LGBTQIA+ INCLUSIVE HEALTHCARE VERSUS TRADITIONAL: COMPARING PATIENT SATISFACTION

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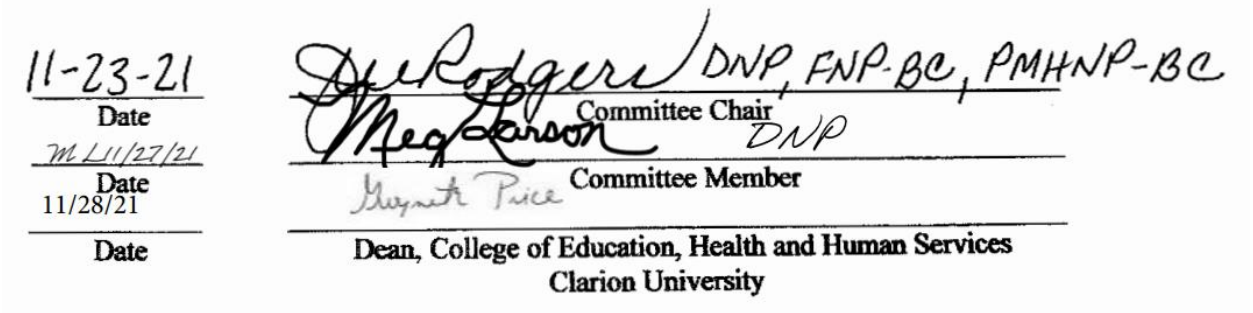

LGBTQIA+ INCLUSIVE HEALTHCARE VERSUS TRADITIONAL: COMPARING PATIENT SATISFACTION

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LGBTQIA+ Inclusive Healthcare Versus Traditional: Comparing Patient Satisfaction

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Abstract

Study Aim: The aim of this study was to evaluate the difference in patient satisfaction scores between lesbian, gay, bisexual, transgender, questioning or queer, intersex, and asexual (LGBTQIA+) individuals who receive healthcare from LGBTQIA+ inclusion clinics and LGBTQIA+ individuals who receive healthcare from traditional clinics. ***Background:*** LGBTQIA+ individuals have unique healthcare needs and require safe, affirming, culturally competent, and inclusive healthcare environments that will meet these unique needs, eliminate health disparities and inequities, and improve patient reported outcomes such as patient satisfaction. ***Theoretical Framework:*** This study was guided by the Health Equity Framework, centered on three foundational concepts: equity at the core of health outcomes; multiple, interacting spheres of influence; and a historical and life-course perspective. ***Methodology:*** Study protocol review and approval were obtained from Edinboro University's Institutional Review Board. This study was an on-line questionnaire study and was conducted using a nonexperimental, nonrandom, cross-sectional study adhering to a quantitative methodology. A nonrandom convenience sample of LGBTQIA+ individuals (n=56) was selected, and study participants were invited to participate in this study via an on-line survey link by way of Qualtrics. Data were collected using the Short-Form Patient Satisfaction Questionnaire (PSQ-18). ***Results:*** To test for differences in patient satisfaction between groups, the independent samples t-test statistical method was utilized. There was not a statistically significant difference in mean values between groups. Due to assumption violations, the Communication sub-scale was tested using the independent samples Mann-Whitney U test to determine if the distributions

in the two groups were significantly different from each other. It was found that the distributions in the two groups significantly differed. ***Conclusions:*** LGBTQIA+ inclusion health plays a critical role in improving patient satisfaction and the health and well-being of LGBTQIA+ individuals. ***Implications for Nursing Practice:*** Nursing professionals play an integral role in transforming healthcare for LGBTQIA+ individuals and must align their practices with their professional duty of delivering equitable and culturally competent and sensitive care to LGBTQIA+ individuals. ***Recommendations:*** Further research is needed with larger sample sizes to investigate the relationship between receiving healthcare from LGBTQIA+ inclusion clinics and improved patient satisfaction and whether there is a difference in patient satisfaction between those who receive healthcare from LGBTQIA+ inclusion clinics and those who do not. Because study respondents who went to LGBTQIA+ inclusion clinics had significantly higher communication satisfaction than those who did not go to inclusion clinics, the impact of culturally competent communication on improved patient satisfaction should also be investigated further in future research.

Table of Contents

List of Tables

List of Figures and Charts

List of Appendices

Chapter 1

Introduction

The lesbian, gay, bisexual, transgender, questioning or queer, intersex, and asexual (LGBTQIA+) community is a multifaceted community involving considerable complexity (Goldberg et al., 2018). Individuals who self-describe or self-identify as LGBTQIA+ represent every community (Centers for Disease Control and Prevention [CDC], 2014). The LGBTQIA+ community is remarkably diverse and embodies all genders, all races and ethnicities, all ages, and all socioeconomic statuses across the nation (CDC, 2014). According to Bonvicini (2017), historically, the terms gay and lesbian were utilized to encompass sexual minorities. Later, to include bisexual and transgender individuals, the initialism LGBT was adopted. Over the years the nomenclature continued to expand to become even more broadly defined with added initials of Q, I, and A (Bonvicini, 2017). To represent individuals who identify along the continuum of LGBTQIA+ and to signify diversity and inclusion, the initialism LGBTQIA+ will be used when referring to sexual and gender minority individuals throughout this study. This initialism is well understood by the LGBTQIA+ community. It extends beyond discreet boundaries and encompasses all gender and sexual minorities (Goldberg et al., 2018).

Demographics

Due to a variety of factors, it is difficult to determine the size of the LGBTQIA+ population (National LGBTQIA+ Health Education Center, 2016). Factors include the heterogeneity of LGBTQIA+ communities, the paucity of research concerning these communities, and the reluctance of LGBTQIA+ individuals to answer state surveys. In fact, most national or state surveys do not ask sexual orientation or gender identity questions, making

it challenging to approximate the percentage of U.S. adults who self-describe or self-identify as LGBTQIA+ (HealthyPeople.gov, 2021).

According to Jones (2021), approximately 5.6% of U.S. adults self-describe or self-identify as LGBTQIA+. From Gallup's 2017 data, the estimate has risen more than one percentage point and is up from 4.5% (Jones, 2021). The estimate rise is thought to correlate with the increase in support of equal rights for LGBTQIA+ individuals in the U.S. As a result, younger persons are more freely identifying themselves as something other than heterosexual, such as sexually and gender fluid (Jones, 2021).

A Vulnerable Population

Although support of equal rights for LGBTQIA+ individuals in the U.S. has increased, LGBTQIA+ individuals remain a vulnerable population due to prejudice and exclusion. According to Ekmekci (2017), because of their mere state of existence, LGBTQIA+ individuals experience disadvantages in relation to equal and fair opportunities. "Lesbian, gay, bisexual, transgender (LGBT) people are among the vulnerable populations with significant disadvantages related to health and the social determinants of health" (p. 335). Legal discrimination in access to health insurance, lack of social programs, and shortage of healthcare providers who are knowledgeable and culturally competent in LGBTQIA+ health are considered social determinants that affect the health and well-being of LGBTQIA+ individuals and are largely related to oppression and discrimination (HealthyPeople.gov, 2021).

Healthcare Inequities

Social and structural inequalities, such as oppression and discrimination, as well as stigmatization, remain significant obstacles to the health and well-being of LGBTQIA+ individuals. Discrimination, societal stigma, and denial of civil and human rights put

LGBTQIA+ individuals at increased risk for health disparities and poor health outcomes (HealthyPeople.gov, 2021). According to Marbury (2017), social norms, and institutions that stigmatize, marginalize, and devalue the lives of LGBTQIA+ individuals, continue to be the root causes of health disparities amongst these vulnerable individuals. Research suggests that "health equality, and appropriate and specific care, for the LGBTQ community starts with abolishing discrimination, ending stigma, and addressing disparities" ("Meeting the Unique Health-care Needs," 2016). To advance toward health equity and achieve the best possible health and well-being, LGBTQIA+ individuals need personal agency and equitable access to resources and opportunities (Peterson et al., 2020). Health inequities will persist for LGBTQIA+ individuals if inequitable access to resources and opportunities are left unmitigated (Peterson et al., 2020).

Sexual orientation and gender identity contribute to an individual's ability to achieve good health (HealthyPeople.gov, 2021). Although diversity initiatives within the healthcare system remain on the rise, treatment standards continue to be grounded in a sociocultural privileging of heteronormativity, rendering LGBTQIA+ individuals invisible (Goldberg et al., 2018). Compared to their heterosexual counterparts, LGBTQIA+ individuals are at increased risk for a number of health-related threats due to their sexual orientation (CDC, 2014). Like an individual's age, sexual orientation and gender identity are irrelevant when it comes to an individual's right to health (Ekmekci, 2017). However, based on their sexual orientation and gender identity, systematically, LGBTQIA+ individuals experience greater barriers to health (HealthyPeople.gov, 2021). Healthcare systems have both an opportunity and a responsibility to provide equitable care to all LGBTQIA+ individuals regardless of their sexual orientation and gender identity (Furness et al., 2020).

Barriers to Healthcare

Common experiences of stigma and discrimination are what bind LGBTQIA+ individuals together as social and gender minorities (Giri et al., 2019). More precisely, with respect to healthcare, LGBTQIA+ individuals are further bound by a lengthy history of prejudice and a dearth of awareness of health needs by healthcare professionals (National LGBTQIA+ Health Education Center, 2016). Unfortunately, these shared experiences also create barriers to health for LGBTQIA+ individuals, resulting in decreased access to culturally competent healthcare and poor health and mental health outcomes. According to Bouma (2016), dissatisfaction with healthcare creates a barrier to access and exacerbates health concerns amongst LGBTQIA+ individuals. Although the reasons LGBTQIA+ individuals face barriers to accessing healthcare are many, they can be placed into three major categories: limited access, discrimination from healthcare providers, and healthcare provider lack of knowledge in caring for LGBTQIA+ individuals (National LGBTQIA+ Health Education Center, 2016).

Limited Access

LGBTQIA+ individuals often remain under- and ill-served, and access to health and mental health services continues to be a major health concern for them (Romanelli & Hudson, 2017). There are a variety of factors that prevent LGBTQIA+ individuals from accessing high-quality healthcare, such as availability of appropriate care, lack of affordability of care, financial barriers, and socioeconomic barriers (Giri et al., 2019). Basic access to healthcare is an unrelenting problem for LGBTQIA+ individuals, as they are more likely to be uninsured as a consequence of homelessness and unemployment status (National LGBTQIA+ Health Education Center, 2016). Additionally, regardless of their insurance status, LGBTQIA+ individuals may outright be denied healthcare solely based upon their sexual orientation or gender identity (Giri et al., 2019). To adequately address the numerous health and mental health disparities faced by

LGBTQIA+ individuals, it is imperative that these individuals gain access to high-quality healthcare (Romanelli & Hudson, 2017).

Discrimination from Healthcare Providers

In addition to limited access to healthcare, the attitudes, behaviors, and beliefs of healthcare providers create significant barriers to accessing and receiving healthcare for LGBTQIA+ individuals as well: "Research suggest that attitudes of healthcare providers may be a contributing factor in both accessing and receiving care" (Dorsen & Van Devanter, 2016, p. 3716). While seeking healthcare services, LGBTQIA+ individuals may experience discrimination or prejudice from healthcare providers (National LGBTQIA+ Health Education Center, 2016). In fear of being discriminated against, they may postpone receiving medical care, even while sick or injured. According to Giri et al. (2019), "LGB persons' previous negative experiences with the health care system or perceptions of discrimination in the system may cause them to delay seeking health care" (p. 19). Further perpetuating their reluctance to seek healthcare, LGBTQIA+ individuals frequently engage in undesirable interactions in doctor's offices as well (Marbury, 2017). The ability to effectively serve LGBTQIA+ individuals will require healthcare providers to understand the cultural context of the lives of LGBTQIA+ individuals and to modify their behavior and language to be inclusive and non-judgmental when providing care (National LGBTQIA+ Health Education Center, 2016).

Healthcare Provider Lack of Knowledge

A lack of knowledge persists in the healthcare system, and LGBTQIA+ individuals continue to report negative experiences with their healthcare providers (Bonvicini, 2017). Negative experiences reported included encountering homophobia and unsatisfactory or unequal healthcare treatment (Bonvicini, 2017). Poor encounters with intolerant and improperly

educated healthcare professionals are a sizeable reason as to why LGBTQIA+ individuals either delay or refuse to seek healthcare (National LGBTQIA+ Health Education Center, 2016). When being cared for, they may discover that healthcare providers have a paucity of knowledge, expertise, and understanding of their unique healthcare needs, further contributing to ongoing health disparities and discrimination (American Nurses Association [ANA], 2018). LGBTQIA+ individuals also fear being "outed" when seeking healthcare from non-LGBTQIA+ friendly providers (Marbury, 2017). Creating a LGBTQIA+ friendly environment will require healthcare providers to receive adequate didactic and clinical training regarding the role of stigma and discrimination, as well as the unique healthcare needs of LGBTQIA+ individuals (Dorsen & Van Devanter, 2016).

Healthcare Disparities

Health disparities exist when health outcomes are seen to a greater or lesser extent between populations and are strongly associated with social, economic, and environmental disadvantages (HealthyPople.gov, 2021). According to CDC, "health disparities are preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other populations, and communities" (2017). Based on their sexual orientation or gender identity, which historically are correlated with discrimination or exclusion, LGBTQIA+ individuals are adversely affected by health disparities (HealthyPeople.gov, 2021). Furthermore, discrimination and exclusion "(…) place disparities in health status between sexual- and gender-minority and heterosexual individuals" (Giri et al., 2019, p. 15).

Health-seeking behavior and access to healthcare for LGBTQIA+ individuals continues to be shaped by a long-history of anti-LGBTQIA+ bias within the healthcare system (National

LGBTQIA+ Health Education Center, 2016). Thus, LGBTQIA+ individuals suffer a multitude of health disparities related to social and structural inequalities, including higher prevalence of human immunodeficiency virus (HIV) and other sexually transmitted infections, higher rates of substance use and abuse, mental health issues and suicide, increased odds of obesity and eating disorders, and higher rates of violence victimization. These health disparities are primarily driven by the social determinants of health, such as legal discrimination in access to health insurance, employment and housing, limited access to appropriate healthcare, social discrimination, and shortage of knowledgeable and culturally competent healthcare providers. Although social and structural inequalities, as well as differences in sexual behavior are often associated with poorer health status amongst LGBTQIA+ individuals, the physical environment also contributes to the health disparities experienced by these individuals. It is essential that LGBTQIA+ individuals have access to healthcare, safe meeting places, and safe neighborhoods and housing (HealthyPeople.gov, 2021).

To address these health disparities experienced by LGBTQIA+ individuals, specific attention to LGBTQIA+ health is required from healthcare professionals (HealthyPeople.gov, 2021). Healthcare professionals must abandon the historical heteronormative and gender binary approach to LGBTQIA+ health and pay specific attention to the unique healthcare needs of LGBTQIA+ individuals. Institutional norms must be abandoned as well, and in order to transform institutional norms, specific attention must be given to the wholeness of LGBTQIA+ individuals (Goldberg et al., 2018).

Unique Healthcare Needs

LGBTQIA+ individuals have unique healthcare needs from those healthcare needs of heterosexual individuals. Addressing the unique healthcare needs of LGBTQIA+ individuals

begins with understanding the unique needs of each individual and creating an environment that is aimed at providing culturally affirming care and inclusive of all LGBTQIA+ individuals. Historically, the healthcare needs of LGBTQIA+ individuals have been seen through a heteronormative and gender binary lens, assuming their healthcare needs are comparable to the healthcare needs of their heterosexual and cisgender counterparts (Colpitts & Gahagan, 2016). The unique healthcare needs of LGBTQIA+ individuals are dismissed by this heteronormative and gender binary approach and further impedes their access to culturally affirming and inclusive care (Colpitts & Gahagan, 2016).

LGBTQIA+ inclusion health will improve healthcare quality and eliminate health disparities and inequities. Recognizing LGBTQIA+ individuals experience social, structural, and interpersonal challenges can be helpful for understanding the impact these challenges can have on their health. Addressing the unique healthcare needs of LGBTQIA+ individuals and lowering health disparities have many benefits, including reductions in disease transmission and progression, increased mental and physical well-being, reduced healthcare costs, and increased longevity (HealthyPeople.gov, 2021).

Inclusion Health and Patient Satisfaction

A variety of factors affect health outcomes and patient satisfaction among LGBTQIA+ individuals. According to McClain et al. (2016), "health outcomes are affected by patient, provider, and environmental factors" (p.387). "Environmental factors include both the context in which care is delivered (…) as well as how care is delivered" (McClain et al., 2016, p. 387). For instance, while some LGBTQIA+ individuals may interact well with their healthcare providers, others postpone or even fail to seek healthcare because of being subjected to discrimination in the healthcare setting as a result of their sexual orientation and gender identity (McClain et al.,

2016). From the patient's viewpoint, every interaction they have with their healthcare provider may contribute to their overall satisfaction with their healthcare experience (Bonvicini, 2017). According to Bonvicini (2017), "patient satisfaction is significantly enhanced when all members of the healthcare team communicate respectfully and sensitively with patients" (p. 2359).

Considering the effect of the physical environment on health outcomes, patient satisfaction, and on the unique healthcare needs of LGBTQIA+ individuals, enhancing clinical spaces where LGBTQIA+ individuals can receive safe and inclusive healthcare is vital (McClain et al., 2016). Because safe and healing clinical spaces are especially important to LGBTQIA+ individuals, creating such spaces should have two foci: the environment and the provider (McClain et al., 2016). By creating safe and inclusive clinical spaces free from discrimination and judgement, LGBTQIA+ individuals are afforded an opportunity to receive quality comprehensive healthcare in an entirely "out" environment. Seeking healthcare in an entirely "out" environment will positively affect health outcomes and increase patient satisfaction among LGBTQIA+ individuals.

Viewed as safe and welcoming spaces where stigma and bias are absent, inclusion clinics offer LGBTQIA+ individuals with a sense of community (McClain et al., 2016). Highlighting their specialized attention on the LGBTQIA+ community, inclusion clinics strive to establish the warmest and culturally competent settings for LGBTQIA+ individuals. Inclusion clinics also strive to offer LGBTQIA+ individuals an LGBTQIA+ patient centric and patient friendly environment. Because these environments aim at improving patient satisfaction and providing the LGBTQIA+ community with sensitive, quality health and wellness services, the overall physical, emotional, and social well-being of LGBTQIA+ individuals may be enriched.

Background of the Problem

According to HealthyPeople.gov (2021), achieving the highest degree of health for all individuals is health equity defined. It is achieved by abating the pervasive inequalities, injustices, and health disparities that still exist, and it requires valuing each individual equally (HealthyPeople.gov, 2021). "The absence of disease does not automatically equate to good health" (HealthyPeople.gov, 2021). Rather, according to World Health Organization [WHO] (n.d.), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO, 2017).

Before LGBTQIA+ individuals can achieve the highest degree of health, the systemic roots of inequity must first be acknowledged (Peterson et al., 2020). According to Peterson et al., (2020), health inequities are "the systematic and preventable differences in health outcomes closely linked to social, economic, and environmental conditions" (p. 2). Health equity for LGBTQIA+ individuals begins with eliminating social and structural inequalities, such as oppression, discrimination, and stigmatization. The physical and mental health of individuals are jeopardized when they are marginalized or encounter stigma or discrimination (WHO, 2017). Achieving sustainable and comprehensive health equity for LGBTQIA+ individuals goes far beyond the individual level. Rather, according to Keuroghlian et al., (2017), it will require a significant societal shift to adequately address an array of adverse health outcomes experienced by LGBTQIA+ individuals.

The Health Equity Framework focuses on health outcomes at the population level rather than the individual level to raise and swing our understanding and attention to health equity (Peterson et al., 2020). According to Peterson et al. (2020), "health equity is defined as having

the personal agency and fair access to resources and opportunities needed to achieve the best possible physical, emotional, and social well-being" (p. 1). To achieve health equity, LGBTQIA+ individuals must be provided with equal access to resources and opportunities that enable healthy lives (Peterson et al., 2020). The Health Equity Framework acknowledges equal distribution of resources and opportunities, as well as access, are hindered by prejudices, such as racism, sexism, homophobia, and transphobia (Peterson et al., 2020). Targeting these hindrances is critical for LGBTQIA+ individuals to achieve health equity.

Health and social inequities are a consequence of cumulative experiences across the lifespan (Peterson et al., 2020). Because LGBTQIA+ individuals encounter these inequities across their lifespan, they require an approach to healthcare that can meet their unique health needs (Goldhammer et al., 2018). Inclusion health is a promising approach that aims to remedy the excessive health and social inequities felt by vulnerable and excluded individuals (Luchenski et al., 2018). Focusing efforts on the unique health needs of LGBTQIA+ individuals through inclusion health may reduce discrimination and stigma, as well as promote patient satisfaction, empowerment, equality of care, and health equity.

Statement of the Problem

In spite of the considerable progress and recent advances that have been made in the sociocultural-political landscape, the present-day healthcare environment remains markedly influenced by social, political, and economic norms that perpetuate gender binaries, heteronormativity, and discriminatory practices, rendering LGBTQIA+ individuals vulnerable (Goldberg et al., 2018). Healthcare systems that continue to embrace gender binaries, heteronormativity, and discriminatory practices as the assumed norms, further perpetuate the pervasive harms suffered by LGBTQIA+ individuals (Goldberg et al., 2018). Vulnerable to a

vast array of healthcare disparities and inequities based on their sexual orientation and gender identity, LGBTQIA+ individuals, compared to gender binary and heterosexual individuals, endure higher rates of health problems, both physical and mental, as well as poorer health outcomes and health status.

Attention to these healthcare disparities and inequities that negatively impact the physical and mental health of LGBTQIA+ individuals is vital in order for these individuals to gain optimal physical, mental, and social well-being. With an extensive history of discrimination in healthcare and a dearth of LGBTQIA+ competent environments and healthcare professionals, there is a call for action to create environments where LGBTQIA+ individuals wish to seek healthcare. Advocating for LGBTQIA+ inclusion health, as well as healthcare environments that welcome, include, and protect LGBTQIA+ individuals will redress these disparities and inequities and provide LGBTQIA+ individuals with access to safe and affirming, high-quality healthcare (Keuroghlian et al., 2017).

PICO Question

Using the Population, Intervention, Comparison, and Outcomes (PICO) approach, the following PICO question was formulated to further investigate this research topic and to guide this study: Do LGBTQIA+ individuals who receive healthcare from LGBTQIA+ inclusion clinics feel more satisfied with their healthcare than those LGBTQIA+ individuals who receive healthcare from traditional clinics? Following the PICO approach, the Population of interest is LGBTQIA+ individuals, the Intervention is inclusion healthcare clinics, the Comparison is traditional healthcare clinics, and the Outcome is patient satisfaction.

Hypothesis

It was hypothesized that (H_1) LGBTQIA+ individuals receiving healthcare from LGBTQIA+ inclusion clinics will have greater satisfaction with their healthcare compared to LGBTQIA+ individuals receiving healthcare from traditional clinics. In this case, the null would be rejected. The null hypothesis that was tested was that (H_0) LGBTQIA+ individuals receiving healthcare from LGBTQIA+ inclusion clinics will not have greater satisfaction with their healthcare compared to LGBTQIA+ individuals receiving healthcare from traditional clinics. In this case, the null would be accepted.

Definition of Terms

Operational Terms

1. LGBTQIA+ represents lesbian, gay, bisexual, transgender, questioning or queer, intersex, and asexual individuals. The "+" signifies the diversity and inclusivity within the LGBTQ community and encompasses individuals of all genders and sexualities (Goldberg et al., 2018).
2. Cisgender is defined as a person who identifies as their sex assigned at birth (Jennings et al., 2019).
3. Transgender is defined as a person whose gender identity differs from their sex assigned at birth (Jennings et al., 2019).
4. Questioning is defined as an individual exploring and considering his or her sexual orientation and gender identity (Bonvicini, 2017).
5. Intersex is defined as an individual whose anatomy is not solely male or female and describes an individual who is born with sex chromosomes, external genitalia, or an internal reproductive system that is not exclusively male or female (Bonvicini, 2017; LGBT Center UNC-Chapel Hill, n.d.).

6. Asexual is defined as someone who lacks feelings of sexual attraction toward individuals of any gender and is considered a sexual orientation (LGBT Center UNC-Chapel Hill, n.d.).
7. Gender Binary is defined as a person who identifies as either a male or female.
8. Gender Fluid is defined as being a person whose gender identity is not fixed (Merriam-Webster, n.d.).
9. Gender Identity is defined as a person's internal sense of being a man/male, woman/female, both, neither, nor another gender (National LGBTQIA+ Health Education Center, 2021).
10. Sexual Orientation is defined as how a person describes their attraction to others both sexually and emotionally (National LGBTQIA+ Health Education Center, 2021).
11. Heteronormative is defined as heterosexuality as the natural expression of sexuality (Merriam-Webster, n.d.).

Conceptual Terms

1. Health Inequity is defined as differences in health outcomes across sectors of the population that are systematic, unfair, and avoidable (Penman-Aguilar et al., 2016).
2. Health Equity is defined as fairness and justice in health and the absence of that which is inequitable (Penman-Aguilar et al., 2016).
3. Health Disparities are defined as differences in health or determinants of health that unfavorably impact marginalized groups (Braveman et al., 2017).
4. Personal Agency is defined as self-agency and the sense of being in control of our actions and the consequences they have on our lives (Owusu, 2021).

5. Inclusive Healthcare is defined as healthcare that is specifically designed to comprehensively meet the unique healthcare needs of the LGBTQIA+ community.
6. Traditional Healthcare is defined as healthcare that is not specifically tailored toward meeting the unique healthcare needs of the LGBTQIA+ community.

Need for the Study

The need for this study aligned with Healthy People's goal to "improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals" (HealthyPeople.gov, 2021). The need for this study further aligned with Healthy People's expanded goal to attain health equity, remove disparities, and improve the health of all groups (HealthyPeople.gov, 2021). According to Peterson et al., (2020), health equity is a public health priority requiring health strategies that recognize the systemic origins of inequity. Congruent with the Health Equity Framework, to advance toward health equity, improve health outcomes, and effectively remove health disparities and inequities for LGBTQIA+ individuals, health equity approaches must consider the interplay of structural, relational, individual, and physiological factors (Peterson et al., 2020).

Furthermore, the need for this study was to illustrate the necessity for LGBTQIA+ culturally affirming healthcare environments that welcome, include, and protect LGBTQIA+ individuals (Keuroghlian et al., 2017). This study will close a gap in this field of research by including marginalized voices on LGBTQIA+ inclusion health. According to HealthyPeople.gov (2021), spanning the next decade, a multitude of LGBTQIA+ health-related concerns will require continued evaluation and attention. These health-related concerns include the following:

- Prevention of violence toward LGBTQIA+ individuals
- Resilience amongst LGBTQIA+ individuals
- Health and well-being for aging LGBTQIA+ individuals
- Necessity for a LGBTQIA+ model of wellness

- As deemed medically necessary, identification of transgender health needs

Approaches to further close the gaps in health disparities and inequities specific to LGBTQIA+ individuals and advance toward equitable and inclusive care must be identified and explored further.

Significance of the Problem

LGBTQIA+ individuals face various health concerns because of their sexual orientation and gender identity (Ekmekci, 2017). More specifically, as sexual- and gender minorities, they experience disparities and inequities in health outcomes due to unfair access to resources that foster positive physical, mental, and social health. Such resources include education, health services, support systems, safe environments, and social capital (Peterson et al., 2020).

> No one facing health concerns should also have to worry about receiving inequitable or substandard care because of their LGBTQ status. Yet many LGBTQ Americans experience these challenges when seeking health care, which can intensify whatever worries they may have about their health (Healthcare Equality Index [HEI], 2020).

According to the HEI 2020 Report, 56% of lesbian, gay, or bisexual patients, and 70% of transgender or gender non-conforming patients reported having experienced some level of discrimination in healthcare, and 29% and 73% respectively, reported that they believed they would be treated differently by healthcare professionals due to identifying as LGBTQ (HEI, 2020). Consequently, it is crucial that the provision of healthcare for LGBTQIA+ individuals be equitable, knowledgeable, sensitive, and welcoming, as well as free from discrimination (HEI, 2020).

There is an urgent need to provide inclusive, high-quality health services to LGBTQIA+ individuals so they can achieve the highest possible level of health (National LGBTQIA+ Health Education Center, 2016). If inclusive, high-quality health services are not accessible, LGBTQIA+ individuals will continue to experience disparities and inequities in health outcomes, both physical and mental, compared to their heterosexual and cisgender counterparts (Valdiserri et al., 2019). LGBTQIA+ individuals can suffer life-long health disparities if their health is neglected and their unique healthcare needs are marginalized ("Meeting the Unique Health-care Needs," 2016). Eliminating LGBTQIA+ health disparities and enhancing efforts to improve LGBTQIA+ health are necessary to ensure that LGBT individuals can lead long, healthy lives (HealthyPeople.gov, 2021).

Assumptions

For this study, it was assumed that LGBTQIA+ inclusive healthcare would eliminate health inequities and disparities, as well as promote social justice and health equity for LGBTQIA+ individuals. It was also assumed through inclusion health that the unique healthcare needs of LGBTQIA+ individuals would be adequately met. Further, it was assumed that LGBTQIA+ individuals receiving inclusive healthcare, rather than non-inclusive healthcare, would result in greater patient satisfaction, access to high-quality healthcare, and improved health outcomes. Another assumption was that through welcoming, culturally affirming, and inclusive healthcare, LGBTQIA+ individuals would have improved physical, mental, and social health, safety, and well-being. Last, it was assumed that all individuals who participated in this on-line questionnaire study were members of the LGBTQIA+ community and answered the questionnaire honestly.

Summary of the Problem

The LGBTQIA+ community is one that is multilayered, of great complexity, and profoundly diverse. Encompassing all walks of life, at present, it is estimated that 5.6% of U.S. adults either self-describe or self-identify as LGBTQIA+. Despite equal rights efforts, LGBTQIA+ individuals remain vulnerable and continue to encounter considerable social and structural inequalities, such as discrimination, exclusion, oppression, and stigmatization. These pervasive social and structural inequalities persist as major barriers to high-quality healthcare and place LGBTQIA+ individuals at significant risk for disparities in health outcomes due to their sexual orientation and gender identity.

Mitigating these health-related disparities and meeting the unique healthcare needs of LGBTQIA+ individuals necessitates healthcare settings that are inclusive, safe, and welcoming, and healthcare professionals that are LGBTQIA+ culturally competent. Creating an inclusive, safe, and welcoming environment in which LGBTQIA+ individuals can establish trust and open and honest communication with their healthcare providers can improve provision of care, patient satisfaction, and ultimately their health and well-being (National LGBTQIA+ Health Education Center, 2016). The following chapter discusses the review of the literature on this study topic.

Chapter 2

Review of the Literature

To establish the value of previous research on LGBTQIA+ health and health-related disparities and inequities, a comprehensive literature search and critical appraisal were conducted. The guiding PICO question for this literature review and synthesis was: Do LGBTQIA+ individuals who receive healthcare from LGBTQIA+ inclusion clinics feel more satisfied with their healthcare than those LGBTQIA+ individuals who receive healthcare from traditional clinics? Three major themes emerged as a result of this literature review: life course

health disparities; healthcare access and utilization; and cultural competence. These three themes, along with this study's guiding theoretical framework, the Health Equity Framework, are discussed in this chapter.

Literature Search

Several on-line databases and resources were used to conduct the electronic literature search. Electronic databases included APA PsycInfo, Business Source Complete, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Directory of Open Access Journals, EBSCOhost, Education Source, Google Scholar, Humanities Source, MEDLINE Complete PubMed, and SocINDEX. The electronic literature search was filtered by peer-reviewed, by publication date from 2016 to 2021, academic journal, subject (i.e., LGBT), and English language. Using the keywords "LGBTQ health", "barriers to LGBTQ healthcare", "LGBTQ healthcare disparities", "sexual minority health disparities", "LGBTQ perceptions of health", "LGBTQ healthcare access", "LGBTQ supportive healthcare environments", "LGBTQ vulnerable", "vulnerable populations in healthcare LGBTQ", "unique healthcare needs of LGBTQ", "holistic care", "patient-centered care", "LGBTQ inclusion health", "LGBTQ focused healthcare", "LGBTQ specific clinics", "lack of competent inclusive LGBTQ healthcare", "LGBTQ competent healthcare providers", "LGBTQ culturally competent healthcare", "health equity", "LGBTQ health equity", "LGBTQ health inequalities" and "health equity framework" in the search criteria yielded 42 results.

Inclusion Criteria

Inclusion criteria were based on the PICO framework of this study. Only articles that met the inclusion criteria were included in the literature review. Inclusion criteria included articles that were full-text articles, were undertaken in the past five years from 2016 to 2021, have been

peer reviewed, have appeared in academic journals, published in the English language, and were relevant to the research topic of this study. Articles that did not meet the inclusion criteria were excluded from the literature review.

Critical Appraisal

Following further evaluation, synthesis, and critical appraisal of the research articles, 22 articles were eliminated from the literature review and 20 articles that were relevant to the research topic of this study were included and used in the final literature review. Research articles reviewed and synthesized bring relevance to the PICO question under investigation.

Life Course Health Disparities

Based on a review of the current literature, research suggests across their life course, LGBTQIA+ individuals are confronted with a plethora of health disparities (Goldhammer et al., 2018). In part, these health disparities may be further precipitated by biases of healthcare providers (Morris et al., 2019). Further, compared to heterosexual and cisgender individuals, LGBTQIA+ individuals endure significant disparities in physical and mental health outcomes (Valdiserri et al., 2019). They are plagued with higher rates of anal cancer, asthma, cardiovascular disease, obesity, substance abuse, cigarette smoking, and suicide (Morris et al., 2019). Additionally, there are fewer lifetime Pap tests reported by sexual minority females (Morris et al., 2019). Lower healthcare utilization by LGBTQIA+ individuals may further contribute to these disparities in physical and mental health outcomes (Morris et al., 2019). Mitigating these life course health disparities experienced by LGBTQIA+ individuals will call for expanded access to LGBTQIA+ inclusive healthcare (Goldhammer et al., 2018).

The literature also suggests that shared experiences amongst LGBTQIA+ individuals, such as perceived discrimination from healthcare providers and overt refusal of healthcare, may

also contribute to disparities in healthcare access and health outcomes (Morris et al., 2019). According to Morris et al. (2019), "implicit physician biases may result in LGBTQ patients receiving a lower standard of care or restricted access to services as compared to the general population" (p. 2). In a study conducted by Dorsen and Van Devanter (2016), nurse practitioner's attitudes toward working with LGBTQIA+ patients were examined, and although study results illustrated their desire to provide quality care to LGBTQIA+ individuals, they reported having conflicting attitudes about caring for these patients. Attitudes varied from open and accepting, to uncomfortable and uncertain. More specifically, they reported having insecurities regarding their lack of knowledge to provide appropriate care to LGBTQIA+ individuals (Dorsen & Van Devanter, 2016).

According to Goldberg et al. (2018), "LGBTQ+ identities thus continue to be unsettling and disrupting for many nurses and health care providers; they evoke discomfort; they can disarm and disquiet" (p. 264). Biases of healthcare providers are linked to inequitable access to healthcare, reduced quality of care, and less favorable physical and mental health outcomes (Morris et al., 2019). To ensure they do not play a part in the healthcare disparities LGBTQIA+ individuals contend with, healthcare providers must acknowledge and direct their attention to their own biases (Morris et al., 2019).

Healthcare Access and Utilization

LGBTQIA+ individuals are challenged with numerous obstacles when accessing quality and timely healthcare (Margolies & Brown, 2019). In contrast to heterosexual and cisgender individuals, LGBTQIA+ individuals are twice as likely to be uninsured and, in most cases, do not have a regular healthcare provider (Margolies & Brown, 2019). According to Morris et al. (2019), access to healthcare for transgender youth is challenging and LGBTQIA+ individuals,

even when medical care is needed, are less apt to seek care. Jennings et al. (2019) concluded, compared to non-LGBTQIA+ individuals, LGBTQIA+ individuals faced detrimental differences in healthcare access and utilization and in the quality level of the healthcare they received. Further, Jennings et al. (2019) reported transgender respondents had a greater tendency to postpone seeking healthcare, as they were 2.76 times more likely to receive subquality healthcare and to be discriminatorily treated when seeking healthcare compared to cisgender respondents. The demand for improving healthcare access and utilization for LGBTQIA+ individuals cannot be underestimated (Ortelli, 2020). To promote health equity and encourage healthcare utilization, improved access to high-quality healthcare for LGBTQIA+ individuals is warranted (Jennings et al., 2019).

Data from the literature reveals LGBTQIA+ individuals face an array of issues and profound disadvantages in terms of access to healthcare because of their sexual orientation and gender identity (Ekmekci, 2017). In a study conducted by Giri et al. (2019), 42.5% of the study participants reported fear of being discriminated against by healthcare staff on the basis of their sexual orientation and gender identity. LGBTQIA+ individuals describe observing deleterious attitudes and behaviors from their healthcare provider upon disclosure of their sexual orientation and gender identity, and recent research has clarified that healthcare providers express feelings of conflict when asking questions about sexual orientation (Kuzma et al., 2019; Margolies & Brown, 2019). Results of a study conducted by Goldhammer et al. (2018) discovered 55.4% of clinicians surveyed disclosed they infrequently inquired about a patient's sexual orientation, or not all, and 71.9% infrequently inquired about a patient's gender identity.

Additional obstacles to accessing healthcare for these individuals include scarcity of culturally sensitive and competent healthcare providers, as well as scarceness of LGBTQIA+

inclusive clinics (Qureshi et al., 2018). In a study conducted by Banerjee et al. (2018) to assess healthcare providers' knowledge concerning caring for LGBTQIA+ individuals, of those healthcare providers surveyed, only 4.6% could correctly answer all knowledge questions, signifying that healthcare providers possess substantial knowledge gaps. The delivery of culturally competent healthcare is of particular importance to LGBTQIA+ individuals, as health disparities they experience are in part a result of poor cultural competence amongst healthcare professionals (Ruben, 2017).

An essential component of the healthcare environment for LGBTQIA+ individuals is LGBTQIA+ inclusion health, but access to quality healthcare remains a significant obstacle to utilization for these individuals (Martos et al., 2019). Confronted with a lengthy history of socially mediated stigma and systemic discrimination within the healthcare setting, LGBTQIA+ individuals avoid utilization of the healthcare system and seeking healthcare services. According to Giri et al. (2019), approximately 60% of the study participants reported fear of mistreatment by healthcare providers as the primary reason for delaying their medical treatment. The corrosive and sustained effect of socially mediated stigma and systemic discrimination on health outcomes of LGBTQIA+ individuals underscores the professional responsibility of healthcare providers to create safe, affirming, and inclusive healthcare environments and to provide culturally sensitive and competent care (Bonvicini, 2017; Morris et al., 2019).

Although research is limited on how LGBTQIA+ individuals utilize LGBTQIA+ inclusion clinics, these clinics offer alternative spaces where issues of stigma and discrimination may be avoided (Martos et al., 2019). According to Luchenski et al. (2018), "inclusion health is a service, research, and policy agenda that aims to prevent and redress health and social inequities among the most vulnerable and excluded populations" (p. 266). Inclusive and

culturally affirming care environments can increase LGBTQIA+ engagements in healthcare and have the potential to greatly advance health outcomes for LGBTQIA+ individuals (Furness et al., 2020).

Cultural Competence

Because LGBTQIA+ individuals have unique physical and mental health problems, there is a need to understand how to improve healthcare quality and delivery for these individuals (Ruben, 2017). One novel approach noted in the literature is the field of cultural competence combined with cultural humility (Kuzma et al., 2019). According to Kuzma et al. (2019), cultural humility encompasses reflecting on one's own knowledge, beliefs, and attitudes, building partnerships with LGBTQIA+ patients and learning from them, committing to ongoing personal and professional growth, and considering one's own conscious and unconscious biases. Cultural humility prepares healthcare personnel to rid themselves of their personal biases and to take an inclusive, holistic, and patient-centered approach to caring for LGBTQIA+ individuals.

In contrast, cultural competence comprises a vast array of aptitudes, including cultural knowledge, welcoming attitudes toward the LGBTQIA+ community, and the adeptness to effectively communicate with this community, respectively (Margolies & Brown, 2019). Cultural competence lays a firm foundation for learning about the unique physical, mental, and social health problems suffered by the LGBTQIA+ community, but alone, it does not adequately provide healthcare personnel with the appropriate cultural perspective concerning this vulnerable population (Kuzma et al., 2019).

According to Bonvicini (2017), "in the effort to reduce health disparities between specific patient populations, cultural competence and cultural humility programs have been the primary, yet broadly defined approach for training interventions for clinicians and healthcare personnel"

(p. 2358). To adequately address cultural and health-related issues specific to the LGBTQIA+ community, cultural competence and cultural humility must be employed by healthcare personnel in tandem, as these two approaches work synergistically and are necessary to deliver culturally congruent care to LGBTQIA+ individuals (Kuzma et al., 2019).

Cultural Competency Education and Training

Cultural competency education and training concentrating on clinical assessment and treatment of LGBTQIA+ individuals is lacking for healthcare professionals across disciplines and creating a supportive environment that is non-judgmental and welcoming for all patients requires all members of the healthcare team to be properly educated and trained (Bonvicini, 2017). To reduce the healthcare disparities felt within the LGBTQIA+ community, the profound knowledge gap in cultural competency that still exists must be closed. Healthcare providers are long overdue for cultural competency education and training that will enrich their professional development and shape their knowledge, attitudes, and beliefs toward LGBTQIA+ individuals (Bonvicini, 2017).

Medical Education

A key driver in increasing physicians' awareness and sensitivity toward LGBTQIA+ individuals is knowledge of LGBTQIA+ healthcare, yet substantial knowledge gaps and gaps in practice suggest the need for more education and training for physicians (Banerjee et al., 2018; Goldhammer et al., 2018). In spite of growing efforts to incorporate LGBTQIA+ specific content into medical school curricula, education on LGBTQIA+ health in medical school is still lacking (Goldhammer et al., 2018). In fact, approximately a third of medical schools in the U.S. reported 0 h of LGBTQIA+ specific content (Bonvicini, 2017, as cited in Obedin-Maliver et al., 2011). Julia Applegate from Equitas Health was quoted in an article published by Marbury

(2017) and stated, “On average, medical providers receive five hours of LGBT cultural competence training in their entire medical education”. Congruent with the current literature, studies conducted nationally have found that LGBTQIA+ specific content in medical school and residency programs is profoundly scarce (Goldhammer et al., 2018).

Education and training on LGBTQIA+ health for physicians in the clinical environment are scarce as well (Goldhammer et al., 2018). Sixteen percent of academic medical institutions in the U.S. provided cultural competence education and training, and more than half provided no training (Goldhammer et al., 2018, as cited in Khalili et al., 2015). In an organizational needs assessment conducted by Goldhammer et al. (2018), 20% of physicians conveyed unfamiliarity with LGBTQIA+ health issues. Such scarcities in cultural competence education and training for physicians could be the result of a number of barriers, including ineffective curricular materials, lack of trained faculty, limited instruction time, perception by faculty that LGBTQIA+ specific content is irrelevant, and the absence of LGBTQIA+ specific content on medical boards (Bonvicini, 2017, as cited in Tamas et al., 2010). Cultural competence education and training are critical next steps in increasing physicians’ awareness and sensitivity toward LGBTQIA+ individuals.

Nursing Education

The discipline of nursing is the largest discipline amongst healthcare professionals. Consequently, this puts nursing professionals in a prime position to exceedingly impact the healthcare experiences of LGBTQIA+ individuals (Ortelli, 2020). The degree to which LGBTQIA+ specific healthcare issues are incorporated into nursing school curricula is unclear (Bonvicini, 2017). Disappointingly, nursing students receive an average of 2.13 hours of LGBTQIA+ related content across their entire nursing school curriculum, leaving several nurses

poorly educated on the delivery of LGBTQIA+ culturally competent and sensitive healthcare (Kuzma et al., 2019, as cited in Lim et al., 2013; Ortelli, 2020). Findings from a study of practicing nurses illustrated most had not received any education or training in LGBTQIA+ health (Margolies & Brown, 2019, as cited in Carabez et al., 2015). In a study conducted by Dorsen and Van Devanter (2016), study participants noted no recollection of LGBTQIA+ cultural competence content in their undergraduate or graduate nursing programs. Study participants also noted that they did not learn about LGBTQIA+ health in their clinical training. These findings may in part be due to nursing educators being uncomfortable with and ill-prepared to deliver such content, as 72% reported being unprepared (Bonvicini, 2017, as cited in Sirota, 2013). This gap in knowledge may to some extent elucidate the claim that the nursing profession has historically disregarded LGBTQIA+ health-related needs and concerns (Ortelli, 2020).

Lack of cultural competency education and training hinders nurses' ability to provide high-quality healthcare to LGBTQIA+ individuals. However, "the literature is unclear about what constitutes best practices and acceptable measures for evaluating LGBT competency training" (Bonvicini, 2017, p. 2359). According to Jennings et al. (2019), to redress health disparities amongst LGBTQIA+ individuals, additional research must be conducted on how to construct and deploy interventions that improve training in caring for persons that self-describe and self-identify as LGBTQIA+ for nursing professionals.

A study conducted in 2015 revealed that nursing professionals possessed implicit heteronormative preferences (Margolies & Brown, 2019, as cited in Sabin et al., 2015). Even well-intended nurses, ones that believe they treat all patients the same regardless of their sexual orientation and gender identity, have not received adequate cultural competence education and

training (Margolies & Brown, 2019). If nurses are not adequately educated and trained about the unique healthcare needs of LGBTQIA+ individuals, they might, as a consequence, harbor poor attitudes and discomfort toward caring for LGBTQIA+ individuals, as well as condone stereotypes (Margolies & Brown, 2019). To provide LGBTQIA+ individuals with high-quality healthcare, LGBTQIA+ culture, language, and healthcare barriers must be well understood by nursing professionals (Margolies & Brown, 2019, as cited in Margolies & Brown, 2018).

Non-Clinical Staff Training

Creating a culturally competent and inclusive healthcare environment for LGBTQIA+ individuals requires the involvement of all members of the healthcare team, including the involvement of non-clinical staff from the parking lot attendant to the custodian. Patients' healthcare experiences begin the moment they arrive to the healthcare facility. "From the patient's perspective, every interaction contributes to the care experience beginning with the security guard at the hospital or clinic entrance, front office staff for registration, medical assistants, nurses, technicians, physicians, and billing staff" (Bonvicini, 2017, p. 2359). To guarantee the most optimal healthcare experience for LGBTQIA+ individuals, it is essential that non-clinical staff members receive cultural competency education and training. Ensuring all members of the healthcare team both clinical and nonclinical are appropriately and adequately trained will translate into patient-centered care and improved patient satisfaction.

Theoretical Framework

The Health Equity Framework developed by ETR, a not-for-profit organization dedicated to improving health outcomes and promoting health equity (ETR.org, n.d.), was selected as the theoretical framework to guide this study and to guide this study's PICO question under investigation: Do LGBTQIA+ individuals who receive healthcare from LGBTQIA+ inclusion

clinics feel more satisfied with their healthcare than those LGBTQIA+ individuals who receive healthcare from traditional clinics?

Background

According to Peterson et al. (2020), "health equity is a public health priority" (p. 1). However, according to research, present strategies to mitigate health disparities and inequities may be difficult for researchers and health professionals to adopt and may not gain public endorsement. Because present strategies fail to recognize the systemic roots of inequity, these health strategies often do not succeed in mitigating health disparities and inequities (Peterson et al., 2020). Consequently, to guarantee joint efforts of researchers and health professionals exemplify mutual views and opinions in reducing health disparities and advancing equity, gaining clarity on present health equity strategies is crucial (Peterson et al., 2020). Necessitating a single framework based on shared assumptions and practices, the Health Equity Framework was formulated to improve inequities of priority health outcomes.

The Health Equity Framework

The Health Equity Framework as shown in Appendix A is a science- and justice-based framework that demonstrates how health outcomes are influenced by complex interactions between individuals and their environments and highlights how cumulative experiences across the life-course give rise to health inequities (Peterson et al., 2020). Designed to address health inequities and advance health equity, the Health Equity Framework focuses on three core constructs: equity at the core of health outcomes; multiple, interacting spheres of influence; and a historical and life-course perspective (Peterson et al., 2020).

Development of Framework

The Health Equity Framework was developed as a unifying framework to support researchers and health professionals in employing a health equity strategy that would effectively address social determinants of health, decrease health disparities and inequities, improve health outcomes, and promote health equity (Peterson et al., 2020). The Health Equity Framework was developed in two phases (Peterson et al., 2020). During the first phase of development, researchers and health professionals evaluated several theoretical and conceptual frameworks that studied influences on health at various levels. Influences such as socio-political, neighborhood and community, family and relationships, and development of biology were studied. The advantages and disadvantages of these frameworks were discussed, and the researchers and health professionals could not reach consensus, as no one framework met their criteria. Therefore, features from a number of frameworks were modified to develop a single and simplistic framework to describe and investigate strategies to address social determinants of health (Peterson et al., 2020).

During the second phase of development, frequent interviews occurred with stakeholders in health equity, public health, and social science (Peterson et al., 2020). "The interviews centered on conceptual understanding of the framework and its functionality in application in research and practice" (Peterson et al., 2020, p. 2).

Foundational Concepts of Framework

The Health Equity Framework focuses on three core concepts: equity at the core of health outcomes; multiple interacting spheres of influence; and a historical and life-course perspective (Peterson et al., 2020). The Health Equity Framework encourages researchers and health professionals to think beyond traditional approaches in addressing health inequities and to

recognize the interplay between structural, relational, individual, and psychological factors as the systemic roots of inequity (Peterson et al., 2020).

Equity at the Core of Health Outcomes. Health equity, as defined by the Health Equity Framework, is possessing the personal agency and just access to resources and opportunities necessary to reach optimal physical, emotional, and social health (Peterson et al., 2020). Conversely, according to ETR (n.d.), "health inequities are the preventable differences in health outcomes closely linked to social, economic, and environmental conditions". Historically, interventions aimed at modifying an individual's personal agency to achieve optimal health outcomes (Peterson et al., 2020). Unfortunately, modifying an individual's personal agency alone was not sufficient, as this approach neglected to address the upstream social determinants that prohibited individuals and communities from achieving the best possible health and well-being (Peterson, et al., 2020). Rather, acknowledging that resources and opportunities are inequitably distributed amongst communities and access is thwarted by institutional and interpersonal prejudices, interventions must be aimed at modifying factors at a community level to shift our focus to health equity (Peterson, et al., 2020). If left unrectified, health inequities and suboptimal health outcomes will endure.

Spheres of Influence. Unlike other theoretical or conceptual frameworks where factors that impact health outcomes are either stratified or demonstrate pathways from factors to health behaviors, the Health Equity Framework illustrates four interconnected and interacting spheres of influence that shape health outcomes and inhibit or advance health equity and health inequities (Peterson et al., 2020). These four intersecting spheres of influence include systems of power, relationships and networks, individual factors, and physiological pathways. They embody both

risk factors and protective factors that determine health outcomes, as well as represent strategies and interventions that address those factors (Peterson et al., 2020).

Systems of Power. Distribution and access to resources and opportunities necessary to live healthy lives are governed by systems of power, which refers to policies, processes, and practices (Peterson et al., 2020). These policies, processes, and practices comprise both institutionalized and interpersonal signs of prejudice and perpetuate systematic and differential treatment amongst populations (Peterson et al., 2020). Though systems of power may foster health equity through unbiased access to resources and opportunities, they may conversely exacerbate health inequities through the allowance of biased social, economic, or environmental advantages for some populations, undermining fair access to resources and opportunities that afford populations the ability to live healthy lives (Peterson et al., 2020).

Relationships and Networks. The numerous associations and support systems comprised of family, friends, loved ones, and communities concurrently act as protective measures from behaviors that are detrimental to an individual's health, as well as sources that reinforce stigma, discrimination, or social pressure that result in worse health outcomes (Peterson, et al., 2020). Although social networks may facilitate health equity through support structures that ease the social handicap generated by systems of power, they may simultaneously worsen health outcomes either by the adverse effects of these social networks, or the social pressures to participate in risky behaviors that are health-harming (Peterson et al., 2020).

Individual Factors. Frequently driven by other spheres of influence such as systems of power, an individual's attitudes, skills, and behaviors are molded by their personal experiences and affect how they respond to social, economic, and environmental situations (Peterson et al., 2020). There is a strong correlation between improved health outcomes, greater life satisfaction,

and longer life expectancy when an individual possesses healthy social and emotional skills such as relationship skills and coping skills (Peterson et al., 2020).

Physiological Pathways. The Health Equity Framework acknowledges an individual's biological, physical, cognitive, and psychological aptitudes make a significant contribution to health outcomes (Peterson, et al., 2020). However, these aptitudes cannot be simplistically, or in certain instances, ethically altered through intervention. In a similar vein, the Health Equity Framework also acknowledges how other determining factors, and their respective timing and intensity may change biological, physical, cognitive, and psychological progression, which will lead to poor health outcomes (Peterson et al., 2020).

Historical and Life-Course Perspective. The Health Equity Framework emphasizes the effects the historical and developmental stages of the lifespan, from infancy, through adolescence, to adulthood, have on forming an individual's attitudes, behaviors, and outcomes (Peterson, et al., 2020). The Health Equity Framework also underscores that health inequities are a consequence of culminating factors throughout an individual's lifetime and spans generations.

Applicability of Framework to Doctor of Nursing Practice

According to Braveman et al. (2017), "health equity means that everyone has a fair and just opportunity to be as healthy as possible" (p. 1). Providing LGBTQIA+ individuals with an equal opportunity to live the best life possible involves eliminating the most ubiquitous barrier to LGBTQIA+ health, discrimination. Although recognition and acceptance of LGBTQIA+ individuals has increased, discrimination remains a major issue for these individuals, as many have reported encountering some degree of discrimination when seeking healthcare services (ANA, 2018).

According to the Robert Wood Johnson Foundation [RWJF] (n.d.), “discrimination has been widely shown to have significant, harmful effects on health and well-being”. In a study conducted by the Harvard T.H. Chan School of Public Health, RWJF, and National Public Radio (NPR), findings revealed extensive encounters of both institutional and individual discrimination amongst LGBTQIA+ Americans because of their LGBTQIA+ identity (RWJF, n.d.). More specifically, of the 489 LGBTQIA+ adults surveyed, 18% reported avoiding healthcare altogether in fear of being discriminated against (RWJF et al., 2017). Transgender individuals also reported extensive encounters of discrimination, as 22% reported avoiding healthcare altogether and 31% reported having no regular doctor or form of healthcare (RWJF et al., 2017).

Despite recent advances in equality for LGBTQIA+ individuals, the LGBTQIA+ community remains an excluded and marginalized population. LGBTQIA+ individuals have been pushed to society’s margins, often suffering discrimination, exclusion, and marginalization from society and the health promoting resources it has to offer (Braveman et al., 2017). “Health disparities among LGB persons are attributed to the common experience of stigma and marginalization, including that from healthcare providers and health institutions (Dorsen & Van Devanter, 2016, p. 3716).

At the core of healthcare is the nurse-patient relationship, and regardless of an individual’s sexual orientation or gender identity, nurses have a professional and an ethical duty to practice with compassion and respect for the human rights of all LGBTQIA+ individuals (ANA, 2018). According to Goldberg et al. (2018), “Nurses are guided by a code of ethics and a commitment to provide equitable and ethically sensitive care” (p. 262). However, developing a more authentic, compassionate, and politicized understanding of how to render LGBTQIA+ individuals visible in the context of their daily care is challenging (Goldberg et al., 2018).

To decrease health disparities and achieve greater health equity for this marginalized group, the Health Equity Framework can be integrated into nursing practice. Integrating the Health Equity Framework into nursing practice will allow the nurse to adopt an unbiased, science- and justice-based approach to caring for LGBTQIA+ individuals. Moreover, it will allow the nurse to deliver culturally congruent, safe care and advocate for LGBTQIA+ individuals (ANA, 2018). To demonstrate cultural congruence and safe care, nurses must advocate for equal access, services, and resources for LGBTQIA+ individuals (ANA, 2018). By employing a health equity strategy into nursing practice that would effectively address social determinants of health, decrease health disparities, and improve inequities of priority health outcomes, nurses could provide LGBTQIA+ individuals with an equal opportunity to live the best life possible.

Applicability of Framework to Study

Figure 1 below illustrates the applicability of the Health Equity Framework in creating inclusive and equitable healthcare for LGBTQIA+ individuals. See Appendix A for complete infographic of ETR's Health Equity Framework and permission from ETR to reprint the Health Equity Framework infographic in this study.

Figure 1

The Health Equity Framework Applied

While healthcare is an immense policy matter that drives health outcomes for LGBTQIA+ individuals at the population level, health equity policies that mitigate the effects of big policies on health disparities for LGBTQIA+ individuals at the institutional level must be endorsed as well (Peterson et al., 2020). To improve health outcomes for LGBTQIA+ individuals, the healthcare environment, and strategies to restore justice and equity must shift healthcare practices toward repairing harm, elevating the voices of LGBTQIA+ individuals, and improving the healthcare climate (Peterson et al., 2020).

Summary of the Review of Literature

Earlier research revealed LGBTQIA+ individuals continue to be threatened by stigma and discrimination, plagued with an overabundance of health-related disparities and inequities, and confronted with significant obstacles when accessing high-quality healthcare. As a result, LGBTQIA+ individuals underutilize the healthcare system, underscoring the high demand for LGBTQIA+ inclusion health services and culturally competent and sensitive healthcare providers. The following chapter outlines the study's methodology.

Chapter 3

Methodology

This study was an on-line questionnaire study aimed at evaluating the difference in patient satisfaction scores between LGBTQIA+ individuals who receive healthcare from LGBTQIA+ inclusion clinics and LGBTQIA+ individuals who receive healthcare from traditional clinics. This chapter describes the methods and procedures that were used to conduct this research study.

Study Design

This study adopted a nonexperimental, nonrandom, cross-sectional study adhering to a quantitative methodology.

Sample and Setting

This study was an on-line questionnaire study. Research subjects were located through the Wisconsin LGBT Chamber of Commerce, the Outreach LGBT Community Center in Madison, Wisconsin, and LGBTQIA+ on-line communities such as Oncology Nursing Society Member Community and Facebook, an on-line social media and social networking service. A nonrandom convenience sample of LGBTQIA+ individuals was selected from these respective LGBTQIA+ organizations and on-line communities and invited to participate in this on-line questionnaire study by way of Qualtrics, a web-based survey tool. The on-line survey link was sent to these respective LGBTQIA+ organizations and on-line communities for dissemination to their members. Snowball sampling by study participants was encouraged, and study participants were instructed to share survey links with other potential study subjects. A nonrandom convenience sample of 56 study participants (n=56) participated in this on-line questionnaire study. Study inclusion criteria included self-describing or self-identifying as LGBTQIA+, being a member of the LGBTQIA+ community, and being $\geq$ 18-years old.

To determine an adequate sample size for this study, a power analysis was conducted. To allow for a closer estimate of the sample size needed, preliminary calculations were conducted at different values of d using G*Power (Faul et al., 2017). Based on preliminary calculations, it was determined that an adequate sample size needed for this study with an estimated cohen's d of .5 (medium effect) was 210. This sample size would be needed to achieve a 95% power rate, correctly rejecting our null hypothesis 95% of the time, with a p-value of .05 assuming equal sample sizes.

Procedure and Ethical Considerations

To protect human study subjects from violation of human rights, study protocol review and approval was obtained from Edinboro University's Institutional Review Board (IRB) prior to recruitment and participation of human subjects. Edinboro University's IRB awarded expedited review for this study protocol. The study protocol approval memo from the IRB is available in Appendix B. Informed and written consent as shown in Appendix C was obtained electronically from all study participants. The consent to participate in this research study was embedded in the Qualtrics on-line survey. Prior to entering the on-line survey, study participants were asked whether they consent to completing the survey. If study participants answered yes, they were allowed to enter the survey. If study participants answered no, the survey was discontinued.

Study participants were members of the LGBTQIA+ community and active members of the Wisconsin LGBT Chamber of Commerce, the Outreach LGBT Community Center in Madison, Wisconsin, LGBTQIA+ on-line communities such as Oncology Nursing Society Member Community and Facebook, and potential referrals from other study participants. Permission to distribute the on-line questionnaire to members of these respective organizations was requested and obtained. Permission was requested from the Milwaukee LGBT Community Center in Milwaukee, Wisconsin, the LGBT Center of Southeastern Wisconsin in Racine, Wisconsin, and the University of Wisconsin – Milwaukee LGBT Resource Center to distribute the on-line questionnaire, but permission was not granted

Following informed and written consent, study participants were asked to complete an electronic version of the Short-Form Patient Satisfaction Questionnaire (PSQ-18). The questionnaire was administered by way of Qualtrics, a web-based survey tool. The survey

link was sent to the respective LGBTQIA+ organizations and on-line communities for dissemination to their members as previously described. A cover letter as shown in Appendix D describing the questionnaire, along with questionnaire instructions, was included. An explanation regarding who qualifies as a "Doctor" was provided within the questionnaire at its start. Similarly, an explanation of "Inclusion" health clinic was also provided when study participants were asked whether they seek healthcare from an LGBTQIA+ inclusion health clinic. Study participants' consent to participate in this study was required to access the questionnaire. Study participants must have been $\geq$ 18-years old and self-described or self-identified as LGBTQIA+.

Measure

The Short-Form Patient Satisfaction Questionnaire (PSQ-18) as shown in Appendix E was utilized to evaluate the difference in patient satisfaction scores between LGBTQIA+ individuals who receive healthcare from LGBTQIA+ inclusion clinics and LGBTQIA+ individuals who receive healthcare from traditional clinics. The PSQ-18 is a public document obtained from RAND Health Care and is available without charge. Permission from RAND Health Care to use the PSQ-18 was not required. The PSQ-18 was derived from the Patient Satisfaction Questionnaire (PSQ-III), which is a 50-item questionnaire evaluating universal satisfaction with medical care, as well as satisfaction with six aspects of care (RAND Health Care, n.d.). The six aspects of care include technical quality, interpersonal manner, communication, financial aspects of care, time spent with doctor, and accessibility of care.

The short-instrument, the PSQ-18, retains many features of the PSQ-III (RAND Health care, n.d.). It is a18-question instrument drawing from each of the seven aspects of satisfaction with medical care measured by the PSQ-III: general satisfaction, technical quality, interpersonal

manner, communication, financial aspects, time spent with doctor, and accessibility and convenience (RAND Health Care, n.d.). The PSQ-18 uses a 5-point Likert-type scale where 1 is strongly agree and 5 is strongly disagree. These 18 questions align well with the three foundational concepts of the Health Equity Framework: equity at the core of health outcomes; multiple, interacting spheres of influence; and a historical and life-course perspective (Peterson et al., 2020). Each question of the PSQ-18 questionnaire is constructed as a statement of opinion (RAND Health Care, n.d). The PSQ-18 takes nearly three to four minutes to complete.

The PSQ-18, although brief, is a comprehensive and effective instrument. According to Thayaparan and Mahdi (2013), the PSQ-18 is a "concise, validated tool that may be applied to various settings, as well as comparing interventions" (p. 1). Although derived and abridged from much larger questionnaires, the PSQ-18 was developed through rigorous research, preserving internal consistency and reliability (Thayaparan & Mahdi, 2013). According to RAND Health Care (n.d.), its sub-scale scores are markedly associated with their full-scale counterparts, illustrating acceptable internal consistency reliability. "Moreover, both the magnitude of the correlation coefficients and the overall pattern of correlations among PSQ-18 sub-scales are highly similar to those observed for the PSQ-III" (RAND Health Care, n.d.). Because the PSQ-18 was validated in its entirety, the questionnaire was utilized as specified by the survey developer, RAND Health Care.

Data Collection

Sociodemographic data and primary data were collected from 56 study participants (n=56). Basic sociodemographic data such as sexual orientation, gender identity, age, race and ethnicity, education level, employment status, income level, and insurance status was collected at the completion of the PSQ-18 questionnaire. Study participants were also asked whether or not

they self-described or self-identified as LGBTQIA+. This was designed as a logic question. If the study participant answered yes, the survey advanced to the next question to ascertain the respondent's sexual orientation. If the respondent answered no, the sexual orientation question was skipped. To maintain privacy and confidentiality, direct identifiers were not collected from study participants, and anonymity was maintained. In addition to ascertaining basic sociodemographic data, one researcher-generated question was used to determine whether study participants receive healthcare from LGBTQIA+ inclusion clinics or from traditional clinics. To organize and secure data, collected demographic data was coded and electronically exported into an IBM SPSS Statistics Version 28 data sheet, stored there, and later used for data analysis.

The data collection procedure was conducted over a three-week period. Primary data was collected using an electronic version of the PSQ-18 to evaluate the difference in patient satisfaction scores between LGBTQIA+ individuals who receive healthcare from LGBTQIA+ inclusion health clinics and LGBTQIA+ individuals who receive healthcare from traditional health clinics. This instrument was selected because it is a valid and reliable measure. The PSQ-18 was used to measure overall satisfaction with medical care, as well as satisfaction with seven aspects of care: overall satisfaction, technical quality, interpersonal manner, communication, financial aspects of care, time spent with doctor, and accessibility of care. The instrument is comprised of 18 questions using a 5-point Likert-type scale where 1 is strongly agree and 5 is strongly disagree.

Primary data was collected electronically from enrolled study participants through Qualtrics, a web-based survey tool, sent by way of a survey link to LGBTQIA+ community organizations and on-line communities for dissemination to their respective members. Again, to maintain privacy and confidentiality, direct identifiers were not collected from study

participants, and anonymity was maintained. Survey administration, sampling, and scoring guidelines provided by the survey developer, RAND Health Care, were followed. To organize and secure data, the PSQ-18 data was coded and electronically exported into an IBM SPSS Statistics Version 28 data sheet, stored there, and later used for data analysis.

Study Timeline

This study was completed over a three-week data collection period.

Summary of Methodology

This chapter outlined the methods and procedures that were used to answer whether LGBTQIA+ individuals who receive healthcare from LGBTQIA+ inclusion clinics feel more satisfied with their healthcare than those who do not receive healthcare from inclusion clinics. The following chapter discusses this study's data analysis procedure, results, and limitations.

Chapter 4

Results and Discussion

Given the paucity of research on whether the healthcare provided by LGBTQIA+ inclusion clinics results in improved patient satisfaction, this study sought to measure differences in overall patient satisfaction between those who receive healthcare from LGBTQIA+ inclusion clinics and those who receive healthcare from traditional clinics. The study results will be discussed in this chapter.

Data Analysis

The data analysis employed both descriptive and inferential statistics. Sociodemographic data was summarized and reported using descriptive statistics and frequencies. Descriptive statistics were also used for patient satisfaction to test against assumptions for inferential procedures. To test for differences in patient satisfaction amongst LGBTQIA+ respondents who

receive healthcare from LGBTQIA+ inclusion health clinics and LGBTQIA+ respondents who receive healthcare from traditional health clinics, the independent samples *t*-test was conducted on each sub-scale and overall scale of patient satisfaction. In cases of assumption violations, the nonparametric independent samples Mann-Whitney *U* test was completed instead of the parametric independent samples *t*-test. To determine the relationship between high- and lower-income earners and patient satisfaction, a point-biserial correlation was conducted. IBM SPSS Statistics Version 28 statistical software was used to perform the statistical analysis. The study used a two-tailed alpha level of .05 for all significance tests.

Missing Data

Fifty-six (*n=56)* of 60 total survey respondents completed the on-line survey in its entirety for a response rate of 93%. Because sociodemographic information was not collected from 4 respondents, their characteristics could not be described. With the exception of clicking yes on the consent form and consenting to complete the survey, 4 observations were completely missing. Therefore, these 4 respondents were removed from the dataset, as they did not complete any section of the on-line survey.

Discussion of Results

Fifty-six study subjects (*n*=56) participated in this research study. Thirty-seven of the fifty-six survey respondents (66.1%) indicated that they did not seek healthcare from LGBTQIA+ inclusion clinics, whereas 25% of the fifty-six survey respondents indicated they did seek healthcare from LGBTQIA+ inclusion clinics, or they were unsure (8.9%). This resulted in an unbalanced design for the independent samples *t*-test. To determine if there is a statistically significant difference in mean values between these two groups, the independent samples *t*-test was conducted on each sub-scale and overall scale of patient satisfaction. None of the

sub-scale or overall scale comparisons tested were statistically significant using a two-tailed test at α=.05. Study results indicated that there was too small a sample size to detect differences in the population. For the Communications sub-scale, respondents who went to inclusion clinics had significantly higher communication satisfaction than those who did not go to inclusion clinics as illustrated by the nonparametric independent samples Mann-Whitney *U* test. The distributions in the two groups significantly differed and had a small effect size. To determine the relationship between high- and lower-income earners and patient satisfaction, a point-biserial correlation was conducted. It was concluded that there was not a relationship between the two variables, as there was a non-significant positive correlation between income and patient satisfaction.

Sociodemographic Characteristics

As part of the on-line survey, basic sociodemographic data such as sexual orientation, gender identity, age, race and ethnicity, education level, employment status, income level, and insurance status was collected from 56 study participants (*n*=56). The sample that was collected was primarily white 85.7% (*n*=48), highly educated, with high salaries. Fifty percent (*n*=28) of the respondents reported having a Bachelor's degree, 28.5% (*n*=16) of the respondents reported having a Master's degree, and 55.3% (*n*=31) earned salaries greater than $100,000 annually. In the overall population, the majority of respondents 87.5% (*n*=49) identified as cisgender. None of the survey respondents identified as transgender. One hundred percent (*n*=56) of the respondents had health insurance. To describe demographic characteristics more effectively, frequency distribution tables of demographic variables by clinic type with correlating graphs for visualization are illustrated below in Tables 1 through 8 and Charts 1 through 8.

Table 1

Frequency Distribution of Sexual Orientation of Survey Respondents by Clinic Type (n=56)

Do you seek healthcare from a LGBTQIA+ inclusion health clinic?		Frequency	Percent
Yes	Bisexual	1	7.1
	Gay	11	78.6
	Lesbian	2	14.3
	Total	14	100.0
No		1	2.7
	Asexual	1	2.7
	Bisexual	3	8.1
	Gay	12	32.4
	Lesbian	19	51.4
	Pansexual	1	2.7
	Total	37	100.0
Unsure	Asexual	1	20.0
	Gay	2	40.0
	Lesbian	2	40.0
	Total	5	100.0

Chart 1

Sexual Orientation of Survey Respondents by Clinic Type (n=56)

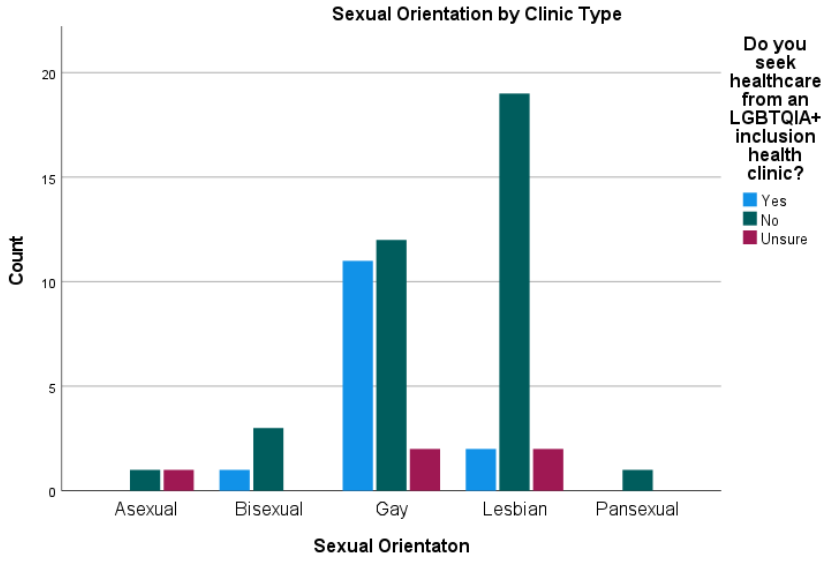


Table 2

Frequency Distribution of Gender Orientation of Survey Respondents by Clinic Type (n=56)

Do you seek healthcare from a LGBTQIA+ inclusion health clinic?		Frequency	Percent
Yes	Cisgender Female	5	35.7
	Cisgender Male	9	64.3
	Total	14	100.0
No	Missing	3	8.1
	Bigender	1	2.7
	Cisgender Female	20	54.1
	Cisgender Male	11	29.7
	Genderqueer	1	2.7
	Non-binary	1	2.7
	Total	37	100.0
Unsure	Missing	1	20.0
	Cisgender Female	2	40.0
	Cisgender Male	2	40.0
	Total	5	100.0

Chart 2

Gender Orientation of Survey Respondents by Clinic Type (n=56)

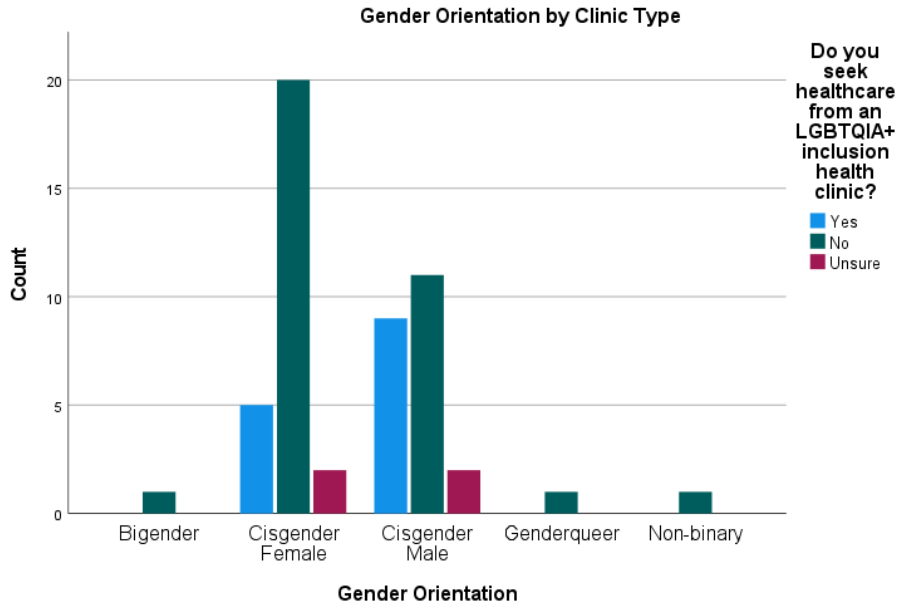


Table 3

Frequency Distribution of Race/Ethnicity of Survey Respondents by Clinic Type (n=56)

Do you seek healthcare from a LGBTQIA+ inclusion health clinic?		Frequency	Percent
Yes	Asian or Pacific Islander	1	7.1
	Hispanic or Latino	1	7.1
	White or Caucasian	12	85.7
	Total	14	100.0
No	Asian or Pacific Islander	2	5.4
	Hispanic or Latino	1	2.7
	Multiracial or Biracial	2	5.4
	Native American or Alaskan Native	1	2.7
	White or Caucasian	31	83.8
	Total	37	100.0
Unsure	White or Caucasian	5	100.0

Chart 3

Race/Ethnicity of Survey Respondents by Clinic Type (n=56)

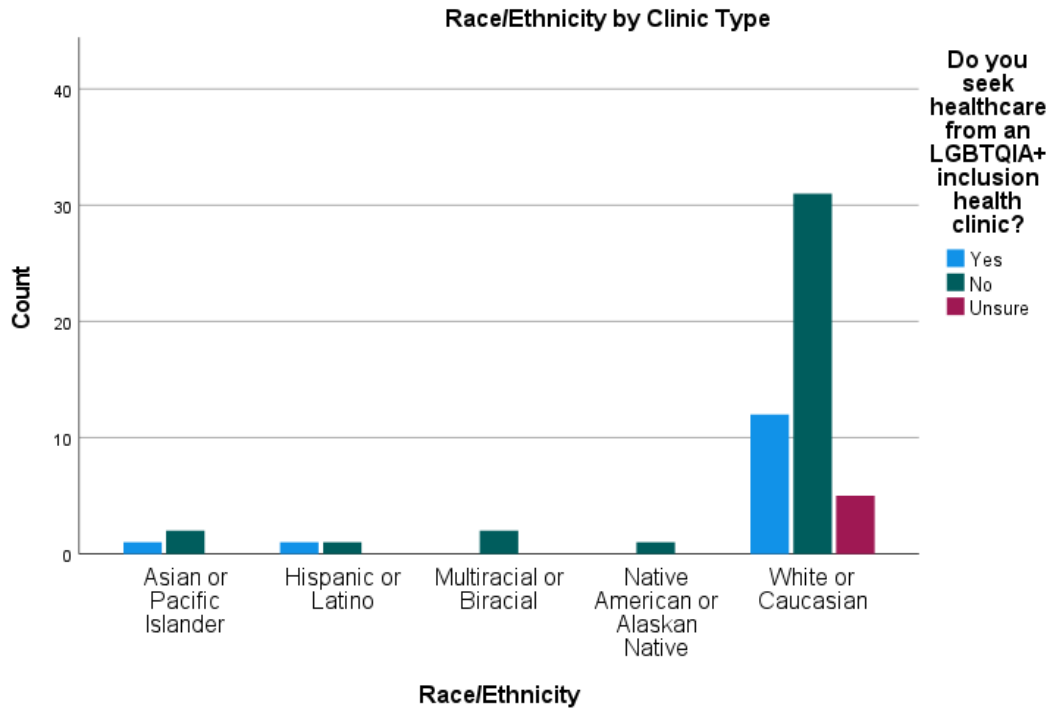


Table 4

Frequency Distribution of Age of Survey Respondents by Clinic Type (n=56)

Do you seek healthcare from a LGBTQIA+ inclusion health clinic?		Frequency	Percent
Yes	25-34 years old	3	21.4
	35-44 years old	2	14.3
	45-54 years old	6	42.9
	55 or older	3	21.4
	Total	14	100.0
No	18-24 years old	1	2.7
	25-34 years old	2	5.4
	35-44 years old	8	21.6
	45-54 years old	8	21.6
	55 or older	18	48.6
	Total	37	100.0
Unsure	25-34 years old	1	20.0
	35-44 years old	2	40.0
	45-54 years old	1	20.0
	55 or older	1	20.0
	Total	5	100.0

Chart 4

Age of Survey Respondents by Clinic Type (n=56)

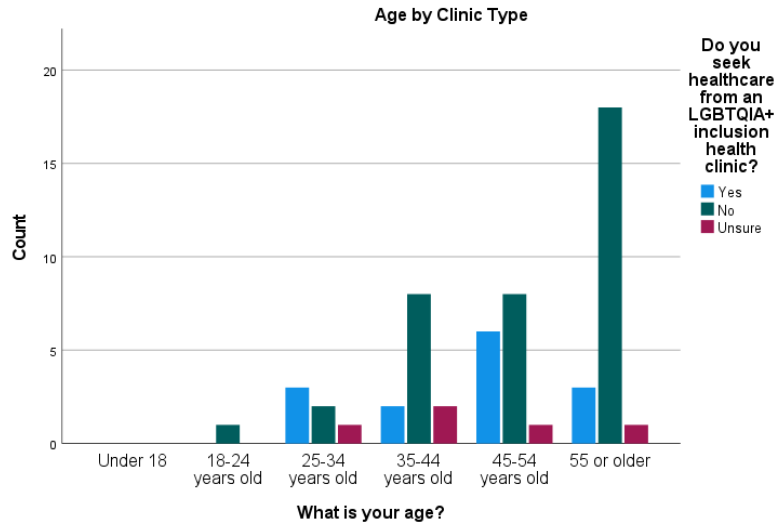


Table 5

Frequency Distribution of Education Level of Respondents by Clinic Type (n=56)

Do you seek healthcare from a LGBTQIA+ inclusion health clinic?		Frequency	Percent
Yes	Some college, no degree	1	7.1
	Bachelor's degree (e.g. BA, BS)	8	57.1
	Master's degree (e.g. MA, MS, MEd)	5	35.7
	Total	14	100.0
No	Some college, no degree	3	8.1
	Associate degree (e.g. AA, AS)	3	8.1
	Bachelor's degree (e.g. BA, BS)	19	51.4
	Master's degree (e.g. MA, MS, MEd)	10	27.0
	Doctorate (e.g. PhD, EdD)	2	5.4
	Total	37	100.0
Unsure	Some college, no degree	1	20.0
	Bachelor's degree (e.g. BA, BS)	1	20.0
	Master's degree (e.g. MA, MS, MEd)	1	20.0
	Professional degree (e.g. MD, DDS, DVM)	1	20.0
	Doctorate (e.g. PhD, EdD)	1	20.0
	Total	5	100.0

Chart 5

Education Level of Respondents by Clinic Type (n=56)

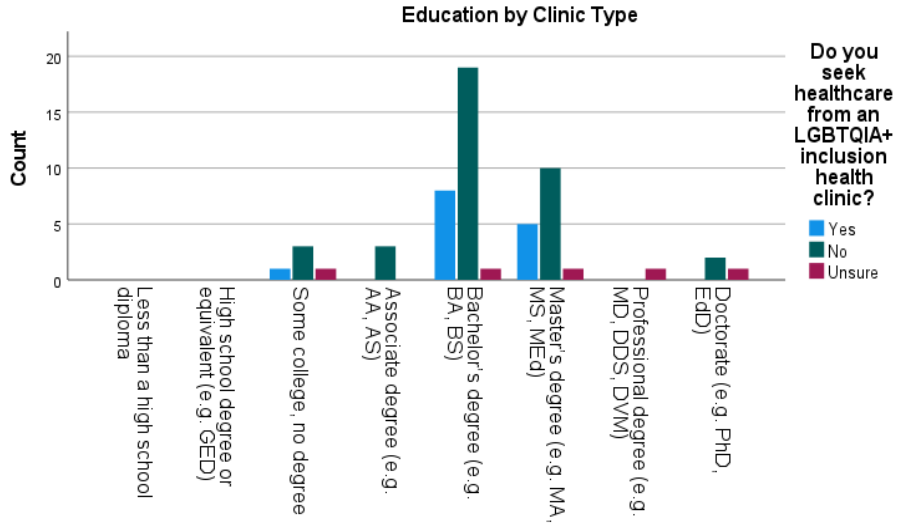


Table 6

Frequency Distribution of Health Insurance Status of Survey Respondents by Clinic Type (n=56)

Do you seek healthcare from a LGBTQIA+ inclusion health clinic?	Insured	Frequency	Percent
Yes	Yes	14	100.0
No	Yes	37	100.0
Unsure	Yes	5	100.0

Chart 6

Health Insurance Status of Survey Respondents by Clinic Type (n=56)

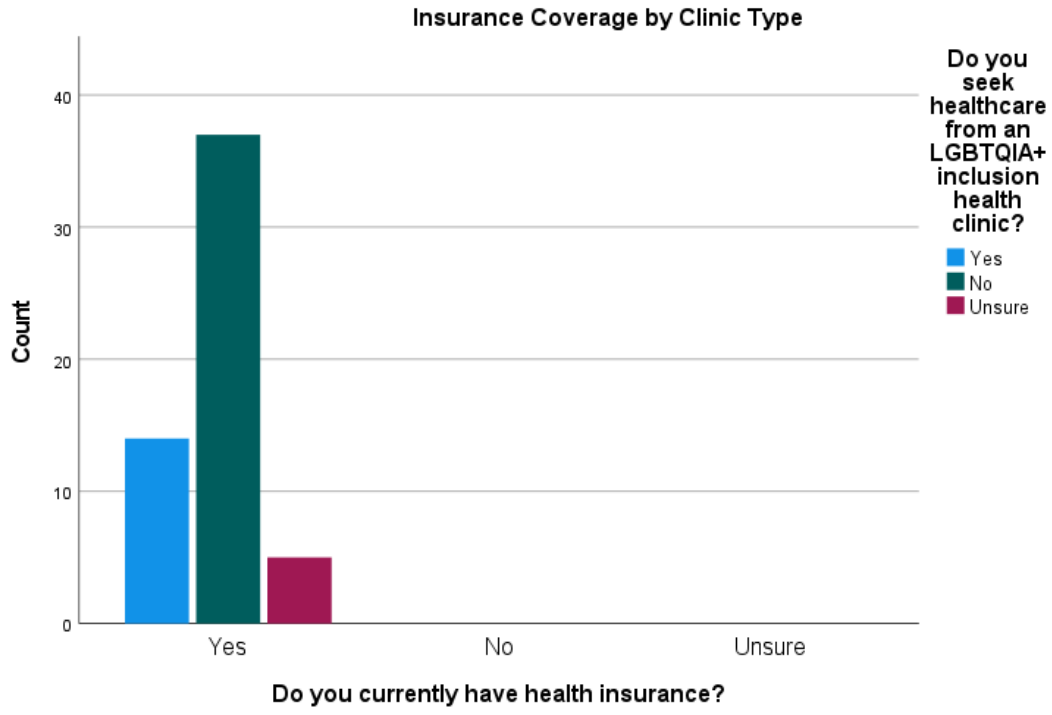


Table 7

Frequency Distribution of Employment Status of Survey Respondents by Clinic Type (n=56)

Do you seek healthcare from a LGBTQIA+ inclusion health clinic		Frequency	Percent
Yes	Employed full time (40 or more hours per week)	11	78.6
	Employed part time (up to 39 hours per week	1	7.1
	Homemaker	1	7.1
	Self-employed	1	7.1
	Total	14	100.0
No	Employed full time (40 or more hours per week)	24	64.9
	Employed part time (up to 39 hours per week	3	8.1
	Retired	5	13.5
	Self-employed	3	8.1
	Student and Employed full time (40 or more hours per week)	1	2.7
	Unable to work	1	2.7
	Total	37	100.0
Unsure	Employed full time (40 or more hours per week)	4	80.0
	Unemployed and currently looking for work	1	20.0
	Total	5	100.0

Chart 7

Employment Status of Survey Respondents by Clinic Type (n=56)

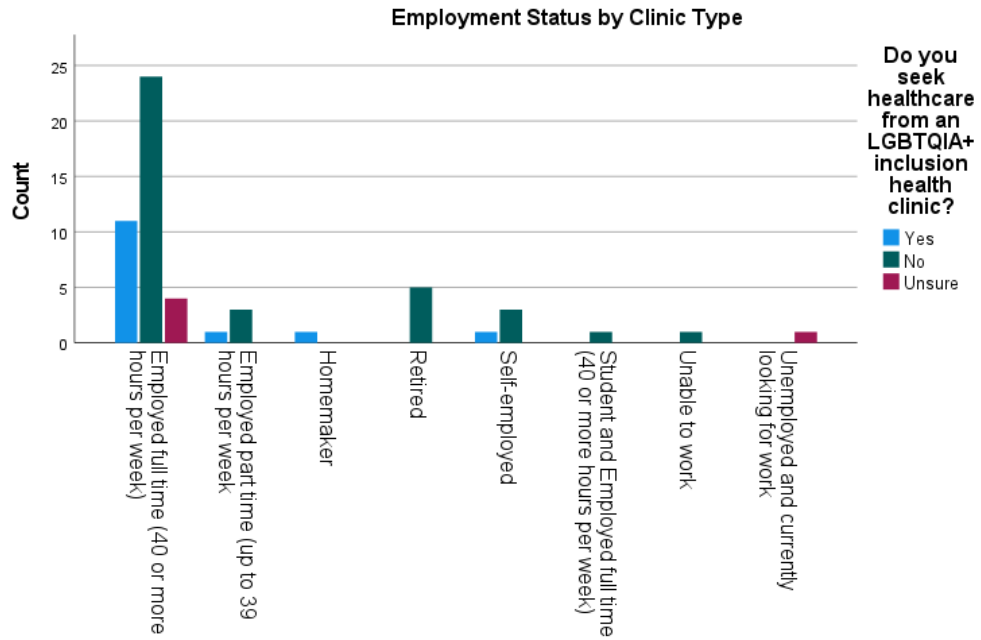


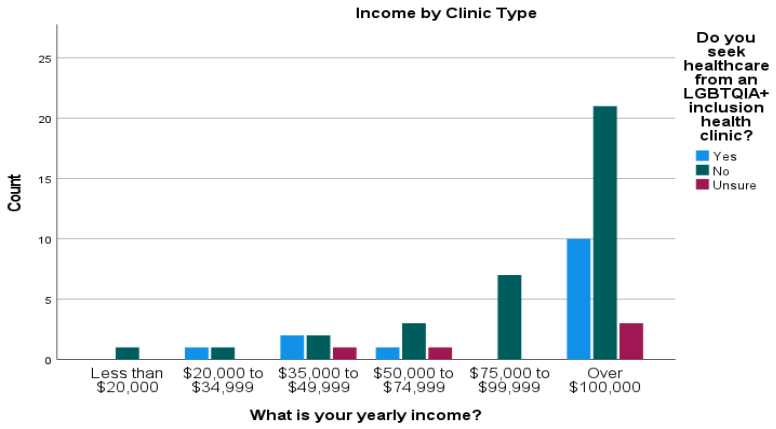
Table 8

Frequency Distribution of Income Level of Survey Respondents by Clinic Type (n=56)

Do you seek healthcare from a LGBTQIA+ inclusion health clinic?		Frequency	Percent
Yes	$20,000 to $34,999	1	7.1
	$35,000 to $49,999	2	14.3
	$50,000 to $74,999	1	7.1
	Over $100,000	10	71.4
	Total	14	100.0
No	Less than $20,000	1	2.7
	$20,000 to $34,999	1	2.7
	$35,000 to $49,999	2	5.4
	$50,000 to $74,999	3	8.1
	$75,000 to $99,999	7	18.9
	Over $100,000	21	56.8
	Total	35	94.6
	Missing	2	5.4
	Total	37	100.0
Unsure	$35,000 to $49,999	1	20.0
	$50,000 to $74,999	1	20.0
	Over $100,000	3	60.0
	Total	5	100.0

Chart 8

Income Level of Survey Respondents by Clinic Type (n=56)



Comparing Survey Respondents by Clinic Type

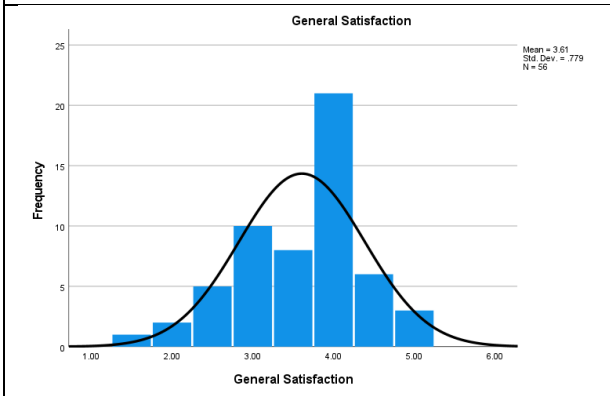
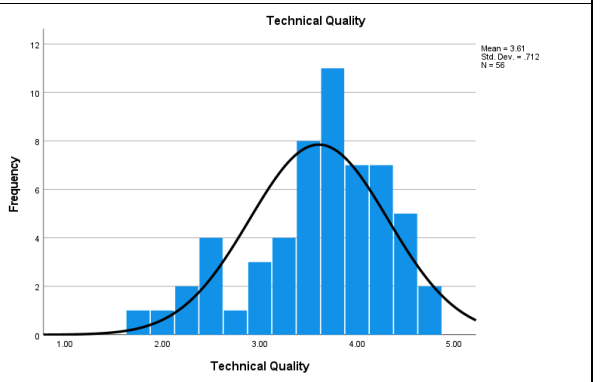
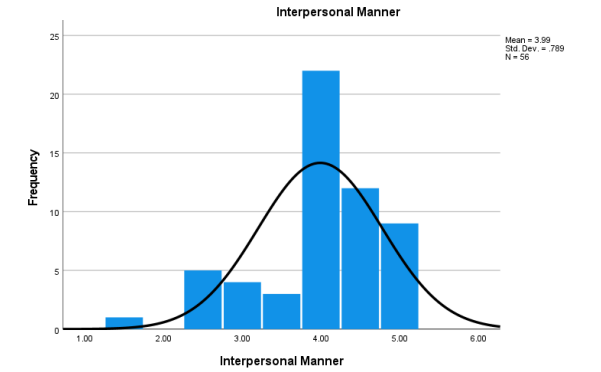
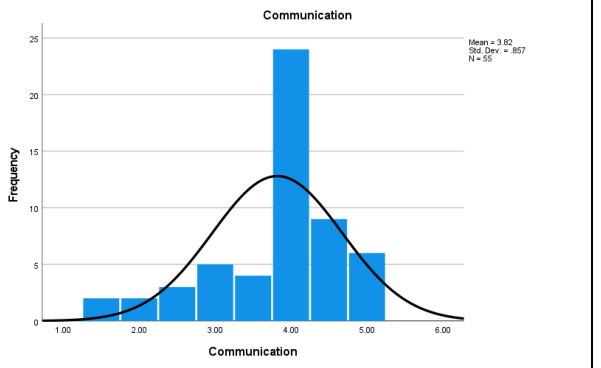
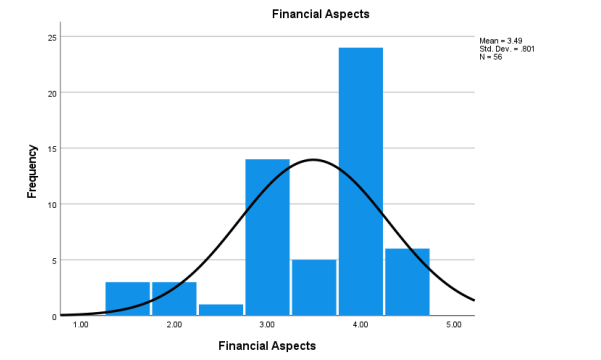
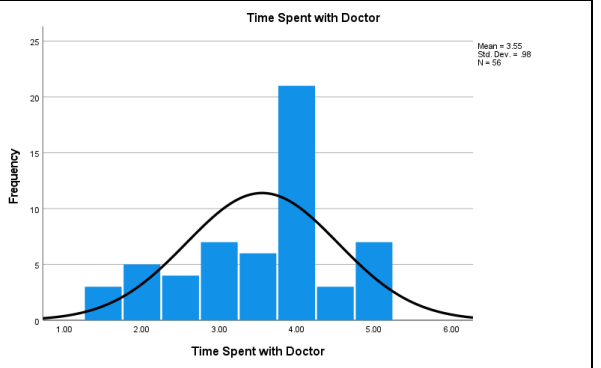
The PSQ-18 questionnaire was used to measure respondents' overall level of satisfaction with their healthcare using a 5-point Likert-type scale where 1 is strongly agree and 5 is strongly disagree. The PSQ-18 measures seven aspects of satisfaction with medical care: general satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with doctor, and accessibility and convenience (RAND Health Care, n.d.). Respondents were asked whether they "seek healthcare from a LGBTQIA+ inclusion clinic". Fourteen of the 56 respondents (n=56) indicated that they did seek care at a LGBTQIA+ inclusion clinic, and 37 of the 56 respondents (n=56) indicated that they did not seek care at a LGBTQIA+ inclusion clinic. The remaining 5 respondents were unsure whether they sought care at a LGBTQIA+ inclusion clinic. Because 66.1% of respondents did not seek care at a LGBTQIA+ inclusion clinic, this resulted in an unbalanced design for the independent samples *t*-test. This imbalance is congruent with what is elucidated in the current literature. In a study conducted by Martos et al. (2019), only 13% of LGBTQIA+ individuals surveyed reported utilizing LGBTQIA+ inclusion clinics in the past five years.

Assumption Check

The assumptions for the independent samples *t*-test were reasonably well met for most of the comparisons. The normality assumption was met for all sub-scales and overall scale except the Communication and Financial Aspects sub-scales. Communication and Financial Aspects sub-scales as shown in Chart 9 had a negatively skewed distribution, thus leaning to the higher end. The Levene's test for equality of variances (see Table 9) was rejected for the Financial Aspects sub-scale, therefore equal variances could not be assumed for this sub-scale.

Chart 9

Normality Assumption of Scales

General Satisfaction Sub-scale	Technical Quality Sub-scale
	
Interpersonal Manner Sub-scale	**Communication Sub-scale**
	
Financial Aspects Sub-scale	**Time Spent with Doctor Sub-scale**
	
Accessibility and Convenience Sub-scale	**Overall Scale**

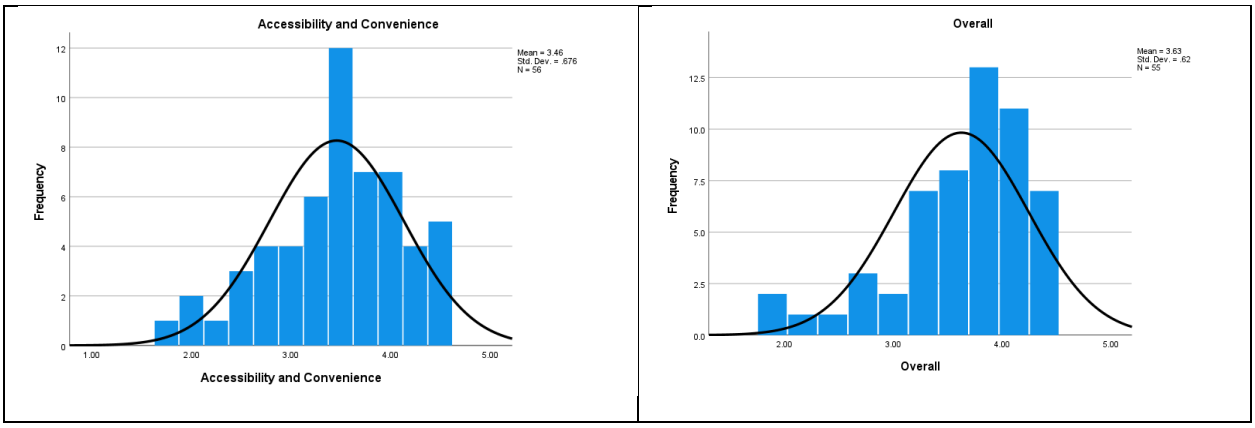


Table 9

Levene's Test for Equality of Variances

Scale	**Levene's Statistic (F)**	***p* value**
General Satisfaction Sub-scale	.007	.935
Technical Quality Sub-scale	.008	.929
Interpersonal Manner Sub-scale	.261	.612
Communication Sub-scale	.058	.811
Financial Aspects Sub-scale	**4.337**	**.043**
Time Spent with Doctor Sub-scale	1.463	.232
Accessibility and Convenience Sub-scale	.004	.952
Overall Scale	.151	.699

Due to assumption violations, the Communication and Financial Aspects sub-scales were tested using the nonparametric independent samples Mann-Whitney *U* test instead of the parametric independent samples *t*-test. The Mann-Whitney *U* test is a nonparametric test that has very few assumptions about the data. The test compares the difference between two independent groups when the dependent variable is ordinal or continuous, but not normally

distributed. The test does not have an assumption for equality of variance, which makes this test a good substitution for the Communication and Financial Aspects sub-scales. However, because this is a nonparametric test, inferences cannot be drawn about the overall population of LGBTQIA+ individuals that seek care at both inclusive clinics and traditional clinics. For these sub-scales, the sample data can only be looked at and checked for differences at the sample level. Due to this, caution must be exercised when interpreting the results of the nonparametric tests.

Parametric Independent Samples t-test

To test for differences in patient satisfaction between LGBTQIA+ respondents who receive healthcare from LGBTQIA+ inclusion clinics and those who do not, the independent samples *t*-test was conducted on each sub-scale and overall scale of patient satisfaction to determine if there is a statistically significant difference in mean values between these two groups. None of the sub-scale or overall scale comparisons tested were statistically significant using a two-tailed test at $\alpha=.05$ as shown in Table 10. Effect sizes were medium for General Satisfaction, Interpersonal Manner, and Accessibility and Convenience sub-scales, as well as the Overall scale. This indicated that there was too small a sample size to detect differences in the population. To test this theory, achieved power was calculated using G*Power. The probability to correctly reject the null hypothesis with this sample size is quite low. Four of the six scales tested had between 34.22% and 37.52% chance of correctly rejecting the null hypothesis. The Time Spent with Doctor sub-scale only had a 7.43% chance of correctly rejecting the null hypothesis. The Technical Quality sub-scale also had a small chance at 9.83%. Even if there is a difference in the population, given the small sample size, it is unlikely the difference would be detected. More research is needed with larger sample sizes to investigate whether there is a

difference in patient satisfaction between those who seek healthcare at LGBTQIA+ inclusion clinics and those who do not.

Table 10

Parametric Independent Samples t-test Findings

Scale	*t*-statistic	df	*p* value	Mean Difference	Effect Size (Cohen's d)	Achieved Power
General Satisfaction Sub-scale	1.674	49	.101	.40637	.5068	.3535
Technical Quality Sub-scale	.664	49	.510	.14913	.2053	.0983
Interpersonal Manner Sub-scale	1.593	49	.118	.39382	.4970	.3422
Time Spent with Doctor Sub-scale	.494	49	.312	.15637	.1464	.0743
Accessibility and Convenience Sub-scale	1.683	49	.099	.35618	.5151	.3631
Overall Scale	1.722	48	.092	.34026	.5400	.3752

Nonparametric Tests

Mann-Whitney *U*. An independent samples Mann-Whitney *U* test as shown in Table 11 was conducted for the Communication and Financial Aspects sub-scales to determine if the differences in the inclusion clinic and non-inclusion clinic distributions were significantly different from each other. This is only for this particular sample, as the assumptions for these sub-scales were not met**.**

For the Financial Aspects sub-scale, the mean for LGBTQIA+ inclusion clinic respondents is 3.75 (SD=.546), and the mean for non-inclusion clinic respondents is 3.42 (SD=.901) as shown in Table 13. The distributions in the two groups did not differ significantly (Mann–Whitney $U = 215.5$, $n = 51$, $p = .332$).

For the Communications sub-scale, the mean for LGBTQIA+ inclusion clinic respondents is 4.15 (SD=.851), and the mean for non-inclusion clinic respondents is 3.69 (SD=.853) as shown in Table 13. The distributions in the two groups significantly differed and

had a small effect size (Mann–Whitney U = 147, n=50, p=.030, $\frac{Z}{\sqrt{n}}$=.3067). In this sample, respondents who went to LGBTQIA+ inclusion clinics had significantly higher communication satisfaction than those who did not go to inclusion clinics.

Table 11

Mann-Whitney U Test Findings for Communication and Financial Aspects Sub-scales

Scale	Mann-Whitney *U*	n	*p*-value	Effect Size		Achieved Power
Communication Sub-scale	147	50	.030	.3067		.3665
Financial Aspects Sub-scale	215.5	51	.332	.1358		.2732

Point-Biserial Correlation. A point-biserial correlation was conducted to determine the relationship between high- and lower-income earners (high income = $100,000 or higher; lower income = 99,999 or below) and patient satisfaction. As shown in Chart 10, there was a non-significant positive correlation between income level and patient satisfaction, (r_{pb} =.232, n = 53, p = .095). This finding further supports the need for a more diverse and representative sample of the overall LGBTQIA+ population. Correlations are illustrated in Table 12.

Chart 10

Point-Biserial Correlation Between High- and Lower-Income Earners and Patient Satisfaction

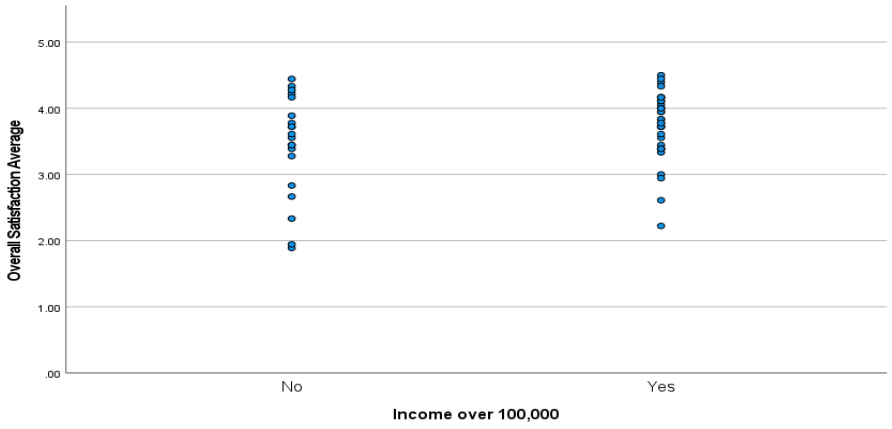


Table 12

Correlations Between High- and Lower-Income Level and Overall Satisfaction

		Income over 100,000	Overall Satisfaction
Income over 100,000	Pearson Correlation	1	.232
	Sig. (2-tailed)		.095
	N	54	53
Overall Satisfaction	Pearson Correlation	.232	1
	Sig. (2-tailed)	.095	
	N	53	55

Descriptive Statistics of Scales of Satisfaction

The mean, standard deviation, and variance for each of the sub-scales and the overall scale are illustrated below in Tables 13 and 14. Descriptive statistics for each of the scales in Table 13 are organized by clinic type.

Table 13

Descriptive Statistics of Sub-scales and Overall Scale of Satisfaction by Clinic Type

Do you seek healthcare from an LGBTQIA+ inclusion health clinic?		N	Minimum	Maximum	Mean	Std. Deviation	Variance
Yes	General Satisfaction Sub-scale	14	2.00	5.00	3.8929	.85886	.738
	Technical Quality Sub-scale	14	2.25	4.75	3.6964	.74794	.559
	Interpersonal Manner Sub-scale	14	2.50	5.00	4.2857	.80178	.643
	Communication Sub-scale	13	2.00	5.00	4.1538	.85109	.724
	Financial Aspects Sub-scale	14	3.00	4.50	3.7500	.54596	.298
	Time Spent with Doctor Sub-scale	14	1.50	5.00	3.6429	1.18368	1.401
	Accessibility and Convenience Sub-scale	14	1.75	4.50	3.7143	.72627	.527
	Overall Scale	13	2.22	4.50	3.8718	.66333	.440
No	General Satisfaction Sub-scale	37	1.50	5.00	3.4865	.74056	.548
	Technical Quality Sub-scale	37	1.75	4.50	3.5473	.70425	.496
	Interpersonal Manner Sub-scale	37	1.50	5.00	3.8919	.78294	.613
	Communication Sub-scale	37	1.50	5.00	3.6892	.85270	.727
	Financial Aspects Sub-scale	37	1.50	4.50	3.4189	.90149	.813

	Time Spent with Doctor Sub-scale	37	1.50	5.00	3.4865	.93902	.882
	Accessibility and Convenience Sub-scale	37	2.00	4.50	3.3581	.65495	.429
	Overall Scale	37	1.89	4.28	3.5315	.59512	.354
Unsure	General Satisfaction Sub-scale	5	2.50	4.50	3.7000	.75829	.575
	Technical Quality Sub-scale	5	2.50	4.50	3.8000	.75829	.575
	Interpersonal Manner Sub-scale	5	3.00	5.00	3.9000	.74162	.550
	Communication Sub-scale	5	2.50	4.50	3.9000	.82158	.675
	Financial Aspects Sub-scale	5	3.00	4.00	3.3000	.44721	.200
	Time Spent with Doctor Sub-scale	5	3.00	5.00	3.8000	.75829	.575
	Accessibility and Convenience Sub-scale	5	2.50	4.00	3.5000	.61237	.375
	Overall Scale	5	2.67	4.39	3.6889	.63294	.401

Table 14

Descriptive Statistics of Sub-scales and Overall Scale of Satisfaction

	N	Minimum	Maximum	Mean	Std. Deviation	Variance
General Satisfaction Sub-scale	56	1.50	5.00	3.6071	.77878	.606
Technical Quality Sub-scale	56	1.75	4.75	3.6071	.71168	.506
Interpersonal Manner Sub-scale	56	1.50	5.00	3.9911	.78908	.623
Communication Sub-scale	55	1.50	5.00	3.8182	.85723	.735
Financial Aspects Sub-scale	56	1.50	4.50	3.4911	.80052	.641
Time Spent with Doctor Sub-scale	56	1.50	5.00	3.5536	.98016	.961
Accessibility and Convenience Sub-scale	56	1.75	4.50	3.4598	.67551	.456
Overall Scale	55	1.89	4.50	3.6263	.62016	.385

Study Limitations

Several imitations were identified within this study. One potential limitation of this study was utilizing a nonrandom convenience sampling recruitment method. A primary weakness of utilizing a nonrandom convenience sampling recruitment method is that the sample selected may not be entirely representative of the overall population (Terry, 2015). Because study subjects were recruited using a nonrandom convenience sampling recruitment method, subjects self-selected themselves. As a result, a very homogenous sample was

obtained. The sample obtained was not a good diversity sample and was mainly white or Caucasian, cisgender, and highly educated with high salaries. Most study subjects were employed full-time, and all study subjects had health insurance. It is assumed that underserved and disadvantaged LGBTQIA+ subjects were under sampled in this study. Thus, this sample is not completely representative of the overall LGBTQIA+ population and findings of this study cannot be generalized to this population.

Another limitation of this study was a small sample size and the lack of observations collected. If more observations had been collected, the study would have had more statistical power to answer this study's PICO question under investigation and to find a statistically significant difference between comparison groups. A larger sample size may have been more representative of the overall LGBTQIA+ population as well, as the larger the sample size, the more representative it will be of the greater population (Terry, 2015). Because random sampling may have selected a sample more representative of the LGBTQIA+ population's characteristics over nonrandom sampling (Terry, 2015), the random sampling recruitment method should be considered in future research.

An additional limiting factor identified in this study was an imbalance between comparison groups, as two-thirds of the survey respondents indicated that they did not seek healthcare from LGBTQIA+ inclusion clinics, leaving a third of the respondents that did or were unsure. It is usually best for the independent samples *t*-test to have balanced groups. This can make it easier to find statistical significance, as fewer degrees of freedom (df) would need to be taken. Additionally, this unbalanced design for the independent samples *t*-test made it harder to reject the null hypothesis that the patient satisfaction is the same regardless of clinic type.

Last, poor outreach may have been a study limitation as well. Poor responses were received from LGBTQIA+ community organizations and on-line communities regarding their willingness to participate in this on-line questionnaire study. Had there been a higher response rate from LGBTQIA+ community organizations and on-line communities, presumably, the study sample may have been larger, more diverse, and more well-balanced.

Summary

This chapter discussed the results of the study using both descriptive and inferential statistics. Study limitations were also described. The following chapter will discuss the study summary of findings, implications for nursing practice, and recommendations for further research on this study topic.

Chapter 5

Summary, Conclusions, and Recommendations

Summary of Findings

In spite of extensive efforts to gain equal rights for LGBTQIA+ individuals, they remain confronted with widespread health-related disparities and inequities due to stigma, discrimination, exclusion, and oppression because of their sexual orientation and gender identity. These persistent disparities and inequities are major obstacles to high-quality healthcare for LGBTQIA+ individuals and detrimentally affects their health and well-being. To redress these disparities and inequities and to afford LGBTQIA+ individuals an opportunity to receive high-quality healthcare, safe and inclusive clinical spaces free of stigma and discrimination must be created.

To explore this area of research further and to guide this study, the following PICO question was developed: Do LGBTQIA+ individuals who receive healthcare from LGBTQIA+

inclusion clinics feel more satisfied with their healthcare than those LGBTQIA+ individuals who receive healthcare from traditional clinics? To answer this question, a nonexperimental, nonrandom, cross-sectional study adhering to a quantitative methodology was conducted. The nonrandom convenience sampling recruitment method was utilized, and fifty-six subjects (n=56) participated in this on-line questionnaire study. The PSQ-18 questionnaire was administered to evaluate study subjects' overall satisfaction with their healthcare. To test whether the null hypothesis could be rejected, the independent samples t-test statistical method was utilized. The null hypothesis that was tested was that (H_0) LGBTQIA+ individuals receiving healthcare from LGBTQIA+ inclusion clinics will not have greater satisfaction with their healthcare compared to LGBTQIA+ individuals receiving healthcare from traditional clinics.

The findings of this study revealed that the sample size was too small to detect differences in the population, and the probability of rejecting the null hypothesis was quite low with this small sample size. However, for the Communications sub-scale, respondents who received healthcare from LGBTQIA+ inclusion clinics had significantly higher communication satisfaction than those who did not receive healthcare from inclusion clinics, as the distributions in the two groups significantly differed.

Implications for Nursing Practice

This study concludes with implications for future nursing practice to transform healthcare for LGBTQIA+ individuals. Offering LGBTQIA+ patients culturally congruent care will require nursing professionals to become more aware of their own attitudes, beliefs, and prejudices toward working with the LGBTQIA+ community. Integrating an unbiased, science- and justice-based approach, such as the Health Equity Framework into their respective nursing practices, will allow them to become more mindful of their personal attitudes, beliefs,

and prejudices. This can reshape the delivery of LGBTQIA+ specific healthcare and translate to greater health equity and improved satisfaction and health outcomes for this community. "In so doing, nurses have transformative potential to override their bias, render LGBTQ+ visible, and align their practices with their professional mandate of providing equitable and ethically sensitive care to all" (Goldberg et al., 2019, p. 270).

Nursing professionals have an ethical and professional responsibility to foster a safe, inclusive, and culturally sensitive and competent environment for LGBTQIA+ individuals; however, when it comes to meeting the unique healthcare needs of LGBTQIA+ individuals, they lack fundamental knowledge, education, and training on LGBTQIA+ health-related issues. To make certain these unique healthcare needs are met for the LGBTQIA+ community, nurses and advanced practice nurses have a professional obligation to close this knowledge gap. To ensure their preparedness and readiness in caring for this vulnerable population, it will be imperative that they receive adequate cultural competency and sensitivity education and training. This education and training will also help alleviate any insecurities that nursing professionals may harbor regarding their scarcity of knowledge in delivering proper care to LGBTQIA+ individuals. Furthermore, because nurses and advanced practice nurses are dutybound to advance the profession of nursing through knowledge dissemination (ANA, 2015), it will be equally imperative that they not only apply this knowledge to their own practices, but to disseminate this knowledge to their fellow nursing colleagues, as well as to other interprofessional team members.

Nurses and advanced practice nurses play a pivotal role in advancing the discipline and profession of nursing through scholarly inquiry and research (ANA, 2015). According to (Bonvicini, 2017), compared to other healthcare professionals, the nursing profession has lagged

behind in conducting research to address health needs of the LGBTQIA+ community. To advance the discipline and profession of nursing, nurse researchers must contribute to the nursing body of knowledge by translating research into evidence-based nursing practice (ANA, 2015). This research study provides direction for nursing researchers to further investigate whether the healthcare provided by LGBTQIA+ inclusion clinics results in improved patient satisfaction for the LGBTQIA+ community.

In spite of heightened awareness concerning LGBTQIA+ health disparities and their associated causes, they still widely exist (Jennings et al, 2019). Consequently, to achieve health equity for the LGBTQIA+ community, significant improvements within healthcare organizations are essential to mitigate these health disparities respectively (Jennings et al., 2019). Nursing professionals, regardless of their role or practice setting, are integral in removing institutional barriers to high-quality healthcare for LGBTQIA+ individuals, and they have the capacity to positively influence change against stigma and discriminatory practices within their respective practice settings. Nurses and advanced practice nurses spend a considerable amount of time with patients, leaving them in the perfect position to take on the role of a champion, advocate for organizational change, and lead healthcare organizations to improvements in the delivery of LGBTQIA+ healthcare (Margolies & Brown, 2019).

Recommendations for Further Research

Based on this scholarly work, further research with larger sample sizes to investigate whether there is a difference in patient satisfaction between those who receive healthcare from LGBTQIA+ inclusion clinics and those who receive healthcare from traditional clinics is recommended. The results of this study suggested the sample size was too small to detect differences in patient satisfaction between those respondents who received healthcare from

inclusion clinics and those who did not. Had the sample size been larger, more statistically significant results may have been observed. Therefore, a larger sample size is recommended to give future research studies more statistical power to detect differences in patient satisfaction between comparison groups. If differences were to be detected, it is recommended that researchers further investigate strategies and best practices in the healthcare setting that have been linked to improved patient satisfaction for the LGBTQIA+ community.

Whether the healthcare provided by LGBTQIA+ inclusion clinics results in improved patient satisfaction has not been well established in the current literature. Therefore, further research is needed to understand the relationship between receiving healthcare from LGBTQIA+ inclusion clinics and improved patient satisfaction. Future research studies may evaluate the utilization of LGBTQIA+ inclusion clinics and their association with not only improving patient satisfaction, but also with mitigating health disparities and achieving greater health equity for this vulnerable and marginalized population.

Because underserved and disadvantaged LGBTQIA+ individuals were not well sampled in this study, it is recommended that future researchers make a concerted effort to collect data from these historically under sampled populations. Had the sample been more diverse and representative of underserved and disadvantaged individuals, point-biserial correlation tests to determine the relationship between socioeconomically advantaged and disadvantaged LGBTQIA+ individuals and patient satisfaction may have resulted in a significantly positive correlation between well-served and underserved individuals and patient satisfaction.

To obtain a larger sample size and a less homogenous sample, future researchers may wish to consider a simple random sampling recruitment method rather than a nonrandom convenience sampling recruitment method and target communities with a higher density of

LGBTQIA+ individuals. A simple random sampling recruitment method may lead to a more representative well-balanced and heterogenous sample, with more observations.

Earlier research suggests that effective communication skills exhibited by healthcare providers can positively influence patients' satisfaction with their healthcare encounters and appreciably contribute to their health outcomes (Berman & Chutka, 2016). In this study sample, respondents who received healthcare from LGBTQIA+ inclusion clinics had significantly higher communication satisfaction than those who did not receive healthcare from inclusion clinics. Although this finding may presumably be true for different groups, without further research, it should not be generalized beyond this study sample. However, in the context of existing literature, to better serve the unique healthcare needs of LGBTQIA+ individuals, open communication behaviors toward these individuals is necessitated.

Forming the foundation for a more positive patient-provider relationship, effective communication skills result in increased patient satisfaction and warrants further research (Berman & Chutka, 2016). According to Banerjee et al. (2018), how healthcare providers communicate with LGBTQIA+ individuals is integral to the provision of culturally competent care. Behaviors and beliefs needed to provide inclusive, culturally competent care can be measured through the comfort level of the healthcare provider with effective communication, as well as through patient satisfaction (Keuroghlian et al. (2017).

Prior studies have discovered that training on LGBTQIA+ health topics in healthcare settings is fairly limited, and the extent to which LGBTQIA+ cultural and sensitivity competencies have been implemented by healthcare organizations is unknown (Goldhammer et al., 2018). Additionally, there is a paucity of research on the training needs of healthcare professionals with regard to LGBTQIA+-related healthcare. Given this paucity of research and

enduring knowledge gaps in LGBTQIA+ health awareness and readiness amongst healthcare professionals, further research is recommended to evaluate their educational and training needs. Resolving the gaps in LGBTQIA+ health preparedness can better equip healthcare professionals to deliver culturally competent care to patients who self-identify as LGBTQIA+.

Conclusion

Although the findings of this research study did not demonstrate statistically significant differences in patient satisfaction between LGBTQIA+ respondents who receive healthcare from LGBTQIA+ inclusion clinics and those who do not, based on a comprehensive examination of relevant research it was concluded that LGBTQIA+ inclusion health plays a critical role in improving patient satisfaction and the health and well-being of LGBTQIA+ individuals. Remaining an insufficiently researched area of healthcare utilization, further research on understanding the role of LGBTQIA+ inclusion clinics and their influence on improving patient satisfaction is warranted (Martos et al., 2019).

Hence, priorities for future research include assessing the impact LGBTQIA+ inclusion health utilization has on addressing the complex health issues and unmet healthcare needs of LGBTQIA+ individuals, as well as assessing the impact LGBTQIA+ inclusion health utilization has on redressing health disparities and inequities amongst this community. Further, because study results revealed individuals who went to LGBTQIA+ inclusion clinics had significantly higher communication satisfaction than those who did not go to inclusion clinics, investigating the impact of culturally competent communication on improved patient satisfaction should also be a priority for future research.

Lack of access to safe, culturally competent and sensitive, and inclusive healthcare will further perpetuate the widespread health disparities and inequities suffered by

LGBTQIA+ individuals (Kuzma et al. 2019). To advance the health of LGBTQIA+ individuals and achieve health equity, safe, affirming, and inclusive healthcare environments must be created for these individuals.

Disclosure Statement

With respect to the research and authorship of this study, the study author does not have any conflicts of interest to disclose.

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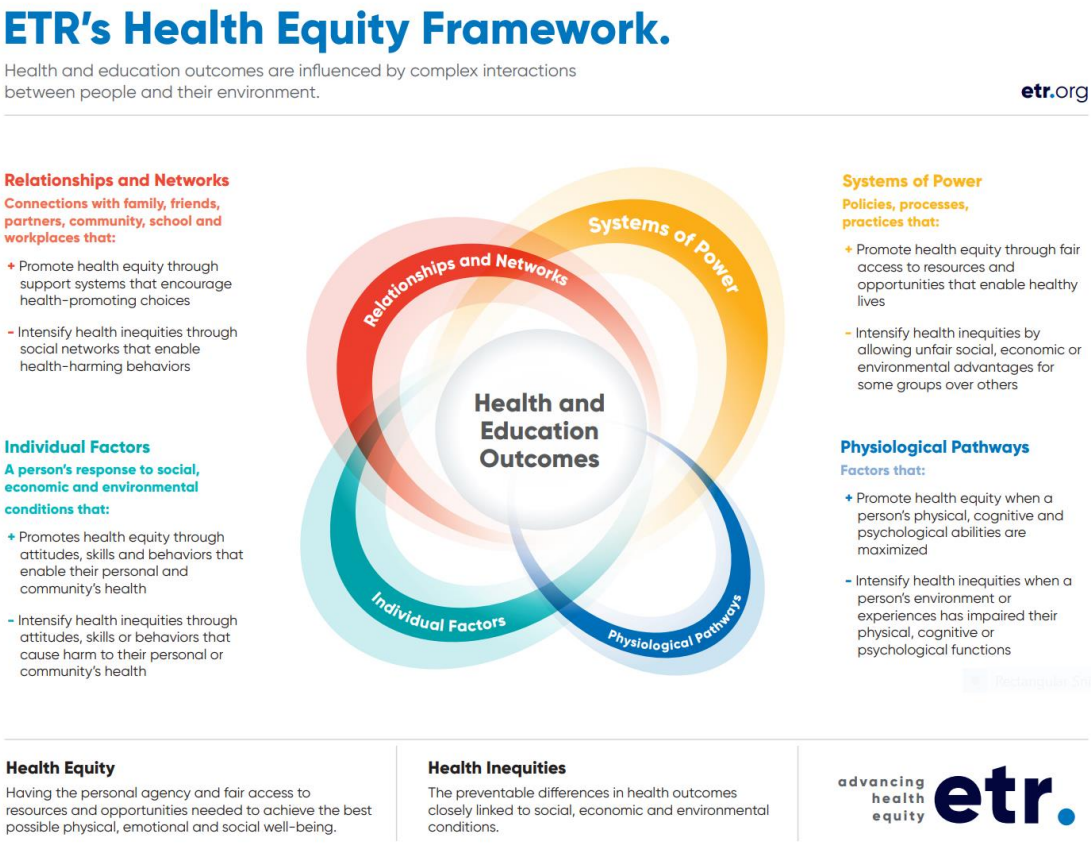
Appendices

Appendix A

Theoretical Framework – The Health Equity Framework



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Appendix B

Edinboro University's IRB Approval of Human Subjects Protocol

EDINBORO UNIVERSITY

INSTITUTIONAL REVIEW BOARD

This memo provides the notification concerning EU's Institutional Review Board (IRB) determination of the human subjects protocol:

To: Jill Rodgers DNP; Principal Investigator
Gayle Kempinski; Co-Investigator

From: , Erik Bentsen, Ph.D.; Edinboro University Institutional Review Board Chair

Protocol # EU2021302 **Approval Date:** September 16, 2021

Title: LGBTQIA+ Inclusive Healthcare Versus Traditional: Comparing Patient Satisfaction

The Edinboro University IRB has reviewed your submitted application. It has determined that your protocol is categorized as **Expedited** under federal regulations 45 CFR 46.110 since the research design involves one or more of the following criteria:

(b)(1) An IRB may use the expedited review procedure to review the following:

(i) Some or all of the research appearing on the list of categories established by the Secretary of HHS, unless the reviewer determines that the study involves more than minimal risk;

Collection of data through noninvasive procedures …routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing.

Expedited protocol means that as long as you continue your research as described in your protocol application, the research does not require any further review or oversight by the IRB. Should you change any procedure within your research, you are required to resubmit the protocol to the IRB for reconsideration and determination before you implement any change. All data must be retained and accessible for three (3) years after the completion of the project.

Designation as expedited signifies that the proposal adequately qualifies under 45 CFR 46.110 for such status.

At this time, COVID-19 remains a concern for any studies requiring face-to-face contact. To maintain safety for human subjects, make needed arrangements to your study to remain in line with federal, state and local guidelines, restrictions and laws.

If appropriate, alternate methods of data collection using non-face-to-face procedures should be considered. If you elect to use a virtual meeting or other methods in place of a face-to-face, please submit an update to your protocol for the IRB Chair to review.

Should you have any questions or concerns, please feel free to contact me at 814-732-1358

Appendix C

Informed Consent Form

Edinboro University of Pennsylvania
CONSENT TO PARTICIPATE IN RESEARCH STUDY

Title of Study: LGBTQIA+ Inclusive Healthcare Versus Traditional: Comparing Patient Satisfaction

Principal Investigator: Dr. Jill Rodgers, DNP, FNP-BC, PMHNP-BC, Edinboro University Faculty

Co-Investigator(s): Gayle Kempinski, DNP(c), MSN, APNP, ANP-BC, OCN, Clarion and Edinboro University Doctor of Nursing Practice Student

KEY INFORMATION

You are being asked by Dr. Jill Rodgers and Gayle Kempinski, DNP(c) to participate in a non-location, on-line questionnaire research study. Taking part in the study is voluntary, and you may stop at any time.

The purpose of the study is to evaluate the difference in patient satisfaction scores between lesbian, gay, bisexual, transgender, questioning or queer, intersex, and asexual (LGBTQIA+) individuals who receive healthcare from LGBTQIA+ inclusion clinics and LGBTQIA+ individuals who receive healthcare from traditional clinics.

In the study, you will be asked to complete an on-line patient satisfaction survey. It will take you approximately 5 minutes to complete the survey.

There are no potential risks to participate in the study, and there are no direct benefits to participants from the research. However, the study will help raise awareness around the need for LGBTQIA+ inclusion health clinics to meet the unique health needs of LGBTQIA+ individuals. The study will also help the researchers better understand how this research relates to their profession of nursing practice.

The information that you give in the study is anonymous. Your name and other information that could be used to identify you will not be collected or linked to the data.

Remember, taking part in the study is voluntary. If at any time during the study you feel uncomfortable or no longer want to participate, you may stop being a part of the study with no consequences.

You should know that information collected as part of this research will be kept as confidential as possible, within local, state, and federal laws. This consent may be reviewed by the Edinboro University Institutional Review Board (IRB). The results of the study may be shared in aggregate form at a meeting or in a journal, but your personal information will not be revealed. Records from the study will be kept by the Principal Investigator, Dr. Jill Rodgers, for a minimum of three (3) years after the study is complete. Information that is collected as part of this research will not be used or distributed for future research studies.

If you have questions about the study, you can contact Gayle Kempinski, Co-Investigator, at gayle_kempinski@outlook.com. If you have a question about your rights as a research participant that you need to discuss with someone, you can contact the Edinboro University Institutional Review Board at irb.Edinboro@edinboro.edu. If you would like a copy of this informed consent, please contact Gayle Kempinski, Co-Investigator, at gayle_kempinski@outlook.com.

SUBJECT'S STATEMENT

If I have questions prior to completing the non-location, on-line questionnaire study, I will contact Gayle Kempinski, Co-Investigator, at gayle_kempinski@outlook.com.

I understand that my participation is completely voluntary, and I may quit the study at any time without penalty. I am at least 18 years of age. I have read the consent form. Prior to entering the survey, you will be asked whether you consent to completing the survey. If you answer yes, you will enter the survey. If you answer no, the survey will be discontinued.

Appendix D

PSQ-18 Cover Letter and Instructions

LGBTQIA+ Inclusive Healthcare & Patient Satisfaction Survey

Survey Participants,

Thank you for participating in this on-line survey. In fulfilment of my Doctor of Nursing Practice degree requirements, I am conducting a study to evaluate the difference in patient satisfaction scores between LGBTQIA+ individuals who receive healthcare from LGBTQIA+ inclusion clinics and LGBTQIA+ individuals who receive healthcare from traditional clinics. Prior to entering the survey, you will be asked whether you consent to completing the survey. The survey is completely anonymous. The survey will take you approximately 5 minutes to complete. Please complete it in its entirety.

Please forward the survey link to other potential participants within the LGBTQIA+ community. Please click the survey link below to begin.

https://milwaukee.qualtrics.com/jfe/form/SV_ebqvym8f0KCQSfs

Thank you,

Gayle Kempinski, MSN, APNP, ANP-BC, OCN
Doctor of Nursing Practice Candidate
gayle_kempinski@outlook.com

Appendix E

Instrument: Short-Form Patient Satisfaction Questionnaire (PSQ-18)

On the following pages are some things people say about medical care. Please read each one carefully, keeping in mind the medical care you are receiving now. (If you have not received care recently, think about what you would expect if you needed care today.) We are interested in your feelings, good and bad, about the medical care you have received.

How strongly do you AGREE or DISAGREE with each of the following statements?

(Circle One Number on Each Line)

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. Doctors are good about explaining the reason for medical tests	1	2	3	4	5
2. I think my doctor's office has everything needed to provide complete medical care	1	2	3	4	5
3. The medical care I have been receiving is just about perfect	1	2	3	4	5
4. Sometimes doctors make me wonder if their diagnosis is correct	1	2	3	4	5
5. I feel confident that I can get the medical care I need without being set back financially	1	2	3	4	5
6. When I go for medical care, they are careful to check everything when treating and examining me	1	2	3	4	5
7. I have to pay for more of my medical care than I can afford	1	2	3	4	5
8. I have easy access to the medical specialists I need	1	2	3	4	5

How strongly do you AGREE or DISAGREE with each of the following statements?

(Circle One Number on Each Line)

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
9. Where I get medical care, people have to wait too long for emergency treatment	1	2	3	4	5
10. Doctors act too businesslike and impersonal toward me	1	2	3	4	5
11. My doctors treat me in a very friendly and courteous manner	1	2	3	4	5
12. Those who provide my medical care sometimes hurry too much when they treat me	1	2	3	4	5
13. Doctors sometimes ignore what I tell them	1	2	3	4	5
14. I have some doubts about the ability of the doctors who treat me	1	2	3	4	5
15. Doctors usually spend plenty of time with me	1	2	3	4	5
16. I find it hard to get an appointment for medical care right away	1	2	3	4	5
17. I am dissatisfied with some things about the medical care I receive	1	2	3	4	5
18. I am able to get medical care whenever I need it	1	2	3	4	5