gender as having three distinct aspects. The total average score for the knowledge portion was 56%. The highest percentage of correct answers on the knowledge portion came from a heterosexual female NP (70%), a bisexual RN (70%), and a heterosexual male social worker (70%). The heterosexual female that did not identify her role scored 20% on the knowledge portion of the survey. The one person that identified as a lesbian RN scored 40% on the knowledge portion of the survey (Table 5).

TABLE 5. *Knowledge survey.*

Group	N	Percentage Correct	SD
Sexual Orientation			
Heterosexual Male	1	70%	-
Bisexual Female	2	65%	0.70
Heterosexual Female	6	53%	1.75
Lesbian	1	40%	-
Role			
NP	1	70%	-
Social Work	3	63%	0.57
RN	4	57.5%	1.25
BHT	1	50%	-
No identified role	1	20%	-
Age Range			
21-29 yrs	2	55%	0.70
30-39 yrs	1	20%	-
40-49 yrs	3	66.6%	0.57
50-59 yrs	2	60%	0
60 yrs and older	2	55%	2.12
Taken CC101			
3-6 months ago	1	60%	-
6-9 months ago	1	60%	-
9 months- 1 yr. ago	3	66%	0.57
Not taken	3	53%	1.52
Unsure if taken	2	40%	2.82

TABLE 5. – *Continued*

Group	N	Percentage Correct	SD
Taken CC200			
Yes	1	-	-
No	7	58%	1.06
Unsure	3	53%	2.88
GAP Belief Score			
75-61	8	56%	1.76
60-46	2	55%	0.70
GAP Behavior Score			
75-61	4	62.5%	0.5
60-46	5	50%	2.12

DISCUSSION

Belief on CC101 Effectiveness

The aim of this DNP project was to evaluate if the current CC program is meeting the staff's needs and strengthening knowledge of, beliefs about and attitudes towards LGBTQ patients at a rural mental health facility. When directly asked on the survey if respondents felt prepared by the mandatory training only one respondent answered yes with four answering no and five answering unsure. The one respondent that did believe the mandatory training was effective also answered that they were unsure if they had taken the course. The respondent (identified as a cisgender heterosexual) may be basing this on perceived environment of the organization. When given the opportunity to write in a responds this particular respondent wrote:

> *I believe that WYGC has embraced the LBGTQ population and been very accommodating of needs specific to the individual.*

Two respondents that did not take the course, one that was unsure if they had, one that had taken the course nine months to a year ago, and another that had taken the course six to nine months ago all answered they were unsure if the training was helpful. Those that did not believe the training to be helpful in preparing them to care for LGBTQ patients included one respondent that

had taken the course three to six months ago, two that had taken the course nine months to a year ago, and one that had not taken the course.

A respondent that answered they had not taken the course and did not believe the training provided adequate training to care for LGBTQ patients identified as a cisgender bisexual. While the respondent did not provide a written reason for their belief, it may be possible their perception of colleagues' behavior or expressed beliefs towards LGBTQ patients influenced their opinion that the training was not effective. Anticipated stigma has been reported higher than enacted stigma among rural sexual minorities making this a plausible explanation (Marsack & Stephenson, 2017). The remaining sexual minorities (one bisexual and the other lesbian) stated they were unsure if the training was effective.

One of the respondents who took CC 101 nine months to a year ago and identified as a cisgender heterosexual social worker, believed the training to be ineffective. They included the following suggestion on how the organization can better support them in working with LGBTQ individuals:

> *Really focusing on tolerance (meaning disagreeing is okay) not dominance. When EVERYONE feels comfortable (not just the LGBTQ community) the world is a better and safer place for all.*

As the surveys were anonymous it was not possible to follow up with this respondent to further explore what they meant by this statement. The statement suggests that respondent would prefer a broader focus to the message of tolerance.

GAP Belief Scores

The GAP scale belief scores showed the respondents had overall affirmative beliefs in practice when working with LGBTQ patients. The belief statement most strongly agreed with was *practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients,* with 90% strongly agreeing and 10% agreeing. The next most strongly agreed on belief statement was *practitioners should help clients reduce shame about homosexual feelings* with 80% strongly agreeing, 10% agreeing, and 10% neither agreeing nor disagreeing. In the beliefs section none of the respondents strongly disagreed with any statement, however one cisgender heterosexual did disagree with the statement *practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals.* The respondent who was the only BHT to reply to the survey also included the following feedback,

> *I don't find your survey method to be very objective. On the rating scale, you should have an option for "does not apply" or "have never experienced". I have not had the opportunity to perform several of the services queried about, so responses were based on frequency of opportunity.*

It is unclear if the respondent found both the behavior and belief scales to be non-objective. On all other belief statements at least half of all respondents strongly agreed with the statements.

GAP Behavior Scores

Behavior scores on the GAP were lower than belief scores indicating HCPs may not always know how to translate affirmative beliefs into actions. The two highest ranked behaviors were *I respond to a client's sexual orientation when it is relevant to treatment and I am open-minded when tailoring treatment for gay/lesbian clients*. Eight respondents reported always and

two respondents usually for both of these behaviors. The lowest ranked behavior was *I help clients identify their internalized homophobia.* One respondent reported always, two usually, one sometimes, one rarely, and five never.

Those that reported they had taken the CC101 class did have higher mean behavior scores than those that were unsure or had not taken the class. This suggests that the CC101 may be helping provide guidance on affirmative behaviors towards LGBTQ patients. Social workers had the highest mean behavior score (64.6) followed by RNs (57.3), NP (56), and BHT (55). Social workers do psychosocial assessments and may be presented with more opportunities to provide LGBTQ affirmative behaviors. The respondent that identified as lesbian had the lowest affirmative behavior score at 51 compared to the highest a heterosexual male at 62.

Knowledge Survey

In the knowledge section of the survey only seven respondents answered all the questions with three respondents answering only some of the questions. Two questions all respondents answered correctly. The first correctly answered question, all respondents were able to identify that hiding one's sexual identity was associated with a higher risk of suicidal ideation and suicide attempts. In the second question answered correctly, all respondents identified gender variance could be respected by avoiding assumptions, using preferred name/pronouns, and not asking overly personal questions that have no bearing on treatment. No respondent knew the percentage of Arizona adults that identify as LGBTQ is 4%, instead respondents over estimated with responses of 12% and 18%.

Among sexual orientations the highest score was from a heterosexual male (70%), followed by bisexual females (65%, SD 0.70), heterosexual females (53%, SD 1.75), and the

lowest from a lesbian (40%). Among the questions answered incorrectly by the respondent that identified as lesbian included the definition of gender in which she answered it is assigned at birth based on genital and that mental health disparities in the LGBTQ community are attributed to their culture. It should also be noted the respondent that identified as lesbian indicated she had not taken CC101.

Among professional roles the highest score came from the NP (70%), followed by social workers (63%, SD 0.57), RNs (57.5%, SD 1.25), BHT (50%), and one person that did not identify their role scored a 20%. The person that did not identify their role was also the only person in the 30-39 year age range. The highest scoring age range came from those 40-49 years old (66.6%, SD 0.57) followed by 50-59 year olds (60%, SD 0). Both 21-29 year olds and those 60 years and older had an average score of 55% however the SD was 0.70 for those 21-29 years old and an SD of 2.12 for those 60 years and older.

Those that did recall taking the CC 101 course did score higher on the knowledge section that those that did not or did not recall. This may indicate some success in increasing participants' knowledge by taking the course. Those that had higher GAP scores also tended towards higher knowledge scores indicating knowledge might have some influence on beliefs and behaviors of HCPs.

Limitations

The results of this DNP project provide a limited insight into rural HCPs knowledge, beliefs, and behaviors towards LGBTQ patients at a mental health facility. Limitations of the project include the small number of completed surveys and the limited professions represented. Surveys were sent to work emails with a reminder email one week after the original was

delivered. It is unknown if these emails were delivered to spam folders or overlooked in a crowded inbox. Additionally, as it was a work email potential participants may have felt too busy at work to take the survey and not in the routine of checking work email at home. Not all roles were represented in the survey. Additionally both NP and BHT roles were represented by one person each. The lack of responses allows for little generalizability to the facility as a whole.

The project design allows for only correlations to be made about the effectiveness of the CC training. Information was not gathered on HCPs ethnic, racial, cultural, regional, or religious backgrounds. These factors may have influenced belief and behaviors about LGBTQ individuals. Deep-seated beliefs about the LGBTQ population can be difficult to assess in self-reported measures (Gendron et al., 2013). Self-reported measures are also prone to social desirability bias in culturally sensitive subjects such as LGBTQ (Dorsen & Van Devanter, 2016; Colton & Covert, 2007). The national trend in the United States has been towards increased LGBTQ tolerance, thus HCPs with negative views of LGBTQ patients may not have felt free to express true views and instead answered how they thought the researcher wanted them to (Dorsen & Van Devanter, 2016).

The GAP scale was designed to address practice beliefs and behaviors towards gay and lesbians and therefore omits bisexual, transgender and other queer persons from mention. Some of the respondents reported they did not feel like the GAP objectively measured their beliefs and behaviors towards LGBTQ individuals. The GAP scale was developed with social workers in mind over a decade ago and has not been updated since.

Conclusion

This DNP project contributes towards and highlights the need for further studies on the knowledge of rural Arizonian mental health HCPs knowledge, beliefs, and behaviors towards LGBTQ patients. While the sample size was very limited the results showed that overall those that had attended the CC101 course had higher GAP scores and knowledge scores compared to those that did not attend. Although only one respondent reported CC101 to be helpful in caring for LGBTQ patients, the results suggest the course may have been helpful. Overall respondents reported higher GAP belief scores than behavior scores and relatively low knowledge scores. Future CC should focus on how HCPs can display affirmative behaviors towards LGBTQ and increase general LGBTQ knowledge. One respondent requested that information on local resources be included in the training. Being prepared with resources may strengthen HCPs confidence in addressing affirmative behaviors.

Projected Budget

Significant time was invested into this project; however, no monetary funds were used.

APPENDIX A:

LETTERS TO PARTICIPANTS

Cover Letter

Dear Participant:

My name is Catherine Dockery-Jackson and I am a doctoral nurse practitioner student at the University of Arizona. I am currently doing a clinical rotation at West Yavapai Guidance Clinic. For my doctoral project, I am examining the impact of the current LGBTQ cultural competency program on knowledge of, beliefs about, and behaviors towards the LGBTQ population. Because you are employed at West Yavapai Guidance Clinic crisis stabilization unit, I am inviting you to participate in this project by completing the attached Qualtrics surveys within the next two weeks.

The following surveys will require no more than ten minutes to complete. There is no compensation for responding nor is there any known risk. Information will be collected anonymously through Qualtrics, please do not include your name when completing the survey. If you chose to participate in this project, please answer all of the questions as honestly as possible. Upon completing the survey click submit and the results will be electronically submitted. Participation is strictly voluntary and you may refuse to participate at any time. Employment will not be impacted in choosing to participate or not in this project.

Thank you for taking the time to assist me in my educational endeavors. The data collected will be useful in evaluating how effective the current LGBTQ cultural competency program is and how it can better serve staff's needs. If you require additional information or have questions or comments, please email at: dockeryjackson@email.arizona.edu.

Sincerely,

Catherine Dockery-Jackson RN, BSN, PMHNP student
Email: dockeryjackson@email.arizona.edu

Reminder Letter

Dear Participant:

As a reminder my name is Catherine Dockery-Jackson and I am a doctoral nurse practitioner student at the University of Arizona. I am currently doing a clinical rotation at West Yavapai Guidance Clinic. For my doctoral project, I am examining the impact of the current LGBTQ cultural competency program on knowledge of, beliefs about, and behaviors towards the LGBTQ population.

I would like to take this opportunity to thank all of you that have already completed the surveys. I deeply appreciate your participation in my academic pursuit towards my doctoral nurse practitioner degree. For those of you that have yet to fill out the survey I'd like to remind you the study is closing in a week. You can participate by clicking on the link and anonymously filling out the survey. This should require no more than ten minutes of your time. Participation in this project is completely voluntary and you may refuse to participate at any point during the project. Employment will not be impacted in choosing to participate or not in this project. There is no compensation for responding nor is there any known risk. Information will be collected anonymously through Qualtrics, please do not include your name when completing the survey. If you chose to participate in this project, please answer all of the questions as honestly as possible. Upon completing the survey click submit and the results will be electronically submitted.

Thank you for taking the time to assist me in my educational endeavors. The data collected will be useful in evaluating how effective the current LGBTQ cultural competency program is and how it can better serve staff's needs. If you require additional information or have questions or comments, please email at: dockeryjackson@email.arizona.edu.

Sincerely,

Catherine Dockery-Jackson RN, BSN, PMHNP student
Email: dockeryjackson@email.arizona.edu

APPENDIX B:

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

This questionnaire will help me understand more about your background. The information will be used for the study and all of your answers are confidential. There are no right or wrong answers. By answering the questions, you are agreeing to let me use your information in the study. Thank you for completing the questionnaire.

1. What is your gender identity?
   ___ Cisgender male (male identity and assigned male at birth)
   ___ Cisgender female (female identity and assigned female at birth)
   ___ Transgender female (female identity and assigned male at birth)
   ___ Transgender male (male identity and assigned female at birth)
   ___ Genderqueer (Umbrella term-those who do not identify with binary of man/woman)

2. What is your sexual orientation?
   ___ Heterosexual female (female attracted to males)
   ___ Heterosexual male (male attracted to females)
   ___ Lesbian (female attracted to females)
   ___ Gay (male attracted to males)
   ___ Asexual (not attracted to any gender)
   ___ Bisexual (either gender attracted to both males and females)
   ___ Queer (Umbrella term for those not identifying as heterosexual)

3. Which describes your role at the CSU?
   ___ Registered Nurse ___ Behavioral health technician
   ___ Social worker/case manager ___ Paramedic
   ___ Physician __ Nurse Practitioner
   ___ Crisis Counselor __Other (describe) _____

4. How old are you?
   ___ Less than 21yrs ___ 21-29yrs ___ 30-39yrs
   ___40-49 yrs ___ 50-59 yrs ___60 or older

5. How long ago did you take Cultural Competency 101?

___ less than 3 months ago ___ 3-6 month ago ___ 6-9 months ago

___ 9-month to a year ___ I have not taken it ___ I don't know

6. Did you take Advance Cultural Competency 200?

___ yes (how long ago?_____) ___ no ___ I don't know

APPENDIX C:

GAY AFFIRMATIVE PRACTICE SCALE (GAP)

GAY AFFIRMATIVE PRACTICE SCALE (GAP)

This questionnaire is designed to measure clinicians' beliefs about treatment with gay and lesbian clients and their behaviors in clinical settings with these clients. There are no right or wrong answers. Please answer every question as honestly as possible.

Please rate how strongly with you agree or disagree with each statement about treatment with gay and lesbian clients on the basis of the following scale:

SA = Strongly agree
A = Agree
N - Neither agree nor disagree
D = Disagree
SD = Strongly disagree

1. ___ In their practice with gay/lesbian clients, practitioners should support the diverse makeup of their families.
2. ___ Practitioners should verbalize respect for the lifestyles of gay/lesbian clients.
3.___ Practitioners should make an effort to learn about diversity within the gay/lesbian community.
4. ___ Practitioners should be knowledgeable about gay/lesbian resources.
5.___ Practitioners should educate themselves about gay/lesbian lifestyles,
6. ___ Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals.
7.___ Practitioner should challenge misinformation about gay/lesbian clients.
8. ___ Practitioner should use professional development opportunities to improve their practice with gay/lesbian clients.
9. ___ Practitioners should encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals.

10. ___ Practitioners should be knowledgeable about issues unique to gay/lesbian couples.
11. ___ Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients.
12.___ Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients.
13. ___ Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients.
14. ___ Practitioners should help clients reduce shame about homosexual feelings.
15. ___ Discrimination creates problems that gay/lesbian clients may need to address in treatment.

Please rate how frequently you engage in each of the behaviors with gay and lesbian clients on the basis of the following scale:

A=Always

U= Usually

S= Sometimes

R= Rarely

N= Never

16. ___ I help clients reduce shame about homosexual feelings.
17. ___ I help gay/lesbian clients address problems created by societal prejudice.
18. ___ I inform clients about gay affirmative resources in the community.
19.___ I acknowledge to clients the impact of living in a homophobic society.
20.___ I respond to a client's sexual orientation when it is relevant to treatment.
21.___ I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.
22.___ I provide interventions that facilitate the safety of gay/lesbian clients.
23.___ I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.
24. ___ I demonstrate comfort about gay/lesbian issues to gay/lesbian clients.

25. ___ I help clients identify their internalized homophobia.
26. ___ I educate myself about gay/lesbian concerns.
27. ___ I am open-minded when tailoring treatment for gay/lesbian clients.
28. ___ I create a climate that allows for voluntary self-identification by gay/lesbian clients.
29. ___ I discuss sexual orientation in a non-threatening manner with clients.
30. ___ I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.

APPENDIX D:

SURVEY

Survey

Please answer the following questions to the best of your ability. Answering with your current knowledge allows insight to effectiveness of cultural competency training. The information will be used for the study and all of your answers are confidential. By answering the questions, you are agreeing to let me use your information in the study. Thank you for completing the survey.

Choose the correct answer:

1. What is gender?
    A. What you are assigned at birth based on genital
    B. How you identify and see yourself
    C. How you present yourself to the world based on how you dress, talk, and act
    D. All of the above
    E. Being either male or female
2. What is sexual orientation?
    A. Who you are physically attracted to
    B. Who you are romantically attracted to
    C. Who you are emotionally attracted to
    D. All of the above
    E. Being either male or female
3. Being a sexual or gender minority can be stressful due to:
    A. It is unnatural so it becomes stressful
    B. It is not stressful
    C. Having to face prejudice, discrimination, rejection, concealing true self, and/or internalized stress
    D. They are not as resilient as most people
4. What percentage of transgender people are sexually assaulted?
    A. 10%
    B. 47%
    C. 80%

D. None

5. Which group is most likely to experience rape?
   A. Bisexual women
   B. Heterosexual women
   C. Lesbian women
   D. Heterosexual men
6. In Arizona which cities or counties have specific ordinances prohibiting discrimination based on gender identity or sexual orientation in private employment, housing, and public accommodations?
   A. All of Arizona counties
   B. Maricopa and Pima counties
   C. Tempe, Phoenix, Flagstaff, Tucson, and Sedona
   D. Just Phoenix
7. What percentage of Arizona adults identify as LGBTQ?
   A. 12%
   B. 2%
   C. 4%
   D. 18%
8. Studies have shown those that hide their sexual identity for fear of rejection are at ____ risk of suicidal ideation and suicide attempts
   A. Less
   B. Higher
   C. No
9. How can you respect gender variance among patients?
   A. Avoid assumptions
   B. Use preferred name and pronouns
   C. Do not ask overly personal questions that have no bearing on treatment
   D. All of the above

10. For LGBTQ individuals _____is associated with high rates of depression, anxiety, drug and alcohol abuse and dependency.
    A. Poor work ethic
    B. Discrimination
    C. Nothing
    D. Their culture
11. Do you feel like mandatory training from WYGC prepared you to take care of those that are LGBTQ?
    A. Yes
    B. No
    C. Unsure
12. How can the organization better support you in working with LGBTQ individuals? (For example: Education focused on terminology, stigma/discrimination, sexuality, sexual history taking, specific health risks, screenings, or health disparities. Information on LGBTQ community resources for patients. Training that involves small group discussions, community speakers, role play or case study reviews. Or other ideas).

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