Evaluating experiences of healthcare providers and administrators for LGBTQ+ inclusive care and affirmative practices

by

Tiasia Saunders

B.S., Austin Peay State University, 2019

A THESIS

submitted in partial fulfillment of the requirements for the degree

MASTER OF PUBLIC HEALTH

Department of Food, Nutrition, Dietetics, and Health
College of Health and Human Sciences

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2022

Approved by:

Co-Major Professor
Dr. Ellyn Mulcahy

Approved by:

Co-Major Professor
Dr. Sandy Procter

Copyright

© Tiasia Saunders 2022.

Abstract

Background: Affirmative care has been recognized as a best-practice form of service for the LGBTQ+ population. However, little is known about what health care providers and administrators are doing to transform towards affirmative and inclusive care practices. The purpose of this study was to: (1) measure the experiences of providers and administrators on their affirming and inclusive practices or those who are in the process and (2) provide recommendations for sustainable affirming and inclusive care practices. This study sought to develop a new instrument to measure the experiences of health care providers and administrators, including awareness, barriers, knowledge, and resources of the LGBTQ+ community.

Methods: A mixed-methods approach was used to obtain qualitative and quantitative data. An online survey was sent via email and electronic flyer to health care providers and administrators to evaluate experiences of becoming more affirming and inclusive by transforming their practices. Essential components from the literature that enable the incorporation of LGBTQ+ inclusive care practices were assessed.

Results: Health care providers and administrators (N = 159) from across 11 different states answered the online survey. The survey instrument achieved acceptable internal validity (Cronbach's alpha = 0.7). Organizational change in health care is challenging but achievable. With support, incremental and sustainable changes are possible and would benefit the patient population in receiving optimal care.

Conclusions: Essential components from the literature were detailed. Notably, among the health care providers and administrators responding, there were limited barriers to transforming their environment. Future implications for research show that openness, vulnerability, curiosity, and other personality traits should be considered along with education, physical environment,

and training. This research provides a structure that hospitals and other health care and public health organizations can use to better align their facilities with inclusive and affirmative health care practices.

Keywords: LGBTQ+, affirmative care, inclusive practices, affirmative and inclusive care practices, health care environment

Table of Contents

List of Figures

List of Tables

Acknowledgements

I would like to give a huge thanks to my preceptor, Hope Krebill for her time, support, and guidance throughout this research as well as my principal investigator (PI) Dr. Susan Rensing who has been instrumental in the IRB and data analysis process. I would like to thank my co-major professors, Dr. Sandy Procter and Dr. Ellyn Mulcahy for their support, encouragement, and guidance throughout my entire graduate studies. I would also like to extend my thanks to my committee member, Dr. Tandalayo Kidd and the MPH Program assistant Barta Stevenson.

A special thanks to Dr. Tori Gleason, Dawna Raehpour, Judi Brown, and the Wichita LGBT+ Health Coalition for your support and assistance throughout this research. A huge thanks to the health care practitioners and administrators who were willing to complete the survey.

To my husband, Givanni Saunders, and my parents, Zalando Barnes and Travis Creech, thank you for your support and encouragement. I am eternally grateful for your love and support.

Dedication

I would like to dedicate this to my younger sisters Kaia Creech and Damani Bookert who are proud members of the LGBTQ+ community as well as any other members of this community. Everyone deserves the right to healthcare and deserves to feel safe and welcome in a healthcare setting no matter their identity. Thank you to all of the wonderful healthcare providers and administrators who work hard every day to make sure their patients are seen and heard.

Chapter 1 - Introduction

Affirmative care has been recognized as a best-practice form of service for the LGBTQ+ population (Mendoza et al., 2020). Affirmative care is defined as an approach to health care delivery in which organizations, programs, and providers recognize, validate, and support the identity stated or expressed by the individuals served (Mendoza et al., 2020). It is essential to understand the LGBTQ+ population's unique needs to provide personalized health care and inclusive healthcare work environments, which help to foster more inclusive care for the LGBTQ+ population. Affirmative care requires the practitioner to actively honor and celebrate identity while at the same time validating the oppression felt by individuals seeking services (Mendoza et al., 2020). Affirming care may also be enhanced by having a receptive and inviting environment, such as including art that reflects cultural aesthetics and acts as a mirror, so patients feel respected and valued (Mendoza et al., 2020). Affirming care may include revised forms to ensure all sexual orientations and gender identities are represented. Affirmative care should be instituted across cultures, systems, and settings in which health and behavioral health are offered.

The movement toward affirmative practice began in the late 1970s and early 1980s; it was founded on the assumption that sexuality and gender identities different from heterosexual and cisgender experience were normal and, additionally, that acknowledging and affirming identity and experience was a critical component of helping clients integrate their identity with the rest of their lived experience (Mendoza et al., 2020). Current literature has shown that there has been a global emergence of LGBTQ+ inclusive health care programs in cities and densely populated regions (Menkin et al., 2020). The framework (Figure 1-1) presented in the study by (Menkin et al., 2020) emphasizes essential components for high-quality inclusive LGBTQ+ care,

including organizational buy-in, customer service and engagement, physical environment, forms and data collection, staff training, and health system policies (Menkin et al., 2020).

Figure 1-1 Essential Components for High-Quality Inclusive LGBTQ+ Care (Menkin et al., 2020).

Organizational buy-in emphasizes that support needs to be provided by executive leadership to spearhead a culture shift that requires participating in training and examination of personal biases (Menkin et al., 2020). Customer service and engagement prioritizes collecting and incorporating patient voices to determine how changes should be planned, how to measure them, and how to determine if any success is occurring (Menkin et al., 2020). Physical environment as emphasized by Menkin et al., 2020, is one of the measurable components that we evaluated in this research. In this context it is defined as visible changes that will enhance visible support for LGBTQ+ patients. Visible support for LGBTQ+ patients include having LGBTQ+ specific reading materials in the lobby or waiting area (Menkin et al., 2020), displaying artwork or posters on clinic walls that represent LGBTQ+ faces and images (Menkin et al., 2020),

providing educational material specifically for LGBTQ+ patients about HIV testing, STI screening, brochures on Intimate Partner Violence and similar topics, upcoming LGBTQ+ events in the community and other support services (Menkin et al., 2020). A facility electronic medical record (EMR) capability and options for customization is strongly recommended and many electronic medical records are moving towards using language and options, which are not limited to a binary sex system (Menkin et al., 2020). Key considerations for staff training include the source of training materials, the level of training each member requires and the logistics of the training (Menkin et al., 2020). It is crucial for the training information being used to be unbiased and be relevant to the community and population that the facility serves (Menkin et al., 2020). Explicit policies that affirm both patients and staff throughout the health care system will set a tone of inclusivity (Menkin et al., 2020). For example, placing a sign up in the clinic lobby that states '*Degrading racial, sexist, homophobic, transphobic, or otherwise offensive language will not be tolerated here. We practice respect for all*' is a clear way of communicating a system's premium on affirming care (Menkin et al., 2020). The authors concluded that implementing high-quality and comprehensive LGBTQ+ services in health care settings is challenging but achievable. The essential components detailed in the framework as noted by the authors illuminate some key considerations that may be useful for others wanting to undertake similar practice improvements. This framework was based on recent experiences of practitioners and was used as a guide for this research.

To be affirmative, health care providers should become familiar with best practices for managing and navigating dual relationships which occurs when provider can also act as a listener or counselor and become comfortable with working to create enhanced feelings of privacy and confidentiality for patients. With the demand for accessible and high-quality LGBTQ+ health

care provision moving at a fast pace, health care systems are identifying their roles in the delivery of these services (Menkin et al., 2020).

Health care providers and administrators play an important role in providing services that are not only physically related to the patients but also those aspects that are emotionally supportive. Social determinants of health (SDOHs) are defined by the WHO as "the conditions in which people are born, grow, live, work and age" and that are "shaped by the distribution of money, power, and resources (2017)." Pega and Veale argue for the recognition of gender identity as a SDOH (2015). Pega and Veale (2015) argue that social conditions disadvantage LGBTQ+ people through social exclusion and privilege cisgender people through social inclusion, resulting in differential health outcomes. Additionally, prejudice, stigma, transphobia, discrimination, and violence targeted at LGBTQ+ people produce differential levels of social exclusion for populations defined by gender identity, including in health care settings. So, although gender identity does not determine health, it socially stratifies the population into differential exposures to SDOHs such as transphobia. The health disparities are not inherent to LGBTQ+ individuals but stem from structural factors such as government policy and hostile health care environments, as well as community and interpersonal factors such as social discrimination and rejection by families (De Vries et al., 2020). Such structural, community and interpersonal factors can contribute to a delay in accessing gender-affirming care (De Vires et al., 2020). A study conducted by Seelman and colleagues (2017) found that among 417 transgender individuals, those who delayed healthcare because of fear of discrimination had worse general health in the past month than those who did not delay or delayed care ($B=-0.26$, $p<0.05$); they also had 3.08 greater odds of having current depression, 3.81 greater odds of a past year suicide attempt, and 2.93 greater odds of past year suicidal ideation ($p<0.001$). This study suggests a

significant association between delaying healthcare because of fear of discrimination and worse general and mental health among transgender adults (Seelman et al., 2017).

Purpose

The purpose of this study is to answer the following research questions:

1. Are practitioners looking to transition their practices to be more inclusive and affirming? If so, what can they do to make this transition?
2. What are the barriers to making the transition to a more LGBTQ+ inclusive and affirming practice?
3. What are the recommendations and best practices for practitioners and administrators who are looking to make more inclusive and affirming environments?

Justification

Research and experience show that leading health equity strategies for hospitals and health systems can be in any of the following positions along the continuum (American Hospital Association, 2021).

- Exploring the values and resources needed to publicly commit to embarking upon a journey toward health equity.
- Committing the resources to listen, learn, train, and implement policies and practices that establish equity as the standard practice.
- Immersing the leadership and system into accountability for implementing policies, procedures, and cultural structures that support diversity, equity, and inclusion.
- Affirming a just and equitable system culture with continuous equity self-assessments of policies and practices that remove structural barriers to equity.

- Transforming beyond the system toward supporting a sustainable and equitable ecosystem of health care within the community.

Changes in provider attitudes, knowledge, and skills are necessary, but for those gains to translate into culturally competent behaviors which involve the integration and transformation of knowledge about individuals or groups into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services. Changes in the structures and culture of health care systems and organizations need to happen (Agency for Healthcare Research and Quality, 2016). This study is intended to focus on the perspectives of health care administrators and providers, at the system or organizational level. Several best practices are available and exist such as providing visual cues that a facility is a safe place by displaying brochures and educational materials about LGBTQ+ health concerns or displaying posters from nonprofit LGBTQ+ or HIV/AIDS organizations (American Medical Association, 2021). Additionally, common best practices include customizing patient intake forms to include inclusive language, providing staff sensitivity and training, and providing access to a universal gender-inclusive restroom (Gay and Lesbian Medical Association, n.d.). Furthermore, there are common heteronormative and cisnormative assumptions made in health care settings. Heteronormativity is "the assumption that everyone is heterosexual, and that heterosexuality is superior to all other sexualities" (De Vries et al., 2020). Cisnormativity is "the assumption all people are cisgender, that those assigned male at birth always grow up to be men and those assigned female at birth always grow up to be women" (De Vries et al., 2020). Sexual and gender minority groups often experience social exclusion, stigma, discrimination, violence, as well as ignorance from health professionals (De Vries et al., 2020). These experiences are rooted in societal heteronormativity and cisnormativity that generally marginalizes non-heteronormative

sexual and gender identities (De Vries et al., 2020). Over 16.5 million Americans currently self-identify as LGBTQ+ (Human Rights Campaign, 2022), including nearly 16% of young people in Generation Z (those aged 18-24 at the time of the survey). Data from the Census Bureau's recent 2022 Household Pulse survey, found roughly 8% of respondents identified themselves as lesbian, gay, bisexual or transgender, with millions more potentially identifying as terms beyond these (Census Bureau, 2022).

In order to reduce health disparities that are seen specifically in the areas of mental health, chronic diseases, violence, and victimization; and to provide quality health care to LGBTQ+ people in the most effective way, providers and institutions must understand how LGBTQ+ people's identities, experiences, and relationships with the world around them impact their health. We have conducted this study to provide insight into what other healthcare professionals are doing to ensure healthcare settings are inclusive and affirming. Continued evaluation and recognition of the growing LGBTQ+ population are important, ensuring that health services are beneficial for all.

Additionally, many insurance nondiscrimination laws and policies protect LGBTQ people from being unfairly denied health insurance coverage or from being unfairly excluded from coverage for certain health care procedures on the basis of sexual orientation or gender identity (Movement Advancement Project, 2022). However, laws and policies vary across states and healthcare facilities (See Figure 1-2). Notably, 27 states do not have LGBTQ+ inclusive insurance protections, and one state permits insurers to refuse to cover gender-affirming care (Figure 1-2). Lack of insurance protection creates issues accessing gender-affirming care for the LGBTQ+ population. Patient navigation resources and financial insurance resources specific to the LGBTQ+ community are addressed in this study.

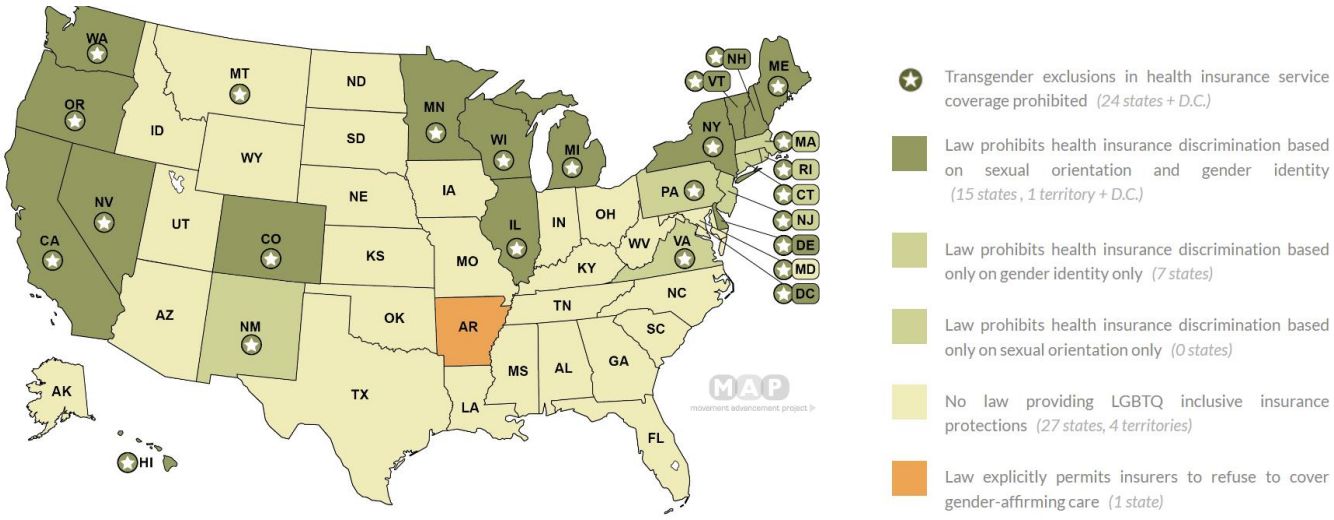


Figure 1-2. U.S. Prevalence of health insurance discrimination 2022 (from MAP)

Chapter 2 - Methods

This was a mixed methods study. An online survey composed of quantitative and qualitative variables were used to evaluate health care providers and administrators.

Participants and recruitment

An online survey was anonymously distributed through the Qualtrics survey system after approval from the Institutional Review Board (IRB). The survey participation was entirely voluntary. Participants that gave informed consent and chose to fill out the survey were enrolled in the study. A flyer was posted on social media, including in social media groups on Facebook and LinkedIn. As well as in professional networks. A link to the survey was also sent via email to a list of health care providers and administrators provided by the Wichita LGBT+ Health Coalition. A link to the survey was sent to members of the Masonic Cancer Alliance as well as Kansas Oncology social worker list serve.

Online survey

A 27-item questionnaire that addressed multiple inclusive and affirmative care topics (Figure 1-1) was created and distributed through Qualtrics. Prior to implementation, a pilot survey was distributed to 13 health care professionals 2 weeks before the initial survey was released for distribution. During this time valuable feedback was collected which helped to improve the validity of the survey. Edits were made to the survey and this revision was approved by the Committee on Research Involving Human Subjects (see Appendix A) prior to implementation.

The 15-minute online Qualtrics survey inquired about resources, skills, and knowledge base of the LGBTQ+ community as well as barriers to affirming and inclusive practices. Data on inclusive practices such as accessible training for staff, display of affirmation for LGBTQ+ patients, gender-neutral bathrooms accessible to patients, and inclusive intake paper work was also gathered. Survey distribution was initiated on January 28, 2022, and concluded on February 25, 2022.

Inclusion/Exclusion Criteria

Participants had to be either health care administrators or a practitioner. Participants that did not meet these criteria were excluded from the study.

Statistics

Data was collected via Qualtrics, and analysis were ran within the software. An SPSS file was downloaded from Qualtrics on February 28, 2022. Excel and IBM SPSS Statistics were used to clean data and run preliminary data tests. A reliability analysis to study the properties of measurement scales and the items that compose the scales was conducted. Reliability analysis of

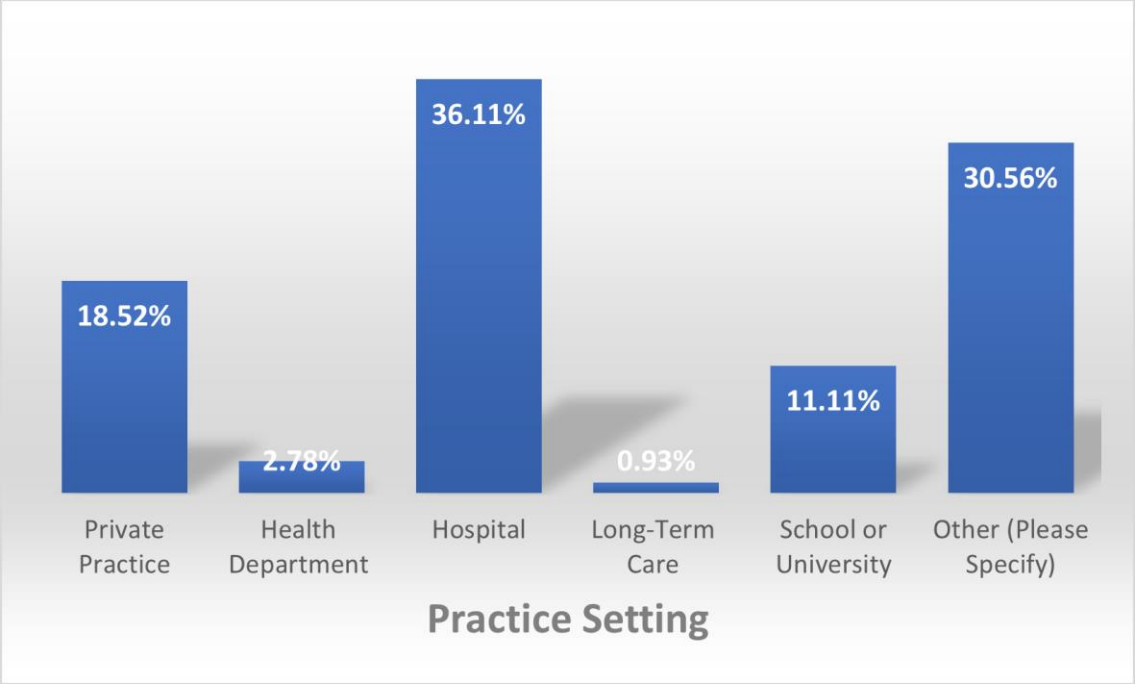
0.7 was generated, which according to Cronbach's alpha is considered high reliability for internal consistency of items within the survey.

The qualitative data analysis was performed in Excel. Open coding was used to identify themes within and across each question. A theme was considered important if it represented a meaningful pattern from the data. Using an Excel file created from all responses, and divided by each question to which it pertained, responses were reviewed, and a list of potential codes was identified. Codes were refined via comparison and discussion, and re-organized until consensus was reached. Several themes were identified at first and then narrowed down based on three attributes that summed up the responses, including a) disposition which refers to characteristics and qualities of health care providers and administrators, including responses such as attitudes & ongoing self-reflection, and b) specific inclusive practices of healthcare processes include how to set up an office and inclusive forms, c) clinical advice and training include continuing education & prescribing gender affirming hormones. Results are shown by key themes in Table 3-2.1 and exemplary quotes to characterize each theme.

Chapter 3 - Results

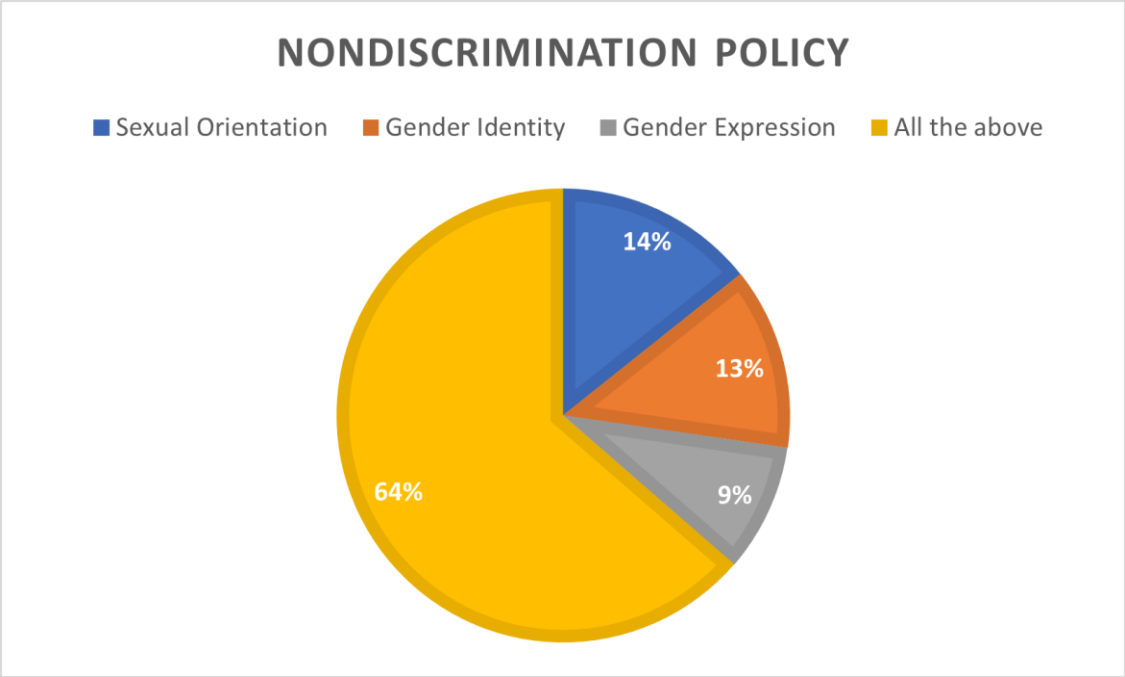
Many respondents were health care providers (47.41%, n = 64), health care administrators (12.59%, n = 17), both administrator and provider (6.67%, n = 9), while (33.33%, n = 45) were neither administrator nor provider. Representatives from (N = 11) states answered the survey with majority of respondents being from Kansas and Missouri. The breakdown of responses per area is as follows: rural defined as country (15.04%, n = 17), urban defined as city or town (50.44%, n = 57), suburban defined as outside city or town (34.51%, n = 39). The primary area of practice for most participants was oncology (36.26%, n = 33), other areas of practice consisted of family medicine (10.99%, n = 10), nutrition (6.59%, n = 6), OBGYN (4.40%, n = 4), pediatrics (3.30%, n = 3), psychiatry (3.30%, n = 3), internal medicine (2.20%, n = 2), radiology (2.20%, n = 2), and other (30.77%, n = 28). Most respondent's practice or treat patients in a hospital setting (figure 3.1). Other respondent's areas include nonprofit, community health, outpatient clinics, and telehealth. The majority self-identified as female (85.00%, n = 51), white (93.65%, n = 59), non-Hispanic (93.33%, n = 56), and heterosexual (66.67%, n = 40).

Figure 3-1. Practice setting of responding health care professionals



More than half of respondents (68.48%, n = 63) identified that their organization has an LGBTQ+ inclusive patient nondiscrimination policy. Additionally, 63.64%, n = 49 of respondents indicated that the policy includes sexual orientation, gender identity, and gender expression. Figure 3-2.

Figure 3-2. Nondiscrimination policy with inclusive language



Most respondents indicate that their facilities nondiscrimination policy is available for patients to have a copy (38.75%, n = 31) or available on their website (48.75%, n = 39), while only (5.00%, n = 4) indicated that it is displayed in the office and (7.50%, n = 6) indicated other which includes unsure, displayed in admission handbook, bylaws, and shared drive. Respondents answered that their organizations display affirmation for LGBTQ+ individuals through pamphlets, posters, educational resources (23.66%, n = 31), through gender neutral forms (26.72%, n = 35) (e.g., "Parent/Guardian 1" and "Parent/Guardian 2" instead of mother/father), through gender inclusive and gender-affirming forms (38.93%, n = 51) (i.e., asking about sex assigned at birth, but also asking about gender identity and pronouns), and (4.58%, n = 6) answered other while (6.11%, n = 8) indicated that their organization does not display affirmation for LGBTQ+ patients. Over half of respondents (73.61%, n = 53) indicate that their organization provide training specific to nondiscrimination practices. However, most indicate that the training is annually (51.79%, n = 29), while others indicate once during onboarding

(23.21%, n = 13). Other responses (25.00%, n = 14) included unsure, only if assigned by manager, or as needed. (70.91%, n = 39) indicated that the trainings include nondiscrimination practices specific to the LGBTQ+ community. Furthermore, (78.18%, n = 43) of participants indicate that the training is mandatory.

When asked if their organizations new patient intake paperwork included LGBTQ+ options when asking for gender, sexual orientation, partner, and/or emergency contact (58.21%, n = 39) of respondents answered yes while (20.90%, n = 14) responded no and the remaining (20.90%, n = 14) somewhat. When asked does your organization have gender neutral bathrooms accessible to patients (56.72%, n = 38) responded yes, while (25.37%, n = 17) responded no and (17.91%, n = 12) responded somewhat. When asked does your organization have gender neutral bathrooms accessible to staff (64.71%, n = 44) responded yes, while (23.53%, n = 16) responded no, and (11.76%, n = 8) responded somewhat.

Respondents were asked to identify barriers to implementing a more LGBTQ+ friendly practice. They were asked to consider the following statement: “I and/or my organization are/were hesitant to implement a more LGBTQ+ affirming and inclusive care practice because” (Table 3.1). The Majority of respondents either disagreed or strongly disagreed to the majority of the barrier to implementing a more LGBTQ+ friendly practice (38.3%; n = 61). Additionally, reasons for not implementing a more LGBTQ+ friendly practice vary among respondents with the most significant response for barrier being “While I have done some things to create a more inclusive environment, I also feel that there isn't much more that I can” (22.95%; n = 14).

Table 3-1 Barriers to implementing a more LGBTQ+ friendly practice

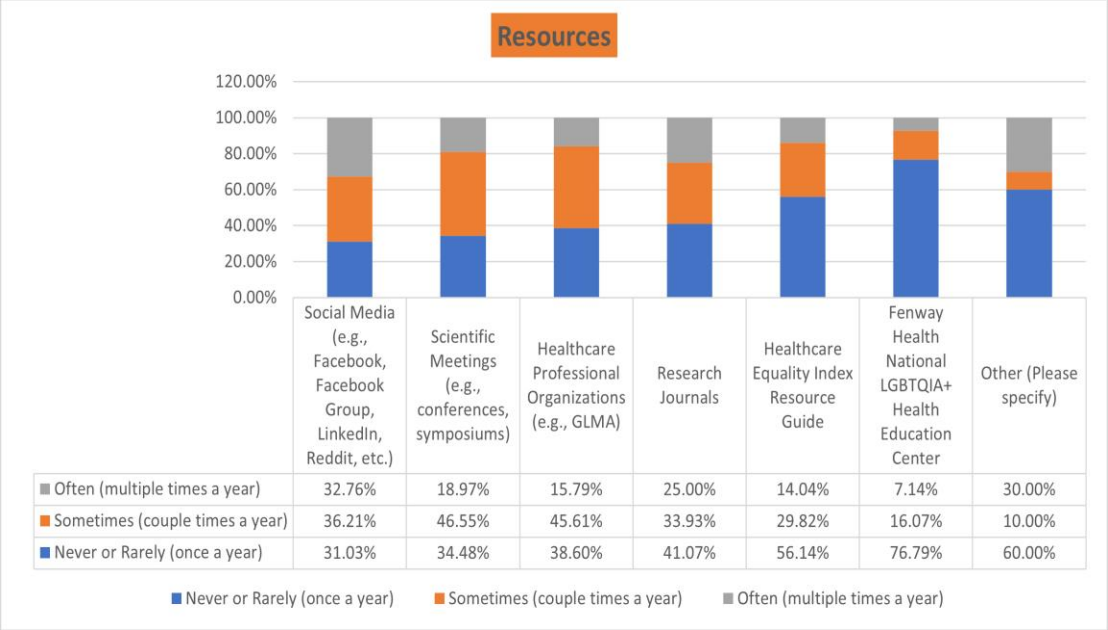
#	Question	Strongly disagree	N	Disagree		Neither agree nor disagree	N	Agree	N	Strongly agree	N	Total
1	I do not know what would be helpful for this community	23.33%	14	38.33%	23	16.67%	10	18.33%	11	3.33%	2	60
2	I share a practice with other providers and want to be considerate of my colleagues	16.67%	10	30.00%	18	15.00%	9	16.67%	10	21.67%	13	60
3	I do not have the resources, skills, or knowledge base (i.e., training, LGBTQ colleagues or team)	26.23%	16	44.26%	27	14.75%	9	14.75%	9	0.00%	0	61
4	I would be concerned that I am creating an uncomfortable environment for other patients (i.e., people not a part of the LGBTQ community)	37.70%	23	44.26%	27	11.48%	7	4.92%	3	1.64%	1	61
5	While I have done some things to create a more inclusive environment, I also feel that there isn't much more that I can do	19.67%	12	39.34%	24	16.39%	10	22.95%	14	1.64%	1	61

6	Healthcare administrators are resistant to making the changes	27.87%	17	18.03%	11	32.79 %	20	16.39 %	10	4.92%	3	61
7	Healthcare providers are resistant to making the changes	25.00%	15	31.67%	19	26.67 %	16	15.00 %	9	1.67%	1	60
8	I believe it is against the organizations policy to make changes	49.18%	30	32.79%	20	14.75 %	9	3.28%	2	0.00%	0	61
9	Other (Please specify)	25.00%	2	25.00%	2	37.50 %	3	12.50 %	1	0.00%	0	8

Respondents were asked if their organization offered any patient navigation resources and/or financial/insurance resources specific to the LGBTQ+ community. Majority respondents (49.18%, n = 30) indicated that their organization does not offer any patient financial/insurance resources specific to the LGBTQ+ community.

Respondents were asked to rate how often they use channels or resources as a form of information seeking to gain more knowledge concerning the LGBTQ+ community. (Figure 3-3) Respondents indicated they sometimes (36.21%, n = 21), or often (32.76%, n = 19) use social media (e.g., Facebook, Facebook Group, LinkedIn, Reddit, etc.) as a form of information seeking.

Figure 3-3 Channels and resources used to seek information regarding the LGBTQ+ community



	Social Media (e.g., Facebook, Facebook Group, LinkedIn, Reddit, etc.)	Scientific Meetings (e.g., conferences, symposiums)	Healthcare Professional Organizations (e.g., GLMA)	Research Journals	Healthcare Equality Index Resource Guide	Fenway Health National LGBTQIA+ Health Education Center	Other (Please specify)
Often (multiple times a year)	32.76%	18.97%	15.79%	25.00%	14.04%	7.14%	30.00%
Sometimes (couple times a year)	36.21%	46.55%	45.61%	33.93%	29.82%	16.07%	10.00%
Never or Rarely (once a year)	31.03%	34.48%	38.60%	41.07%	56.14%	76.79%	60.00%

Majority of respondents (71.19%; n = 42) indicate that they would consider their organization to be an inclusive and affirming health care practice. When asked to explain why or why not, many respondents mentioned the nondiscriminatory practices of the organization including safe zone training and changes to forms. Nearly ¾ of respondents (74.14%, n = 43) were interested in learning of additional ways to transition their environment to an inclusive and affirming practice setting.

One of the main goals of this research was to get feedback from healthcare professionals on what they are currently doing or have experience in their inclusive and affirming journey. One hundred fifty-nine respondents answered the survey, of those 25 individuals responded to the optional opened ended question section of the survey. The qualitative questions were list as follows: “Please describe procedures your organization implemented to create an LGBTQ+ affirmative care environment.” “What is one lesson that you learned on your journey of becoming a more affirmative care practice by transforming your workspace”. “How do you believe affirmative and inclusive practices can be sustained throughout the year?” “Please share

a piece of advice that you believe would be helpful for another provider or administrator looking to transition their practice into a more LGBTQ+ inclusive and affirming environment." Respondents were to ask to share any additional thoughts. Several providers mentioned that inclusive care starts with the disposition of the provider. Personal qualities such as openness, vulnerability, humility, and curiosity were often mentioned. By going through the qualitative responses, we discovered three overarching themes: a) disposition, b) specific inclusive practices of healthcare processes, c) clinical advice and training. Table 3-2.1.

Table 3-2.1. Open-ended Responses to LGBTQ+ Inclusive and Affirmative Care Practices

Disposition	*"I'm new to the organization (one month). Personally, I have experienced a more open, welcoming, and inclusive environment than in my previous workplace. I feel as though it also translates to our patients."* *"It is okay to ask questions to people who identify under different names/pronouns/race/disability or are different. Ignorance to social norms regarding someone's personal background and beliefs is not a flaw in character, it is just gap that we have not encountered, and we hope to fill with knowledge, compassion, understanding and respect. The more we know about people and their values/traits the more we can better advocate for our patients and their families."*
	"In a past practice, we became more inclusive in a variety of ways. I think part of the start was with inclusive gender-neutral bathroom signs, and then we had a provider who started prescribing gender-affirming hormones. Gradually others became interested in prescribing and in doing more trans care. We also had a Safe zone training led by a KU trainer that was excellent and helped our staff gain more information and understanding--as we started collecting SOGI data on intake paperwork soon after."

Specific inclusive practices of healthcare processes	*"Very recently altered EMR to allow for gender identity and preferred pronouns in patient demographics."* *"Asked about identity and orientation at every visit. Educate patients that are conservative or older about why it's important."* *"Including options for pronouns and gender identity and gender assigned at birth on the patient portal. Prescribing and administering hormones for gender-affirming care. Providing lab work and Free STI testing. Prescribing PrEP and others."*
Clinical advice and training	*"Staff turnover is a major barrier in training and keeping the entire team up to date on SOGI concerns/interactions."* *"OBGYN Facebook group has honestly provided some of the most important duration regarding care of trans patients that impact my daily practice; same FB group has also highlighted inherent bias and pathways for improvement I have found applicable to my own care of ALL patients and hopefully allow me to make more obvious my affirmation (Ie make more obvious my support and comfort discussing these topics when it may not have been as transparent)."*

Participants were asked if their organization displayed affirmation for LGBTQ+ patients. Only 6% (n = 8) reported their organization does not display affirmation for LGBTQ patients. The majority of participants 38% reported displaying affirmation through gender-affirming forms.

Chapter 4 - Discussion

The main objective of this research was to evaluate the extent that health care organizations have adopted an LGBTQ+ affirmative care. This study analyzed barriers to transforming practices and invited participants to share their experiences with their practice setting. Notably, we anticipated more barriers than respondents reported. Things that we thought were barriers, respondents said that those were not barriers, such as not knowing what would be helpful for the LGBTQ+ community or that health care organizations are resistant to making changes. The results provide an understanding of how organizations provide a sense of transformation to their environments and how majority of health care providers are open to continual learning to better affirm the LGBTQ+ community.

The strengths and limitations of this study are important to note. A strength of the online survey was the high response rate (N = 159) and representation from 11 states and 9 practice areas. Consistent with national trends in previously reported literature we encourage health systems to commit to workforce education, upgrade physical environments, and support health care providers and administrators to implement strategies to provide inclusive services and the development of LGBTQ+ services (Menkin et al., 2020).

Limitations of this study include the survey did not include definitions for all terminology. We saw this as a limitation because some participants may not be familiar with the terminology used in the survey. Another limitation is that we did not ask participants how they identify in public. This is an important factor that would be seen as a limitation because there is a remarkable difference in affirming practice between providers that are out as LGBTQ+ and those that are not. In some areas of health care, the providers that are out are the ones that are most affirming and are driving the push for more affirming care. A small percentage of affirming

practices are run by cisgender providers and the normative population just refers to the already openly LGBTQ+ providers to specialize in their own communities and populations. Another limitation of this survey is that the qualitative section of the questionnaire was optional and therefore did not receive as many responses as the quantitative section.

In conclusion, many health care providers and administrators are transforming and are open to transforming their environments to become more inclusive and affirming. Notably, among the health care providers and administrators responding, there were limited barriers to transforming their environment. It is important to note that the disposition and personality traits of health care providers and administrators were recurring themes presented by respondents, which were not included in the survey. This presents implications for future research because it shows that openness, vulnerability, curiosity, and other personality traits should be considered along with education, physical environment, and training. Addressing social determinants of health is important for improving health and reducing longstanding disparities in health and health care. Efforts to improve health in the United States have traditionally looked to the health care system as the key driver of health and health outcomes. However, there has been increased recognition that improving health and achieving health equity will require broader approaches that address social, economic, and environmental factors that influence health.

Chapter 5 - Recommendations

The current findings provide several implications for LGBTQ+ inclusive and affirmative practices. The findings offer a comprehensive outlook in the promotion of training so that administrators and providers can utilize the information collectively in developing and implementing strategies and interventions.

For those looking to transform, resources are available, including, The Health Equity Transformation Assessment, an electronic assessment tool, by the American Hospital Association (AHA), which provide hospitals and health systems with their current position on the health equity journey (American Hospital Association, 2021). The American Hospital Association supported the development of the Equity Roadmap, a tool designed to help members and the health care field dismantle structural barriers, advance equitable health outcomes and systems in the communities they serve and accelerate health equity (2021). The road map consists of three components – 1) the Health Equity Transformation Model, 2) the Health Equity Transformation Assessment and 3) the Health Equity Action Library (American Hospital Association, 2021). Health care organizations and those taking the health equity journey make a deliberate choice to act, dismantle structural barriers (i.e., racism, sexism, etc.) and mobilize to advance health equity (American Hospital Association, 2021). Six levers represent operational practices familiar to health care organizations when it comes to assessing performance, improving patient health outcomes and community collaboration; there are essential markers for measuring success and evaluating where improvements can be made, which included the following: 1) Equitable and Inclusive Organizational Polices, 2) Collection and Use of Data to Drive Action, 3) Diverse Representation in Leadership and Governance, 4) Community Collaboration for Solutions, 5) Systemic and Shared Accountability, and 6) Culturally Appropriate Patient Care (American Hospital Association, 2021). Hospitals and health systems can gauge where they stand or how they may improve on a continuum of progress because the continuum represents opportunities for continuous quality improvement.

One recommendation presented by respondents was training specific to the LGBTQ+ community. We suggest starting with videos, webinars, some educational materials as finding

and implementing the right training for the workforce in any given health care system is challenging. Recommended conferences and educational opportunities for providers to gain more knowledge around LGBTQ+ identities and healthcare concerns include Fenway Institute National LGBTQIA+ Health Education Center, US Professional Association for Transgender Health (USPATH), World Professional Association for Transgender Health (WPATH), The National LGBTQ Health Conference, and Health Professionals Advancing LGBTQ Equality (GLMA).

Another common recommendation presented by respondents was to update electronic medical records (EMR) to include inclusive language and options. Inquiry about a facility's electronic medical record capability and options for customization is strongly recommended.

To identify LGBTQ+ patients inside an examination room, a providers may ask, 1) 'What is the sex you were assigned at birth (male or female)?' and 2) 'What is the gender you identify as now (male, female, MTF, FTM, non-binary, etc.)?'. Similarly, to gather information regarding sexual orientation, designing a form to state 'Which word or words best describes your sexual orientation?' is a normalized way to be inclusive. Answers provided on a form or when verbally asked by a staffer may include the following: 'Common options include straight, gay, lesbian, bisexual or you may choose not to disclose or add something else' (Menkin et al., 2020).

References

Agency for Healthcare Research and Quality. *Improving Cultural Competence to Reduce Health Disparities for Priority Populations*. (2014). https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol

American Hospital Association. *The Health Equity Transformation Assessment*. (2021). Health Equity Transformation Model: Literature Overview. https://equity.aha.org/health-equity-transformation-model-literature-overview

American Medical Association. *Creating an LGBTQ-friendly Practice*. 2021. https://www.ama-assn.org/delivering-care/population-care/creating-lgbtq-friendly-practice

Begun, James W. PhD; Kahn, Linda M. MPH, CPA; Cunningham, Brooke A. PhD, MD; Malcolm, Jan K. BA; Potthoff, Sandra PhD A Measure of the Potential Impact of Hospital Community Health Activities on Population Health and Equity, *Journal of Public Health Management and Practice*: September/October 2018 - Volume 24 - Issue 5 - p 417-423 doi: 10.1097/PHH.0000000000000617

Currin-McCulloch, J., & Todic, J. (2018). LGBTQ-Inclusive hospice and palliative care: A practical guide to transforming professional practice. Journal of psychosocial oncology, 36(1), 134–136. https://doi.org/10.1080/07347332.2017.1379047

De Vries, E., Kathard, H., & Müller, A. (2020). Debate: Why should gender-affirming health care be included in health science curricula?. *BMC medical education*, *20*(1), 51. https://doi.org/10.1186/s12909-020-1963-6

Fasullo, K., McIntosh, E., Buchholz, S. W., Ruppar, T., & Ailey, S. (2021). LGBTQ Older Adults in Long-Term Care Settings: An Integrative Review to Inform Best Practices. *Clinical gerontologist*, 1–16. Advance online publication. https://doi.org/10.1080/07317115.2021.1947428

Foronda, C., MacWilliams, B., & McArthur, E. (2016). Interprofessional communication in healthcare: An integrative review. *Nurse education in practice*, 19, 36–40. https://doi.org/10.1016/j.nepr.2016.04.005

Gay & Lesbian Medical Association. *Guidelines of Care for Lesbian, Gay, Bisexual and Transgender (LGBT) Patients*. (n.d.). Accessed June 2022 https://www.glma.org/_data/n_0001/resources/live/Welcoming%20Environment.pdf

Healthcare Equality Index Resource Guide. *Human Rights Campaign Foundation*. (n.d.). https://www.thehrcfoundation.org/professional-resources/hei-resource-guide

Heredia, D., Jr, Pankey, T. L., & Gonzalez, C. A. (2021). LGBTQ-Affirmative Behavioral Health Services in Primary Care. Primary care, 48(2), 243–257. https://doi.org/10.1016/j.pop.2021.02.005

Human Rights Campaign. *President on New Gallup Poll that Reinforces the Growing Power of the LGBTQ+ Community*. (2022). https://www.hrc.org/press-releases/human-rights-campaign-president-on-new-gallup-poll-that-reinforces-the-growing-power-of-the-lgbtq-community

Jones, J. LGBT Identification in U.S. Ticks Up to 7.1%. (2022). *Gallup*. https://news.gallup.com/poll/389792/lgbt-identification-ticks-up.aspx

Maclachlan, M., Khasnabis, C., & Mannan, H. (2012). Inclusive health. *Tropical medicine & international health: TM & IH*, *17*(1), 139–141. https://doi.org/10.1111/j.1365-3156.2011.02876.x

Mendoza, N. S., Moreno, F. A., Hishaw, G. A., Gaw, A. C., Fortuna, L. R., Skubel, A., Porche, M. V., Roessel, M. H., Shore, J., & Gallegos, A. (2020). Affirmative Care Across Cultures: Broadening Application. *Focus (American Psychiatric Publishing)*, *18*(1), 31–39. https://doi.org/10.1176/appi.focus.20190030

Menkin, D., Tice, D., & Flores, D. (2020). Implementing inclusive strategies to deliver high-quality LGBTQ+ care in health care systems. *Journal of Nursing Management*, 10.1111/jonm.13142. Advance online publication. https://doi.org/10.1111/jonm.13142

Movement Advancement Project. "Equality Maps: Healthcare Laws and Policies." https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies. Accessed 06/08/2022.

Nowaskie, D. Z., & Roesler, A. C. (2022). The impact of COVID-19 on the LGBTQ+ community: Comparisons between cisgender, heterosexual people, cisgender sexual minority people, and gender minority people. *Psychiatry research*, 309, 114391. https://doi.org/10.1016/j.psychres.2022.114391

Pega, F., & Veale, J. F. (2015). The case for the World Health Organization's Commission on Social Determinants of Health to address gender identity. *American journal of public health*, *105*(3), e58–e62. https://doi.org/10.2105/AJPH.2014.302373

Seelman, K. L., Colón-Diaz, M., LeCroix, R. H., Xavier-Brier, M., & Kattari, L. (2017). Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults. Transgender health, 2(1), 17–28. https://doi.org/10.1089/trgh.2016.0024

Shamrova, D., Cummings, C., Baier, H. & Lampe, J. (2020). Wichita LGBTQ+ Health Needs Assessment: Final Report. Retrieved from: https://issuu.com/home/published/lgbt_health_needs_assessment_final_report_cc.docx

Stanford University. Haas Center for Public Service. (2019). *Principles of Ethical and Effective Service*. https://haas.stanford.edu/about/our-approach/principles-ethical-and-effective-service#:~:text=In%202002%2C%20Stanford%20University's%20Haas,organizations%20involved%20with%20public%20service

The Fenway Institute. The National LGBTQIA+ Health Education Center. (2022). https://fenwayhealth.org/the-fenway-institute/education/the-national-lgbtia-health-education-center/

United States Census Bureau. Measuring Household Experiences during the Coronavirus Pandemic. (2022). https://www.census.gov/data/experimental-data-products/household-pulse-survey.html

Utamsingh, P. D., Richman, L. S., Martin, J. L., Lattanner, M. R., & Chaikind, J. R. (2016). Heteronormativity and practitioner–patient interaction. *Health Communication*, 31(5), 566–574

World Health Organization. Social determinants of health: WHO; 2017. http://www.who.int/social_determinants/sdh_definition/en/. Accessed 27 July 2022

Wichita LGBT+ Health Coalition. *Provider Directory Application*. (2021). https://wichitalgbthealth.org/select-your-county-to-see-providers-near-you/

Appendix A - IRB Approvals

KANSAS STATE UNIVERSITY | University Research Compliance Office

TO: Susan Rensing
Gender, Women, & Sexuality

Proposal Number: IRB-10814

FROM: Rick Scheidt, Chair
Committee on Research Involving Human Subjects

DATE: 09/08/2021

RE: Proposal Entitled, "Evaluating experiences of clinicians and administrators for LGBTQ+ inclusive care & affirmative practices: A qualitative study."

The Committee on Research Involving Human Subjects / Institutional Review Board (IRB) for Kansas State University has reviewed the proposal identified above and has determined that it is EXEMPT from further IRB review. This exemption applies only to the proposal - as written – and currently on file with the IRB. Any change potentially affecting human subjects must be approved by the IRB prior to implementation and may disqualify the proposal from exemption.

Based upon information provided to the IRB, this activity is exempt under the criteria set forth in the Federal Policy for the Protection of Human Subjects, **45 CFR §104(d), category:Exempt Category 2 Subsection ii.**

Certain research is exempt from the requirements of HHS/OHRP regulations. A determination that research is exempt does not imply that investigators have no ethical responsibilities to subjects in such research; it means only that the regulatory requirements related to IRB review, informed consent, and assurance of compliance do not apply to the research.

Any unanticipated problems involving risk to subjects or to others must be reported immediately to the Chair of the Committee on Research Involving Human Subjects, the University Research Compliance Office, and if the subjects are KSU students, to the Director of the Student Health Center.

Electronically signed by Rick Scheidt on 09/08/2021 10:27 AM ET

203 Fairchild Hall, Manhattan, KS 66502 | (785) 532-3224 fax: (785) 532-3278

KANSAS STATE UNIVERSITY | University Research Compliance Office

TO: Susan Rensing
Gender, Women, & Sexuality

FROM: Rick Scheidt, Chair
Committee on Research Involving Human Subjects

DATE: 01/05/2022

RE: Proposal #IRB-10814, entitled "Evaluating experiences of clinicians and administrators for LGBTQ+ inclusive care & affirmative practices: A qualitative study."

MODIFICATION OF IRB PROTOCOL #IRB-10814, ENTITLED, "Evaluating experiences of clinicians and administrators for LGBTQ+ inclusive care & affirmative practices: A qualitative study"

EXPIRATION DATE: Exempt

The Committee on Research Involving Human Subjects (IRB) has reviewed and approved the request identified above as a modification of a previously approved protocol. **Please note that the original expiration remains the same.**

All approved IRB protocols are subject to continuing review at least annually, which may include the examination of records connected with the project. Announced in-progress reviews may also be performed during the course of this approval period by a member of the University Research Compliance Office staff. Unanticipated adverse events involving risk to subjects or to others must be reported immediately to the Chair of the IRB, and / or the URCO

It is important that your human subjects activity is consistent with submissions to funding / contract entities. It is your responsibility to initiate notification procedures to any funding / contract entity of any changes in your activity that affects the use of human subjects.

KANSAS STATE UNIVERSITY | University Research Compliance Office

TO: Susan Rensing
Gender, Women, & Sexuality

FROM: Rick Scheidt, Chair
Committee on Research Involving Human Subjects

DATE: 01/26/2022

RE: Proposal #IRB-10814, entitled "Evaluating experiences of clinicians and administrators for LGBTQ+ inclusive care & affirmative practices: A qualitative study."

MODIFICATION OF IRB PROTOCOL #IRB-10814, ENTITLED, "Evaluating experiences of clinicians and administrators for LGBTQ+ inclusive care & affirmative practices: A qualitative study"

EXPIRATION DATE: Exempt

The Committee on Research Involving Human Subjects (IRB) has reviewed and approved the request identified above as a modification of a previously approved protocol. **Please note that the original expiration remains the same.**

All approved IRB protocols are subject to continuing review at least annually, which may include the examination of records connected with the project. Announced in-progress reviews may also be performed during the course of this approval period by a member of the University Research Compliance Office staff. Unanticipated adverse events involving risk to subjects or to others must be reported immediately to the Chair of the IRB, and / or the URCO

It is important that your human subjects activity is consistent with submissions to funding / contract entities. It is your responsibility to initiate notification procedures to any funding / contract entity of any changes in your activity that affects the use of human subjects.

Appendix B - Survey

Evaluation of Affirmative Care Practices for LGBTQ+ Community

---

Start of Block: Introduction & Informed Consent

Topic: Evaluating experiences of health care providers and administrators for LGBTQ+ inclusive care & affirmative practices

Researchers:
Tiasia Saunders, CHES®
Hope Krebill, MSW, BSN, RN
Susan Rensing, Ph.D.

Thank you for supporting our research. We realize that your time is valuable, and we appreciate your participation. The purpose of this study is to measure the experiences of providers and administrators who have transformed, or are in the process of transforming, existing practices to provide more LGBTQ+ inclusive care or have started new practices with the hope of creating a more affirming practice. This is an academic survey that is being conducted as part of a final Master of Public Health Project in collaboration with the Wichita LGBT Health Coalition. Information gathered will be used in recommendations for sustainable affirmative and inclusive health care practices.

Your responses will be kept anonymous, and your participation is completely voluntary. You will not be penalized for choosing not to answer questions. Your responses will be reported in aggregate only with no identifying information shared. Please answer all questions truthfully and to the best of your ability.

This survey will take about 15 minutes or less of your time. This study is completely anonymous and your name or other personal information that could identify you will not be asked or recorded. This project has been approved by Kansas State University's Institutional Review Board (IRB #10814). **You must be at least 18 years or older to participate.**

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely

voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled.

By clicking the "I accept" button below, you are providing your implied consent to participate in this survey. You verify that you have read and understood this information, and willingly agree to participate in this study under the terms described.

- ○ I Accept (1)
- ○ I Decline (2)

Skip To: End of Survey If Topic: Evaluating experiences of clinicians and administrators for LGBTQ+ inclusive care & affirm... = I Decline

Page Break

Q1 Are you currently a health care provider and/or health care administrator?

- ○ Health care provider (e.g., physician, nurse practitioner, medical dietitian, or other health care worker who treats patients directly).
- ○ Health care administrator
- ○ Neither administrator nor provider
- ○ Both administrator and provider

Q2 Would you categorize the area in which you provide service as? *Select all that apply.*

- ○ Rural
- ○ Urban
- ○ Suburban

Q3 In what state is your current practice location.

Page Break

Q4 What is your primary area of practice?

- ○ OBGYN
- ○ Psychiatry
- ○ Nutrition
- ○ Pediatrics
- ○ Preventive Medicine
- ○ Internal Medicine
- ○ Family Medicine
- ○ Oncology
- ○ Radiology
- ○ Other (Please specify) _____

Q5 What is your current practice setting? Where do you treat patients? *Select all that apply.*

- ○ Private practice
- ○ Health department
- ○ Hospital
- ○ Long-term care
- ○ School or university
- ○ Other (please specify)

_____

Q6 Does your organization have an LGBTQ inclusive **patient** nondiscrimination policy?

- ○ Yes (1)
- ○ No (2)
- ○ Somewhat (Please specify) (3)

Q6.1 If yes, does your nondiscrimination policy include sexual orientation, gender identity, and gender expression? (select all that apply)

- ○ Sexual Orientation
- ○ Gender Identity
- ○ Gender Expression
- ○ All the above
- ○ None

Q6.2 If you answered "Yes" to the prior question, is your nondiscrimination policy: (please check all that apply):

- ○ Displayed in the office (1)
- ○ Available on your website (2)
- ○ Available for patients and employees to have a copy (3)
- ○ Other (Please specify) _____

Q7 Does your organization have a LGBTQ inclusive **employee** nondiscrimination policy?

- ○ Yes (1)

- ○ No (2)
- ○ Somewhat (Please specify) (3)

Q7.1 If yes, does your nondiscrimination policy include sexual orientation, gender identity, and gender expression? (Select all that apply)

- ○ Sexual Orientation
- ○ Gender Identity
- ○ Gender Expression
- ○ All the above
- ○ None

Q7.2 If you answered “Yes” to the prior question, is your nondiscrimination policy: (please check all that apply):

- ○ Displayed in the office (1)
- ○ Available on your website (2)
- ○ Available for patients and employees to have a copy (3)
- ○ Other (Please specify) _____

Q8 In what ways does your organization display affirmation for LGBTQ individuals? (*Check all that apply)*

- ○ Through pamphlets, posters, or educational resources (1)
- ○ Through gender neutral forms (2) (e.g., Parent/Guardian 1" and "Parent/Guardian 2" instead of mother/father.
- ○ Through gender inclusive or gender-affirming forms (3) (i.e., asking about sex assigned at birth, but also asking about gender identity and pronouns.
- ○ Do not display affirmation for LGBTQ (4)
- ○ Other (Please specify) (5)

Q9 Does your organization provide training to your **employees** specific to nondiscrimination practices?

- ○ Yes (1)
- ○ No (2)
- ○ Somewhat (Please specify) (3)

Q9.1 If yes, how often is the training?

- ○ Once during onboarding (1)
- ○ Annually (2)
- ○ Other (Please specify) (3) _____

Q9.2 If yes, does it include LGBTQ nondiscrimination training?

- ○ Yes (1)
- ○ No (2)
- ○ Somewhat (Please clarify) (3)

9.3 Is the training mandatory or optional?

- ○ Mandatory (1)
- ○ Optional (2)
- ○ Somewhat (Please clarify) (3) _____

Q10 Does your new patient paperwork/intake paperwork include LGBT options when asking for gender, sexual orientation, partner and/or emergency contact?

- Yes (1)
- No (2)
- Somewhat (Please specify) (3)

Q11 Does your organization have gender neutral bathrooms accessible to staff?

- Yes (1)
- No (2)
- Somewhat (Please specify) (3)

Q12 Does your organization have gender neutral bathrooms accessible to patients?

- Yes (1)
- No (2)
- Somewhat (Please specify) (3)

Page Break

Q13 Some organizations experience barriers when they implement changes. Please indicate below if you have experienced any of the following barriers to implementing a more LGBTQ+

friendly practice. (Please consider this statement: I and/or my organization are/were hesitant to implement a more LGBTQ+ affirming and inclusive care practice because ….)

	Strongly disagree (1)	Disagree (2)	Neither agree nor disagree (3)	Agree (4)	Strongly agree (5)
I do not know what would be helpful for this community (1)	○	○	○	○	○
I share a practice with other providers and want to be considerate of my colleagues (2)	○	○	○	○	○
I do not have the resources, skills, or knowledge base (i.e., training, LGBTQ colleagues or team) (3)	○	○	○	○	○

I would be concerned that I am creating an uncomfortable environment for other patients (i.e., people not a part of the LGBTQ community) (4)	○	○	○	○	○
While I have done some things to create a more inclusive environment, I also feel that there isn't much more that I can do (5)	○	○	○	○	○

Healthcare administrators are resistant to making the changes (6)					
Healthcare providers are resistant to making the changes (7)					
I believe it is against the organizations policy to make changes (8)					

Other (please specify) (9)

Page Break

Q14. Does your organization offer any patient navigation resources financial/insurance resources **specific** to the LGBTQ+ community? (e.g., Medicaid, Medicare)

- ○ Yes (1)
- ○ No (2)
- ○ Somewhat (please specify) (3)

Q15 In this section we will ask you about your use of the following channels/resources as a form of information seeking to gain more knowledge regarding the LGBTQ+ community.

Please rate how often you use the following channels to identify tools and best practices to provide a more inclusive experience for the LGBTQ+ population.

	Never or Rarely (once a year) (1)	Sometimes (couple times a year) (2)	Often (multiple times a year) (3)
Social Media (e.g., Facebook, Facebook Group, LinkedIn, Reddit) (1)	○	○	○
Scientific Meetings (e.g., conferences, symposiums) (2)	○	○	○
Healthcare professional organizations (e.g. GLMA) (3)	○	○	○
Healthcare Equality Index Resource Guide (4)	○	○	○
Research Journals (5)	○	○	○

Fenway Health National LGBTQIA+ Health Education Center (6)	○	○	○
Other (Please specify) _____(7)	○	○	○

Page Break

Q16 Would you consider your organization to be an inclusive and affirming health care practice? Why or why not?

- ○ Yes (1)
- ○ No (2)
- ○ Somewhat (Please specify) (3)

Q17 Are you interested in learning of additional ways to transition your environment to an inclusive and affirming practice setting?

- ○ Yes (1)
- ○ No (2)
- ○ Somewhat (Please specify) (3)

Q18
Now tell us about yourself.

What is your current age?

- ○ 18 - 34 (1)
- ○ 35 - 49 (2)
- ○ 50 - 64 (3)
- ○ 65 and over (4)

Q19

Sexual orientation (select all that apply:

Do you think of yourself as:

o Heterosexual

o Gay

o Lesbian

o Bisexual

o Asexual

o Pansexual

o Queer

o Not listed, please specify: _____

o Don’t know or questioning

o Decline to answer

Q20

Gender identity

Do you think of yourself as:

o Male

o Female

o Transgender woman/trans woman/ male-to-female (MTF)

o Transgender man/trans man/female-to-male (FTM)

o Genderqueer/gender nonconforming neither exclusively male nor female

o Additional gender category (or other) please specify: _____

o Decline to answer

Q.20.1 What sex were you assigned at birth?

o Male

o Female

o Decline to Answer

Q21 What is your racial background (select all that apply)?

- American Indian or Alaska Native
- Black or African American
- Asian
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White

Q22 What best describes your ethnicity (select all that apply)?

- Hispanic or Latino
- Non-Hispanic or Latino
- Not listed, please name: _____

You are almost done!

This section is optional but please consider how your thoughts and experiences would be valuable for this research and community:

Q23 Please describe procedures that your organization implemented to create a LGBTQ+ affirmative care environment.

Q24 What is one lesson that you learned on your journey of becoming a more affirmative care practice by transforming your workspace?

Q25 How do you believe affirmative and inclusive practices can be sustained throughout the year?

_____

Q26Please share a piece of advice that you believe would be helpful for another provider or administrator looking to transition their practice into a more LGBTQ+ inclusive environment.

Q27 Please share any additional thoughts here. _____

End of Block: Introduction & Informed Consent

Thank you for your response to this survey! We appreciate your time and your comments. If you have any questions about this research protocol, please contact Tiasia Saunders (tiasia@ksu.edu), or Susan Rensing (rensing@ksu.edu). Questions or concerns about your rights as a research participant may be directed to Rick Scheidt, Chair, Committee on Research Involving Human Subjects, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224.

Appendix C - Glossary

It is important to understand some terms and acronyms while reading this research. Terms that are specific to the LGBTQ+ community from sources including the National LGBTQ+ Health Education Center at Fenway Health. A few terms are introduced in this section to help better flow through this research. The LGBTQ+ community use a variety of terms, not all of which are included in this glossary.

- LGBTQ+ – An acronym for "lesbian, gay, bisexual, transgender and queer" with a "+" sign to recognize the limitless sexual orientations and gender identities used by members of the community.
- Inclusive Healthcare – Inclusive health is about health for all humankind; it requires health services that are efficacious, equitable, and affordable (MacLachlan et al, 2012).
- Affirmative Care – An approach to health care delivery in which organizations, programs, and providers recognize, validate, and support the identity stated or expressed by the individuals served (Mendoza et al, 2020).
- Gender Identity – One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from the sex assigned at birth.
- SOGI – Sexual Orientation and Gender Identity
- Cisgender – A term used to describe a person whose gender identity aligns with the sex assigned to them at birth.
- Heteronormative – Relating to a world view that promotes heterosexuality as the normal or preferred sexual orientation.

- Cisnormative – The assumption that all human beings are cisgender, i.e. have a gender identity which matches their biological sex.
- Non-binary – An adjective describing a person who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all non-binary people do. Non-binary can also be used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender-fluid.