



## An Evaluation of a Culturally Competent Intervention of Military Health Care Providers Caring for the LGB Active Duty Patient

Marguerite Lawrence\*, Sarah Gravel, Aimee Vael, Gwen Miller

\*Columbus State University, School of Nursing Columbus, USA

\*Corresponding Author: Marguerite Lawrence, Columbus State University, School of Nursing Columbus, USA

Citation: Lawrence M, Gravel S, Vael A, Miller G. (2020) An Evaluation of a Culturally Competent Intervention of Military Health Care Providers Caring for the LGB Active Duty Patient. Trends in General Practice and Primary Care. Trends Gen Pract Prim Care 1: 106. DOI: 10.29011/TGPPC-106.100006.

Received Date: 6-11-2019; Accepted Date: 30-12-2019; Published Date: 01-01-2020

The views expressed in this manuscript are those of the authors and do not reflect official policy of the Department of Defense, or U.S. Government.

### Abstract

**Purpose:** To evaluate the effect of a tailored culturally competent intervention of the military health care providers caring for the LGB active duty service members at the largest Department of Defense medical center.

**Methods:** Using a pre-posttest, quasi-experimental design an invitation to view the culturally competent educational intervention was sent to the 1700 credentialed medical providers at the largest Department of Defense tertiary medical center on the east coast. The 25-item Gay Affirmative Practice (GAP) scale was the instrument utilized in the survey. The GAP scale was used to determine the effectiveness of the cultural competence educational intervention.

**Results:** There were sixty-nine responses  $n=69$ , noting a 2.1 % response rate. The differences in responses from pretest to posttest were examined by category (attitude, knowledge and practice). Overall, there was no statistical improvement from pretest to posttest ( $p>.367$ ). The greatest difference between the pretest and posttest was related to attitude.

**Implications for Practice:** Most recent estimates suggest greater than 70,000 active duty service members self-identify as Lesbian, Gay and Bisexual (LGB), and the LGB population has been found to be a health disparate population, it is imperative for military health care providers provide culturally competent care.

**Keywords:** Active Duty; LGB Service Member; Military Health Care

### Introduction

Census projections suggest that the U.S. population will grow to more than 130 million by 2030, and will approach 164 million by 2060 [1]. Current national estimates suggest that 2.6-4.9 million of the population will self-identify as lesbian, gay and bisexual (LGB) [2]. Lack of knowledge of the health and well-being of the LGB population remains a significant shortcoming in health disparities research [2,3]. Additionally, the LGB population has been found to be a health disparate population, showing higher rates of poor mental and physical health when compared to the heterosexual population [2]. According to [4], the LGB community rate their overall health to be poorer than the heterosexual com-

munity, and report a greater number of acute and chronic health symptoms. The Institute of Medicine (IOM) found that the LGB population, when compared to heterosexuals, are at risk for the following high risk behaviors; smoking, excessive alcohol use, illegal drug use, suicide attempts, and depression [5]. A major goal of the [6] initiative is to improve the health and medical well-being of the LGB population [7]. The LGB population may encounter negative experiences within the health care system in the form of enacted, perceived, or internalized stigma. According to [8], this is due to the limited number of culturally competent providers training in LGB health needs. As a result of these negative experiences, the LGB individuals may delay obtaining medical care, and are less likely to have a preferred primary medical provider for care [8]. In fact, several studies have shown that LGB individuals are more likely to delay medical care and to experience inadequate

care than their heterosexual counterparts [8]. According to [9], primary care physicians may lack resources and information on how to effectively provide care to the LGB patient. Additionally, [9] note that the LGB population face worse health outcomes due feelings of distrust for the healthcare system which results in a failure to disclose sexual orientation and gender identity to their healthcare provider. The choice of non-disclosure precludes providers from educating and counseling for health risks; and ultimately, contributes to a lack of care. According to [9], a survey of medical providers who treat the LGB population revealed that 66% of the physician respondents are aware of patients who were denied care or received substandard care due to their sexual orientation. Fifty-two percent of these respondents observed colleagues providing poor care or denied care to patients based on sexual orientation, and 88% of respondents have heard their colleagues make despairing remarks about LGB patients [10]. In an effort to rectify the disparity of care in the LGB population, [11] has targeted medical training institutions and recommended medical curricula to incorporate content that helps students master the knowledge, skills, and attitudes, also known as cultural competence, necessary to provide excellent and comprehensive care for the LGB patients [11]. Cultural competency is defined as a person's cultural awareness, knowledge and skills; specific to intrinsic sensitivities or attitudes [12]. Furthermore, according to [9], the AAMC emphasizes the need for cultural competence in attending to LGB patients and the integration of the same into medical curricula.

Although the AAMC has mandated specific training to decrease the disparity of care in the LGB population, research by [13], indicate that nursing and medical curricula pay little if any attention to non-heterosexual aspects of care, despite evidence demonstrating that students frequently display negative attitudes and have a low knowledge regarding the LGB population. Additionally, the lack of cultural competence also acts as a barrier in addressing the major health concerns of the LGB patient. As research continues addressing the health disparities of the LGB population, there is a lack of scientific knowledge pertaining to the physical health care needs of the active duty LGB population. Since 2011, with the cancellation of the Don't Ask, Don't tell (DADT) policy, active duty service members have been permitted to openly practice their homosexuality without fear of reprisal. Only recently has the Department of Defense (DoD) identified LGB active duty service members as a population within the military health care system with unique health care needs [14]. Like other healthcare systems, the Military Healthcare System (MHS) has begun to focus on the environment of care and specific needs of the LGB active duty service member. As the LGB active duty service members and L, G, B military dependents have started to seek care in the MHS, the MHS must be prepared to welcome and provide tailored services to the population. Additionally, the MHS must develop excellent

strategies to train military health care providers to understand the experiences and health disparities of this unique population and to provide best practices and culturally competent care.

### **Purpose**

The purpose of this quality improvement project is to evaluate the effect of a tailored culturally competent intervention for the military health care providers caring for the LGB active duty service members. A review was conducted examining the differences in attitudes, knowledge, and behavior before and after the intervention.

### **Methods**

#### **Design Setting**

Medical health care providers at the largest DoD military medical center on the east coast. This tertiary hospital serves more than 150,000 active and retired personnel from all branches of the military, admitting 16,000 patients a year.

#### **Sample**

Random sampling was used to obtain participants for this project. The sample for this study was the credentialed medical providers at the largest DoD military medical center on the east coast. This included all Medical Doctors (MD), Advanced Practice Registered Nurse (APRN), Physician Assistants (PA), Registered Dietitians (RD), and Clinical Nurse Specialists (CNS) from various sections of the hospital including primary care, internal medicine, and cardiology.

#### **Process of acquiring participants**

Upon receiving an approval from the institutional review board, an invitation to participate in the survey was sent to the (n=1500) credentialed medical providers over a three-month period. Informed consent was obtained from the participants prior to them accessing the survey. The survey was conducted using Qualtrics, and the survey link was sent out every two weeks for a total of twelve weeks. Log-in information was de-identified and detached from all survey responses. We requested the participants not to take the survey twice.

#### **Instrument**

The 25-item Gay Affirmative Practice (GAP) (Crisp, 2006) scale was the instrument utilized in the survey. The GAP scale was used to determine the effectiveness of the cultural competence educational intervention. The GAP assessment tool had internal consistency reliability (Cronbach's alpha of .93) and significant validity (> .60). The GAP assessment tool was applicable across a variety of healthcare settings, including management, primary care and social services.

**Procedure**

The 25-item GAP tool consisted of 10 demographic items and 15 items on the subject matter. We used a 5-point Likert agreement scale to measure the responses. The pretest was divided into three sections: practice behavior (5 questions), attitude, (5 questions) and knowledge, (5 questions) derived from the GAP tool. Once the pretest was completed, a link to the LGB cultural competence educational intervention was displayed. The 5-minute tailored cultural competence educational intervention consisted of a PowerPoint webinar on the health issues of active duty LGB patients. The cultural competence educational intervention included a set of evidence-based LGB provider awareness trainings comprised of information from the Fenway Institute [3,6,15-17]. The cultural competence educational intervention also included the most recent active duty LGB military statistics, significant policy changes, and pertinent preventive health issues of active duty LGB service members. After the intervention, a link to the hospital’s LGB health care resources were provided. The health care resources include LGB best practices, risk factors, and known health disparities of the LGB population [17]. Participants took the post-test after viewing the intervention. After completing the post-intervention survey, an exit page containing the author’s information would display thanking the participants for taking part in the survey.

**Data analysis**

Data was coded for each question and basic descriptive statistics was computed using IBM SPSS 22.0. We used the Wilcoxon signed rank test to analyze the participants’ pre and post test scores. Cross tabulation was conducted to compare the relationship between the variables. A statistician compiled the data and interpreted the findings.

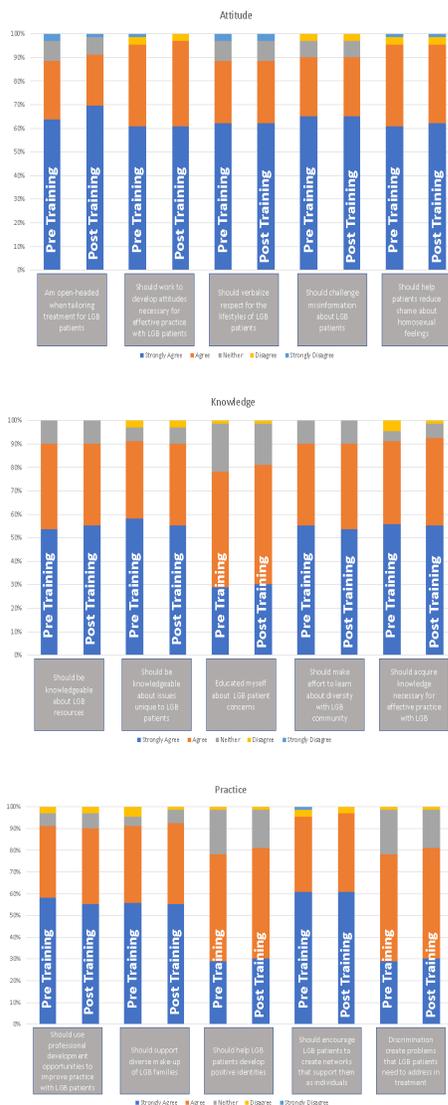
**Results**

There were sixty-nine responses n=69, noting a 2.1 % response rate. Fifty-three percent (n=37) were females and 46% (n=32) were males. Majority of the participants (69 respondents)—Caucasian (72%), Black (15%), Asian (9%), Hispanic (2%)-identified themselves as heterosexual. Most of the respondents identified themselves as Christians, (70%), and the rest identified themselves as Jewish (10%), Buddhist (3%), and the remainder as unknown (15%). The majority of credentialed providers who participated were medical doctors (50%), and the rest were APRN (25%), CNS (4%), and other (RDs/PAs) (22%) see (Table 1).

	Frequency	Percent
<b>Characteristics</b>		
Gender Male	32	46.4
Female Race	37	53.6
Caucasian	50	72.5
Black	11	15.9
Hispanics	2	2.9
Asians	6	8.7
<b>Religion</b>		
Christian	48	69.6
Jewish	7	10.1
Sikhism	1	1.4
Buddhism	2	2.9
Unknown	11	15.9
<b>Type of Provider</b>		
APRN	17	24.6
CNS	3	4.3
Other	15	21.7
MD	34	49.3
<b>Current Rank</b>		
Military Officer	45	65.2
Govt Service	17	24.6
Contractor	2	2.9
Civilian	2	2.9
Other	3	4.3

**Table 1:** Demographics of Survey Participants.

The differences in responses from pretest to posttest were examined by category (attitude, knowledge and practice). Overall, there was no statistical improvement from pretest to posttest ( $p > .367$ ). The greatest difference between the pretest and posttest was related to attitude. When asked if providers were open-minded while tailoring treatment for LGB patients, the pretest showed that 61% strongly agreed to this, this percentage rose to 70% in the posttest (Table 2). Of the three categories, the health care providers' cultural competence had increased in the area of attitude demonstrating that they were more apt to approach the LGB patient with an open mind following viewing the educational intervention.



**Table 2:** Culturally Competent Intervention.

### Effectiveness of the Educational Intervention

The purpose of this quality improvement project was to assess the effect of a tailored cultural competence intervention for the military health care providers attending to LGB active duty service members. There was no difference in the pre and posttests ( $p > .367$ ), which shows that the educational intervention did not change the providers' cultural competence.

### Discussion

To our knowledge, this is the first evaluation of an online cultural competence intervention assessing the military health care providers attending to the active duty LGB population. Although there was no statistical difference in the pre and post surveys ( $p > .367$ ), one question—"Am I open minded when tailoring treatment for LGB?"—noted clinical significance pre and posttest. The knowledge gained from this project may result in improved care in the MHS.

### Limitations

The low response rate, 2.1 %, can be due to a myriad of factors. Security protection software on DoD computers made the initiation and completion of web-based survey challenging, especially since the DoD email servers do not permit live web links. As a result, the participant had to copy and paste the link in a Firefox browser. This specific browser is not installed on many computers at the military health care facility where this survey was conducted. The military tertiary medical center has high workloads for all providers, and hence time constraints prohibited the providers from conducting the survey. Additionally, two months prior to the distribution of this survey, all medical providers in the tertiary medical center were instructed to complete the DoD's LGBT training. A phenomenon known as "survey overload" may have contributed to the lack of responses. Although we determined that the educational intervention did not change the respondents' views on LGB health care, a response bias may have occurred. The respondents may have selected responses that may be perceived socially desirable (response acquiescence). Additionally, although the repeal of DADT was 10 years ago, military health care providers may still be uncomfortable participating in surveys regarding sexuality or sexual health behaviors. With the small response set (N=69), it is not possible to generalize these findings to other medical treatment facilities of similar sizes or to generalize the findings to the larger population of health care providers attending to the LGB population.

### Conclusion

A study on a larger sample of military health care providers is required to confirm the results of this quality improvement

project. Additionally, more studies may be beneficial to ascertain if LGB health training aids is needed to address potential gaps in cultural competency of the military health care providers towards active duty members of the LGB population.

## Acknowledgement

The authors would like to thank Dr. Theresa Wadas, for her assistance on this quality improvement project.

## References

1. U S Census Bureau (2015) 2014 National population projections: Summary tables. Table 9. Projections of the population by age and sex for the United States: 2015 to 2060.
2. Hoy-Ellis C, Fredriksen-Goldsen K (2016) Lesbian, gay, & bisexual older adults: linking internal minority stressors, chronic health conditions, and depression. *Aging and Mental Health* 20: 1119-1130.
3. Centers for Disease Control and Prevention (2010) BFRSS annual survey data, summary data quality reports, 2010 summary data quality report.
4. Crisp C. The Gay Affirmative Practice Scale (GAP): A New Measure for Assessing Cultural Competence with Gay and Lesbian Clients. *Social Work*. 2006;51(2):115-126. doi:10.1093/sw/51.2.115.
5. Ryan W, Hunger H, Major B (2017) Applying intergroup relations research to understanding LGB health disparities. *Journal of Social Issues* 73: 477-492.
6. NIH LGBT Research Coordinating Committee (2011) Consideration of the Institute of Medicine (IOM) Report on the Health of Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals.
7. Institutes of Medicine(IOM). (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.
8. U S Department of Health and Human Services (2011) Healthy people 2020: Lesbian, gay, bisexual and transgender health. Washington D.C
9. Dahlmaer J, Galinsky A, Joestl S, Ward B (2016) Barriers to health care among adults identifying as sexual minorities: A US national study. *American Journal of Public Health* 106: 1116-1122.
10. Shetty G, Sanchez J, Lancaster J, Wilson L, Quinn G, et al. (2016) Oncology healthcare providers' knowledge, attitudes, and practice behaviors regarding LGBT health. *Patient Education and Counseling* 99: 1676-1684.
11. Sherman MD, Kauth MR, Shipherd JC, Street RL (2014) Provider beliefs and practices about sexual orientation in two veterans health affairs hospitals. *LGBT Health* 1: 185-191.
12. Association of American Medical Colleges (2007) AAMC recommendations regarding institutional programs and educational activities to address the needs of gay, lesbian, bisexual and transgender students and patients. Washington, DC.
13. Kaihlanen A, Hietapakka L, Heponiemi T (2019) Increasing cultural awareness: Qualitative study of nurses' perceptions about cultural competence training. *BMC Nursing* 18: 1-9.
14. Chapman R, Watkins R, Zappia T, Nicol P, Shields L (2012) Nursing and medical students' attitude, knowledge and beliefs regarding lesbian, gay, bisexual and transgender parents seeking health care for their children. *J Clin Nurs* 21: 938-945.
15. Biddix JM, Fogel CI, Perry Black B (2013) Comfort levels of active duty gay/bisexual male service members in the military healthcare system. *Military Medicine* 178: 1335-1340.
16. Makadon H, Mayer K, Potter J, Goldhammer H (2008) *The Fenway guide to lesbian, gay, bisexual, and transgender health*. Philadelphia, PA: The American College of Physicians.
17. The Joint Commission: Advancing effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: A field guide (2011) Oak Brook, IL.
18. American Medical Association (AMA) (2017) Policies on lesbian, gay, bisexual, transgender & queer (LGBTQ) issues.