LGBT Client Satisfaction at a University-Associated Primary Care Center

Christopher M. Bouma
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LGBT CLIENT SATISFACTION AT A UNIVERSITY-ASSOCIATED PRIMARY CARE CENTER

Christopher Michael Bouma

A Dissertation Submitted to the Graduate Faculty of
GRAND VALLEY STATE UNIVERSITY

In
Partial Fulfillment of the Requirements
For the Degree of
DOCTOR OF NURSING PRACTICE

Kirkhof College of Nursing

December 2016
Dedication

This work is dedicated to my late father, Dr. Hessel Bouma III, who died of cancer while I was in graduate school. As a PhD in biology with particular interest in genetics and ethics, he challenged me growing up with questions on many topics that provoked consideration on issues in science and social justice. He would have been proud to see this completed.
Acknowledgements

I wish to acknowledge the support of Grand Valley State University in producing this work. Without the assistance of numerous faculty and staff, this would not have been possible. Thank you, GVSU.

I wish to acknowledge the support of Andrea Bostrom, my chair. She has made herself available to me, and stood by me despite a long process that was rarely anything but rocky. She was able to help me navigate throughout the project, and without her this could not have come to fruition. Thank you, Andee.

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Abstract

Sexual minority individuals are a vulnerable population. Historically this has led to worse access to care and worse health outcomes compared to heterosexual individuals; this can be addressed through changes to practice. Patient satisfaction has also been a health care focus in recent years for all patients. This project examined patient satisfaction in a small university-associated primary care center and compared patient satisfaction scores for sexual minorities to heterosexual respondents. This was conducted after a series of lesbian, gay, bisexual, and transgender (LGBT) educational initiatives with center staff. A total of 73 individuals chose to participate. Most individuals were highly satisfied with all forms of care. Sexual minority participants reported they were more likely to “Probably” use the center again instead of “Definitely,” as compared to heterosexual individuals; it is possible this finding was an artifact. Sexual minorities were also more likely to report a history of smoking. No other differences between the two groups were noted; sexual minorities were just as satisfied as heterosexual respondents.
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CHAPTER 1

INTRODUCTION

Scope of the Problem

Lesbian, gay, bisexual, and transgender (LGBT) individuals are a vulnerable population. They have been collectively referred to as a sexual minority. Among other societal, legal, and discriminatory concerns, are health concerns. College students are also a vulnerable population, as they transition into new roles and demands. These include social and academic concerns, new living circumstances (Leary & DeRosier, 2012), and an environment rife with alcohol (White & Hingson, 2013), all in the context of increased independence from parental authority. It may be that LGBT college students are especially vulnerable as they are members of both populations.

If discrimination and negative social attitudes are present in the health care environment, it stands to reason that there may be adverse effects on patient satisfaction. The guiding question for this project was to measure patient satisfaction at a university associated primary health center that serves college students and a local, downtown population. A secondary question was to compare satisfaction between LGBT and heterosexual respondents.

Size of the Population

In a 2006-2008 random sample telephone survey among American adults 25-44 years old, 12% of women and 5.8% of men reported same-sex sexual contact (Chandra, Mosher, Copen, & Sionean, 2011). This was similar to numbers reported in an earlier 2002 survey with 11% of women and 6.5% of men reporting the same (Mosher, Chandra, & Jones, 2005). These data are believed to be representative. If so, this would suggest a
population of 1.8 million men and 3.2 million women who reported sexual contact with a same sex partner. This estimate may be low given the context of continued stigma and discrimination that could contribute to an unknown level of underreporting. It should be noted that the number of people self-identifying as lesbian, gay, bisexual (LGB), and transgender is approximately half of the people who have had same-sex sexual contact (Chandra et al., 2011).

Institute of Medicine

The Institute of Medicine (IOM, 2011) released a report on the state of the science regarding LGBT health care. The findings are summarized by age category, with transgender health sometimes separately reported in the age category. This will be addressed here using LGB when the results do not apply to transgender individuals.

IOM (2011) reported that there were disproportionate rates of human immunodeficiency virus (HIV), depression, suicide attempts, substance disorders, homelessness, harassment, and victimization among LGB youth. Little research was found on transgender youth. The report noted disproportionate rates of depression, anxiety, suicide attempts, HIV, social stigma, substance disorders, female obesity, and female avoidance of preventative health among LGB adults. The IOM reported that little high quality research on transgender adults was available, but what was available was largely similar in trend. There were higher rates of HIV, social stigma, discrimination, and lower rates of help given to elders by children among LGBT older adults. Older LGBT adults were more likely to exhibit resilience and hardiness; this may be the result of surviving the HIV epidemic or having lived a long life in the face of church and state-sanctioned discrimination. Among transgender older adults, research found negative long
term effects from hormone therapy which may include effects on cardiac and pulmonary function. The IOM report found there was a need for research on interventions intended to address healthcare inequalities for the LGBT population.

**Healthy People 2020**

Healthy People 2020 (HP2020) from the US Department of Health and Human Services (2014), recognized that LGBT health is important, because this focus can reduce disease transmission of both sexually-transmitted infections (STIs) and other diseases, reduce disease progression, increase mental and physical well-being, reduce healthcare costs, and increase longevity. Specific objectives for 2020 include development of population based measurements in order to gather data on LGBT populations. Other health-related objectives include reducing alcohol and tobacco use, reducing bullying, treating mental health, and increasing health insurance coverage, cancer screening, and condom use.

**Health Care Needs and Barriers for the LGBT Population**

**Unique Health Care Needs**

There are unique health care needs for this population. The IOM report (2011) noted needs for mental health, substance disorders, STIs, and preventative care. Culturally sensitive primary care may contribute towards more adequately addressing these needs. The same report identified a need for additional interventional inquiries. The HP2020 report included very similar goals and identified needs for health promotion. Other unique needs to be addressed by health care providers include screening, immunization, a welcoming environment, knowledge of sexual practices, and culturally appropriate approaches to transgender clients.
Client Barriers to Health Care

There are client-based barriers to health care for LGBT individuals. These include lack of access to healthcare and nondisclosure of sexual preference (Buchmueller & Carpenter, 2010). Other barriers include mistrust of the healthcare system, mistreatment by the healthcare system, and outright refusal of care (Harvey et al., 2014). Individuals who are LGBT can have difficulty locating a culturally sensitive provider (Khalili, Leung, & Diamant, 2015); additionally, even rural LGBT individuals find a provider who sees other LGBT individuals to be highly desirable (Whitehead, Shaver, & Stephenson, 2016). Transgender individuals are often uncomfortable discussing primary care needs (Bauer, Zong, Scheim, Hammond, & Thind, 2015). These identified barriers may result in discriminatory treatment or non-treatment for LGBT individuals. Further, reduced access to health care is associated with adverse outcomes such as lack of knowledge of HIV status (McKirnan, DuBois, Alvy, & Jones, 2012). The lack of authenticity in the provider-patient relationship may damage rapport and patient satisfaction.

Provider Barriers

There are also barriers to health care for LGBT individuals within the health care organizations attempting to help them. Heterosexual providers and nurses do have some sexual prejudice, preferring to work with heterosexual clients (Sabin, Riskind, & Nosek, 2015). Providers lack cultural sensitivity and lack knowledge about healthcare issues unique to the LGBT population (Makadon, Mayer, & Garofalo, 2006). For example, providers may not be aware of risk associated with anal carcinoma secondary to human papillomavirus infection in bisexual men even if they are aware of the involvement of the
virus in many head and neck cancers. Makadon (2011) recommends that providers take a full sexual history, including assessing risky behavior and gender identity, as well as being aware of mental health concerns and family life issues for LGBT clients.

**Mental Health Disparities**

LGBT individuals are more likely to require mental health services. A study in Minnesota found that LGBT individuals were at higher risk for depression, anxiety, substance use, and more likely to report unmet healthcare needs. The authors also found that societal discrimination alone did not account for this disparity (Burgess, Lee, Tran, & van Ryn, 2008). A meta-analysis identified that lesbian, gay, and bisexual individuals were 1.5 times more likely to present with depression, anxiety, and substance disorders (King et al., 2008). They further found that these individuals were 2.5 times more likely to have attempted suicide than heterosexual individuals. A study of rural LGBT individuals found that 50% of survey respondents had symptoms of depression (Whitehead et al., 2016). Provision of culturally sensitive care in the primary care site is important, as it may serve as a port of entry for mental health services.

**Changes Meant to Help**

**The Human Rights Campaign**

One identified means to increase cultural sensitivity in health care organizations is through certification as a Leader in LGBT Healthcare Equality (Human Rights Campaign, 2016). This is attained by meeting specific criteria in the Healthcare Equality Index. Unfortunately, this is not available for small primary care centers. While it is possible that a hospital system with which a clinic is affiliated could gain this status, primary care centers associated with universities may not have this option.
Human Resources Diversity Initiatives

The Human Rights Campaign has developed an analog of the Healthcare Equality Index called the Corporate Equality Index. It allows businesses to measure levels of equal treatment. However, little research has been done on sexual minorities in the workplace. Yet there are opportunities for research and leadership. Sexual minorities can be viewed as similar to the focus of other human resource diversity initiatives in that they seek to eliminate discrimination, prevent harassment, and promote inclusion (Schmidt, Githens, Rocco, & Kormanik, 2012). As such, sexual minorities could be considered for diversity interventions.

Nursing and Medical Curricula

Changing the education of health care workers has been suggested as a possible mode of addressing LGBT cultural sensitivity (Röndahl, 2006). The rationale for this is simply that if education is provided in a routine manner, this will improve eventual outcomes. Overall it appears that nursing and medical schools have identified a deficiency and wish to correct it within each curriculum (Röndahl, 2006). However, curriculum changes do not address the current workforce or address current conditions in hospitals and small primary care centers. For example, some 80% of practicing nurses in San Francisco reported no LGBT-specific training (Carabez et al., 2015). This seems to suggest little movement in terms of adding this content to prelicensure education.

Current Practice

It has been noted above that there are problems in current practice at present. Nondisclosure of LGBT status and mistrust of health care providers have already been mentioned. Other problems include lack of provider education on specific
recommendations, such as for pre-exposure prophylaxis for HIV, cancer screening, and hormone replacement therapy. Finally, when discussing cultural sensitivity concerns for any minority background, bias remains a factor to be considered.

**Guiding Question**

The guiding question for this project is composed of two parts. First, it focused on measuring and describing the level of patient satisfaction at a small, nurse-managed, university-associated primary care center. Second, it focused on comparing satisfaction between sexual minority participants and others. To support this effort, literature will be discussed next.
CHAPTER 2
LITERATURE REVIEW

The goal for this project is to measure patient satisfaction for all participants and to compare patient satisfaction between LGBT respondents and heterosexual respondents. There is little literature on this. Because lack of patient satisfaction with health care services creates a barrier to access and exacerbates health problems among LGBT people, three relevant foci will be considered. The first focus will summarize the health care problems for LGBT individuals. The second will discuss attitudes and knowledge of physicians and nurses about LGBT issues. The third will discuss efforts to address LGBT concerns through human resources initiatives and educational programs as a model for the health care system. Finally, patient satisfaction will be addressed.

Health Care Problems for LGBT Individuals

This focus will start with a brief examination of physical health issues for the LGBT population. It will then discuss perceptions of primary care by LGBT individuals. It will also discuss how LGBT individuals can be asked about sexual orientation and gender identity. Finally, it will review an article on college student sexual behavior. This will give the general background whereby patient satisfaction is an important consideration for managing LGBT health care needs.

Sexual Orientation Identity and Adult Health

Conron, Mimiaga, and Landers (2010) completed a population level study of sexual orientation and adult health. This was a secondary analysis of data collected in the Massachusetts Behavioral Risk Factor Survey. This survey collected data yearly from 2001 to 2008, with a total of 67,359 participants. The study randomly sampled the
residents of Massachusetts using phone numbers. Of respondents, 3% identified as sexual minorities. Questions were asked about 22 health characteristics, including such characteristics as cigarette smoking, diabetes, HIV screening, weight, and health insurance. All responses were self-reported single items (Conron et al., 2010).

Health was worse among sexual minorities on 16 of 22 health characteristic areas (Conron et al., 2010). Sexual minorities were more likely than heterosexuals to report activity limitation, tension or worry, smoking, drug use, asthma, lifetime sexual victimization, and HIV testing. Areas that were not different included heart disease, diabetes, cervical cancer screening, and lifetime mammography. Gay men fared better than heterosexuals in two areas, reporting lower weight and more frequent instances of sigmoidoscopy and colonoscopy. Bisexuals reported poorer health and worse socioeconomic status than heterosexual, gay, and lesbian individuals (Conron et al., 2010).

One strength of this study was that it utilized random sampling procedures, as compared to most similar studies, which often utilize convenience samples. Another was that a large sample size was obtained. One weakness is that the sample was composed entirely of people living in Massachusetts. This may limit generalizability to the rest of the United States. Another limitation of this study was the design, which gathered data over a very long time span, but treated it in aggregate as a cross-section. Additionally, some items were not carried through all years of the survey. Finally, the study was not designed to be inclusive of transgender individuals.
Breast Cancer Risk and Screening

Brandenburg, Matthews, Johnson, and Hughes (2008) investigated breast cancer risk and screening. This was a secondary examination of data collected in the Multisite Women’s Health Study, which used a convenience sample. This study collected data from 1994 to 1996 in Chicago, New York City, and Minneapolis-St. Paul. The design was cross-sectional with a self-administered questionnaire. Demographics, sexual orientation, weight, alcohol use, breast self-exam adherence, and mammogram adherence were recorded. A total of 550 lesbian women and 279 heterosexual women completed the survey. Data from 33 bisexual women were not examined, as the authors deemed the sample size too small. The study did not comment on possible inclusion of transgender women (Brandenburg et al., 2008).

The Gail Model was used for breast cancer prediction (Brandenburg et al., 2008). Risk factors examined included age, age of first menarche, age at first live birth or nulliparity, history of breast biopsy, and number of first degree maternal relatives with breast cancer, weight, alcohol use, and adherence to breast cancer screening recommendations.

Estimated five year and lifetime breast cancer risks were higher for lesbians than for heterosexual women (Brandenburg et al., 2008). Lesbians reported both heavier drinking and more frequent abstinence from alcohol than did heterosexual women. No differences in adherence to breast cancer screening were identified. No difference in self-perception of being overweight was noted (Brandenburg et al., 2008).

This study had a number of limitations. The sample was entirely recruited from three major metropolitan areas in the Midwest and New England. As such, the results
may not translate to West Coast metropolitan areas, suburban areas, or rural areas. The health of bisexual and transgender women was not examined. Finally, these results were somewhat time-limited, as they were derived from data gathered in the mid-1990s, but not published until a decade later.

**Health Care Disparities Studied in the Pacific Northwest**

Dilley, Simmons, Boysun, Pizacani, and Stark (2010) investigated health care disparities in the Pacific Northwest. This was a secondary analysis of data collected from 2003 to 2006 in the Washington State Behavioral Risk Factor Surveillance System. Sampling used random digit dialing on landline telephones from English and Spanish speaking adults. If a household was reached, a random adult in the household was selected to participate. Annual response rates ranged from 43% to 47%. Measures included Center for Disease Control core questions, fielded in every state. Demographics, poverty level, and sexual orientation were also gathered.

A number of disparities were identified. Lesbian and bisexual women were more likely than heterosexual women to have poor physical health, poor mental health, and asthma (Dilley et al., 2010). They found that lesbian and bisexual women were more likely than heterosexual women to be overweight, to drink excessively, and to smoke. Lesbian and bisexual women were less likely to have access to care and less likely to use preventative services. Bisexual women were more likely than heterosexual women to have diabetes. Gay and bisexual men were more likely than heterosexual men to have poor mental health, to smoke, and to have activity limitations as a result of poor health. Male and female bisexuals had the greatest number and greatest magnitude of disparities as compared to heterosexuals (Dilley et al., 2010).
This study had a number of limitations. The sample was random, but was limited to those who had landline telephones. The sample was entirely recruited from the state of Washington. As such, the results may not translate to areas outside the Pacific Northwest. Transgender health was not examined. Finally, the original data were from the early 2000s, but the results were not published until half a decade later. This demonstrates a common limitation of this kind of research. Despite these limitations, this study found that LGB individuals have reduced access to care.

**Physical Health Complaints Studied in California**

Cochran and Mays (2007) examined physical health complaints of LGB individuals in California. This study additionally included individuals who considered themselves to be heterosexual, but who had engaged in sexual activity with someone of the same gender. This was a secondary analysis of data in the 2004-2005 California Quality of Life Survey, with a total sample of 2272. The 2004-2005 survey was in turn a follow-up study of participants of the 2003 California Health Interview Survey. This survey was a random telephone number survey of 42,000 California adults. Participants who were available for follow up were disproportionally older. Data gathered included general physical health and disability, chronic physical conditions, psychological distress, sexual orientation, and demographics (Cochran & Mays, 2007).

Results were reported for the portion of the sample that was not exclusively heterosexual. This was done in order to include those who engaged in same-sex sexual behavior, but did not identify themselves specifically as LGBT. Individuals who were not exclusively heterosexual had higher risk for common health conditions and activity limitations (Cochran & Mays, 2007). Among men, this was largely, but not completely,
explained by HIV infection. Psychological distress was elevated among non-exclusively heterosexual individuals, and largely explained differences in health between exclusively heterosexual groups and non-exclusively heterosexual groups. Finally, not all non-exclusively heterosexual groups were similar. For example, self-identified bisexual men did not have the same response patterns as heterosexual men who reported past same-sex experience, with the latter reporting significantly more distress (Cochran & Mays, 2007).

This study had a number of limitations. Participants were entirely recruited from California. As such, the results may not translate to other areas. Transgender health was not examined. These results reflect matters as they were in the early 2000s. Finally, due to original study design, the data only reflected respondents who were willing to respond to the first 2003 survey and then also the 2004-2005 survey. As a higher proportion of younger individuals were lost to follow up, this might have resulted in bias towards higher rates of reported conditions and disability from older respondents. Despite these limitations, this study found a higher disease burden among LGB individuals.

**Perceptions of Lesbian, Gay, and Bisexual Individuals Toward Primary Care**

Neville and Henrickson (2006) examined the perceptions of LGB individuals toward primary care in New Zealand. A total of 2269 individuals completed a 133 item questionnaire. It was promoted both through mainstream and gay-friendly media sources. Participants could complete the questionnaire either online or on paper. The study was undertaken as part of a larger research project intended to be strengths-based rather than problem-based, as that is the usual focus of LGBT studies. The instrument was developed by an interdisciplinary team who consulted with local LGB community
leaders and members. It included both forced response items and 7-point Likert-like scales (Neville & Henrickson, 2006).

Both genders and all age ranges identified that the healthcare professionals attitude towards sexual identity was important to them (Neville & Henrickson, 2006). About three quarters (73.7%) stated that their providers always or usually assumed that they were heterosexual. Some respondents (18.1%) reported their healthcare professional seemed uncomfortable or ignored disclosure. Few respondents (3.6%) reported that disclosure affected care in a negative way (Neville & Henrickson, 2006).

Strengths of the study include a broad-based survey asking many questions and covering many topics. Specific recommendations were made to include LGB topics in nursing education. A weakness was that this was a self-selected sample. The authors also identified a need for future research in particular age groups, as well as specifically with gay men, lesbians, and bisexual men and women. This study did not address college-age students as a group, but could be replicated with college students. The instrument is fairly lengthy with 133 items; this may also be a weakness due to the high instrument burden. This may be too great a burden for clients to easily and quickly complete.

Acceptability of Routine Collection of Data on Sexual Orientation

Cahill et al. (2014) investigated the acceptability of routinely collecting sexual orientation and gender identity (SOGI) information in community health centers. The community health centers were affiliated with the Community Health Applied Research Network, an initiative funded by the Health Resources and Services Administration. The Health Resources and Services Administration funded this study.
A total of 301 randomly sampled patients from four community health centers were asked SOGI questions of a type that could be utilized with an electronic health record and follow-up questions. They were compensated with $10 gift cards. The community health centers were located in rural South Carolina, Boston, Baltimore, and Chicago. Racial minorities and diverse sexual orientations were well represented. For example, 47 of the 301 reported they were transgender, and this is often the most difficult group from which to gain representation in many LGBT studies.

The instrument took five minutes to complete (Cahill et al., 2014). Sexual orientation questions were those previously in use by the Fenway Institute in Boston, Massachusetts. It included gender identity and birth sex questions validated in the United States and internationally. This questioning method is referred to by the authors as the two step method. Questions include sex assigned at birth, current gender identity, and reported sexual orientation. Follow-up questions about these questions ascertained whether respondents believed the instrument was adequate for them to accurately document their gender. The instrument had been piloted and altered prior to use in this study (Cahill et al., 2014).

The participants largely answered the SOGI questions and indicated they were appropriate to ask (Cahill et al., 2014). However, straight respondents understood the SOGI questions less often than others. All respondents indicated they understood the importance of asking SOGI questions, with 78% agreeing it was important for their primary care provider to know this information. Some non-LGBT individuals reported some confusion on how to answer the gender questions, but were able to answer accurately. LGBT individuals believed the questions allowed them to accurately
document their sexual orientation and gender identity. However, older adults tended to agree less with all of the above than younger individuals (Cahill et al., 2014).

Strengths of this study included use of several sites, verified age groups, and ethnically diverse respondents. The major strength of this study is that it demonstrated a set of questions about sexual orientation and gender identity that could be included in an electronic health record. Further, it demonstrated they were acceptable to clients of all sexual orientations and adequate to document SOGI status. Weaknesses included different sampling methodologies at each site. Also, only clients who arrived for appointments could fill out surveys.

This study had a brief and easy instrument and asked specific, well-focused questions. This could be easily implemented for clients in a community-based health center. In fact this happened in California, and after some initial resistance was successful (Callahan et al., 2015). As these questions are inclusive by design, they may affect LGBT patient satisfaction.

**Sexual Health Behaviors Among LGBT College Students**

Oswalt and Wyatt (2013) examined sexual health behaviors of a sample of American college students with regard to sexual orientation. This was a secondary analysis of primary data from the 2009 American College Health Association—National College Health Assessment. The total response rates were 36% (n=25,553). The survey procedures used both paper and computer collected surveys. Of the total sample, 1.1% (n=273) were gay men, 0.7% (n=184) were lesbian, 2.9% (n=731) were bisexual, and 1.5% (n=394) were unsure. Data examined included sexual orientation, sexual behavior,
safer sex behaviors, preventive and screening behaviors, and sexual health related
diagnoses (Oswalt & Wyatt, 2013).

One analysis evaluated number of partners (Oswalt & Wyatt, 2013). Among
females, bisexual women reported more partners in the previous 12 months (M=2.54)
than heterosexual (M=1.77), lesbian (M=1.75), and unsure females (M=2.27). Unsure
males reported more partners (M=7.56) in the last 12 months than gay males (M=4.91).
Bisexual (M=3.99) and heterosexual males (M=2.32) both reported fewer partners in the
last 12 months. However, 34.5% (n=8735) of all respondents reported no partners in the
previous 12 months; these individuals were removed from subsequent analysis about
sexual behaviors (Oswalt & Wyatt, 2013).

Results for safer sex behaviors, preventive behaviors, and diagnoses were mixed
(Oswalt & Wyatt, 2013). Bisexual women were more likely than other women to have
been tested for HIV. Bisexual and heterosexual women were more likely than other
women to have had a gynecological exam. Gay and bisexual men were more likely to
have been tested for HIV than heterosexual and unsure men. Notably, some statistically
significant results were noted for human papillomavirus, HIV, gonorrhea, and genital
herpes with regard to sexual orientation categories, but these were weak associations
based on too few cases to warrant clinical significance in the cases of each non-
heterosexual group. Additionally, males were more likely to use condoms during anal
sex, but all groups were unlikely to use protection for oral sex (Oswalt & Wyatt, 2013).

One strength of this study is that it examined data from a large sample with
satisfactory numbers of individuals with diverse sexual orientations. A powerful strength
of this study was that it allowed individuals to report they were unsure of sexual
orientation. However, a weakness was that it utilized self-reported orientation, rather than relying on actual sexual behaviors. One weakness was that in the sexual behaviors sections, the questions that assessed particular acts were restricted to three: oral, vaginal or anal sex. The questions do not distinguish between receptive and insertive roles. Other behaviors were not reported at all, such as mutual masturbation, digital sex, use of sex toys, or multiple partner scenarios. Additionally, this was not a random sample and there was a low response rate, both of which limit generalizability. Finally, transgender students could have been in the study, but were invisible in this analysis.

This analysis does help inform the present project. It is well established that there are higher rates of STIs in LGBT individuals. However, this analysis did not demonstrate extremely high rates in LGBT individuals. Instead, it showed real areas of concern across all college students. From a clinical standpoint, these data make it clear there is a lot of risk to manage for all college students. As LGBT students may engage in differing behaviors from heterosexual students, the clinician needs to be aware both of the risks and of the behaviors. Clinicians who are aware of these things will be well placed to help both college students and members of the community who may have these concerns. This understanding of sexual behaviors and knowledge of indicated screenings and treatments may have effects on client satisfaction.

**Summary of Health Care Problems**

There are health care problems faced by LGBT people. General health is worse among LGB individuals, with bisexual individuals reporting the poorest health of those three groups. Lesbians had higher risk of breast cancer than did heterosexual women. There is also reduced access to care for LGB individuals. Few data are available for
transgender people. What few data are available suggests health disparities may be even greater for transgender individuals.

**Physicians and Nurses**

The second focus will be background literature concerning professional issues for health care staff around the topic of providing care for LGBT clients. While it should be noted that significant discriminatory behavior has been noted by both LGBT nurses (Eliason, DeJoseph, Dibble, Deevey, & Chinn, 2011) and LGBT physicians (Eliason, Dibble, & Robertson, 2011) in their workplaces, this will not be addressed in order to keep the focus on the LGBT client rather than the LGBT staff. The first article is on heterosexual assumption, which is a term that refers to acting as though every person is of clear gender identity and is only interested in the opposite sex. The second article is on barriers to good care for transgender clients as perceived by physicians. The third article discusses the silence on LGBT issues in nursing literature. This information helps to illuminate some of the barriers to patient care that are likely to affect patient satisfaction.

**Heterosexual Assumption in Nursing**

Heterosexual assumption or heteronormativity refers to the assumed social norm that all people are heterosexual, which can lead to awkwardness in the cases of those who are not. A qualitative study in Sweden sought to learn about experiences of gay men and lesbians as both patients and partners with regard to nursing in hospital care (Röndahl, Innala, & Carlsson, 2006). Researchers interviewed 17 women and 10 men. This resulted in the description of 46 patient experiences. A further 31 experiences were described by the participants as partners of the patients. Inclusion criteria required self-identification as a gay man or lesbian and hospital experience as a patient or a partner.
within the last five years. Sampling was accomplished via snowball sampling as well as use of key informants, and advertising on websites for gay people. The authors reported reaching information saturation.

Nearly all informants described situations indicating that heteronormative assumptions were made by nurses (Röndahl et al., 2006). They described noting this immediately on brochures and forms. During admission, questions asked by staff also displayed this assumption. One example is that after asking if patients were in a relationship, they were asked for the name of the partner using the opposite gender pronoun. Furthermore, informants believed that nurses were unaware of the restraining effect on communication of such assumptions. Informants also noted staff were often uncomfortable because they did not wish to offend gay or lesbian patients, and this tended to lead the patients to believe they would react negatively to the disclosure. Finally, informants reported worse treatment as a partner than patient, with some staff excluding and neglecting them in their roles as partners of LGBT individuals (Röndahl et al., 2006). This identified problem may be ongoing. Even in San Francisco nearly a decade later nurses report that they are comfortable with LGBT care; however, they may not be providing culturally sensitive care (Carabez et al., 2015).

One strength was the inclusion of specific, actionable recommendations for nursing and nursing education. Another was the use of a structured interview guide. One weakness was that bisexual and transgender individuals were not included. However, this may have been by design as bisexual individuals could have been more difficult to sample, and this may have been believed to be true of transgender individuals as well.
Additionally, including transgender individuals might confound gender assumptions with sexual orientation assumptions.

For the present project, many of the recommendations can apply to a university-affiliated primary care office. Recognition of heterosexual assumption, use of gender neutral terms, a non-judgmental approach, and availability of literature are all changes that can be applied to health care, regardless of setting and professional background of the health care worker in question. Doing so may result in increased rates of client satisfaction.

**Physician-Perceived Barriers for Transgender Clients**

A qualitative study investigated barriers related to physicians when treating transgender clients (Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012). This was conducted in the Canadian province of Ontario. Semi-structured interviews were used with a grounded theory approach. A total of 13 physicians were interviewed. The goal of this study was to examine provider perspectives of the barriers of care for transgender individuals.

Physicians were found to perceive significant multifactorial barriers to good transgender care (Snelgrove et al., 2012). Physicians were concerned about a dearth of good treatment information. Physicians did not feel they had adequate knowledge of clinical management of a transgender client. Physicians also noted that healthcare is structurally set up for two genders and this can be a difficulty that is largely unaddressed by policy. The authors concluded that informational interventions would be helpful, as would inclusion of transgender health in medical education. The authors also suggested
that transgender individuals would benefit from continuing with primary health care management for health care issues beyond those matters relating to transitioning.

One strength of this study was the inclusion of physicians from a variety of specialties. A weakness was that only 13 physicians were interviewed, and non-physician providers were excluded. With regard to the present project, providers who are familiar with LGBT health care needs before LGBT individuals present for care may result in changes to patient satisfaction.

**Nursing Silence**

Nursing research has been characterized as silent on the topic of LGBT issues (Eliason, Dibble, & DeJoseph, 2010; Cloyes, 2016). This was associated with a number of problems, including the following: practicing nurses having insufficient knowledge about LGBT issues (Carabez et al., 2015), lack of nursing student readiness to learn (Cornelius & Carrick, 2015), insufficient transgender content in nursing programs (Walsh & Hendrickson, 2015), and limited faculty knowledge, experience and readiness to teach about LGBT issues (Lim, Johnson, & Eliason, 2015).

From a review of the top ten nursing journals for 2005-2009, about 0.16% of the articles discussed LGBT issues, and all of these were from authors outside the United States (Eliason et al., 2010). The authors noted more than a dearth of nursing research on LGBT issues. They also noted that nursing has historically been silent when other professions have issued statements about same-sex marriage or reparative therapy (attempts to change sexual orientation). It is asserted that heterosexuality is assumed in the vast majority of nursing literature (Eliason et al., 2010). A more recent similar effort focused on LGBT older adults reached similar conclusions (Cloyes, 2016).
However, recommendations were made for improving the state of nursing science with regard to LGBT issues. One recommendation was to infuse nursing curriculum with LGBT content (Eliason et al., 2010). This was similar to what was recommended for physician assistant programs (Compton & Whitehead, 2015). Another recommendation was to encourage nurse researchers to include LGBT and gender related questions in demographic data collection wherever possible. Nursing journals could create a special journal issue on LGBT topics, as several other journals have successfully done. Nursing professional organizations can recommend policy changes in both institutions and curricula, and could also create special interest task forces. A final recommendation is a call on nursing to regard diversity as broader than race and ethnicity and to end nursing’s silence on LGBT issues (Eliason et al., 2010). The present project is an effort in this direction.

**Programs**

The third focus is to examine several programs which have been initiated to address perceived concerns about adequate LGBT care. This information is needed in order to understand what efforts have been made to address this care, and that these efforts could have effects on patient satisfaction. Human resources (HR) departments have been identified as possible agents to address LGBT issues, and this will be discussed further. Two programs will also be reviewed. One discusses evaluation of a program for transgender education. The other is an educational offering discussing LGBT older adults.
Human Resources

LGBT education has been examined from the point of view of HR development and adult education (Schmidt, Githens, Rocco, & Kormanik, 2012). The authors conducted a review of the literature. While this review was focused on LGBT employees, it seemed wise to review this work as adult education was also a focus. The authors noted that LGBT individuals should largely be considered as a minority that should be supported from a diversity standpoint. They shared data to support this assertion, as well as other ideas detailed below. The civilian labor force was approximately 4% disabled, 13% Hispanic, 12% African-American, 5% Asian, and about 7% or more lesbian, gay, or bisexual. However, the authors also noted that LGBT individuals in the workplace were not as extensively studied as these other groups, and identified a need for additional quantitative research (Schmidt et al., 2012).

In matters of diversity, an inclusive atmosphere increases creativity, performance quality, cooperation, and number of perspectives considered by an organization. However, attempts to improve diversity are difficult to maintain without attention to policy, procedure, and culture (Schmidt et al., 2012).

Workforce diversity initiatives for sexual minorities were generally focused on four areas (Schmidt et al., 2012). These included increasing workforce representation, eliminating discrimination, preventing harassment, and promoting inclusion. There were multiple problems with same-sex benefits, including the federal tax code, ongoing documentation of relationship status (not required of opposite-sex relationships), forms that retain gender exclusive language, earnings differences, and availability of hormone replacement therapy through insurance.
The authors concluded by suggesting that HR has served either reactively or not at all with regard to many diversity issues. The reader will note that this is similar to how nursing and medicine have reacted to such issues as well. LGBT issues should be discussed at an organizational level. Finally, “in an environment where organizations need the productivity and full participation of all types of talent, this issue is a bottom-line business concern as well” (Schmidt et al., 2012, p. 343).

Many of these issues could be applied to a university-associated primary health center. However, it must be noted that the larger number of staff that HR may have in even a small hospital is significantly greater than HR in a small primary health center. Indeed, the latter may be represented by only one person. On the other hand, the site under consideration is university-associated. Some matters such as institution-level antidiscrimination policies were already in place. However, it is important to keep in mind that sensitivity to diversity should be maintained at all levels. Certainly, inclusive policies that are easily accessed may affect client satisfaction.

Transgender Workplace Training

Community competency trainings for transgender health care exist, and they have been investigated for effectiveness (Hanssmann, Morrison, Russian, Shi-Thompson, & Bowen, 2010). Using a mixed methods approach, three trainings were investigated with regard to knowledge, skills, and attitudes. The three trainings were of differing lengths and were given to different groups with varied backgrounds. The first training lasted 6 hours and was given to a group of public school employees. The second lasted 2 hours and was comprised of employees from local non-profit clinics; these were largely licensed practical nurses. The third training was one hour and focused on employees
from a university associated clinic, largely health care providers. Similar concepts were
 taught in all three trainings, with the third somewhat more focused on the educational
 needs of providers. To be included in the study, participants had to have a background in
 health care or social service, attend the whole training, and complete the pre- and post-
 training surveys. A total of 68 individuals qualified, although the breakdown of who
 attended which sessions was not reported. One trainer, a white transgender man, was
 common to all three trainings; he presented alone in one session, but with one of two
 other presenters in the other two sessions.

 Quantitatively, a tool was customized to measure competence using 16 self-
 assessed items on a 5-point response scale (Hanssmann et al., 2010). This tool was the
 “Cultural Competence Self-Assessment Questionnaire.” Qualitatively, interviews were
 conducted in a semi-structured format.

 Results indicated the training was beneficial (Hanssmann et al., 2010). There
 were gains made in self-assessed knowledge, and participants felt they could utilize this
 information in practice. The results were both statistically significant and clinically
 significant. Participants perceived a need for concrete knowledge, such as terminology,
 and interviews revealed some providers took it upon themselves to plan and implement
 changes based on knowledge gained (Hanssmann et al., 2010).

 One strength was the identification that some providers are self-motivated to
 implement knowledge. Another was that participants responded positively to the
 training. However, the study authors noted that they may have inadvertently narrowed
 conceptions of what gender noncomformity means, as the intervention was carried out by
 a white transgender man who was “passing,” i.e. appearing to be male. The study
instrument was adapted from an instrument designed to measure service to people of color, and this may have affected results as well. Another possible weakness the authors identified was that all three trainings were different in length, varied somewhat in content, and presenter(s) were not the same across all three.

This study informs the present effort in that it indicates that educational offerings at the agency level are well received, and that participants may view the information as valuable. Moreover, it noted that such education is efficacious in assisting participants to gain knowledge. Additionally, some participants took it upon themselves to make changes. While this study was targeted purely towards educating about transgender individuals, it does provide conceptual support for LGBT continuing education efforts. It is also easy to see that an educated staff may be viewed more positively by clients.

**Older Adult Educational Initiative**

A six module curriculum intended to educate health care staff on geriatric LGBT issues was tested under a federal grant by Howard Brown Health Center in Chicago (Hardacker, Rubinstein, Hotton, & Houlberg, 2014). The curriculum was evaluated by professionals in LGBT health education. About half of participants were registered nurses. Modules were all focused on elders. The topics were as follows: introductory, barriers, sexuality, legal issues, transgender issues, and HIV. It was administered to participants in 23 sites in Chicago over a three year period. Over 500 nurses and providers participated. Sites were hospital academic centers, community based clinics, or nursing homes. A pre-test and post-test were completed.

There were knowledge gains and confidence gains in each of the six modules across both types of setting (Hardacker et al., 2014). Initial scores and gains in scores
were lower in nursing home/home health settings than in hospital/educational sites. Nursing home participants objected to the training the most, and had the largest number of religion-based questions. While many sites made training mandatory, many staff refused to attend. In academic sites, participants were supportive of the education, but some reported they did not support such training in an academic site. Results demonstrated a need for this education, and there were gains in knowledge without regard to educational level (Hardacker et al., 2014).

Strengths of this study included a large amount of education. Also, following publication the authors were contacted by a hospital system and asked to provide the training in two all-day sessions. A weakness was that progressively fewer participants attended all six sessions, with 848 attending module one and 537 attending module six. However, 10 of the original 16 sites asked the presenters to return the following year. An additional weakness was that targeting nurses may insufficiently include physician assistants, physicians, and frontline staff who interact with clients.

A curriculum that was somewhat similar was implemented at the site under consideration. The present effort will examine client satisfaction in the wake of such an initiative.

**Client Satisfaction**

**Client Satisfaction and Return Visits**

The effects of client satisfaction on likelihood to have a return visit have been investigated (Iaconi, Chang, Feldman, & Balkrishnan, 2011). The authors hypothesized that returning clients would have higher satisfaction than first visit clients. A cross-section of a total of 15,341 clients participated in the study. Of these, 3695 were first
visit clients and 11,646 were return visit clients. Most clients were female (about 70%) and most were between 18 and 44 years of age (around 90%). About 40% of first visit clients and 60% of return visit clients reported that their provider spent more than 12.5 minutes with them (Iaconi et al., 2011).

Data were collected anonymously via the online internet site “DrScore” (Iaconi et al., 2011). This site is used by clients to rate their physicians. Ratings covered five areas: overall care, personal information, health care information, clinic rating, and area of improvement.

Waiting time was inversely associated with satisfaction (Iaconi et al., 2011). Length of time with the provider was directly associated with satisfaction. The return visit group had a mean satisfaction score of 80.28 whereas the first visit group had a score of 64.48. This result demonstrated that return visit clients are 10 times as satisfied as those on their first visit (Iaconi et al., 2011).

Strengths of this study included large sample size and a hypothesis that was shown to be significant ($p < 0.0001$). This demonstrated possible support for continuity of care, longitudinal care, and a strong client-provider relationship. Weaknesses included that as a cross-sectional analysis, causation could not be addressed. It could be that more satisfied clients return, or that clients who have a good experience the first time are more likely to come back, or both. The authors also noted that sample bias and recall bias might be present, and that the same patients could show up in both groups. Additionally, one of the authors was the founder of the DrScore website.

With regard to the present effort, this study provides some useful background information. It seems that clients on return visits have higher satisfaction. This supports
the operation of the primary care center in question, which has a focus on longitudinal care and good relationships with clients. Conversely, those with lower satisfaction might not return. Cultural sensitivity training may lead to increased patient satisfaction, and higher patient satisfaction is observed in return visits. As such, it makes sense to measure patient satisfaction.

**Client Satisfaction and Attributes of Primary Care**

Otani, Kurz, and Harris (2005) investigated client satisfaction in an effort to learn which attributes of the primary care experience were most important. They examined three attributes: access, staff care, and physician care. Each attribute also had a number of subcategories. Access had five subcategories, staff care had eight subcategories, and physician care had fourteen subcategories (Otani et al., 2005).

The study design was cross-sectional. The total number of participants was 8465 (Otani et al., 2005). Sampling was random, across five practices that were affiliated with Indiana University Medical Group. Practices were independently managed. They used satisfaction data and physician evaluation data for quality improvement (Otani et al., 2005).

Data collected included the Medical Outcomes Study Visit-Specific Questionnaire, a modified form of the Patient Satisfaction Questionnaire (Otani et al., 2005). Some items were created by the authors to assess access to care, satisfaction with office processes, and personnel. Various aspects of each of the three attributes were also measured, such as bedside manner of physicians, compassionate behaviors of staff, and prompt service. Surveys were mailed to clients’ homes, if they were over 18 years of
Follow-up was by phone if they did not respond to the mailed survey. This resulted in a response rate of 53.9% (Otani et al., 2005).

Each of the three attributes was directly related to satisfaction (Otani et al., 2005). Age was also directly related to satisfaction, with older individuals being more satisfied. African-Americans were also more satisfied. Among the three attributes, physician care was the strongest, with staff care a close second; access was considerably less important. Each attribute had significant subcategories. In the physician attribute, seven subcategories were significant with two subcategories carrying much larger correlations. These two were explaining what was being done (r = 0.241) and length of time spent with the provider (r = 0.212). In the staff attribute, six subcategories were significant, and three subcategories carried much larger coefficients. These three were personal manner of the staff assisting the provider (r = 0.207), check-out efficiency (r = 0.199), and length of time in the waiting room (r = 0.173). In the access attribute, all five subcategories were significant. The two highest rated subcategories were the personal manner of staff helping with making an appointment (r = 0.243) and how long the client had to wait to get an appointment (r = 0.160; Otani et al., 2005).

Strengths of this study included that it addressed numerous aspects within each of the three attributes, and the results show what is most important to clients. Weaknesses include that the cross-sectional observational design cannot speak to causation, as well as the self-selected nature of the sample.

The most important aspects of the primary care visit to a client demonstrated by this study were that they were adequately treated and that staff treated them well. These were operationalized in the study by three subcategories. First, that the physician
explained what was done for them. Second, that they had enough time with the 
physician. Third, that nurses and staff were caring and compassionate. This informs the 
present effort in that changes to practice that would directly affect adequate treatment and 
cultural sensitivity have strong impacts on client satisfaction.

Conclusion

Sexual minorities appear to have worse health, based on studies on both coasts of 
the United States. Sexual minority individuals also identified that the attitudes of 
healthcare staff towards sexual identity were important to them. Collection of sexual 
orientation and gender identity information is acceptable to people. Healthcare providers 
may engage in heterosexual assumption. The topics of health care needs and culturally 
sensitive care of sexual minorities have been notably absent in the nursing literature. 
Several programs were identified that sought to increase education for professionals 
currently in practice.

The research reviewed here suggests that a university based, nurse managed 
primary health center could benefit from a cultural sensitivity initiative. The literature 
also suggests that such an effort could be useful for education and could result in 
increased culturally sensitive care. In fact, this education has already occurred at the site 
in question. Therefore, this effort seeks to examine patient satisfaction given this 
background.
The purpose of this section is to describe the conceptual frameworks guiding this project. The guiding question remains to investigate the level of patient satisfaction and to compare LGBT respondents to heterosexual respondents. The Health Equity Promotion Model will be described, as will the Promoting Action on Research Implementation in Health Services (PARiHS) change framework. Finally, an organizational assessment using the Framework for Improving Performance will be briefly discussed.

**Health Equity Promotion Model**

**General Description**

The Health Equity Promotion Model (Fredriksen-Goldsen et al., 2014) is a framework intended to assist LGBT individuals to maximize their mental and physical health. It considers both protective and adverse circumstances. The model also considers the environmental context. Background consideration within the model includes a life course developmental perspective. Additionally, and as the name of the model implies, a health promotion perspective also informed model development.

The model consists of three parts (see Figure 1). These parts are context, pathways, and health. Context affects both pathways and health directly, and pathways also affect health directly. Health is seen as downstream over the life course. A general background called social positions (intersectionality) underlies all three parts, and affects all parts diffusely and generally. Each will be described in more detail.

Multi Level Context

The multi level context is itself comprised of two subsections, structural and individual. Context affects pathways directly. It also affects health directly and indirectly through the mediating effects of pathways.

Structural level. The first subsection is the structural level, which includes social stigma, social exclusion, and institutionalized heterosexism. Systematic injustices
represent institutionalization of practices that marginalize or continue to marginalize individuals. One example of a disadvantage comes from data indicating LGBT individuals have health insurance at reduced numbers (Buchmueller & Carpenter, 2010), which represents reduced access to care. The protective factor of the recent legal change with regard to marriage equality is likely to extend the protective effects of marriage to LGBT individuals. Research has demonstrated positive effects of legally recognized relationships with regard to psychological distress (Riggle, Rostosky, & Horne, 2010) and physical health (Williams & Frederiksen-Goldsen, 2014).

**Individual level.** The second subsection is the individual level. This includes discrimination, victimization, and abuse. Such phenomena have psychological effects on individuals. There are increased rates of depression and poorer general health in those who experience discrimination and victimization (Fredriksen-Goldsen et al., 2013).

**Health-Promoting and Adverse Pathways**

The four pathways mediate the effects of structural and individual context on health outcomes. The four pathways are behavioral, social, psychological, and biological. In the model, pathways directly affect health. A brief description of each follows.

**Behavioral pathways.** These include exercise, diet, preventive care, sexual behavior, and smoking. Within health care, we often refer to these as modifiable risk factors. These areas are frequently targeted by health promotion initiatives.

These pathways may be health-promoting or adverse, even within the same topic. One example is alcohol. Small quantities of alcohol have health-promoting effects, but in
larger quantities alcohol quickly becomes health-adverse. Smoking cigarettes is health-adverse; however, any smoking cessation initiative would be health-promoting.

Due to intersectionality, however, things are more complicated. LGBT individuals are not uniformly more at risk, and do not always move as a group. An illustrative example is obesity. Obesity rates have been increasing country-wide, and chronic discrimination has been associated with increased rates of obesity (Hunte & Williams, 2009). Given that background one might be inclined to conclude that LGBT individuals are more likely to be obese than their heterosexual counterparts. This is in fact true for lesbians (Conron et al., 2010). However, gay men are less likely than heterosexual men to be obese (Conron et al., 2010).

**Social and community pathways.** These include family structures (including family-by-choice), social support, networking, LGBT community integration, and LGBT resource centers. Those who are marginalized may be socially isolated, leading to adverse experiences and outcomes. However, for those with strong social networks, the negative experiences are reduced (Fredriksen-Goldsen et al., 2013). The phenomenon of family-by-choice (extended networks of partners and friends) may allow some protective effects of family without reliance on biological relatives (Gabrielson, 2011).

**Psychological pathways.** These pathways include identity management, coping, norms, and expectations. Like the other pathways, both enhancing and adverse pathways are present. Enhancing pathways include problem solving, active coping, and disclosure management. Adverse pathways include rumination, avoidance, and internalized homophobia.
**Biological pathways.** There are biological influences on health, including higher cortisol levels secondary to stress. While such biological processes have been documented in the general population, little research has examined this directly in the LGBT community, and additional investigation is needed (Fredriksen-Goldsen et al., 2014).

**Health**

Health is considered holistically in the model, and includes both physical and mental well-being. Health, under this model, is more than the absence of disease. The goal is to maximize health potential. These goals align well with the goals of the primary care center, the Kirkhof College of Nursing, and the LGBT center on campus.

**Social Positions**

A fault with much of the research is that it often treats LGBT populations in a homogenous fashion. This ignores heterogeneity within the LGBT community, and doing so may ignore how social position affects an individual; this is also termed intersectionality. LGBT health can be affected by sexual identity, gender identity, biological sex, race, age, nationality, immigrant status, disability status, geographic location, and socioeconomic status. For example, the context, pathways, and health of a 17 year old bisexual Syrian refugee who is engaging in survival sex in New York City are all going to be very different from a retired, blind, Asian-American lesbian who lives with her wife in rural northern California.

**Site Considerations**

As a primary care center, a holistic conceptualization of health fits well. The model notes the importance of intersectionality, which has pervasive effects and may be
difficult to recognize. Context is important in the model, and this is true for the primary care center as well. The four types of pathways can be used to guide population-based interventions or for ideas on the individual level of each client. Finally, each type of pathway may have enhancing or adverse effects on health. One can see how a clinician might promote and encourage continued exercise while supporting the client in attempts to quit smoking.

**Promoting Action on Research Implementation in Health Services**

**General Description**

One concern about application of best practice is whether or not evidence is extant, as well as whether it is used in specific cases in an intelligible way. Kitson and Straus (2010) identify this as a knowledge gap. Furthermore, they state that identifying such a gap between evidence and practice is the first step in knowledge translation.

Kitson, Harvey, and McCormack (1998) proposed three steps in their original development of the PARiHS model. Under later revision by Kitson and others (2008) these steps were retained. They also identified that this is best utilized as a two-step model. First, evidence and context are examined. This examination then points to the best facilitation method. This examination also may point the way to the most useful intervention, by targeting specific barriers within the contexts (Wensing, Bosch, & Grol, 2010). The major concepts of evidence, context, and facilitation will be briefly described.

**Evidence**

Evidence includes several sources of knowledge. These may include formal research, professional experience, client experience, and local information (Kitson et al.,
Evidence used to inform practice should be subject to scrutiny (Rycroft-Malone et al., 2003). These same authors recommend use of robust evidence from multiple backgrounds in order to maximize client-centered, evidence-based practice.

In terms of the present study, research would include studies on provider experiences and outcomes as well as client experiences and outcomes. Local information would include stakeholder identification of gaps as well as local demographics. Another source of local information was identification by the LGBT Center Director and for the college of nursing, that additional education around LGBT health care was needed by providers of care in the community.

**Context**

McCormack et al. (2002) noted in concept analysis that context refers to the setting in which practice takes place. The themes of culture, leadership, and evaluation are important. However, the authors noted that this does not really fully explain the idea of context. They also note inconsistent use of the term, and finally conclude that the concept requires further development. This did in fact take place.

Kitson et al. (2008) discuss culture, leadership, and evaluation in their evaluation of the PARiHS framework. They add the idea of contextual strength, with a stronger context being one that is more conducive to change. They retain most of the rest of the features of the original idea of context, and this will be the understanding of the current effort. Context involves developing a shared understanding of evidence. It also requires a team effort. Background features may affect implementation, such as having a transformational leader or working within a learning organization. Appropriate monitoring and evaluative mechanisms are also helpful.
The context in this case was a university-affiliated and nurse-managed urban health center. Being university associated and working closely with an academic liaison, this health center had high contextual strength. The health center had a team approach. Change was understood to be more than a matter of targeting a single discipline, but instead to affect and require effort from every team member. These contextual features which improve rates of success were all present within this health center.

**Facilitation**

Facilitators have a key role in assisting with organizational change (Harvey et al., 2001). This is accomplished by individuals with appropriate skills sets and knowledge to assist this process. These individuals are termed facilitators. Facilitators must demonstrate some flexibility in order to assist the process, as the type of facilitation will be different based on both evidence and context. Internal facilitators and external facilitators both may be employed (Estabrooks, Thompson, Lovely, & Hofmeyer, 2006).

For the present project, internal facilitators include the office manager and nurse practitioner staff. External facilitators include the author, members of the Kirkhof College of Nursing, and individuals from the campus LGBT center.

**Organizational Assessment**

**Framework**

The type of organizational assessment used will be the Framework for Improving Performance (Lusthaus, Adrien, Anderson, Carden, & Montalván, 2002). It postulates that organizational performance grows out of three factors. These factors are organizational capacity, organizational motivation, and external environment factors.
Each will be briefly described in general and applied to the site in question, in a brief rather than an exhaustive manner.

**Enabling Environment**

The enabling environment refers to the background context of an organization (Lusthaus et al., 2002). Three particular areas are suggested for assessment in the model. These are formal rules, institutional ethos, and organizational capabilities.

This organization operated in an urban area of the American Midwest. Many aspects of the background culture were religious and conservative; however the organization itself was not formally religious in the sense that it was associated with a particular religious tradition. At a staff meeting, several staff endorsed additional need for LGBT education, both in healthcare in general in the geographic area and also within the center. The center was in an urban area, within several blocks of a number of low-income housing buildings. Transportation amenities include validated parking, and nearby access to city bus lines.

**Organizational Capacity**

Organizational capacity refers to the overall ability of an organization to perform (Lusthaus et al., 2002). This includes all resources, systems, processes, and practices used by the organization. Eight areas are suggested for assessment. These are strategic leadership, financial management, organizational structure, organizational infrastructure, human resources, program management, process management, and inter-organizational linkages.

When assessing this organization, several areas stood out. In this organization, a particular individual would take the lead on a matter after it had been generally agreed by
the staff that it should be a target. This individual would engage with individuals outside
the organization and act as liaison. This was not left to a single individual or a particular
job title. This answers questions in the areas of strategic leadership, human resources,
program management, and process management, in addition to acting as a key informant.

**Organizational Motivation**

Organizational motivation is what drives individuals in an organization to perform
(Lusthaus et al., 2002). Four particular areas are suggested for assessment. These are
history, culture, mission, and reward system.

This was a nursing-managed primary care center that was associated with a
university. It had several very long-term employees who had worked in the center for
many years. The center did have several student employees as well. Goals of the center
included serving underserved urban populations and the university population, remaining
fiscally solvent, application of evidence to practice, and serving as a clinical site for
undergraduate and graduate nursing students.

**Organizational Performance**

Organizational performance grows out of the enabling environment,
organizational capacity, and organizational motivation (Lusthaus et al., 2002). It should
include considerations such as sustainability, financial viability, relevance, and mission
fulfillment.

When assessing this organization in terms of performance with regard to the
present project, several considerations emerged. In terms of mission fulfillment, the
center continued to deliver primary care service to clients and to provide education to
both clients and students. Academic projects, such as the one under consideration, allow
the center to continue to stay relevant and avoid stagnation. The center remained financially viable, although it should be noted there have historically been financial challenges to serving underserved urban clients.

**Organizational Assessment Considerations**

On assessment, it became clear the present project represented an opportunity to advance organizational objectives. However, several particular observations are relevant. Sustainability was a key concern. This was voiced directly by an individual at the center and echoed by a member of faculty within the university. Financial concerns are important, and as this project could reflect client satisfaction, this was directly relevant. Finally, the organization staff self-identified a need around LGBT concerns. A low-cost, sustainable, series of educational inservices were implemented as a result.

**Integration**

The Health Equity Promotion Model was selected to help guide this intervention. This model was directly designed to facilitate understanding of LGBT health promotion, while not forgetting there are significant inequities that remain in society that cannot be easily undone.

The PARiHS model was selected to assist in implementation. Gaps in knowledge can easily be identified. Robust evidence must be applied within the context of the target organization. This is best accomplished by educated and flexible facilitators both inside and outside the organization in order to increase the chances of successful implementation.

An organizational assessment using the Framework for Improving Performance was briefly examined. It is clear that organizational performance is affected by many
things. Patient satisfaction with care overall is one measure of organizational performance. Comparing satisfaction between LGBT clients and heterosexual clients following the educational offering to staff is another measure of organizational performance. This must be considered in order to reach the goals of the present project.
CHAPTER 4

METHODS

The goal for this project was to measure patient satisfaction at a university associated primary care center and to compare satisfaction scores between LGBT respondents and heterosexual respondents. In order to answer this question, the location, population, and instrument will be discussed next.

Location

The site used for this project is a university-based, nurse-managed primary health center. Unlike some university-associated clinics, it follows a primary care model rather than an urgent care model. Also unlike some university-associated clinics, it is nurse-managed. The center has four exam rooms and one interview room available. It has the capability of performing point of care tests, specifically urinalysis, urine pregnancy, rapid strep, hemoglobin A1C, and blood sugars.

The center is located in the urban center of a city of approximately 200,000 people. It is accessible by the city bus system and is about a 10 minute walk from the main city bus terminal. There are several low income apartment buildings within a few blocks of the center. Geographically, the city is a Midwestern city in a religiously and socially conservative area.

Population

Clientele

The clientele at the time of this project included low income individuals from the city. The key informant from the site shared that the clientele included a large percentage of Medicaid clients. Clients frequently had mental health concerns, addictions concerns,
and homelessness. Significant barriers for the general community were often present with the clientele, such as socio-economic barriers, transportation barriers, and educational barriers. Other clients included students, faculty, and staff from the associated university. Beyond normal primary care, clients may receive services for health compliance for health care programs, such as tuberculosis skin testing, vaccinations, and titers for certain disease antibodies. The center participates with the university insurance company, Medicaid, Medicare, and many commercial insurances. Uninsured clients may receive services on a self-pay basis. It also manages travel vaccines for students studying abroad and community members traveling abroad.

Participants were sufficiently representative of the clinic population. Most participants had been seen in the center previously (71.4%). About half were in for routine visits (52.9%), with most of the rest seen for follow up visits (30.9%). Age ranged from 20 to 67, with an average of about 31 years ($\bar{x} = 30.8, \sigma = 12.4$). Table 1 reports further demographic results for both participants and clients registered with the center.

LGBT Individuals

As noted earlier, the national estimate is that 12% of women and 6% of men have had same-sex sexual contact (Chandra et al., 2011). This is unknown for the local area and this center, but speculated to be similar to national data. The center did not collect these data as a matter of routine.

Staff

The center employed four nurse practitioners at the time of this project. Three nurse practitioners were family nurse practitioners and the fourth specialized in
<table>
<thead>
<tr>
<th>Demographic</th>
<th>Registered Clients</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>55.6 (4892)</td>
<td>64.8 (46)</td>
</tr>
<tr>
<td>30-49</td>
<td>29.0 (2551)</td>
<td>23.9 (17)</td>
</tr>
<tr>
<td>50-64</td>
<td>11.5 (1015)</td>
<td>8.5 (6)</td>
</tr>
<tr>
<td>65+</td>
<td>3.9 (345)</td>
<td>2.8 (2)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>60.3 (6282)</td>
<td>58.9 (43)</td>
</tr>
<tr>
<td>Male</td>
<td>35.4 (3690)</td>
<td>41.1 (30)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>12.7 (1328)</td>
<td>13.7 (10)</td>
</tr>
<tr>
<td>White</td>
<td>52.7 (5488)</td>
<td>69.9 (51)</td>
</tr>
<tr>
<td>Asian</td>
<td>1.5 (158)</td>
<td>6.8 (5)</td>
</tr>
<tr>
<td>Native</td>
<td>0.3 (35)</td>
<td>1.4 (1)</td>
</tr>
<tr>
<td>Other/Multiracial</td>
<td>2.6 (269)</td>
<td>5.5 (4)</td>
</tr>
<tr>
<td>Missing Data/Declined</td>
<td>30.2 (3145)</td>
<td>2.7 (2)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>4.7 (495)</td>
<td>9.6 (7)</td>
</tr>
</tbody>
</table>

*Note. The question on Hispanic status was separate; totals with race may be over 100%.*

pediatrics. There was an office manager, as well as a front desk manager. Student workers assist with greeting clients at the front desk. There were two registered nurses.
Nurse practitioner students, as well as undergraduate nursing students, may engage in rotations in the facility. Most staff were white and female.

**Procedures**

This section will discuss actions taken in the site to improve LGBT health care and the project’s methodology. These included specialized trainings and changes initiated in practice. The intervention framework will be discussed next. This will be followed by a description of the impact of theory on the instrument. Finally, the collection procedures for data will be described.

**Actions to Improve LGBT Health Care**

Following a presentation on the background of LGBT health by this writer to the staff, the staff identified a need for additional education and changes to practice. They pursued specialized training for their staff members. As a result of these trainings, there were several meetings concerning changes to practice. Several changes to practice were ultimately implemented.

**Description of trainings.** Specialized training in LGBT cultural sensitivity occurred via a series of educational inservices. Educational initiatives focused on LGBT topics have been demonstrated to be effective (Jabson, Mitchell, & Doty, 2016). These were planned to be sessions attended by all staff during lunch. Four sessions were completed. One was on LGBT culture, the second was on LGBT health care disparities and issues, the third specifically addressed transgender issues, and the fourth and final one focused on HIV. For an expanded description of these sessions, see Appendix A.

**Changes to practice.** Three practice changes were implemented. The first involved alterations to intake forms, with the goal of making these more inclusive. The
second involved setting up referral services for transgender individuals wishing to pursue hormone replacement therapy. The third change required a number of meetings, but ultimately the center began to prescribe pre-exposure prophylaxis therapy (commonly abbreviated PrEP) for HIV prevention. For an expanded description of these changes, see Appendix B.

**Evaluation of Patient Satisfaction**

**Original survey.** A brief survey that has previously been employed at the site was used to gather data (Benkert et al., 2002). The original portion of the survey was employed to gather data with minor changes. It consists of fifteen items (see Appendix C, page 1). These items are statements about the visit. The client could select a level of agreement on a 4-point scale from “strongly agree” to “strongly disagree.” These fifteen questions fit well with the contextual level of the Health Equity Promotion Model. Three visit questions ask if this was a first visit, the reason for the visit, and the type of clinician seen. The demographic questions asked if the participant was male or female, and requested a date of birth. A section for comments is also included. The instrument had high internal consistency. Factor analysis identified three subscales, for which Cronbach’s alphas were calculated. The reliability for this sample is lower than the original study but still acceptable. See Table 2 for reliability data and comparison with published data.

**Modified survey.** Additional items were developed directly from the Health Equity Promotion Model (see Appendix C, pages 2 and 3). Three items were used to examine the pathway level of the model. One item was aligned with behavioral pathways, one with social pathways, and
one with psychological pathways. Items were statements with which the participant indicates level of agreement on the same 4-point scale used with the original items.

Finally, participants were asked to self-rate their physical and mental health, from very good to very poor on a 5-point scale. This was intended as a self-assessment of the health area of the guiding model.

The demographic questions were modified from the original. Age was asked in years rather than date of birth. Rather than requesting male or female sex, gender identity and sex assigned at birth were requested. Sexual orientation, ethnicity, and smoking status were asked. Checkboxes were used for the participant to select the correct response.

Table 2

*Cronbach's Alphas for the Original Survey and for the Survey as Modified*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Original</th>
<th>Modified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Survey (17 items)</td>
<td>0.94</td>
<td>0.71</td>
</tr>
<tr>
<td>Clinic Care Scale (12 items)</td>
<td>0.95</td>
<td>0.69</td>
</tr>
<tr>
<td>Phone Contact Scale (3 items)</td>
<td>0.83</td>
<td>0.65</td>
</tr>
<tr>
<td>Return Recommend Scale (2 items)</td>
<td>0.78</td>
<td>0.72</td>
</tr>
<tr>
<td>Modified Survey (22 items)</td>
<td>-</td>
<td>0.73</td>
</tr>
<tr>
<td>Pathways (3 items)</td>
<td>-</td>
<td>0.88</td>
</tr>
<tr>
<td>Self-health Assessment (2 items)</td>
<td>-</td>
<td>0.78</td>
</tr>
<tr>
<td>New items (5 items)</td>
<td>-</td>
<td>0.84</td>
</tr>
</tbody>
</table>
Data Collection Procedures

This project had very few risks for the participants. Maintaining confidentiality and privacy were the greatest risk. The Grand Valley State University Human Research Review Committee (HRRC) received an application on this project. It was determined not to be research by the HRRC; this determination letter is available in Appendix D. Permission to attend the site in order to gather data was granted and is available in Appendix E.

Respondents were clearly told to avoid placing their name on the survey. Surveys were placed in a lock box. Surveys were removed at the end of each week and mixed, so no individual survey could be identified. Surveys were kept in a locked drawer at the Kirkhof College of Nursing Research Room. Data were stored on an encrypted flash drive for data security.

Initially, this writer attended the center daily for a total of seven days and approached all clients to participate. This introduction was scripted and is available in Appendix F. Participants were reminded not to place their names on the surveys. Surveys were to be placed directly in the lockbox. After the seven days, the lockbox was examined to determine the number of LGBT clients who had participated. Surveys were then replaced in the lockbox.

Few LGBT clients had participated after the first week. Collection procedures were then modified so that the writer would attend the center on days when known LGBT clients would be present. Nurse practitioners were asked to examine their schedules. On days when LGBT clients would be present, the writer would be directed to attend the center either in the morning or afternoon. The writer was blinded as to which clients
were LGBT. All clients were approached during these times as described above. Surveys were removed and mixed after the end of data collection to maintain anonymity of respondents.

The survey was expected to take less than ten minutes. Individuals had privacy in order to complete the survey, which they could then place directly into a lockbox. A total of 87 clients were approached and 14 declined to participate for a total of 73 surveys collected. Of these, none reported they were transgender, and 12 reported they were LGB.

**Conclusion**

This chapter discussed the procedures to measure satisfaction of LGBT clients following the center’s efforts to improve the environment for these clients. These included specialized trainings and changes in practice. The Health Equity Promotion Model was discussed, along with the impact of this model on the instrument. The sampling and survey administration procedure for participants were also discussed.
CHAPTER 5

RESULTS

This project’s focus was to measure level of overall patient satisfaction, as well as to compare patient satisfaction between LGBT participants and heterosexual participants at the primary care center. This chapter will present the results of the survey.

Data Analysis

SPSS® version 22 software was used to analyze the data. A survey with missing data was included in analysis in each calculation for which it had an entry. Descriptive statistics were calculated in order to obtain study sample characteristics. An independent samples t-test compared the age of LGBT respondents to heterosexual respondents. The nonparametric Mann-Whitney U test was utilized in order to compare responses of LGBT respondents to respondents who reported that they were heterosexual.

Missing Data

A total of 87 individuals were approached, with 73 agreeing to complete a survey. Data are missing on 18 of these surveys, but most of these had handwritten responses next to the missing data, which enabled them to be scored. Almost all of the missing data points were located in two items. These items were “Main reason for visit” and “Whom did you see today?” Clients were asked to identify the type of practitioner seen during their visit. This item was forced choice and did not include a choice for “nurse.” Because some services such as vaccinations and health compliance are performed by the registered nurses, this resulted in some clients leaving this blank or writing a comment. Several others chose “physician” or “physician assistant;” there were no such individuals
of these job classes in the center. In some cases it was possible to identify whom the client saw. Only 3 surveys had missing data outside of those two items.

**Descriptive Analysis**

The initial 15 items used a Likert-like 4-point scale. Table 3 displays responses to the satisfaction items. Most participants strongly agreed or agreed with most statements. Results are reported for all participants, because the rankings were consistently high for both groups. Table 4 displays results of the items added to assess the pathways within the theory. Table 5 displays participant’s self-health assessments.

**Sample Analysis**

Of the 73 respondents, 12 self-identified as LGB and 60 identified as heterosexual; 1 respondent left this blank. An independent t-test was employed to test for age differences between the LGB sample and the heterosexual sample. While the LGB sample was slightly younger ($\bar{x} = 28.42, \sigma = 7.9$) than the rest of the sample ($\bar{x} = 30.9, \sigma = 13.0$), the result was not significant ($t = -0.642, p < 0.523$). Demographic characteristics between LGB and heterosexual participants are compared in Table 6.

Nonparametric Mann-Whitney U tests were completed to test for differences between LGB respondents and heterosexual respondents on the first 27 items. Two items yielded statistically significant results, demonstrating stochastic dominance. On the item “I will probably use this center again,” LGB respondents were less likely to say they would “Definitely” use the center again ($p < 0.007$). With regard to smoking status, LGB respondents were more likely to be current or former smokers ($p < 0.023$). These results will be further examined.
Table 3

*Satisfaction Survey Results (n = 73)*

<table>
<thead>
<tr>
<th>Item</th>
<th>SA/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was easy to make contact with the center by phone.</td>
<td>95.9</td>
<td>2.7</td>
</tr>
<tr>
<td>The person on the center phone was very helpful.</td>
<td>95.9</td>
<td>2.7</td>
</tr>
<tr>
<td>The center staff returned phone calls as soon as possible.</td>
<td>80.8</td>
<td>19.2</td>
</tr>
<tr>
<td>The clinician answered my questions in a way I could understand.</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>The clinician listened carefully to what I had to say.</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>The clinician explained problems and treatments clearly.</td>
<td>98.6</td>
<td>1.4</td>
</tr>
<tr>
<td>The clinician was careful and thorough.</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>I am satisfied with the amount of time the clinician spent with me during my visit.</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>The clinician showed me respect and courtesy.</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>The office staff showed me respect and courtesy.</td>
<td>98.6</td>
<td>0</td>
</tr>
<tr>
<td>The clinician considered my beliefs about health and healing.</td>
<td>95.9</td>
<td>4.1</td>
</tr>
<tr>
<td>I was satisfied with the care I received at the center.</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>The handouts that I received were easy to read and follow.</td>
<td>80.8</td>
<td>17.8</td>
</tr>
<tr>
<td>The overall quality of care I received at the center was good.</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>I am treated the same as other people who get care here.</td>
<td>98.6</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note.* SA/A = Strongly Agree/Agree; NA = Not Applicable.

**Additional Findings**

**Returning to the Center**

One of the statistically significant results showed that respondents who identified as LGB were significantly different on their responses about returning to the center again. Table 7 displays these results. A similar item, “I would tell a relative or friend to use this center again,” did not yield significant results.
Table 4

*Results of Pathway Items (n = 72)*

<table>
<thead>
<tr>
<th>Item</th>
<th>SA % (n)</th>
<th>A % (n)</th>
<th>D % (n)</th>
<th>SD % (n)</th>
<th>N/A % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to get the exercise that I need.</td>
<td>42.5 (31)</td>
<td>43.8 (32)</td>
<td>9.6 (7)</td>
<td>1.4 (1)</td>
<td>1.4 (1)</td>
</tr>
<tr>
<td>I have enough social support.</td>
<td>53.4 (39)</td>
<td>34.2 (25)</td>
<td>6.8 (5)</td>
<td>2.7 (2)</td>
<td>1.4 (1)</td>
</tr>
<tr>
<td>My coping skills get me through hard times.</td>
<td>50.7 (37)</td>
<td>38.4 (28)</td>
<td>5.5 (4)</td>
<td>1.4 (1)</td>
<td>2.7 (2)</td>
</tr>
</tbody>
</table>

*Note.* SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree; NA = Not Applicable

Table 5

*Results of Health Self-Assessments (n = 72)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Very Good % (n)</th>
<th>Good % (n)</th>
<th>So-So % (n)</th>
<th>Poor % (n)</th>
<th>Very Poor % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you rate your physical health?</td>
<td>37.0 (27)</td>
<td>45.2 (33)</td>
<td>15.1 (11)</td>
<td>1.4 (1)</td>
<td>0</td>
</tr>
<tr>
<td>How would you rate your mental health?</td>
<td>39.7 (29)</td>
<td>47.9 (35)</td>
<td>5.5 (4)</td>
<td>4.1 (3)</td>
<td>1.4 (1)</td>
</tr>
</tbody>
</table>

Smoking Status

Some individuals in the overall sample reported current smoking (12.5%) and some were former smokers (15.3%), but most were never smokers (72.2%). The other significant result had to do with smoking status. The twelve participants who reported LGB status included 58.3% current and former smokers, while the heterosexual respondents included only 21.7% current and former smokers.
Table 6

Demographic Characteristics for LGB and Heterosexual Participants

<table>
<thead>
<tr>
<th>Demographic</th>
<th>LGB</th>
<th>Heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Age (n = 71)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>66.7 (8)</td>
<td>65.5 (40)</td>
</tr>
<tr>
<td>30-49</td>
<td>33.3 (4)</td>
<td>17.3 (10)</td>
</tr>
<tr>
<td>50-64</td>
<td></td>
<td>8.5 (5)</td>
</tr>
<tr>
<td>65+</td>
<td></td>
<td>2.8 (2)</td>
</tr>
<tr>
<td>Sex (n = 72)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>41.7 (5)</td>
<td>63.3 (38)</td>
</tr>
<tr>
<td>Male</td>
<td>58.3 (7)</td>
<td>36.7 (22)</td>
</tr>
<tr>
<td>Race (n = 71)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>8.3 (1)</td>
<td>15.0 (9)</td>
</tr>
<tr>
<td>White</td>
<td>75.0 (9)</td>
<td>68.3 (41)</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td>8.3 (5)</td>
</tr>
<tr>
<td>Native</td>
<td>8.3 (1)</td>
<td>-</td>
</tr>
<tr>
<td>Other/Multiracial</td>
<td>8.3 (1)</td>
<td>5.0 (3)</td>
</tr>
<tr>
<td>Missing Data/Declined</td>
<td></td>
<td>3.3 (2)</td>
</tr>
<tr>
<td>Ethnicity (n = 73)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>25.0 (3)</td>
<td>6.7 (4)</td>
</tr>
</tbody>
</table>

Note. The question on Hispanic status was separate; totals with race may be over 100%.
Table 7

Comparative Results on Returning to the Center (n = 72)

<table>
<thead>
<tr>
<th>Item Response</th>
<th>LGB</th>
<th>Heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Definitely Yes</td>
<td>50.0 (6)</td>
<td>85.0 (51)</td>
</tr>
<tr>
<td>Probably Yes</td>
<td>41.7 (5)</td>
<td>6.7 (4)</td>
</tr>
<tr>
<td>Not Sure</td>
<td>8.3 (1)</td>
<td>6.7 (4)</td>
</tr>
<tr>
<td>Probably Not</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Definitely Not</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Comment Data

The item on the survey read “Do you have any additional comments about the center or your visit here today?” As such, many people left it blank, or wrote declinations such as “N/A” or “none.” However, 28 individuals did choose to leave comments. Comments from 26 of the 28 who responded were positive; the remaining two were mixed, and both were complaints about waiting time followed by compliments about the center as a whole. One comment from an LBG individual specifically addressed patient care and patient advocacy, and was overwhelmingly positive. One comment from a heterosexual individual mentioned changes to the intake forms concerning gender identity, and was highly positive about that change. The other comments did not touch on sexual orientation or gender identity, but did comment on a number of staff by name, on particular services, on the parking situation, and on the general friendliness and helpfulness of staff. Table 8 displays further information on
specific keywords found in comments. As part of the presentation back to the center, handouts containing the full text of those comments were given. The presentation and handouts may be examined by the reader in Appendix G.

Table 8

*Comments by Keyword (n = 28)*

<table>
<thead>
<tr>
<th>Keyword</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good, great, helpful</td>
<td>12</td>
<td>41.4</td>
</tr>
<tr>
<td>Friendly, polite, nice, kind</td>
<td>10</td>
<td>34.4</td>
</tr>
<tr>
<td>Drawing of smiley face</td>
<td>4</td>
<td>13.8</td>
</tr>
<tr>
<td>Minutes [waiting for appointment]</td>
<td>2</td>
<td>6.8</td>
</tr>
</tbody>
</table>

**Conclusion**

This chapter discussed the results of the survey. This included descriptive statistics and sample analysis. Additional findings were presented, and will be discussed further. Finally, written comments were summarized.
CHAPTER 6
DISCUSSION

This project measures the level of overall patient satisfaction, as well as comparing patient satisfaction between LGBT participants and heterosexual clients. The present chapter will discuss the results of the project, including strengths and limitations. The relation to the theory, consistency with prior research, and support for the advanced practice role will also be discussed.

Discussion of Findings

Questions

The first question of the project had to do with measuring the level of overall patient satisfaction. This was accomplished; the level of patient satisfaction among participants was determined to be high. Results from the survey were, as demonstrated in Table 3, highly positive. Given that 71.4% of the respondents reported having been to the center for care previously, this makes sense; anyone who disliked the experience would be less likely to return. Results on the items asking about likelihood to recommend the center and plans to use the center again were also highly positive, and this is consistent with high patient satisfaction as well.

The second question intended to compare heterosexual and LGBT subgroups. No differences were found between groups in terms of clinical care or phone contact with the center. The comparison yielded two significant results, one about returning to the center and one about smoking status. Additionally, comments were almost entirely positive, and two comments addressed LGBT topics specifically. These comments supported
changes made in the center, specifically changing intake forms to be more gender inclusive and the implementation of PrEP therapy.

**Returning to the Center**

One of the statistically significant results showed that LGB individuals differed significantly in whether or not they planned to use the center again. It may be that LGB respondents were less welcome or felt less supported; certainly the literature has demonstrated this to be the case in the country overall. Alternatively, they may not anticipate illness in the future or may be unsure where they will be when they become ill. It is unclear from the data collected why LGB respondents would differ from the rest of the sample in this way. In any case, the sample size and the survey methodology limit any ability to explore this further.

Conversely, despite the statistically significant result, given the small sample size it may be that this result does not demonstrate clinical significance. Reference to two other items may be useful. Neither item resulted in a significantly different response between the groups. The other item designed to measure likelihood to return was “I would tell a relative or friend to use this center.” The other item was “I am treated the same as other people who get care here.” If LGB respondents felt less welcome or less supported, they did not demonstrate it on these two related items.

**Smoking Status**

The second significant finding had to do with smoking status. The twelve LGB respondents included 58.3% current and former smokers, while the heterosexual respondents included only 21.7% current and former smokers. Findings here were
consistent with the literature, which does report higher smoking rates in the LGBT community.

Findings and the Health Equity Promotion Model

Brief Description

As discussed in more depth earlier, this model is a framework intended to assist LGBT individuals to maximize their mental and physical health (Fredriksen-Goldsen et al., 2014). The model considers both protective and adverse circumstances. It consists of three parts. Multi level context is upstream of both pathways and health, and affects both. Health is downstream of both context and pathways, and is affected by both. Findings will be related back to each of these.

Multi Level Context

The multi level context is itself composed of two subsections, structural and individual. Structural includes social stigma, social exclusion, and institutionalized heterosexism; these can lead to reduced access to care. The changes to practice and training sessions implemented by center professionals represent structural changes. The individual level includes discrimination, victimization, and abuse. This can lead to increased rates of depression and poorer general health. Context was indirectly measured via self-ratings of health.

Health-Promoting and Adverse Pathways

There are four types of pathways that mediate the effects of context on health. These are classified as behavioral, social, psychological, and biological. Behavioral pathways are well known in healthcare, as they are also called modifiable risk factors. Pathways may be protective or adverse; for example smoking cessation would be
protective while smoking itself would be adverse. Pathways were represented by four items, representing the first three types of pathways. Psychological pathways were represented by an item concerning coping skills. Social pathways were represented by an item asking about social support. Behavioral pathways were represented by an item about exercise, and an additional item about smoking status. Of these items, only smoking status was significant, and it was discussed above. Findings on these four items were not inconsistent with the literature.

**Health**

In the survey, health was operationally represented by two items, which were rated on a 5-point scale self-assessing physical health and mental health. LGB respondents did not differ from heterosexual respondents on either item. However, both the LGB sample and the overall sample were quite young, and perception of physical health is certainly mediated by age.

**Strengths**

**Satisfaction Survey**

The satisfaction data itself was useful to the site. Added to satisfaction data gathered a number of years ago, the center will be able to trend data on items included in both surveys. The survey was updated by the investigator with simple questions about self-assessment of physical health, mental health, exercise, social support, and coping skills. Going forward, such data has the potential to be useful under several theories, particularly self-efficacy and health promotion.

The survey was also updated and piloted through this work. The center has been considering gathering satisfaction data yearly or biannually, possibly through the online
patient portal. In addition to the updates to the original survey mentioned above, several recommendations can be made now that the survey has been used with a newer set of clients.

**Recommended Changes to Survey**

As a result of this project, four specific recommendations were suggested. One of the nurse practitioners expressed curiosity about how someone would score sexual orientation if the participant considered him or herself to be pansexual. An addition to the sexual orientation item, of pansexual would solve this.

Second, an additional item about acceptable waiting time to see the clinician might be considered. Both mixed comments directly mentioned waiting time. It could easily use the same 4-point scale as the first 18 items.

As discussed above, respondents were somewhat confused about how to categorize certain types of visits. Therefore, the third recommendation is to add more types of visits to this item. Additional main types of visits covering skin and blood tests as well as vaccinations would be useful. The main reason for visit “Prenatal Care” could be removed, as this was not a service offered at the time of data collection. However, this should be retained if there were plans to offer such care.

Finally, respondents were confused about the type of provider they had seen. In cases of vaccination and health compliance, the respondent would not have seen the nurse practitioner face to face but would have seen the registered nurse. Therefore it is understandable that respondents were not sure how to answer items about whom they saw. The “Whom did you see today?” question included nurse practitioners/midwives, physicians, student nurse practitioners, social workers, and physician assistants.
However, the center only had nurse practitioners and student nurse practitioners during data collection. Unless there were plans to utilize physicians, social workers, or physician assistants, the center could have fewer categories. Nurse practitioner, student nurse practitioner, registered nurse, and nursing student could cover this well. Changes should reflect future plans in terms of provider mix. Additionally, this may also represent an opportunity to educate clients.

**Limitations**

Limitations of this project include a relatively low sample size and the necessary use of lower-powered nonparametric statistics. It was possible that more statistically significant results might have been noted with a much larger sample. However, Likert-type survey data must be treated nonparametrically. An additional limitation was the lack of any transgender respondents. Also, there was no comparable satisfaction data collected prior to implementation of LGBT-friendly changes at the center, either recently or remotely.

Taken together, it was not possible to know if the null hypotheses were retained due to lack of statistical power or the lack of factual difference between the two groups. Another possibility is that interventions improving LGBT climate at the center were successful in their aim. However, given this as baseline data, the center could now track changes going forward.

**Recommendations**

Based on this work, some recommendations can be made to the Family Health Center. It is recommended that the Center continue to gather sexual orientation and gender identity data as a regular demographic. Periodic review of publications and
continuing education from the Gay and Lesbian Medical Association as well as the Fenway Institute will enable the Center to remain fully up to date on advances and changes to care recommendations for LGBT individuals. Additionally, outreach projects with local organizations that seek to promote inclusion, reduce discrimination, and maintain the health of the LGBT population may be helpful.

There are also some recommendations for the Kirkhof College of Nursing. These would include efforts to integrate LGBT education across the graduate and undergraduate curricula. For graduate students, this could include attention to taking a careful sexual history, as well as mention of hormone replacement therapy and pre-exposure prophylaxis. For both graduate and undergraduate students, this could include inclusive language and education on health care disparities.

**Support for the Advanced Practice Role**

**Expert Clinician**

Chism (2016) discussed the role of the Doctor of Nursing Practice (DNP) graduate as expert clinician. This includes evaluation, translation, and implementation of evidence-based practice, use of informatics, interprofessional collaboration, and precepting at the highest levels. This would include evaluation of practice outcomes, improvement of patient care, and acting as a consultant to interprofessional teams. This role is intimately involved with the Essentials of Doctoral Education (American Association of Colleges of Nursing [AACN], 2006). Essentials reflected in this role include the following: Essential IV, Information Systems; Essential VI, Interprofessional Collaboration; and Essential VIII, Advanced Nursing Practice.
Many of these concepts were integral to bringing this project to a successful conclusion. Identification of this topic as one deserving of attention required evaluation and knowledge of evidence-based practice. Without collaboration with other professionals, capturing these data would not have been possible. Finally, in providing much needed updates to the previously used scale, testing it, and providing feedback to the center required acting as a consultant.

**Healthcare Policy and Advocacy**

Chism (2016) discussed the role of the DNP graduate as involved in healthcare policy and advocacy. This includes education, knowledge, practical experience, leadership skills, and implementation. It is also important to act as advocate for healthcare policy that addresses social justice and equity in healthcare at all levels. This role is also intimately involved with the Essentials of Doctoral Education (AACN, 2006). Essentials reflected in this role include the following: Essential V, Health Care Policy; and Essential VII, Clinical Prevention and Population Health.

This goal was also demonstrated in this project. Advocacy for a specific vulnerable population that has faced much discrimination and vitriol directly addresses social justice and equity in healthcare. This could not have been accomplished without education, knowledge, and practical experience.

**Educator**

Chism (2016) discussed the role of the DNP graduate as educator. This includes understanding scientific underpinnings of practice, analytic methods for practice, and information systems. While not recognized as fully as some other roles, extensive advanced competencies, advanced skills, and specialized knowledge can enable the DNP
to function as the educator. This role is also intimately involved with the Essentials of Doctoral Education (AACN, 2006). Essentials reflected in this role include the following: Essential I, Scientific Underpinnings for Practice; and Essential VI, Interprofessional Collaboration.

The role as educator was what made this project originally move forward. The writer presented to the center on the background of LGBT health. The decision was made to move forward. First, this comprised changes and education performed by other committed individuals, both in the center and in the Kirkhof College of Nursing. A second step was to start gathering patient satisfaction data.

**Ethical Consultant**

Chism (2016) discussed the role of the DNP graduate as ethical consultant. It is important for the DNP graduate to develop ethical understanding as the graduate will encounter ethical scenarios in practice. This role is also intimately involved with the Essentials of Doctoral Education (AACN, 2006). Essentials reflected in this role include the following: Essential II, Organizational and Systems Leadership; Essential V, Health Care Policy; and Essential VII, Clinical Prevention and Population Health.

The most prominent ethical principle in this project was clearly social justice, as the project was a small part of improving LGBT health. However, other principles were certainly present. Beneficence and nonmaleficence were assured via compliance with HRRC requirements. Autonomy was ensured as respondents had the right of refusal.

**Information Specialist**

Chism (2016) discussed the role of the DNP graduate as information specialist. Nursing informatics is specific to nursing as it provides nursing perspective, nursing
values/beliefs, and addresses phenomena of interest to nursing. This role is also intimately involved with the Essentials of Doctoral Education (AACN, 2006). Essentials reflected in this role include the following: Essential II, Organizational and Systems Leadership; Essential III, Clinical Scholarship and Analytic Methods; Essential IV, Information Systems; and Essential V, Health Care Policy.

In some ways this role was less emphasized than others. For example, the survey itself was on paper. However, in terms of information itself experience was available. Data analysis was completed with SPSS by the writer. Additionally, much experience was gained that could be useful in a role such as project manager, product developer, and outcomes manager.

**Conclusion**

Clients making use of the center reported they were highly satisfied with their care. Sexual minority individuals were no less satisfied with care at the center than heterosexual clients, although they did report that they were less likely to return. Sexual minority individuals did not appear to differ from heterosexual individuals on the items that theory helped identify as useful. The LGBT education and changes to practice likely supported sexual minority satisfaction with the care provided at the center. However, the small sample size and lack of data prior to the LGBT-friendly changes limit the conclusions that can be drawn from these data.

Finally, the writer has learned much in this effort. Certainly, this is easily classifiable and categorizable under the aegis of Lisa Chism and under the Essentials, as addressed above. The most surprising knowledge is that even apparently simple things are far more complex than they may appear at first glance. Often, as a staff nurse, it
seemed “easy” to just improve things. The reality is always more complex and interdependent than even a second glance can uncover, and only through painstaking evaluation of existing literature, evidence-based practice, and interprofessional collaboration can we go forward to improve health care.
APPENDICES
APPENDIX A

Description of Trainings
Description of Trainings

Specialized training in LGBT cultural sensitivity occurred via a series of educational inservices. The principal presenter has given permission for inclusion of this information, which can be found in Appendix H. These were planned to be sessions attended by all staff during lunch.

One educational session provided background education on culture. The session was led by representatives from the Kirkhof College of Nursing and the campus LGBT center. The view of sex known as sex positive, an approach that avoids castigation and views mutually consensual activities as healthy, was discussed. The session gave tips on the use of inclusive language and how to avoid making assumptions with language. Vernacular terminology and currently preferred professional terminology were discussed. A question and answer session was included at the end; the key informant reported there were many questions.

A second educational session focused on health care disparities and health issues. This included a discussion of how to reduce those disparities and address those issues. This session was led by a representative from the Kirkhof College of Nursing. Vernacular and professional terminology were discussed. A question and answer session was included.

The third educational session focused particularly on transgender issues. This session was led by a member of the Kirkhof College of Nursing and an outside neuropsychologist. Again, tips on inclusive and acceptable language and the clinical approach were important. Vernacular terminology and currently preferred professional
terminology were again discussed. The question and answer section was again heavily utilized, particularly with questions around use of language.

The final session focused particularly on HIV. It was led by another outside expert from a local HIV prevention organization. Again, tips on inclusive language and the approach to the client with HIV were discussed. The topic of pre-exposure prophylaxis was also discussed. As there was sufficient material to discuss with the staff, the outside expert later returned for a second question and answer session.
APPENDIX B

Changes to Practice
Changes to Practice

The first practice change to be implemented made forms more inclusive. Forms no longer presumed gender or sexual orientation. For example, the term ‘significant other’ is more inclusive than the term ‘husband’ or ‘wife.’ (During the language and sensitivity session, staff were taught to be inclusive with language while talking with clients as well.) This change was implemented prior to legalization of same-sex marriage in the state of Michigan, when use of the term ‘marriage’ would largely not have applied to gay and lesbian individuals, and might not apply to bisexual or transgender individuals either.

Another change had to do with appropriate referral services for transgender clients. Some transgender individuals are interested in pursuing gender transition. This may include hormone replacement therapy and may proceed to surgical approaches. The center was able to identify an endocrinologist to whom they could refer clients who were interested in hormone replacement therapy.

A third change involved clearance for providers to begin prescribing pre-exposure prophylaxis for HIV. This treatment was developed from post-exposure prophylaxis, which was generally employed if a healthcare worker had an exposure to HIV positive blood or body fluids, generally for a few weeks. The PrEP treatment involves an at risk and HIV negative person taking anti-retroviral medication on a consistent basis so that if there is an exposure the person does not seroconvert. After several meetings, including one with an infectious disease specialist, the center began to prescribe and manage PrEP for clients. The key informant on the site noted significant challenges around insurance coverage for PrEP, as not all insurances grant coverage for this, and it is expensive.
APPENDIX C

Satisfaction Survey
Satisfaction Survey

The Center would like to know how well we served you. Please tell us how much you agree or disagree with these statements and check only one box for each statement.

NOTE: The clinician is the person who saw you at the center today (the nurse practitioner, the physician, the student nurse practitioner, the social worker, dentist or dental hygienist.)

<table>
<thead>
<tr>
<th>(Mark one box in each line.)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Doesn’t Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was easy to make contact with the center by phone.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The person on the center phone was very helpful.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The center staff returned phone calls as soon as possible.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The clinician answered my questions in a way I could understand.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The clinician listened carefully to what I had to say.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The clinician explained problems and treatments clearly.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The clinician was careful and thorough.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I am satisfied with the amount of time the clinician spent with me during my visit.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The clinician showed me respect and courtesy.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The office staff showed me respect and courtesy.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The clinician considered my beliefs about health and healing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I was satisfied with the care I received at the center.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The handouts that I received were easy to read and follow.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The overall quality of care I received at the center was good.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I am treated the same as other people who get care here.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please turn to page 2!
(Mark one box in each line.)

<table>
<thead>
<tr>
<th>(Mark one box in each line.)</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Doesn’t Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to get the exercise that I need.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have enough social support.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My coping skills get me through hard times.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Mark one box in each line.)

<table>
<thead>
<tr>
<th>(Mark one box in each line.)</th>
<th>Very Good</th>
<th>Good</th>
<th>So-so</th>
<th>Poor</th>
<th>Very Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you rate your physical health?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you rate your mental health?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Mark one box in each line.)

<table>
<thead>
<tr>
<th>(Mark one box in each line.)</th>
<th>Definitely Yes</th>
<th>Probably Yes</th>
<th>Not Sure</th>
<th>Probably Not</th>
<th>Definitely Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would tell a relative or friend to use this center.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will probably use this center again.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was this your first visit to this clinic? Yes □ No □

Main reason for visit: (Please check only one response.)

<table>
<thead>
<tr>
<th>Routine Checkup</th>
<th>Illness or Injury</th>
<th>Follow-up Visit</th>
<th>Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner or Midwife</td>
<td>Physician</td>
<td>Student Nurse Practitioner</td>
<td>Social Worker</td>
</tr>
</tbody>
</table>

What is your age? __________

<table>
<thead>
<tr>
<th>Circle one:</th>
<th>What is your smoking status?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Smoker</td>
<td>Former Smoker</td>
</tr>
</tbody>
</table>

Please turn to page 3!
Do you consider yourself to be Hispanic or Latin? Yes □ No □

<table>
<thead>
<tr>
<th>Circle one:</th>
<th>Which of these best describe you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African-American</td>
<td>White/Caucasian</td>
</tr>
<tr>
<td>Native/American Indian</td>
<td>Multiracial</td>
</tr>
</tbody>
</table>

Please tell us a little bit more about yourself:

<table>
<thead>
<tr>
<th>Circle one:</th>
<th>What is your gender identity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>FTM/Transgender</td>
<td>MTF/Transgender</td>
</tr>
<tr>
<td>Other:</td>
<td>Decline to answer, please say why:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Circle one:</th>
<th>What sex were you assigned at birth, on your birth certificate?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Decline to answer, please say why:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Circle one:</th>
<th>With which of these do you identify?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesbian/gay/homosexual</td>
<td>Straight/heterosexual</td>
</tr>
<tr>
<td>Don’t know</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Please turn to page 4!
Do you have any additional comments about the center or your visit here today?
APPENDIX D

HRRC Determination Letter
DATE: June 20, 2010

TO: Christopher Bouma
FROM: Grand Valley State University Human Research Review Committee
STUDY TITLE: [898899-1] LGBT Client Satisfaction At A University-Associated Primary Care Center
REFERENCE #
SUBMISSION TYPE: New Project
ACTION: NOT RESEARCH
EFFECTIVE DATE: June 20, 2010
REVIEW TYPE: Administrative Review

Thank you for your submission of materials for your planned research study. It has been determined that this project:

DOES NOT meet the definition of covered human subjects research* according to current federal regulations. The project, therefore, DOES NOT require further review and approval by the HRRC.

However, please not the following advisory comments:

1. The PI states that he will approach potential subjects and ask if they are willing to participate. He should be encouraged to make sure that he does not approach anyone who he knows, especially anyone who he knows to be LGBTQ.
2. The PI also indicates that he will exclude participants under 18 but would not know their age until they complete the survey. He should be encouraged to use age as an exclusion criteria and include it in his script. These comments can be made as advisory since this is not-research.

If you have any questions, please contact the Research Protections Program at (816) 331-3197 or rpp@gvsu.edu. The office observes all university holidays, and does not process applications during exam week or between academic terms. Please include your study title and reference number in all correspondence with our office.

*Research is a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge (45 CFR 46.102 (d)).

Human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains: data through intervention or interaction with the individual, or identifiable private information (45 CFR 46.102 (f)).

Scholarly activities that are not covered under the Code of Federal Regulations should not be described or referred to as research in materials to participants, sponsors or in dissemination of findings.
APPENDIX E

Data Collection Permission Letter
6/14/2016

To whom it may concern,

I, S. Michael Burrill, as manager of the Family Health Center, grant permission to DNP student Christopher Bouma to collect survey data on patient satisfaction in the Center. I have had a chance to examine the survey and info sheet.

Christopher is to coordinate data collection activities with nurse practitioner Jamie Lamers.

Thank you,

S. Michael Burrill
Practice Manager
GVSU Family Health Center
72 Sheldon Bivc.
Grand Rapids, MI 49503
616.988.8774 exten 106
APPENDIX F

Script
Thank you for coming to the Family Health Center today! We want to make sure we are giving everyone good care, so we are asking everyone this week to participate in a brief satisfaction survey. It should take less than 10 minutes. It will be anonymous, so please make sure you do not place your name on the survey! Your care will not be affected by your responses or whether or not you participate. Your input is important! You can put it in the lock box once you are finished, and if you have more questions I will be glad to talk with you afterwards. Completion of the survey will be considered your consent to participate in this project. Thank you so much!

My name is Chris. I am a graduate student in nursing at Grand Valley. This is an evaluation of the center’s service since we provided staff with extra training on diversity issues, including lesbian, gay, bisexual, and transgender issues.

If you have any problems, questions, or concerns, you can contact my advisor, Andrea Bostrom PhD.

Chris: boumac@mail.gvsu.edu
Andrea: bostroma@gvsu.edu
Human Subjects: 616-331-3197
APPENDIX G

Presentation to the Center and Comment Handout
Results of the Satisfaction Survey at the FHC

Christopher Bouma, BA, BSN, RN, DNPe

Recap: Current Practice in US Care
- Worse health outcomes.
- Reduced access.
- Provider nondisclosure.
- Lack of knowledge.
- Lack of cultural competence.
- Lack of continuing education.

Survey Updates
- Three items on exercise, social support, and coping skills
- Two self-health assessments of physical health and mental health
- Smoking status
- Race and ethnicity
- Age asked in years rather than date of birth
- Sexual Orientation/Gender Identity

Methods and Participants
- 87 clients approached, 14 declined

Demographics
- 71.4% previously had been seen
- 52.9% routine appointment
- 30.9% follow-up appointment
- Age 20-67, mean 30.8 (SD 12.4)

Results
- Participants were very satisfied!!

Group Comparison
- Only 2 results significantly different
- Returning to the Center
- Smoking status

Comments

Strengths......and Limitations
- High response rate
- Added to historic data
- Survey piloted
- Survey recommendations
- Statistics
- Small LGB sample size
- No participants reported they were transgender

Survey Recommendations

- Add an item on waiting time.
- Add “pansexual” to sexual orientation.
- Main visit question: add coverage for blood draw, vaccination, TB tests.
- Whom did you see today? Update to accurately reflect labor mix.
### Comments (reproduced exactly as written by participants)

<table>
<thead>
<tr>
<th>Comment</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good experience! ☺</td>
<td>+</td>
</tr>
<tr>
<td>Staff members does not treat you as if you are a number--they offer care. This is why I return to see-[NP name]!!</td>
<td>+</td>
</tr>
<tr>
<td>[NP name] is a pure gem! She has been so helpful as I've navigated the PrEP journey. Whereas I've faced so much vitriol and judgement for choosing to PrEP myself from other physicians, [NP name] was always open, honest, and truly caring!</td>
<td>+</td>
</tr>
<tr>
<td>I noticed that the original form I submitted asked what gender I was born as, and which I identify with. I thought this was very cool! Never seen that before. Everyone was extremely nice and helpful on this visit.</td>
<td>+</td>
</tr>
<tr>
<td>Very polite staff every time I have visited!</td>
<td>+</td>
</tr>
<tr>
<td>Visit was to the point, professional and helpful. Very good experience.</td>
<td>+</td>
</tr>
<tr>
<td>Quick and great!!</td>
<td>+</td>
</tr>
<tr>
<td>Friendly staff. Quick visit.</td>
<td>+</td>
</tr>
<tr>
<td>The Family Health Center is a great resource for the GVSU community. I have gotten great care over the last 8 years here, including identifying an abnormal thyroid that became cancerous.</td>
<td>+</td>
</tr>
<tr>
<td>[RN name] has taken care of me for 5 years now. I wouldn't go anywhere else.</td>
<td>+</td>
</tr>
<tr>
<td>Impressed with the kind demeanor of all staff as a first time visitor/patient to this clinic.</td>
<td>+</td>
</tr>
<tr>
<td>Very friendly staff!</td>
<td>+</td>
</tr>
<tr>
<td>☻</td>
<td>+</td>
</tr>
<tr>
<td>A most helpful visit &amp; place</td>
<td>+</td>
</tr>
<tr>
<td>very satisfied</td>
<td>+</td>
</tr>
<tr>
<td>Nice environment and the parking was easy and free. Workers at the desk are always smiley and helpful.</td>
<td>+</td>
</tr>
<tr>
<td>Everybody is very friendly!</td>
<td>+</td>
</tr>
<tr>
<td>I trust my NP very much. I feel the staff at the Health Center respect me as a person no matter what my status is.</td>
<td>+</td>
</tr>
<tr>
<td>I was here to see [NP name] for medication management due to some issues with comfortability with prior primary care provider. [NP name] is fantastic at what she does and a complex model for those entering the profession.</td>
<td>+</td>
</tr>
<tr>
<td>I am terrified of needles &amp; [RN name] did a fantastic job of drawing my blood. Thank you</td>
<td>+</td>
</tr>
<tr>
<td>Comment</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>They are always very friendly &amp; accommodating, especially w/ my fear of needles</td>
<td>+</td>
</tr>
<tr>
<td>I really like it here, my Doctor is awesome [NP name] ✌️</td>
<td>+</td>
</tr>
<tr>
<td>Everyone was very helpful and friendly. I will recommend to my friends.</td>
<td>+</td>
</tr>
<tr>
<td>Everyone was very helpful and friendly. I will recommend to my friends.</td>
<td>+</td>
</tr>
<tr>
<td>Everytime I come to the clinic everyone is always cheerful and respectful. They always make me feel comfortable. I don't feel ashamed to come in no matter what my appointment may be for. An overall awesome clinic.</td>
<td>+</td>
</tr>
<tr>
<td>I am very pleased with my doctor. I would recommend this office to others. I already referred a friend. Everyone is very nice and helpful ✌️</td>
<td>+</td>
</tr>
<tr>
<td>I have been coming to the center for student health compliance activities and have really appreciated the help and services I have received. Everyone I have been in contact with has been very helpful.</td>
<td>+</td>
</tr>
<tr>
<td>My initial wait was a bit long (25 minutes) but the time that the N.P. spent with me was far better than the level of care I have received at other places. I am v. happy w/ [NP name] and her D.N.P. student [name]. They were thorough, professional, and exceeded my expectations.</td>
<td>+/-</td>
</tr>
<tr>
<td>I may understand GVSU Family Health Service may be understaffed, but I would like my appointments to be seen within 15 minutes of assigned appointment time. Otherwise, keep up the good work ✌️</td>
<td>+/-</td>
</tr>
</tbody>
</table>
APPENDIX H

Training Description Permission Letter
10/21/16

To whom it may concern,

I, Dr. Grace Huizinga, grant permission to Christopher Bouma to include an appendix in his dissertation describing the training I was involved with the site.

For up to date information on the current status of these educational and outreach initiatives, the interested reader is invited to contact Dr. Huizinga.

Thank you,

Grace Huizinga, EdD, RN

Grace Huizinga, EdD, RN
Grand Valley State University
Kirkhof College of Nursing
huizinga@gvsu.edu
LIST OF REFERENCES
References


Lim, F., Johnson, M., & Eliason, M. (2015). A national survey of faculty knowledge, experience, and readiness for teaching lesbian, gay, bisexual, and transgender health in baccalaureate nursing programs. *Nursing Education Perspectives, 36*, 144-152. doi: 10.5480/14-1355


