abstract

In considering the full depth of inclusion in care and work environments (and developing inclusive engagement skills for lesbian, gay, bisexual, transgender, queer or questioning [LGBTQ] patients and their families), professional development leaders must bring these discussions and shared learnings into the open. Understanding the LGBTQ population’s unique needs is essential to providing personalized health care, and inclusive work environments help to foster more inclusive care for this population.


LGBTQ is an acronym for lesbian, gay, bisexual, and transgender. In 2016, the community adopted the inclusion of “Q” to refer to queer. As with all evolutions, there is some disagreement as to the use of the Q, its meaning, and how some perceive or interpret Q. In general, the Q has been adopted within the acronym as an umbrella term. Sometimes people are unsure of their sexual or gender identity, and by saying you’re queer, that sends the message that you’re on the LGBT spectrum in some way. There are generational implications to Q for queer because younger lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals are comfortable with the term, whereas older LGBTQ individuals prefer to consider the Q stands for questioning in deference to former use of queer as a derogatory term.

A recent study of transgender patients revealed that 73% feared their treatment would be different because of their identity (Oliver, 2017), and 89.4% felt health professionals are inadequately trained to care for people who are transgender. Such disparities suggest a deep gap in the services and personalization of care for transgender individuals and a potential boomerang effect within the health care workforce. The ability to respond to the needs of this population is recognized by the Centers for Disease Control (CDC) as a population health issue and a cultural issue requiring provider attention and training. The CDC recognizes this population as having specific risks and potential disparities related in part to social and structural inequalities, such as the stigma and discrimination that LGBTQ populations experience (CDC, 2017). Stigma and discrimination are barriers that educators can significantly affect on through education, dialogue, and skill building.

Ann Devine from the website nursing.org offers 10 excellent tips for caring for LGBTQ patients (Devine, 2017):

- Expand your knowledge about sexual orientation and gender identity.
- Know key LGBTQ definitions.
- Deepen your LGBTQ knowledge.
- Create a welcoming environment for LGBTQ patients.
- Use inclusive language.
- Use gender-neutral language.
- Ask open-ended questions.
- Reflect the patient’s language.
- Investigate mental and physical health risks for LGBTQ patients.
- Convey respect.

This framework is relevant to any population in the sense that deeper knowledge can foster deeper understanding and enable a caregiver to convey respect, thus more effective, personalized care. The first step in engaging the patient is addressing the first three bullet points through education specific to expanding the understanding providers and caregivers have about LGBTQ patients. The National LGBT Health Education Center exists to provide “educational programs, resources, and consultation to health care organizations with the goal of optimizing quality, cost-effective health care for lesbian, gay, bisexual, and transgender (LGBT) people” (The National LGBT Health Education Center, 2018b, para. 1). This center offers an online modular education that is easy to access and completely asynchronous, beginning with an introduction for staff training that includes LGBTQ terminology, disparities faced by LGBT people, and strategies for effective communication to provide affirming care for LGBT patients. There
are more resources available at their website (The National LGBT Health Education Center, 2018a) that can assist educators in developing a threaded curriculum for this population (and perhaps a multi-population threaded curriculum).

One particularly challenging aspect of personalized care is the use of inclusive language. For transgender people, birth name and gender may persist in the medical record despite an individual's focused efforts toward gender transition. The use of pronouns that are not consistent with an individual's declared identity, or use of names that are gender specific and not consistent with an individual's current identity, can add to feelings of distrust of health care providers. The NIH uses the phrase sexual gender minority to identify this population with a specific focus on researching disparities (NIH, 2017). This scientific descriptor may be acceptable as a population identifier, but individuals may prefer LGBTQ or find such labels to be insulting or insensitive. Being able to converse openly and honestly about gender identity, name, personal pronoun usage, and even population identifier are important conversations for opening a dialogue toward inclusive and respectful interaction.

DISPARITIES AND THE IMPERATIVE

While understanding is key, adult learners become more activated and engaged in new learning if the why is evident. In addition to the concerns expressed by LGBTQ health care consumers expressed above, the actual health disparities experienced might help to bring the why into better focus (The National LGBT Health Education Center, 2018b):

- LGBT youth are two to three times more likely to attempt suicide and are more likely to be homeless.
- Gay, bisexual men, and other men who have sex with men account for 64% of new cases of HIV and are at high risk for other STDs.
- In 2006 to 2009, there was a 48% increase in new HIV cases among Black men who have sex with men.
- Lesbians are less likely to get preventive services for cancer and are more likely to be overweight or obese.
- Transgender individuals have a high prevalence of HIV and STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or LGB individuals.
- Elderly LGBT individuals face additional barriers for health because of isolation and a lack of social services and culturally competent providers.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.

Clearly, these disparities affect all ages and ethnicities and reflect significant health risks that with caring, accepting interactions can be reduced. Early intervention with LGBTQ youth can head off significant problems with alienation, feelings of inadequacy and exclusion, all of which are risk factors for nonhealth-promoting lifestyle behaviors. For elderly LGBTQ individuals, the typical risks of social isolation, loneliness, and feelings of social rejection are magnified in this population, as are the physical effects associated with these risks.

CULTURAL COMPETENCE DEVELOPMENT

Education modules are an important aspect of a comprehensive education strategy for this population, but more is needed. Environments that are open and responsive to LGBTQ employees and staff have relied on those individuals to give visibility to the language and environmental barriers that exist so universally they may not even be thought of as creating dissonance. Listening to the advice of LGBTQ employees about how the environment feels to them from sig-

nate to pronoun usage to restroom policies and a host of other normalities that are tone deaf to the needs of this population is an important strategy. Advisory groups and panel discussions of staff and patients, as well as communication role-playing and coaching, can accelerate both understanding and cultural competency. As hospitals and health care facilities have become more aware and awakened to the needs of LGBTQ employees and have become more inclusive, the environments for patient care have also evolved positively.

INCLUSIVE WORK ENVIRONMENTS FOSTER INCLUSIVITY FOR ALL, INCLUDING PATIENTS

In 2017, the Health Equality Index [HEI] (2017) celebrated 10 years as a project of the Human Rights Campaign to measure health care facilities policies and practices for inclusive and equitable care of LGBTQ patients, visitors, and employees. The index scores are based on four areas of focus: nondiscrimination and staff training, patient services and support, patient and community engagement, and employee benefits and policies. More than 1,619 health care organizations nationwide have engaged with HEI benchmarking tool, a process that provides insight into gaps in environmental supports. The HEI website (HEI, 2017) also offers tools and resources to assist organizations in developing greater competency toward more inclusivity. A work environment that is not inclusive and equitable is not likely to be able to support the care and needs of this population. An example of policies that convey respect and inclusivity are policies related to visitation. Although most hospitals have adopted more inclusive visitation policies, the extent that such policies are disseminated are made visible and are routine parts of employee training indicate the level of adoption and inte-
The HEI evaluates organizational commitment at the level of adoption.

WHAT IS A PROFESSIONAL DEVELOPMENT EDUCATOR TO DO?

In addition to identifying and adopting curricular elements such as the modules referenced above, professional development educators should understand the blending of a culture of inclusion for employees and how that translates into patient care personalization, both for this population as well as others. If your organization does not already engage with the HEI, consider introducing this benchmarking index and using the resources it offers to supplement internal training elements. Tap into the educational modules provided by The National LGBTQ Health Education Center (2018a) for the most current and relevant training available. Finally, consider how to use internal resources, including individuals from community organizations, and employees as population experts to create open learning dialogues to accelerate staff competency and proficiency, and norming this new cultural knowledge into practice.

FROM THE NIH: A NOTE ON TERMINOLOGY

To remain inclusive, the NIH has opted to use the term “sexual and gender minority”:

The terms that individuals and groups use to refer to themselves often change or evolve over time; in contrast, a Federal agency requires uniform terminology for reports to Congress and the American people. To remain inclusive, yet consistent, the NIH has opted to use “Sexual and Gender Minority,” an umbrella term that encompasses lesbian, gay, bisexual, and transgender (LGBT) people, as well as those whose sexual orientation and/or gender identity varies, those who may not self-identify as LGBT (e.g., Queer, Questioning, Two-Spirit, Asexual, men who have sex with men [MSM], Gender-variant), or those who have a specific medical condition affecting reproductive development (e.g., individuals with differences or disorders of sex development [DSD], who sometimes identify as intersex). (NIH, 2017, p. 1)

REFERENCES