Building Culturally Competent Care into Healthcare Curriculum

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Doctoral Scholarly Project

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Abstract

The goal of this project was to enhance awareness and improve the quality of care provided to the marginalized LGBTQ+ community. It developed and assessed the effectiveness of a learning module in improving healthcare provider knowledge and cultural competence for providing care to the LGBTQ+ community. The intervention was conducted at an academic school of nursing and allied health in the Midwest, targeting participants enrolled in a master's level program for care coordinators. The study employed a pre-and post-test design, utilizing surveys, a PowerPoint presentation, and a discussion group as part of the intervention. Surveys were used as measurement tools to capture baseline and post-intervention data. Data analysis was conducted using Microsoft Excel, and manual analysis to compare and summarize the results. The study included a single participant who successfully completed both the pre-and post-tests. Analysis of the participant's data revealed a notable increase in knowledge, with a two to five-point improvement in comfortability on a ten-point Likert scale after completing the educational module. The intervention aimed to bridge the existing gaps and foster a more inclusive healthcare environment. These findings highlight the potential effectiveness of the learning module in improving healthcare provider knowledge and cultural competence for LGBTQ+ care.

Keywords: LGBTQ+, Healthcare Provider, Cultural Competence, Healthcare Disparities, Education

Building Culturally Competent Care into Healthcare Curriculum

In 2010, President Barack Obama signed an executive order that required hospitals participating in Medicare or Medicaid programs must not deny access to patients or families based on "race, color, national origin, religion, sex, sexual orientation, gender identity, or disability" (Human Rights Campaign, 2010). In 2011, The Joint Commission followed suit in implementing a change in policy prohibiting discrimination based on sexual orientation, identity, or expression (Cordero & Tschurtz, 2022). Based on these mandates, providers are expected to provide culturally competent care to all patients including those in the Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning, etc. (LGBTQ+), community.

According to a study conducted by Brous (2019), approximately 18% of LGB people and 22% of transgender individuals avoid medical care for fear of discrimination. This fear highlights the importance of ensuring that medical professionals receive the education necessary to provide culturally competent care in a way that makes the population feel safe and welcome. United States (U.S.) and Canadian medical schools allocate approximately 5 hours of curriculum time to LGBTQ+ issues for an entire program and nursing curriculum receives approximately 2 hours (Rider et al., 2019). While it appears the former President's executive order and the Joint Commissions' mandates are addressed in the curriculum, the patient population believes more can be done to prepare providers for future care.

Overview

Problem Description

The biggest barrier to health care reported by transgender individuals is a lack of access due to providers who are not sufficiently knowledgeable on the topic of LGBTQ+ care needs (Safer et al., 2016). Few medical schools or schools of nursing have a curriculum that adequately

trains providers to give competent care to those who identify as LGBTQ+. There is a common misconception among providers that LGBTQ+ health is a niche population and should be reserved for individuals providing care in those settings, what is failed to be recognized is that sexuality and gender are fluid and may evolve and change over time (Solotke et al., 2019). The question guiding this project is, will Master of Science in Nursing (MSN) students in the care coordinator course show increased knowledge in providing competent care to LGBTQ+ patients after a one-week module embedded within a current course?

The outcome for this project was to increase knowledge and cultural competence in providing care to LGBTQ+ patients. This outcome was measured through a pre- and post-test.

Available Knowledge

A marginalized community is one that experiences discrimination or exclusion based on social, political, or economic reasons leading to an unequal power dynamic (National Collaborating Centre for Determinants of Health, 2022). The LGBTQ+ community has been a marginalized community for many years. Changes in the political spectrum have brought conversations about the specific needs of the LGBTQ+ community including providing culturally competent healthcare. Health inequity has been tied directly to sexual and social stigma (Institute of Medicine, 2011), which can be understood as a negative feeling, inferiority, and powerlessness that would otherwise be given to their heterosexual counterparts (Herek, 2007). Heteronormative thinking has led to an increase in social barriers which brings way to legalized discrimination and increased access issues for the community (HealthyPeople, 2016). While there has been a shift in thinking for many individuals' education on providing competent care remains a priority for barriers to be reduced or eliminated.

Disparities in health

Health disparities have been shown to decrease an individual's life expectancy. Members of the LGBTQ+ community face many health disparities when compared to their cisgender counterparts. Health disparities faced by the LGBTQ+ community include higher rates of anal cancer, asthma, obesity, cardiac diseases, substance abuse, nicotine abuse, and suicide (Morris et al., 2019). Women of the LGBTQ+ community have fewer screening tests such as pap smears and transgender patients have less access to care of any type (Morris et al., 2019). Patients further endorse that provider lack of awareness of specific health concerns leads to a delay in seeking care or avoidance altogether (Greene et al., 2018). Many health disparities begin in youth. According to the Centers for Disease Control and Prevention (CDC), 33% of LGB students have been bullied while at school, 48% have seriously considered suicide and 23% have used illicit drugs (2019). These numbers increase if the patient is a transgender individual due to further stigmatization (CDC, 2019).

Implicit and explicit bias

Implicit bias is the silent unknowing. When an individual has implicit bias, they may be unaware of their feelings or actions towards a certain person or group of people (Perception Institute, 2017). Implicit bias can cause unintended damage when people are not aware of their missteps. Explicit bias is a full awareness of feelings, beliefs, and attitudes. An individual's actions are intentional (Perception Institute, 2015). While recognition of both types of bias leads to a better sense of understanding it is important to understand each individually.

Implicit bias among healthcare professionals has been linked to microaggressions, poor communication, and preconceived notions of outcomes (Morris et al., 2019). Microaggressions include indirect or unintentional comments toward a patient. These comments lead to a patient feeling unsafe or discriminated against, leading to further disparities in health. Implicit bias can

be corrected by bringing awareness to the topic and teaching strategies to make conscious decisions about language, posture, and facial expressions. Implicit bias can cause unintentional disparity because the provider has no intent to cause harm and is unaware of the harm being caused.

Explicit bias is intentional and comes with full awareness. When a provider can identify a negative attitude toward an individual or group of individuals this is an explicit bias. These attitudes and beliefs are controlled and conscious by the person (Morris et al., 2019). Explicit bias proves to be more difficult to change. Since explicit bias has a conscious component, an individual's actions are intentional. This bias, while unfortunate, may have less of an impact on the LGBTQ+ community than an implicit bias. Those with explicit bias will typically share outward disagreement that is easily assessed and avoided by an individual seeking care.

Gaps in education

The American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) have recommended LGBTQ+ focused curricula be included in medical education to best prepare practitioners (Greene et al., 2018). The median number of hours of LGBTQ+ education in graduate medical programs is 5 (Cooper et al., 2018) and 2.12 hours within the nursing curriculum (Lim & Hsu, 2016). Many studies have assessed healthcare providers' readiness and comfort levels in providing care to the LGBTQ+ population with mixed results. Studies show that a lack of a dedicated curriculum leads to a feeling of inability to provide care to the LGBTQ+ population (Cooper et al., 2018). Further complicating the issue are faculty members who do not feel comfortable teaching on the topic (Cooper et al., 2018). If knowledge is a barrier to providing culturally competent care, then it must be addressed to further reduce healthcare disparity (Strong & Folse, 2015). Nursing programs believe they

address culturally competent care of vulnerable populations as it is part of the compassionate care model (Strong & Folse, 2015). What fails to be recognized in this care model is that bias is not addressed. Until an individual is in a situation where they must address or recognize bias, they may not recognize that their knowledge is lacking. Nursing students have indicated that the undergraduate curriculum is not adequate in addressing how to care for members of the LGBTQ+ community (Strong & Folse, 2015).

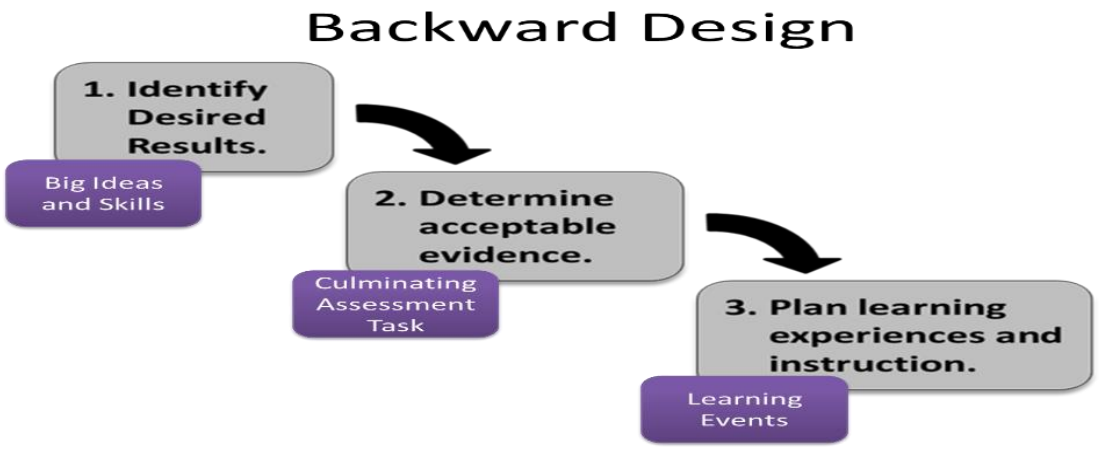
Further, LGBTQ+ patients believe there are not enough practitioners with adequate knowledge to provide competent care which continues the cycle of disparity. Addressing this lack of knowledge at the undergraduate and graduate level starts a positive curve in addressing health equity and disparities of this marginalized community.

Rationale

Research and experience show that healthcare providers continue to struggle with providing care that is without bias and is sometimes discriminatory. Often, the care being provided is due to a lack of education or understanding of the unique care needs of the population. These actions can be alleviated through educational programming that addresses the unique needs of the LGBTQ+ population. To address the educational shortfall the backward design framework is utilized. Ralph Tyler in 1949, created the backward design model to make curriculum planning less daunting (Wiggins & McTighe, 2005) (See Figure 1). There are 3 steps to using the backward design model which include identifying desired results, determining acceptable evidence, and planning learning experiences and instruction (Wiggins & McThighe, 2005). In this instance, the author identified a need that was addressed within the research. The desired result from this research was to create a curriculum that addressed culturally competent care for the LGBTQ+ community. This was accomplished by creating a curriculum addressing

the unique care needs of this population. Using the backward design, the author was able to start with an end goal in mind and through research create a plan and implement it. This process allowed for flexibility and adjustment of the plan along the way.

Figure 1



Wiggins, G. P., & McTighe, J. (2005). *Understanding by design*. Association for Supervision & Curriculum Development.

Purpose

The purpose of this project was to develop a module and assess for improved provider knowledge and cultural competence as it pertains to providing care to the LGBTQ+ community.

Methods

Context

The intervention was implemented in the Midwest, at an academic school of nursing and allied health. The organization prepares healthcare providers by offering several degrees ranging from certificates up to doctoral level. The participants in this study were members of a master's level program for care coordinators. The annual cohort size varies from year to year and currently enrolls approximately 2-4 students. The project was reviewed and approved by the Director of the MSN program and the course was conducted in an online synchronous and

asynchronous format. The academic setting for this proposal was accredited by the Higher Learning Commission, which is a commission of the North Central Association of Colleges and Schools.

Intervention

The intervention included multiple points of participation, including pre-survey, power point, discussion group, and post-survey which were optional for the participants. The pre-and post-survey included objective and subjective questions. The survey allowed the investigator to test social or personal attitudes toward the LGBTQ+ population and education level for providing care as well as gaining an understanding of knowledge regarding the population. Once the survey was complete, the participant was asked to review a case study and engage in dialogue with fellow participants on how they would respond to the scenario. Next, there was a PowerPoint with a voiceover presentation for the participants to watch and gain a better understanding of the terms used, common misconceptions, health concerns for this population, and ways to provide competent care for these patients. Once the participant completed the first three steps, there was a final post-survey that assessed knowledge after the learning piece was complete. Information gathered from both the pre-and post-survey was used to analyze the effectiveness of the course.

Study of Intervention

A pre-and post-survey including subjective and objective questioning was created in Google Forms and served as a tool to interpret the effectiveness of the voice-over presentation, and group discussion forum. Participants completed two online surveys utilizing Google Forms; the investigator gathered and reviewed the data.

Measures

The outcomes measured during this study were used to determine the effectiveness of the intervention, increase awareness, and improve the care provided to a marginalized community. To determine effectiveness a Likert Scale tool mixed with objective questions was created using Google Forms to collect data. This investigator developed the tool using evidence-based literature to guide questioning. Since the investigator created the tool for this project, no validity or reliability data existed.

The measurement tool was made up of a pre-and post-survey that included true and false questions that measured the participant's understanding of key LGBTQ+ terms and preconceived notions. In addition to the true and false questions, three questions addressed the participants' comfortability to provide care to a patient of the LGBTQ+ community. Each of the questions was rated on a 10-point scale with 1= Low and 10=High comfortability with providing care. Each participant also had the option to provide a free text response of feedback back to the investigator.

The post-survey was available immediately after the intervention and consisted of the same questions to determine if the participant had increased knowledge. Any feedback provided by participants was to be used to guide future lectures or studies on this topic. The time required by the participant to complete the pre- or post-survey was less than five minutes.

Analysis

The information examined in this study was obtained from a sample of students who completed pre-and post-tests. However, due to the absence of pre-and post-test responses, the data could not be fully assessed. The responses of a single participant were reviewed to determine if there was a change in knowledge after the educational intervention.

Ethical Considerations

This intervention involved the development of an educational module to increase the knowledge of future healthcare practitioners when providing care to a marginalized population, specifically the LGBTQ+ population. This proposal was deemed ethical based on the critical examination of each component by the Institutional Review Board (IRB) of Nebraska Methodist College. Email data was discarded, and participant responses were kept anonymous. There were no conflicts of interest foreseen by this investigator. Further, this investigator and co-author completed the Collaborative Institutional Training Initiative and previously provided proof of completion with this submission to the IRB. Participants were offered consent to participate before the project began, which explained their involvement and requirements for the project.

Results

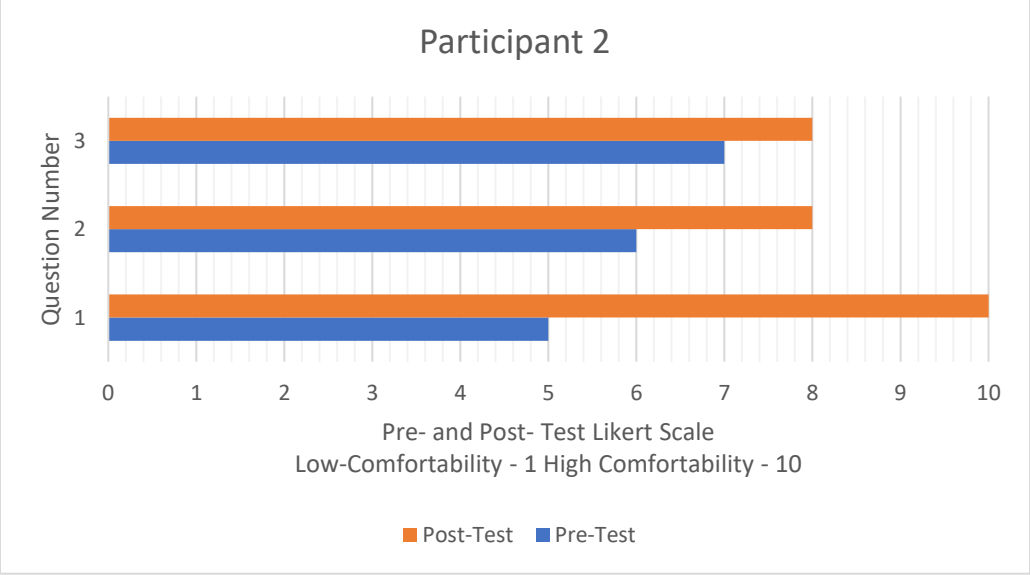
A total of three students participated in the educational intervention. One participant completed their pre-and post-tests. Due to the low census of responses, a statistical analysis was unable to be completed. Participant responses were collated using time-specific responses based on the completion of the pre-test and the post-test. The findings of the data provided by the single successful pre-/post-test respondent suggest that students in healthcare programs would benefit from additional education regarding marginalized communities, specifically, the LGBTQ+ population. The successful completion of one survey shows increased competence and awareness as seen by improved pre-education and post-education Likert scores of two to 5 points overall of comfortability when providing care to these patients. Figure 1 shows the knowledge deficit and gain of the pre-and post-test regarding the comfortability of the knowledge they held before and after the intervention. The survey aimed to assess participants' comfort level and knowledge regarding the healthcare needs of LGBTQ+ patients before and after an intervention. The pre-and post-test results were analyzed to determine the knowledge deficit and gain.

Participants were asked to rank their comfort level on a Likert scale for three specific questions. The first question focused on describing the unique health risks and challenges faced by LGBTQ+ patients, with an average pre-test comfort level of 7 out of 10. The second question aimed to assess participants' understanding of health disparities experienced by LGBTQ+ patients, resulting in an average pre-test comfort level of 6.6 out of 10. The third question evaluated participants' awareness of the importance of using gender-neutral terms when addressing LGBTQ+ patients, with an average pre-test comfort level of 9 out of 10.

Overall, the results indicate that participants had relatively lower comfort levels (below 10) in providing care to LGBTQ+ patients, highlighting a knowledge deficit in this area. The intervention aimed to address these gaps and enhance participants' comfort and knowledge, which would likely lead to improved care for LGBTQ+ individuals.

Figure 1

Participant 2 Pre and Post Scores



Discussion

Summary

The intervention aimed to implement an educational curriculum that could improve care for the marginalized population of the LGBTQ+ community. The curriculum was created and presented by a doctoral student to master's level students. The doctoral student used a pretest, designed by this student, to determine a knowledge base for the participants before implementation. The intervention was delivered, and participants had an opportunity to complete a post-test. The data was not evaluated by a statistician due to lack of participation numbers. The data in this project while not statistically significant suggests a need to investigate further whether to include a more comprehensive curriculum that includes marginalized groups not limited to the LGBTQ+ community.

Interpretation

When a healthcare provider lacks the knowledge and sensitivity required to address the unique needs of the LGBTQ+ community, it can lead to a distressing experience for both the provider and the patient. Patients endorse that provider lack of awareness of specific health concerns leads to a delay in seeking care or avoidance altogether (Greene et al., 2018). Further, this lack of awareness may cause unintentional harm to the patient and result in unintended biases by the provider. Therefore, healthcare providers should be equipped to provide care to all marginalized populations. Nursing students have indicated that the undergraduate curriculum is not adequate in addressing how to care for members of the LGBTQ+ community (Strong & Folse, 2015). Just as the undergraduate students reported in previous studies, graduate-level students also feel a lack of understanding when providing care to this population. Based on the results of the pre-test completed by three students there was a variation of comfortability in providing care to the LGBTQ+ population. The student in this study that successfully completed all portions of the module reported a low understanding of competency before the module was

completed. After the module, the student reported an increase in the knowledge base as evidenced by the increase in the Likert scale. This change in knowledge base provides a baseline of understanding for this student and a successful increase after spending time with the content in the educational module. By offering education on culturally competent care, providers can gain an understanding of the specific requirements of this community and be better prepared to offer appropriate care.

Limitations

The project had several limitations that must be acknowledged. Firstly, the sample size was smaller than anticipated, which restricts the generalizability of the findings to a larger student population enrolled in healthcare curricula. Secondly, it remains uncertain whether the participants found the post-test instructions unclear or struggled to complete them due to time constraints after completing the educational intervention. There were three participants who completed pre-testing; however, only one individual completed the module through to the post-test. Replicating this project on a larger scale and over a more extended period could yield more substantial evidence for analyzing the gains in knowledge and confidence from this education.

Conclusions

The revised standards for quality improvement reporting excellence (SQUIRE 2.0) were used as a framework for reporting this project. The project aimed to increase healthcare providers' confidence and knowledge when caring for the LGBTQ+ community. The module provided new information and encouraged participants to reflect on their biases and understand the community's unique needs. The goal was to boost comfort levels when caring for marginalized populations and acknowledge biases. To expand the project, the institution could offer the course to all education levels or develop an elective that covers topics such as the

community's history and healthcare needs. Such a course would help healthcare providers offer culturally competent care to all patients, including marginalized populations. The outcome can be readily incorporated into future programs and curricula.

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