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Creating Inclusive and Culturally Competent Healthcare for the LGBTQ+ Community: A Curriculum

by

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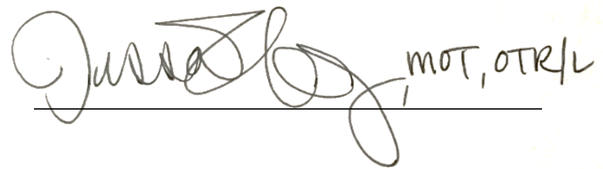
Approval Page

This Scholarly Project Paper, submitted by Caelin Hansen and Jordyn Himley in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.



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Department: Occupational Therapy

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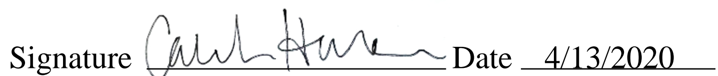
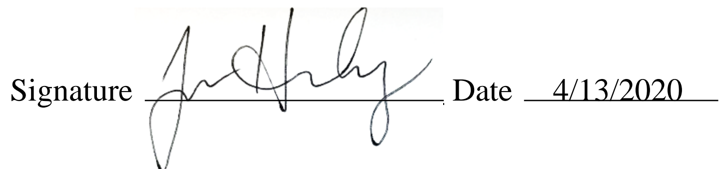
Signature  Date 4/13/2020

Signature  Date 4/13/2020

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ABSTRACT

The lesbian, gay, bisexual, transgender, queer, etc. (LGBTQ+) population is growing in America and in recent years has shown an increase in equal rights and societal acceptance (Newport, 2018). However, despite the positive changes that have been made, the LGBTQ population is still underserved in healthcare and faces health disparities (Dean, Victor, & Grimes, 2016; Institute of Medicine, 2011). This may be due to the fact that medical professionals receive little to no education regarding LGBTQ care, which can result in misconceptions, discomfort, and use of microaggressions towards the population. (Beagan, Chiasson, Fiske, Forseth, Hosein, Myers, & Stang, 2013; Utamsingh, Kenya, Lebron, & Carrasquillo, 2017).

The research and education that is presented for healthcare professionals on the LGBTQ population is limited, and there are limited resources for healthcare professionals to use to increase their knowledge and cultural competence on the population. Because of these issues, an extensive literature review was conducted to address the following: 1) LGBTQ terms and definitions; 2) demographics; 3) identified healthcare disparities; 4) national initiatives and policies; and 5) occupational therapy's role when working with LGBTQ clients. In addition, the director of the Pride Center at the University of North Dakota was consulted to gain information and resources regarding the population.

The result of this scholarly project is a curriculum that can be utilized by health programs to facilitate learning opportunities for students to increase cultural competency with the LGBTQ population in a safe learning environment. It is important to address these issues at the educational level, so healthcare students feel comfortable and are educated on the population prior to entering the workforce.

CHAPTER I
INTRODUCTION

Occupational Therapy is a unique profession that assists individuals of all ages participate in everyday activities in all environments, while also addressing an individual's physical, cognitive, and psychological function (AOTA, n.d.). Due to practitioners treating individuals of all ages, socioeconomic status, race, and ability, the association saw the importance of establishing legal standards, policies, and procedures for practitioners to follow, giving every individual equal access to the quality care that they deserve. In 2014, the American Occupational Therapy Association (AOTA) updated their stance on the profession's nondiscrimination and inclusion document to represent how the practice is committed to serve all populations no matter their culture, ethnicity, race, age, religion, gender, sexual orientation, or capacity (AOTA, 2014). The document states that every individual is "entitled to maximum opportunities to develop and use their abilities" and has "the right to achieve productive and satisfying professional and personal lives" (AOTA, 2014, p. S23). The following statement represents AOTA's stance and commitment:

> We are committed to nondiscrimination and inclusion as an affirmation of our belief that the interests of all members of the profession are best served when the inherent worth of every individual is recognized and valued. We maintain that society has an obligation to provide the reasonable accommodations necessary to allow individuals access to social, educational, recreational, and vocational opportunities. By embracing the concepts of nondiscrimination and inclusion, we

will all benefit from the opportunities afforded in a diverse society (2014, p. S23-S24).

Through this document AOTA expresses the importance of treating all people equally, valuing individual persons, and respecting different cultures, ethnicities, races, ages, religions, genders, sexual orientations, and capacities (AOTA, 2014).

The World Health Organization (WHO) recognizes that sexual health is a human right and fundamental to not only social and economic development, but to the physical and emotional well-being of all persons (2010). Sexual health is "the desire of individuals and couples of all sexual orientations and any background to have fulfilling and pleasurable sexual relationships, and its concerns go beyond fertility and reproduction to encompass issues such as sexual dysfunction and disability, and violence related to sexuality" (WHO, 2010, p. iv). This topic is necessary to address as maintaining sexual health is a basic human right.

In relation to occupational therapy, the subject of sexual health and activity, even though an identified Activity of Daily Living (ADL) within the Practice Framework, is often brushed over within educational and professional settings due to limited education and discomfort (Lohman, Kobrin & Chang, 2017). This discomfort expressed by practitioners, educators, and students is due to institutional sanctions, cultural beliefs, and the lack of quality and amount of education (Egledger et al., 2018; Lohman et al., 2017). However, when the subject of sexual health and activity is omitted this violates the professions holistic approach to evaluation and intervention, therefore individuals are no longer receiving complete and quality healthcare (Lohman et al., 2017).

An aspect of sexual health that is often omitted more frequently due to social controversy is sexual orientation. When reading AOTA's position, stated above, on sexual health and sexual orientation, the association summarizes the importance of nondiscrimination and inclusion of the LGBTQ population. However, this population has continued to experience disparities due to the profession failing to fully support the population within education and practice across the United States.

A challenge that has been presented as a roadblock for practitioners, educators, and students is the lack of access to a resource that is free of cost, easy to navigate, and has a good representation of information. Therefore, the purpose of this scholarly project was to create a resource that is accessible and free, which would increase the likelihood of professional programs incorporating it into curriculums.

Key Concepts and Terms

This section represents the following key concepts that will be referred to throughout this scholarly project. The following sources were used to extract the terms:

- Human Rights Campaign: https://www.hrc.org/resources/glossary-of-terms
- New York University: https://www.nyu.edu/students/communities-and-groups/student- diversity/lesbian-gay-bisexual-transgender-and-queer-student-center/glossary-of-important-lgbt-terms.html
- National LGBT Health Education Center: https://www.lgbthealtheducation.org/wp- content/uploads/LGBT-Glossary_March2016.pdf

1. **Agender:** A person who identifies as having no gender.
2. **Ally:** A person who is not LGBTQ but shows support for LGBTQ people and promotes equality in a variety of ways.
3. **Androgynous:** Identifying and/or presenting as neither distinguishably masculine nor feminine.
4. **Asexual:** The lack of a sexual attraction or desire for other people.
5. **Binding:** The process of tightly wrapping one's chest in order to minimize the appearance of having breasts. This is achieved using constrictive materials such as cloth strips, elastic or non-elastic bandages, or specially designed undergarments.
6. **Bisexual:** A person emotionally, romantically or sexually attracted to more than one sex, gender or gender identity through not necessarily simultaneously, in the same way or to the same degree.
7. **Bottom Surgery:** Colloquial way of describing gender affirming genital surgery.
8. **Cissexism:** The belief that transgender identified genders are inferior to, or less authentic than those of cisgender.
9. **Cisgender:** A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.
10. **Closeted:** Describes an LGBTQ person who has not disclosed their sexual orientation or gender identity.
11. **Coming Out:** The process in which a person first acknowledges, accepts and appreciates their sexual orientation or gender identity and begins to share with others.
12. **Drag:** The performance of one or multiple genders theatrically. Those who perform are called Drag Kings and Drag Queens.

13. **FTM or F2M (Female to Male):** An identity for a person who was assigned female at birth, and who identifies as male, lives as a male or identifies as masculine.
14. **MTF or M2F (Male to Female):** An identity for a person who was assigned male at birth, and who identifies as female, lives as a female or identifies as feminine.
15. **Gay:** A person who is emotionally, romantically or sexually attracted to members of the same gender.
16. **Gender Binary:** A concept that everyone must be one of two genders: men or women. The term describes the system in which society divides people into a masculine or feminine gender roles, gender identities, and gender attribute.
17. **Gender Dysphoria:** Clinically significant distress caused when a person's assigned birth gender is not the same as the one with which they identify. According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), the term - which replaces Gender Identity Disorder - "is intended to better characterize the experiences of affected children, adolescents, and adults."
18. **Gender-Fluid:** A person who does not identify with a single fixed gender; of or relating to a person having or expressing a fluid or unfixed gender identity.
19. **Gender Identity:** One’s innermost concept of self as male, female, a blend of both or neither - how individuals perceive themselves and what they call themselves. One’s gender identity can be the same or different from their sex assigned at birth.
20. **Gender Non-Conforming:** A broad term referring to people who so not behave in a way that conforms to the traditional expectations of their gender, or whose gender expression does not fit neatly into a category.

21. **Gender Role:** A set of societal norms dictating what types of behaviors are generally considered acceptable, appropriate or desirable for a person based on their actual or perceived sex.
22. **Genderqueer:** Genderqueer people typically reject notions of static categories of gender and embrace a fluidity of gender identity and often, though not always, sexual orientation, People who identify as "genderqueer" may see themselves as being both male and female, neither male nor female or as falling completely outside these categories.
23. **Gender Transition:** The process by which some people strive to more closely align their internal knowledge of gender with its outward appearance. Some people socially transition, whereby they might begin dressing, using names and pronouns and/or be socially recognized as another gender. Others undergo physical transitions in which they modify their bodies through medical interventions.
24. **Heteronormativity:** The assumption that everyone is heterosexual, and that heterosexuality is superior to all other sexualities.
25. **Heterosexual (Straight):** A sexual orientation that describes women who are emotionally and sexually attracted to men, and men who are emotionally and sexually attracted to women.
26. **Homophobia:** The fear and hatred of or discomfort with people who are attracted to members of the same sex.
27. **Intersex:** Intersex people are born with sex characteristics that do not fit typical binary notions of male or female bodies. Intersex is an umbrella term used to describe a wide range of natural bodily variations. In some cases, intersex traits are visible at

birth while in others, they are not apparent until puberty. Some chromosomal intersex variations may not be physically apparent at all.

28. **Lesbian:** A woman who is emotionally, romantically or sexually attracted to other women.
29. **LGBTQ:** For the purposes of this product, the authors will use the term LGBTQ when referring to the population.
30. **Minority Stress:** Chronic stress faced by members of stigmatizing minority groups. Minority stress is caused by external, objective events and conditions, expectations of such events, the internalization of societal attitudes, and/or concealment of one's sexual orientation.
31. **Non-Binary:** An adjective describing a person who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories, while many also identify as transgender, not all non-binary people do.
32. **Pangender:** A person whose gender identity is comprised of many genders.
33. **Pansexual:** A person who has the potential for emotional, romantic or sexual attraction to people of any gender though not necessarily simultaneously, in the same way or to the same degree.
34. **Polyamorous:** A person who has or is open to having more than one romantic or sexual relationship at a time, with the knowledge and consent of all their partners. Sometimes abbreviated as poly.
35. **Queer:** An umbrella term to refer to all LGBTQ people as well as an identity which advocates breaking binary thinking and seeing both sexual orientation and gender

identity as potentially fluid. While it has been reclaimed as a unifying, celebratory, and neutral term among many LGBTQ people today, historically it has been derogatory and can still be viewed negatively by some.

36. **Questioning:** An identity for people who are uncertain of their sexual orientation and/or their gender identity.
37. **Sexual Orientation:** An inherent or immutable enduring emotional, romantic or sexual attraction to other people.
38. **Social Stigma:** Negative stereotypes and social status of a person or group based on perceived characteristics that separate that person or group from other members of a society.
39. **Top Surgery:** Colloquial way of describing gender affirming surgery on the chest.
40. **Transgender:** An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.
41. **Tucking:** The process of hiding one's penis and testes with tape, tight shorts, or specially designed undergarments.
42. **Two-Spirit:** A contemporary term that connects today's experiences of LGBT Native American and American Indian people with the traditions from their culture.

CHAPTER II
Literature Review

According to The Williams Institute (2019), approximately 4.5% of the United States' population identifies themselves as being lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual, etc. (LGBTQ+). This is a 2% increase from the 3.5% of Americans that identified with this population in 2012 (Newport, 2018). As the LGBTQ population has increased, they have made significant gains in equal rights and societal acceptance. In 2015, same-sex marriage was made legal in all 50 states, and currently, 21 states have laws that prohibit discrimination against LGBTQ individuals in the workplace (Chappel, 2015; Human Rights Campaign, 2019).

Even with the gains that have been made and the increased societal acceptance, this population is still underserved in healthcare and faces health disparities (Dean, Victor, & Grimes, 2016; Institute of Medicine, 2011). The Joint Commission (2011) requires that accredited healthcare facilities prohibit discrimination based on sexual orientation, gender identity, and gender expression in an attempt to provide safe and culturally competent healthcare for the LGBTQ population. Healthcare facilities have responded to Joint commission requirements by providing diversity training specific to the LGBTQ population.

Despite efforts from the Joint Commission and diversity training, many healthcare spaces are still inhospitable (Dean et al., 2016). This may be due to the fact that medical professionals receive little to no education regarding LGBTQ care, which can result in

misconceptions, discomfort, and use of microaggressions towards the population. (Beagan, Chiasson, Fiske, Forseth, Hosein, Myers, & Stang, 2013; Utamsingh, Kenya, Lebron, & Carrasquillo, 2017).

Based on the identified barriers and needs of health providers and the population, this literature review aims to:

1. Present the complexities and disparities of this cultural group
2. Identify microaggressions of healthcare professionals who are working with this population
3. Present the need for increasing cultural competency in health professionals and the need for incorporating more educational opportunities in health programs
4. Present best practices for facilitating cultural competency with the LGBTQ population

The result of this literature review is a curriculum that can be utilized by health programs to facilitate learning opportunities for students to increase cultural competency with the LGBTQ population in a safe learning environment.

LGBTQ Population

Population Defined

The LGBTQ population is a diverse cultural group that includes people of all races, ages, socioeconomic statuses, and identities. Each of the letters in the acronym plus many more stands for a different identifying term. These identifiers include different sexual orientations and gender identities. The term *sexual orientation* is defined as the physical and/or emotional attraction to another individual (The Joint Commission, 2011). Sexual orientation is a broad spectrum, and individuals can fall anywhere on that

spectrum when describing their attraction to others (The Joint Commission, 2011). The first three letters of the LGBTQ acronym refer to sexual orientation. These stand for lesbian, which refers to a woman who is attracted to a woman; gay, which refers to a man who is attracted to a man; and bisexual, which refers to any individual who is attracted to both males and females. These are the commonly known terms, although there are other identifiers that help individuals define their sexuality along this spectrum. The terms are not concrete, and they are not the same for every individual. For example, an individual may enjoy same-sex actions or feel same-sex attraction, but they may not identify as lesbian, gay, or bisexual (Ard & Makadon, 2012). Because sexual orientation falls along a spectrum, it can be hard to define for many individuals. Therefore, it is important for healthcare providers to be informed of the terms and spectrum of sexual orientation so they can be prepared to address the topic if issues emerge.

The other identifiers in the LGBTQ acronym address gender identity, which also falls along a spectrum. It is a common misconception that an individual's sex and gender identity are the same. A person's *sex* refers to the biological or genetic status of the person (The Joint Commission, 2011). These are generally categorized as female or male, depending on the genetic makeup of the individual at birth (The Joint Commission, 2011). Gender identity, on the other hand, refers to the way that an individual defines his or her gender (The Joint Commission, 2011). Although many individuals identify with their biological sex, other individuals do not (The Joint Commission, 2011). For example, someone who is biologically a man may identify as a woman or vice versa (The Joint Commission, 2011). An individual may also define themselves as *gender nonconforming*. This means that they do not identify with any gender and their identity does not conform

with society's expectations of a male or female (The Joint Commission, 2011). Individuals whose gender identity does not align with their sex may identify as *transgender.* A transgender individual is someone whose gender expression does not match their birth sex (Ard & Makadon, 2012; The Joint Commission, 2011). This can include altering their bodies through surgeries or hormones to affirm their gender identity (Ard & Makadon, 2012). In a more medical setting, terms such as *male-to-female* (an individual who was born male but identifies as female) or *female-to-male* (an individual who was born female but identifies as a male) are used to describe those individuals who have transitioned from one gender to another (Ard & Makadon, 2012; The Joint Commission, 2011). Similar to sexual orientation, not every individual will use these terms to define themselves, and there are many other terms that fall along the gender identity spectrum that people do define themselves with. Therefore, it is important as a healthcare provider to be aware of the terms and to open the conversation with a patient about gender identity so the healthcare provider can use the terms that the patient identifies with.

Societal Disparities

Although everyone in the LGBTQ community is unique and falls on a different place on the spectrum of sexual orientation and gender identity, they still have one commonality: discrimination. In 2017, National Public Radio (NPR), the Robert Wood Johnson Foundation (RWJF), and Harvard T.H. Chan School of Public Health conducted the largest survey to date to determine the experiences of the LGBTQ population (2017). According to results from the survey, many LGBTQ individuals have experienced slurs (57%) or insensitive comments (53%) regarding their sexual orientation or gender

identity (NPR et al., 2017). Fifty-one percent reported being sexually harassed, 51% reported experiencing violence, and 34% have reported being verbally harassed in the bathroom or being told/asked if they were using the wrong bathroom (NPR et al., 2017). LGBTQ individuals have also reported institutional harassment such as being discriminated against because of their sexuality/gender identity when applying for jobs, when being considered for promotions, or when trying to find housing (NPR et al., 2017; Pew Research Center, 2013). About 18% of individuals in this population have also avoided medical care or calling the police when in need due to fear of discrimination (NPR et al., 2017). These statistics show that the LGBTQ population has faced discrimination in many ways. Discrimination comes in many forms, such as stereotypes, which perpetuate bias and stigma against the LGBTQ population.

Stereotypes

Hate crimes, or crimes that are committed against an individual or group due to bias and/or prejudice against that individual or group, have been affecting the LGBTQ population throughout the years at higher rates compared to their heterosexual counterparts (Marzullo & Libman, 2009). Sexual orientation has consistently been the third highest motivator for hate crimes, behind race/ethnicity and religion (Marzullo & Libman, 2009). According to Oudekerk (2019), approximately 200,000 hate crimes occurred annually between 2013 and 2017. These statistics were found through a victimization survey, which is called the National Crime Victimization Survey (NCVS), and police data which is called the Uniform Crime Reporting Program (UCR) (Oudekerk, 2019). Of the 200,000 hate crimes that occurred, the UCR identified that 19.5% were due to discrimination against gender, sexual identity or both (Oudekerk, 2019). The NCVS

identified that 27.2% of the hate crimes were due to gender bias and 25.7% were due to sexual identity (Oudekerk, 2019). These motivators could be stand-alone motivators, or they could be combined with others. Regardless, these crimes are still underreported in the United States (Marzullo & Libman, 2009; Oudekerk, 2019). The prejudice and bias that motivate these hate crimes and violence against the LGBTQ community may be due to misinformation or stereotypes about the community. The following are just a few myths/stereotypes that are focused on the LGBTQ community. In order to decrease prejudice and bias against this population and decrease violence and negative behavior towards individuals in the LGBTQ population, these myths and stereotypes must be debunked. The following myths were gathered from The University of Missouri-St. Louis (n.d.).

Myth: Sexual orientation can be changed.

Fact: APA determined that homosexuality is a normal occurrence and does not indicate any type of disorder (Glassgold, Beckstead, Drescher, Greene, Miller, Worthington, & Anderson, 2009). Nevertheless, sexual orientation conversion efforts (SOCE) have been used to attempt to convert the sexual orientation of LGBT individuals to heterosexuality (Anton, 2010). Dehlin, Galliher, Bradshaw, Hyde, and Crowell (2014) did a study that examined SOCE by surveying 1,612 individuals. Most of the participants in the study reported little to no change in sexual orientation after going through SOCE (Dehlin et al., 2014). Instead, many reported considerable harm (Dehlin et al., 2014). Examples of harm include decreased self-esteem, increased self-shame, increased depression and anxiety, the wasting of

time and money, increased distance from God and the church, worsening of family relationships, and increased suicidality (Dehlin et al., 2014). This study combined with information from the APA shows that attempting to change sexual orientation is ineffective and potentially harmful to LGBTQ individuals. Currently, 20 states have banned conversion therapy practices that attempt to change an individual's sexual orientation or gender identity (Movement Advancement Project, 2020). Although this shows that advancement is being made towards banning SOCE, there are still many states that allow these practices to happen, which shows that this still remains in issue today.

Myth: LGBTQ persons are mentally ill.

Fact: In 1973, APA removed the diagnosis of "homosexuality" from the Diagnostic and Statistical Manual (DSM) (Spitzer, 1981). After reviewing theories that placed homosexuality in the DSM in the first place, the American Psychological Association declared "Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they do not indicate either mental or developmental disorders" (Glassgold, et al., 2009, p. 2). As evidenced by the amount of conversion therapy centers that are still open, it is clear that many individuals still believe that people in the LGBTQ population can be "fixed" so to speak, and that their identity is a mental disorder. Although APA has taken steps long ago to deny this, it is still an issue in society today.

Myth: LGBTQ individuals look a certain way.

Fact: It is a common misconception that men who act feminine must be gay and that women with short haircuts or that are more masculine must be lesbian. This stereotype is often perpetuated by popular media and in shows and movies. Seeing these films and seeing individuals that fit these stereotypes often initiates *selective perception* (Bucher, 2015). Selective perception is when people favor certain information that affirms their predetermined belief (Bucher, 2015). For example, if an individual saw a gay man acting feminine, it would affirm his or her belief that all gay men are feminine. Information that disputes this belief would be disregarded. In all reality, individuals in the LGBTQ community are in every social, racial, religious, and economic group, and only a small percentage fit the stereotype. Challenging selective perception through media and everyday life would assist in eliminating this myth.

Myth: AIDS (Acquired Immune Deficiency Syndrome) is a "gay" disease.

Fact: Although HIV/AIDS is more prevalent in gay men than heterosexual individuals, anyone can obtain this disease (CDC, 2019a). Although anyone can obtain the disease, the Food and Drug Administration (FDA) still has restriction for gay men donating blood (2020). According to the FDA, if a man has had sexual contact with another man in the last 12 months, he is prohibited from donating blood (2020). This perpetuates the stereotype that AIDS is a "gay disease." If this myth is perpetuated, individuals of this population may avoid telling healthcare professionals of

their sexual identity or even getting tested for HIV/AIDS due to fear of being discriminated against. This could lead to a higher spread of the disease due to an individual not knowing he or she has the disease. By decreasing the stigma around HIV/AIDS and increasing education about the different types of prevention, individuals of this population can feel safer seeing a doctor to meet his or her specific needs regarding this topic.

Myth: LGBTQ and Ally's political organizations are asking for "special rights."

Fact: Individuals of the LGBTQ community are not asking for special rights, many are simply asking for the same rights that heterosexual individuals already have, one of those being safety from being discriminated against. Currently, only 21 states have laws that prohibit discrimination against LGBTQ individuals in the workplace (Human Rights Campaign, 2019). In a survey conducted by the Pew Research Center, 21% of LGBTQ individuals reported being treated unfairly by an employer through pay, hiring, or promotions (2013). According to the United States Transgender Survey completed in 2015, 30% of transgender respondents who had a job in the past year reported being fired, denied a promotion, or experiencing some other form of mistreatment related to their gender identity (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). Along with workplace discrimination, only 33 states have laws that address hate crime against the LGBTQ population (Human Rights Campaign, 2019). Of the 200,000 hate crimes that occurred between 2013 and 2017, 19.5% were due to discrimination against gender, sexual

identity or both (Oudekerk, 2019). Lastly, only 21 states have laws against government entities and private businesses discriminating against the LGBTQ population (Human Rights Campaign, 2019). These laws show that although some steps are being taken towards reducing discrimination for LGBTQ individuals, discrimination is still prevalent towards this population. Equal rights and non-discrimination laws should not be considered "special rights" but should be a basic human right for all people.

Healthcare Disparities

Healthcare Needs

Individuals within the LGBTQ population share the same general health risks as their heterosexual peers. However, this population does have additional health related needs that require specific care. The following list is specific to increased rates for this population due to healthcare disparities: Substance abuse, unhealthy weight control, smoking, mental health related disorders, violence, HIV/AIDS and other sexually transmitted infections (Ard & Makdon, 2012; Hafeez, Zeshan, Tahir, Jahan, & Naveed, 2017). Additionally, this population also has lower rates of accessing preventative care such as mammograms and pap smears due to limited access, negative experiences, and lack of knowledge (Hafeez et al., 2017). This section will briefly expand upon each health need identified that is impacting the LGBTQ population.

Substance Abuse

For the purposes of this literature review, substance abuse is defined as the overuse or misuse of alcohol, illicit drugs (marijuana, methamphetamine, cocaine,

hallucinogens, heroin, inhalants, stimulants, sedatives, and misuse of prescription pain relievers), or the co-occurrence of both alcohol and illicit drug use. As the sexual minority, the LGBTQ population faces increased risk for substance abuse. In 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) did a study that showed that 39.1% or two out of five LGBTQ individuals used illicit drugs, which was considerably higher than 17.1% within the sexual majority (Medley, Lipari, Bose, Cribb, Kroutil, & McHenry, 2016). As for alcohol use, SAMHSA broke statistics down into two categories; current alcohol drinkers and binge alcohol drinkers. Statistically, 63.3% of LGBTQ individuals are current alcohol drinkers compared to 36.1% of the sexual majority (Medley et. al., 2016). As for binge alcohol drinkers, this indicates that 56.2% of LGBTQ individuals participate in this behavior compared to 26.7% of the sexual majority (Medley et. al., 2016). As substance use behaviors progress, individuals are more likely to develop a substance use disorder (SUD). In 2015, 15.1% of the sexual minority had a SUD, compared to 7.8% of the sexual majority adults (Medley et. al., 2016). These statistics indicate the need for programs that include prevention and treatment of substance use. As SAMHSA identifies that an increased use of substances or the development of a SUD decreases productivity and daily function. This is due to increased significant impairment, such as health problems, disability, and daily interruptions in meeting responsibilities (Medley et. al., 2016).

Unhealthy Weight Control

Hadland, Austin, Goodenow, & Calzo (2015), report that although body image is an issue many individuals struggle with, LGBTQ youth are more prone to misperceiving their weight status, resulting in higher rates of eating disorders, body dissatisfaction, and

obesity. This misperception can be detrimental physically and psychologically, making LGBTQ individuals more likely to engage in unhealthy weight control behaviors (i.e. binging, purging, misuse of laxatives, self-induced vomiting, or caloric restriction) (Hadland et. al., 2015). These behaviors are four times more likely in sexual minority males, and two times more likely in sexual minority females than their heterosexual counterparts (Hadland et. al., 2015). When individuals engage in these unhealthy weight control behaviors the effects can be lifelong whether mentally or physically. Healthcare providers need to be aware of these behaviors and the increased risk for LGBTQ individuals to engage in unhealthy weight control. This recognition will allow providers to better service their clients, therefore referring them to proper resources, such as counseling and dietitians.

Smoking

Tobacco is a substance used commonly on a daily basis by the LGBTQ population. Tobacco companies created a marketing campaign in the mid-1990s called Project SCUM (Subculture Urban Marketing), which targeted the LGBTQ and homeless populations (CDC, 2019b). Today the LGBTQ population is still targeted by tobacco companies at gay pride festivals. As of 2016 over 20.5% of LGB adults smoke cigarettes compared to 15.3% of straight adults (CDC, 2019b). Individuals in the LGBTQ population are less likely to utilize existing smoking cessation programs due to the lack of health insurance, knowledge and/or access to the programs (CDC, 2019b). These three barriers inhibit individuals from accessing counseling and medication as a treatment for smoking cessation (CDC, 2019b). As the numbers of LGBTQ individuals using tobacco

rise, action needs to be taken to inhibit tobacco companies marketing techniques and make cessation treatments more accessible and inclusive.

Mental Health Disorders

The psychological component of human function is an essential part of holistic health; however, this is an additional area that the LGBTQ population experiences disparity. According to the American Psychiatric Association (APA), the LGBTQ population is "2.5 times more likely to experience depression, anxiety, and substance misuse" (2017). This statistic is supported by SAMHSA's research which reports that 37.4% of sexual minority individuals have a mental illness, compared to 17.1% of the sexual majority (Medley et. al., 2016). Consequently, the increase in mental health disorders contributes to an extra risk factor for suicidal behavior, and a correlation between mental health disorders and increased suicide attempts (Haas, et al., 2011). In fact, the LGBTQ population has been found to have a rate of suicide attempts that is four times greater than their heterosexual peers (APA, 2017). This can be in part associated to individuals within the sexual minority being prone to isolation and feeling disconnect, which can increase the risk of depressive symptoms (Hafeez et al., 2017). As these statistics showcase, the LGBTQ population has an increased risk for mental health related disorders. This exemplifies the need for healthcare providers, facilities, and programs to increase inclusivity and cultural competency. Ultimately, this will allow the LGBTQ population to receive efficient, ethical, and appropriate treatment physically and mentally.

Sexual Violence

Sexual violence can impact an individual's physical and psychological being through trauma, unfortunately individuals within the LGBTQ population suffer higher rates of sexual violence within their lifetimes due to poverty, stigma, and marginalization (Human Rights Campaign, 2020; Smith et al., 2018). The following statistics represent the percentage of individuals within each subgroup that experience rape, physical violence, and/or sexual violence by an intimate partner; 44% of lesbians, 61% of bisexual women, 35% heterosexual women, 26% gay men, 37% bisexual men, and 29% heterosexual men (Human Rights Campaign, 2020; Smith et al., 2018). Additionally, within their lifetime 47% of transgender individuals will experience sexual assault (Human Rights Campaign, 2020; Smith et al., 2018). These statistics drawing attention to the increased rates for bisexual women and individuals who are transgender. This increased risk for sexual violence within the LGBTQ population needs to be considered when healthcare workers are proving care, as many individuals may have residual effects from the trauma. To effectively treat an individual holistically, healthcare practitioners, facilities, and programs need to be informed of these increased risks for trauma.

Sexually Transmitted Infections

The LGBTQ population has an increased risk of contracting STIs and HIV, compared to their heterosexual peers, due to both social and biological factors. The social aspect begins with children and young adults, where individuals within the sexual minority are not receiving relevant or culturally sensitive sexual health education. Due to this disconnect, individuals in the LGBTQ population are more likely than their heterosexual peers to be sexually active, have a sexually debut prior to 13-years-old, be

involved with 4 or more partners, and are “about half as likely to have used a condom at last intercourse (35.8% vs 65.5%)” (Wood, Salas-Humara, & Downshen, 2016). As for biologic factors, men who have sex with men are more susceptible to STIs and HIV due to their anatomy and immunology of their rectal mucosa (Wood et al., 2016). These statistics highlight the importance of healthcare providers not making assumptions based on sexual identity. Instead, healthcare providers must be open to educating themselves on healthy sexual practices within the LGBTQ population. This would allow practitioners to give LGBTQ individuals current and correct information about preventative sexual health, therefore reducing the prevalence of STIs and HIV.

Healthcare Barriers

Discrimination

Along with different health disparities, the LGBTQ community faces many barriers in their everyday lives. The following are statistics that were collected by NPR in a survey about 3,453 LGBTQ individuals’ personal experiences with discrimination (NPR et al., 2017). Overall, 90% of all LGBTQ people believe there is discrimination against gay, lesbian, and bisexual people in America today, and 91% of all LGBTQ people believe there is discrimination against transgender and gender non-conforming people (NPR et al., 2017). Along with the perception of discrimination, NPR et al. (2017) found that 57% of LGBTQ members have experienced slurs, 51% have reported being sexually harassed, 51% reported experiencing violence, and 34% have reported being verbally harassed in the bathroom. These numbers show that, even though society has come a long way in terms of accepting LGBTQ individuals, there is still a long way to go. This discrimination can and has happened anywhere from on the streets to a

professional setting. In fact, many barriers that individuals in the LGBTQ population face are in healthcare facilities. NPR et al. (2017) reported that roughly
(16%). Macapagal et al. (2016) also found that transgender individuals were more likely to report negative effects when disclosing their identity, and individuals who identified as queer or were questioning their sexual orientation identity also reported negative healthcare experiences more frequently than their LGB-identified counterparts. Experiencing discrimination or having a fear of being discriminated against is a significant reason why many individuals in the LGBTQ population avoid seeking healthcare or find it an obstacle to receiving adequate and competent healthcare.

Nearly a quarter (22%) of transgender individuals and 18% of LGBTQ Americans report that they have avoided doctors or healthcare due to concern that they would be discriminated against for their identity (NPR et al., 2017). Macapagal et al. (2016) created a survey where researchers found that, out of 206 LGBTQ participants, 11.7% delayed or did not seek healthcare due to LGBTQ-based discrimination. Transgender patients were more likely than cisgender patients to delay healthcare, and gay men were more likely to avoid healthcare than lesbian women (Macapagal et al., 2016). In a study done by Seelman et al. (2017), researchers found that transgender individuals who delayed their healthcare because of fear of discrimination had worse general health in the past month than those who did not delay healthcare. This included 3.08 greater odds of depression, 3.81 greater odds of suicide attempt, and 2.93 greater odds of suicidal ideation (Seelman et al., 2017). Like stated previously, the LGBTQ population struggles with health disparities that are important to address with a healthcare provider (Hafeez et al., 2017). These statistics show that roughly a fifth of the population avoids healthcare,

which means that these individuals are not getting preventative screening, annual checkups, or important medical care due to the fear of being stigmatized against. Whitehead, Shaver, & Stephenson (2016), stated that higher amounts of sigma were associated with lower utilization of health services, which would in turn create lower health outcomes. It is important that healthcare providers are educated on this population in order to decrease stigmatization and increase awareness. This could lead to decreased avoidance of healthcare and increased health outcomes for this population.

Access to Healthcare

Another barrier that this population faces is access to healthcare (Macapagal et al., 2016). According to NPR et al. (2017), 31% of LGBTQ individuals report that they have no regular doctor or form of healthcare, and 22% report being uninsured. Whitehead et al. (2016) also reported that LGBTQ individuals are more likely to report being uninsured and having more difficulty affording healthcare. They also found that having insurance led to greater health outcomes overall (Whitehead et al., 2016). However, these numbers are variable within the population itself. In a study done by Macapagal et al. (2016), transgender individuals had a higher instance of being uninsured (43%), and racial minorities who also identified with the LGBTQ population had lower instances of being insured or having a regular place of care. Lack of insurance and a regular place of care adds another obstacle that this population faces in order to obtain healthcare.

Providers Viewpoint

Not only has research been done on barriers from the LGBTQ population's perspective, but research has also been done from a provider's perspective as well. Snelgrove, Jasudavisius, Rowe, Head, and Bauer (2012) completed a qualitative research

study to understand what barriers physicians face in addressing transgender care. They found that barriers included inaccessibility of reliable resources, limited knowledge of appropriate referrals, and inadequate medical knowledge, training, and experience (Snelgrove et al., 2012). The most common barrier across all healthcare professions for giving LGBTQ culturally competent care appears to be a lack of knowledge and experience with the population (Beagan et al., 2013; Javaherian, Christy, & Boehringer, 2008; Snelgrove et al., 2012). This lack of knowledge and experience causes healthcare providers to be uncomfortable and/or not address these needs due to not feeling competent in this area. Researchers found that transgender and non-binary individuals were over three times more likely to choose a provider that sees LGBTQ patients (Whitehead et al., 2016). Along with this, transgender and non-binary individuals rated the importance of their provider having LGBTQ-specific knowledge significantly higher than cisgender individuals (Whitehead et al., 2016). GLMA (previously known as the Gay & Lesbian Medical Association) has a resource on their website to find LGBTQ friendly providers in a specific area. After searching major cities in North Dakota (ND), only three LGBTQ friendly healthcare providers were found - one in Minot, ND, and two in Fargo, ND (GLMA, n.d.). This means that many people in the LGBTQ will have to travel in order to see a provider that considers themselves LGBTQ friendly. This, again, can be an obstacle to obtaining culturally competent care. Overall, these facts show that there is a lack of education about the LGBTQ population. Decreasing stigma and increasing education on the population can help LGBTQ individuals feel more comfortable utilizing health services, which therefore may increase preventative care and

health outcomes. One area that is important to address with practitioners is the impact that microaggression have on the LGBTQ population.

Microaggressions

Although facilities have created nondiscrimination policies and included diversity training, which has reduced overt forms of discrimination, individuals of this population are still being impacted by microaggressions (Dean et al., 2016). Microaggressions are "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults to the target person or group" (Sue as cited in Dean et al., 2016, p. 5). These microaggressions can occur interpersonally, environmentally, or institutionally (Dean et al., 2016).

Examples of microaggressions occurring interpersonally could be things such as tone of voice, body language, and word choice (Dean et al., 2016). For example, in a study done by Neville and Henrickson (2006), a statistically significant number of women identified that their healthcare provider "usually" or "always" presumed that they were heterosexual. By asking an individual if he or she has a "husband" or "wife" instead of asking a more inclusive question, such as if he or she has a "partner," a person may refrain from disclosing his or her identity due to the provider already assuming the individual is heterosexual. Although microaggressions may seem small and unintentional, these actions can have great impacts on patients. Hoffman, Freeman, and Swann (2009) found that interpersonal skills of providers and how they interact with patients was more important to youth than the providers' specific competencies. This shows the importance of reducing interpersonal microaggressions against the LGBTQ community. Healthcare

providers must have good interpersonal skills and awareness of microaggressions in order to effectively work with LGBTQ clients and provide a safer and more inclusive environment for all.

Environmental microaggressions are also experienced in healthcare settings. These microaggressions are a form that can be displayed through different advertisements or images, media representations, or organization of spaces (Dean et al., 2016). For example, a lack of resources for the LGBTQ population, lack of gender-neutral bathrooms or areas, or surveys/questionnaires that do not give options for the LGBTQ population may make people feel excluded in that facility. In a study done by Javaherian et al. (2008), it was found that only 14% of occupational therapists worked in a facility that used inclusive language in documentation procedures and only 14% had a list of resources to support the LGBTQ population. This research shows that facilities lack the resources and education they need to successfully support and include the LGBTQ population at an environmental level.

The last form of microaggressions occur institutionally (Dean et al., 2016). These can include things such as curriculum choices, policies, and regulations (Dean et al., 2016). Studies have shown that many healthcare professionals receive little to no training on the LGBTQ community, and many feel that it is inadequate to address the needs of the population (Beagan et al., 2013; Javaherian et al., 2008; Obedin-Maliver, Goldsmith, Stewert, White, Tran, Brenman… Lunn, 2011; Utamsingh et al., 2017). The lack of education on this population leads healthcare providers to feel uncertain and unfamiliar with the needs of LGBTQ individuals (Beagan et al., 2013). This uncertainty and

unfamiliarity may cause more interpersonal and environmental microaggressions to occur unintentionally.

Overall, microaggressions cause individuals of the LGBTQ population to report feeling anxious, distrustful, and judged, which leads them to hide their identity from their providers (Dean et al., 2016; Rossman, Salamanca, & Macapagal, 2017; Snelgrove et al., 2012). Along with non-disclosure, the stigma that still surrounds this population is causing LGBTQ individuals to delay or refrain from using healthcare services in general, which leads to an increase in the disparities in the population (Macapagal et al., 2016; Whitehead et al., 2016). These disparities include things such as less access to insurance and healthcare services, lower overall health status, higher rates of substance use, higher risk for mental illnesses, and higher incidences of sexually transmitted diseases (The Joint Commission, 2015; Whitehead et al., 2016). Transgender individuals who delayed or avoided healthcare had worse health outcomes, including greater odds of depression, suicidal ideation, and suicide attempts (Seelman et al., 2017). As a result, microaggressions, stigma, and fear of discrimination can unintentionally cause not only physical health issues but also mental health issues in individuals of the LGBTQ population.

Limited Education in Health Programs

It is possible that these microaggressions or unintentional biases are present due to the lack of proper education on the LGBTQ community both in school and in the workplace. Obedin-Maliver et al. (2011) determined that in undergraduate medical education in the United States and Canada, the median amount of time spent on LGBTQ related content is five hours. In addition, only 24.2% of the content taught was rated as

"good" or "very good" by the deans of the schools, meaning that 75.8% of the content was deemed inadequate (Obedin-Maliver et al., 2011). Javaherian et al. (2008) found that out of 373 occupational therapists and occupational therapy assistants, only 19% received education on working with LGBTQ clients and only 11% had received training from their employers on diversity issues related to the population. Other studies indicate that medical professionals, in general, receive limited or no education regarding LGBTQ care (Beagan et al., 2013; Utamsingh et al., 2017). These studies show the lack of proper education that is done on this population, making it challenging for providers to give culturally competent and appropriate care, justifying the need for including diversity training within the educational and professional settings.

Progression Toward Inclusivity

National Initiatives

The United States Department of Health and Human Services (HHS) published a national initiative in 2012 to improve the lives of individuals in the LGBTQ population, after President Barack Obama asked for the department to do so in April of 2010 (SAMHSA, 2020). The following is a statement about the commitment made by HHS:

> For too long, LGBT people have been denied the compassionate services they deserve. That is now changing. HHS continues to make significant progress toward protecting the rights of every American to access quality care, recognizing that diverse populations have distinctive needs. Safeguarding the health and well-being of all Americans requires a commitment to treating all people with respect while being sensitive to their differences. (2012)

Additionally, HHS has the following bullet points of the actions the department has taken thus far to improve LGBTQ individuals quality of life: Equal Employment Opportunity Policy, Non-discrimination Policy, hospital visitation, advanced directives, internal LGBT Coordinating Committee, Institute of Medicine study on LGBT health, Healthy People 2020, national HIV/AIDS strategy, The Affordable Care Act, tobacco control, aging services, anti-bullying efforts, improvements in foster and adoptive care, and runaway and homeless youth services (2012). Of this bulleted list, Healthy people 2020 is an initiative conducted by the Office of Disease Prevention and Health Promotion (ODPHP), an organization that is dedicated to furthering research to "improve the health, safety, and well-being of lesbian, gay bisexual, and transgender individuals" (2020). To expand the research, ODPHP has emphasized the importance of increasing nationally representative health-related surveys to collect data on sexual orientation and gender identity (ODPHP, 2020).

Although these national initiatives have opened up the door for increased inclusion with changing policies and regulations, there is still a gap in which health disparities still exist between the individuals receiving services and the policies in place to protect them.

Policies

Nondiscrimination policies have not always been inclusive and have historically evolved through social movements in the United States. In fact, sexual orientation was not mandated to be included until President Clinton issued an executive order in 1998 (Human Rights Campaign, 2020). This mandate forced all nondiscrimination policies to be updated, many continuously improving their statements to be as inclusive as possible.

For example, the American Medical Association's (AMA) updated nondiscrimination policy states "The AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity" (2017). According to the Human Rights Campaign, in 2011 the federal government updated their nondiscrimination employment policy to the following.

> The United States Government does not discriminate in employment on the basis of race, color, religion, sex, national origin, political affiliation, sexual orientation, gender identity, marital status, disability and genetic information, age, membership in an employee organization, or other non-merit factor. (2020)

These policies are in place to protect all populations and individuals from discrimination and should continue to be upheld for the equality of all people.

Standards in Medicine and Allied Health

Along with the policies and initiatives that have been made to increase inclusivity, medicine and allied health professions have created standards in educational programs to address cultural competency in curriculum. Leading organizations in medicine, nursing, occupational therapy, and physical therapy have created non-discrimination policies that aim to increase inclusivity and equity of multiple populations. The following sections will discuss the specific standards and policies that medicine and allied health professions have created in an attempt to increase culturally competency.

Medicine

The American Medical Association (AMA) is the regulatory association for the medical profession. The following statement represents their viewpoint on nondiscrimination, diversity, and inclusion: "The American Medical Association (AMA)

supports the equal rights, privileges, and freedom of all individuals and opposes discrimination based on sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age (n.d.)"

The following table represents the educational standards that the Liaison Committee on Medical Education (LCME) has implemented to address cultural competency and inclusion in medical programs (2019).

Table 1.
Liaison Committee on Medical Education (LCME) accreditation standards (2019)

<table>
<tr><td>7.6</td><td>The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the healthcare delivery process. The medical curriculum includes instruction regarding the following:
The way people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments
The basic principles of culturally competent healthcare
Recognition of the impact of disparities in healthcare on medically underserved populations and potential solutions to eliminate healthcare disparities
The knowledge, skills, and core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society</td></tr>
<tr><td>7.9</td><td>The faculty of a medical school ensure that the core curriculum of the medical education program prepares medical students to function collaboratively on healthcare teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from other health professions.</td></tr>
</table>

Nursing

The American Academy of Nursing (AAN) is the regulatory association that guides the professions standards through creating policies, procedures, and accreditation standards. As for their viewpoint on nondiscrimination, diversity, and inclusion, the AAN is represented by the following statement:

As leaders in advancing health policy to promote health for all populations, the Academy is committed to modeling diversity, inclusivity, and equity in all aspects of our organization's performance. To accomplish this effectively, the Academy must foster diversity among the fellowship, and promote inclusivity in our efforts. Inclusivity refers to the active engagement of all voices within an organization's membership, leadership, policy-setting and decision-making units, and overall profile. The Academy defines diversity as "all the ways in which people differ, including innate characteristics (such as age, race, gender, national origin, mental or physical capacities, gender identity, and sexual orientation) and acquired characteristics (such as education, socioeconomic status, religion, work experience, area of practice, language skills, cultural values, geographic location, family status, organizational level, work style, philosophical and intellectual perspectives, etc. (2016).

The following table represents the educational standards that the American Association of Colleges and Nursing (AACN) has implemented to address cultural competency and inclusion in nursing programs (2008).

Table 2.
American Association of Colleges and Nursing (AACN) educational standards (2008)

1	Apply knowledge of social and cultural factors that affect nursing and healthcare across multiple contexts.
2	Use relevant data sources and best evidence in providing culturally competent care.
3	Promote the achievement of safe and quality outcomes of care for diverse populations.
4	Advocate for social justice, including a commitment to the health of vulnerable populations and the elimination of health disparities.
5	Participate in continuous cultural competence development.

Physical Therapy

The American Physical Therapy Association (APTA) is the regulatory association for the physical therapy profession. Their viewpoint on nondiscrimination, diversity, and inclusion is represented by the APTA's vision and nondiscrimination policies. The vision is stated as the following, "The physical therapy profession embraces cultural competence as a necessary skill to ensure best practice in providing physical therapist services by responding to individual and cultural considerations, needs, and values" (2015). The non-discrimination policy is stated as the following, "The American Physical Therapy Association opposes discrimination on the basis of race, creed, color, sex, gender, gender identity, gender expression, age, national or ethnic origin, sexual orientation, disability, or health status" (2019).

The following table represents the educational standards that the Commission on Accreditation in Physical Therapy Education (CAPTE) has implemented to address cultural competency and inclusion in physical therapy programs (2017).

Table 3.
Commission on Accreditation in Physical Therapy Education (CAPTE) education standards (2017)

6F	The didactic and clinical curriculum includes interprofessional education; learning activities are directed toward the development of interprofessional competencies including, but not limited to, values/ethics, communication, professional roles and responsibilities, and teamwork.
7D8	Identify, respect, and act with consideration for patients'/clients' differences, values, preferences, and expressed needs in all professional activities.
7D10	Apply current knowledge, theory, and professional judgment while considering the patient/client perspective, the environment, and available resources.
7D11	Identify, evaluate and integrate the best evidence for practice with clinical judgment and patient/client values, needs, and preferences to determine the best care for a patient/client.

7D34	Provide physical therapy services that address primary, secondary and tertiary prevention, health promotion, and wellness to individuals, groups, and communities.
7D39	Participate in patient-centered interprofessional collaborative practice.

Occupational Therapy Standards

AOTA Standards

As for the American Occupational Therapy Association (AOTA), the profession released their first statement about nondiscrimination and inclusion in 1995 that summarizes the standards and views of the profession. This since updated statement from AOTA is best summarized through the following:

> "Nondiscrimination exists when we accept and treat all people equally. In doing so, we avoid differentiating between people because of biases or prejudices. We value individuals and respect their culture, ethnicity, race, age, religion, gender, sexual orientation, and capacities. Nondiscrimination is a necessary prerequisite for inclusion. Inclusion requires that we ensure not only that everyone is treated fairly and equitably but also that all individuals have the same opportunities to participate in the naturally occurring activities of society. We also believe that when we do not discriminate against others and when we do not discriminate against others and when we include all members of society in our daily lives, we reap the benefits of being with individuals who have different perspectives, opinions, and talents from our own" (2014).

Additionally, AOTA has a network for lesbian, gay, bisexual, and transgender concerns in the occupational therapy profession. The organization has a LGBTQ committee and continues to be dedicated to being as inclusive as possible. This stretches into not only

practice, but also during the educational process. The table below represents the educational standards for cultural competency and inclusion within program accreditation.

Table 4.
Accreditation Council for Occupational Therapy Education (ACOTE) Education Standards (2011)

B.1.2	Apply and analyze the role of sociocultural, socioeconomic, and diversity factors, as well as lifestyle choices in contemporary society to meet the needs of persons, groups, and populations. Course content must include, but is not limited to, introductory psychology, abnormal psychology, and introductory sociology or introductory anthropology.
B.1.3	Demonstrate knowledge of the social determinants of health for persons, groups, and populations with or at risk for disabilities and chronic health conditions. This must include an analysis of the epidemiological factors that impact public health and welfare of populations.
B.4.1	Demonstrate therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process in both individual and group interaction.
B.4.4	Evaluate client(s)' occupational performance, including occupational profile, by analyzing and selecting standardized and non-standardized screenings and assessment tools to determine the need for occupational therapy intervention(s). Assessment methods must take into consideration cultural and contextual factors of the client. Intervention plans and strategies must be client centered, culturally relevant, reflective of current occupational therapy practice, and based on the available evidence.
B.4.5	Select and apply assessment tools, considering client needs, and cultural and contextual factors.
B.4.18	Assess, grade, and modify the way persons, groups, and populations perform occupations and activities by adapting processes, modifying environments, and applying ergonomic principles to reflect the changing needs of the client, sociocultural context, and technological advances
B.4.23	Identify occupational needs through effective communication with patients, families, communities, and members of the interprofessional team in a responsive and responsible manner that supports a team approach to the promotion of health and wellness
B.4.26	Evaluate and discuss mechanisms for referring clients to specialists both internal and external to the profession, including community agencies.

Occupational Therapy's Role

As an allied health profession, occupational therapy plays an integral role in how the LGBTQ population views the field of healthcare. Occupational therapists have a professional and ethical obligation to provide care that is client-centered best practice, which is outlined in the AOTA code of ethics (2010). Additionally, the profession plays a unique role by providing interventions that target occupation, which could include the following areas: Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), rest and sleep, work, play, leisure, and social participation. To achieve inclusion, practitioners need to be aware of specific occupational needs of the LGBTQ population. For example, knowing that individuals within this population value appearance as this is a method of self-expression and means to their true identity, altering the dressing process compared to their heterosexual peers (Sharber, Silverman, Brim, Kruemmling, & Sponseller, 2018).

Occupation-Based Theory

Occupational therapists address a wide variety of factors when working with clients. To best address these areas, the Person-Environment-Occupation (PEO) model is considered to guide cultural competency in all aspects. This model was created by Mary Law to emphasize the importance of the transactional relationship between the person, the environment, and the occupation, which all impact an individual's overall occupational performance (Law, Cooper, Strong, Stewart, Rigby, & Letts, 1996). Using this model will assure that cultural competency is addressed in a holistic manner.

Strategies/Solutions

Training and Education

Congruent with research suggesting the need for additional training, many healthcare facilities and programs have begun to implement diversity training as a staff requirement to advance cultural competency (Felsenstein, 2018). Cultural competency in the healthcare setting is defined as:

> Understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the healthcare delivery system; and, finally, devising interventions that take these issues into account to assure quality healthcare delivery to diverse patient populations (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003, p. 297).

These trainings present information regarding a broad spectrum of individuals to increase practitioners' awareness of diversity. Although these trainings increase general overall cultural competency, education that is specific to the LGBTQ population would benefit future practitioners, as 64% reported receiving no education on this population (Javaherian et al., 2008). In fact, an "LGBTQ program offers a number of opportunities for a health system, clinic, or hospital to develop welcoming, non-judgmental, and inclusive care policies and procedures which can facilitate access and decrease health disparities for this underserved population" (Nisly et al., 2018, p. 660). Within these specific trainings, the facilitators give out checklists for providing culturally competent care. For example, The Joint Commission (2011) released a checklist in which they ask facilities to use their checklist guide as a roadmap to effective communication and

improve cultural competency. The checklist includes the following steps; (1) Create a welcoming environment that is inclusive of LGBT patients; (2) facilitate disclosure of sexual orientation and gender identity, but be aware that disclosure or "coming out" is an individual process; (3) provide information and guidance for the specific health concerns facing lesbian and bisexual women, gay and bisexual men, and transgender people; and (4) avoid assumptions about sexual orientation and gender identity" (The Joint Commission, 2011). Culture competency programs like the one offered by the Joint Commission, allows facilities to implement change in a structured and effective manner. As these skills allow practitioners to treat all people from a holistic approach congruent with ethical practice.

Discrimination is a large part of the conversation within these trainings, however, what many programs do not include in this conversation are microaggressions. As listed in the healthcare barrier section, microaggressions are a type of discrimination where an individual uses verbal, behavioral, and/or environmental indignities against a population. A recommendation to increase cultural competency within the LGBTQ population is to include education about microaggressions within diversity trainings (Dean et al., 2016). Including microaggressions can be achieved through education, role playing for exposure to real life scenarios, and providing individuals with checklists, scripts, and tools to support providers serving LGBTQ patients (Dean et al., 2016). These strategies can be implemented throughout the course of the training to increase practitioners' understanding and ability to incorporate the suggestions into their daily practice.

Most of these trainings are provided to individuals once they have already began practicing, and for some many years after they began treating clients. However, a solution

reported by Sawning, Steinbock, Croley, Combs, Shaw, and Ganzel (2017) poses a unique point of view, implementing diversity trainings within professional programs. The study was conducted at the University of Louisville and found that the eleven, one-hour sessions increased medical students' knowledge and attitude on the LGBTQ population (Sawning et al., 2017). Although the authors still suggested supplemental trainings throughout individuals' professional careers, implementing these trainings at a university level increases competency before entering practice. As more facilities, programs, and organizations implement these trainings, there is an increase in the quality and effectiveness of healthcare received by the LGBTQ population.

Education-Based Theory

Education is an important part of gaining cultural competency. Because of this, the constructivist theory is considered. When learning about cultural competence from a constructivist perspective, Garneau and Pepin (2015) state that competence is fluid, dynamic, and constantly evolving, and therefore encompasses more than race and ethnicity. Because constructivists state that learning involves developing new knowledge through reflection on previous experiences and taking action, the development of competence is continued throughout life (Garneau and Pepin, 2015). These are all important factors to consider when discussing cultural competency and using this theory to guide education on it will lead to positive, learner-centered outcomes.

Conclusion

The review of literature outlines the issues and disparities that the LGBTQ population are facing in healthcare. Research indicates that the LGBTQ struggles with many physical, mental, and emotional barriers that affect quality of life and access to

quality healthcare. It is the practitioner's role to address these issues and disparities in order to provide a welcoming and comfortable healthcare environment for all. The consensus of the literature is that education is the key to healthcare practitioners gaining a better understanding of the population. Aiming education towards students in healthcare programs is helpful and gives them the tools that they need to become culturally competent practitioners. Through education, students and practitioners can be more knowledgeable, have more comfort, and take the necessary steps to reduce microaggressions and increase culturally competent care throughout the healthcare process.

Chapter III

Methodology

The process of developing this product began with personal interest in advocating for equality and human rights. The authors of this project identified the need for increased knowledge and understanding of sexual orientation and gender identity to feel competent while upholding occupational therapy's code of ethics. Additionally, the researchers identified the need to advocate for the LGBTQ population and build awareness at the varied personal/professional levels of students, educators, and clinicians to ensure true client-centered and culturally competent practice.

An extensive literature review was conducted, which included research from the years 1981-2020. The information was then organized into the following categories pertaining to the LGBTQ population: 1) LGBTQ terms and definitions; 2) demographics; 3) identified healthcare disparities; 4) national initiatives and policies; and 5) occupational therapy's role when working with LGBTQ clients. Search engines that were utilized were PubMed, Cinahl, Google Scholar, AJOT, and OT Search. Key terms used throughout the searching process included: *sexual orientation, gay, bisexual, lesbian, transgender, LGBT, LGBTQ+, health disparities, healthcare, occupational therapy, gender identity, and queer.* The literature used to develop this product was from multiple health medicine disciplines from the United States and various other countries.

Several experts in the field of LGBTQ education were consulted to investigate the need of the product and inclusion of pertinent information. The main contact is the

director of the Pride Center at the University of North Dakota. These conversations were used to enhance the product from the LGBTQ communities' point of view in addition to healthcare. The authors of this product determined that informal conversations assisted them when determining the direction and outcome of the product based on how the population wanted to be represented.

Additionally, the curriculum session was presented to a class of occupational therapy students on the University of North Dakota campus, where students gave the facilitators feedback to enhance the session. The occupational therapy perspective product was then fine-tuned and used as a base to tailor the inclusivity product to the following disciplines: Physical therapy, medical studies, and nursing.

Theory

Theoretical models drive practice for occupational therapists. These models are used to provide an organizing framework to think about practice in a systematic way and to develop an understanding of the concepts upon which the profession is based (Turpin & Iwama, 2011). In addition to theoretical models, learning theories form the foundation of education, have wide applicability, and are used to describe, explain, and predict how people learn (Braungart, Braungart, & Gramet, 2011). Learning theories can be applied by healthcare professionals to teach new material and tasks, solve problems, and build constructive relationships (Braungart et al., 2011). The objective of this project is to create a presentation that will educate interdisciplinary healthcare students on culturally competent care for the LGBTQ population. Due to occupational models and learning theories both providing important aspects for practice and education, both were chosen to guide this project to enhance adult learning while using concepts embedded from

occupational therapy. Bastable and Dart (2011) state that adult learning encompasses the following basic assumptions: An adult learner is an independent, self-directed learner, he or she accumulates previous experience to serve as a resource for learning, readiness to learn becomes oriented to tasks of social roles, the perspective of time is focused on immediate application of knowledge, and learning is problem-centered rather than subject-centered. These assumptions were utilized to select a learning theory that will facilitate the greatest learning experience for adult healthcare students.

The learning theory that was chosen to guide this product is *Constructivism.* Constructivists emphasize connecting existing information with new information and that people learn better when they are actively constructing their own meaning of new content (Clark, 2018). It is important to note that constructivism is a learner-centered model, and constructivists believe that every learner has a different set of experiences which shapes their own learning in individualistic ways (Clark, 2018). When learning about cultural competence from a constructivist perspective, Garneau and Pepin (2015) state that competence is fluid, dynamic, and constantly evolving, and therefore encompasses more than race and ethnicity. Because constructivists state that learning involves developing new knowledge through reflection on previous experiences and taking action, the development of competence is continued throughout life (Garneau and Pepin, 2015).

In addition to constructivism, the Person-Environment-Occupation model (PEO) was used to guide this product from an occupation-based standpoint. This model was created by Mary Law to emphasize the importance of the transactional relationship between the person, the environment, and occupation and the impact it has on occupational performance (Law et al., 1996). This model has four main concepts: the

person, the environment, the occupation, and occupational performance (Law et al., 1996). The *person* is defined as a being that consists of multiple roles, a composite of the mind, body, and spirit, and has a set of attributes such as self-concept, personality, and cultural background (Law et al., 1996). The *environment* encompasses and gives equal importance to the cultural, social-economic, institutional, physical, and social environments (Law et al., 1996). *Occupation* is defined as "groups of self-directed, functional tasks and activities in which a person engages over the lifespan" (Law et al., 1996, p. 16). Lastly, *occupational performance* is the outcome of the transaction between the three concepts (Law et al., 1996). The person, environment, and occupation interact continuously across time and space and will become congruent based upon their interactions (Law et al., 1996). The more harmoniously that the three concepts interact, the greater the occupational performance will be (Law et al., 1996). With the concepts of both constructivism and PEO in mind, this product will take in aspects of both occupational therapy theory and learning theory to adequately address the qualities of both.

2020

LGBTQ+ POPULATION:
A guide for inclusivity in an academic healthcare curriculum

(SatyaPrem, 2019)

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We wish to thank all the people whose assistance was a milestone in the completion of this scholarly project, as we could not have done it without them. First, we would like to recognize our project advisor, Jessa Hulteng, for her continued contribution through proofreading, editing, and guidance throughout the entire process. Secondly, we would like to recognize the director of the Pride Center at the University of North Dakota, as he was an amazing resource throughout the development of content and activities found in this guide. Third, we would like to thank LaVonne Fox for her guidance of theoretical frameworks and the love and support she has given us throughout the entirety of the occupational therapy program. Lastly, we would like to recognize our friends and family, for all their love and support as they were our number one cheerleader throughout this scholarly project.

LGBTQ+ POPULATION: A GUIDE FOR INCLUSIVITY IN HEALTHCARE CURRICULUM

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INTRODUCTION TO THE GUIDE

The purpose of this guide is to assist transdisciplinary faculty members in the process of integrating education on the LGBTQ population within the healthcare curriculum. The purpose is to educate students, prior to professional employment, within medicine, nursing, and the allied health professions to create a more inclusive healthcare experience for their clients. To achieve this, it provides foundational knowledge of the LGBTQ population, and their specific needs and disparities within healthcare. Resources are provided to further education.

This curriculum guide has been prepared by students of the University of North Dakota's Master of Occupational Therapy program, with guidance from an advisor and experts on the topic. Its purpose is to assist transdisciplinary faculty members in integrating education on the LGBTQ population within the healthcare curriculum. This curriculum guide is available as a resource for professional programs to increase or strengthen inclusivity and cultural competency within their programs and courses. The authors acknowledge that this guide may have its limitations blending within each professional program. However, while most professional programs embody common elements, there are variations between institutions, curriculum, and course organization. Regardless of their specific curriculum structure, we have attempted to provide material that is transdisciplinary. Although, if the material does not match, we encourage facilitators or programs to make adaptations to this guide for a natural presentation of the material. The goal of implementation is to educate students through enhancing current courses with inclusive resources, case studies, and activities.

Curriculum committees and other faculty may use this guide through:

1. Direct implementation: The guide can be directly implemented through the authors' creation of session sequences, which provides a discipline-specific perspective and activity choices for faculty to individualize the session to their audience
2. As a consultative measure to infuse the current curriculum to best fit their program. To use this guide consultatively, individual course facilitators can identify the sections of this guide that coincide with current courses being taught to blend material.

Faculty can see the inclusivity guide through completed sessions from the lens of multiple disciplines. Additionally, this guide serves as a menu, where faculty are able to select resources and activities that best fit their targeted audience and class setting. This strategy increases a natural presentation of the material by allowing each facilitator the opportunity to choose their preferred learning style.

We hope that professional healthcare programs will use this guide to strengthen inclusivity within their curriculum. Although we tried to include as many credible resources into this guide as possible, we acknowledge that there may be resources created

or identified by other institutions that were not included. The authors encourage comments and suggestions about the guide for continued inclusivity to strengthen future versions.

Rationale

Medical professionals and allied health professions receive little to no education regarding LGBTQ care, which can result in misconceptions, discomfort, and use of microaggressions towards the population. (Beagan, Chiasson, Fiske, Forseth, Hosein, Myers, & Stang, 2013; Utamsingh, Kenya, Lebron, & Carrasquillo, 2017). Because of this, many healthcare facilities and programs have begun to implement diversity training as a staff requirement or student curriculum to advance cultural competency (Felsenstein, 2018). Although these trainings increase general overall cultural competency, education that is specific to the LGBTQ population would benefit future practitioners, as 64% reported receiving no education on this population (Javaherian, Christy, & Boehringer, 2008). For these reasons, the authors developed a guide to increase education for future healthcare practitioner in an attempt to increase cultural competency with the LGBTQ population.

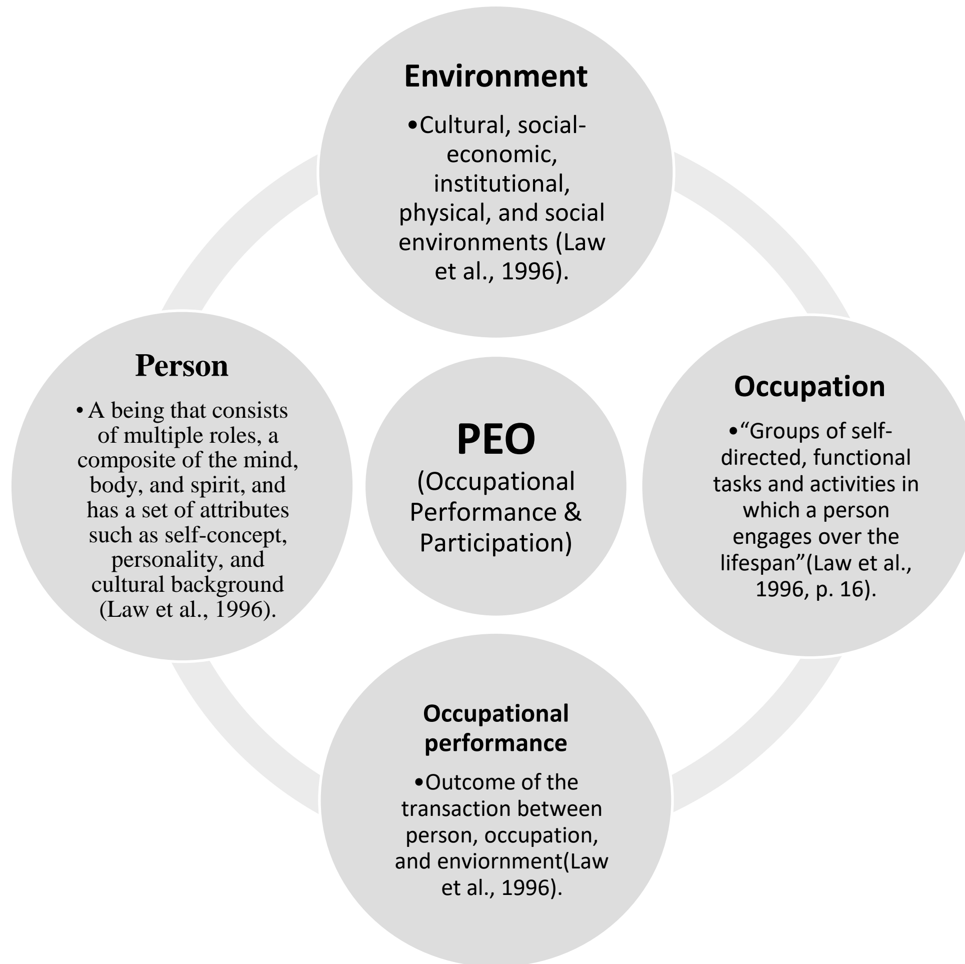
Medical and allied health professions provide physical and mental health services in a multitude of settings, including hospitals, schools, private facilities, telehealth, and within the community. The individuals who receive these services are often referred to as patients, clients, and/or students depending on the setting. For the purposes of this guide we will refer to the consumers as clients and students. Despite the differences between populations and settings, a transdisciplinary approach to care is viewed as best practice. This collaborative approach allows for the client to receive treatment from multiple skilled professionals throughout their treatment process, increasing their outcomes. The following are the professions that this guide specifically includes medical professionals, nursing, Occupational Therapy, and Physical Therapy. Additionally, this collaborative approach allows for professional growth between disciplines as each can learn from each other while appreciating their commonalities. Therefore, this collaborative approach additionally embodies the intended purpose of this guide, inclusivity. Consequently, the transdisciplinary section of this guide was written as an introduction to inclusivity instruction throughout each targeted discipline.

Design

Person-Environment-Occupation Model (PEO)

The authors utilized the occupational concept Person-Environment-Occupation Model (PEO) as an overarching influence for creating this guide. As this model represents a holistic approach to the intervention process. This model was created by Mary Law to emphasize the importance of the transactional relationship between the person, the environment, and occupation and the impact it has on occupational performance (Law, Cooper, Strong, Stewart, Rigby, & Letts, 1996). This model has four main concepts, which are represented in Figure 1.

Figure 1
PEO Diagram



The more harmoniously that the three concepts interact, the greater the occupational performance will be (Law et al., 1996).

Constructivist Learning Theory

To include multiple disciplines, the Constructivist learning theory was also used to organize material and include learning concepts within the cultural competency guide. When learning about cultural competence from a constructivist perspective, Garneau and Pepin (2015) state that competence is fluid, dynamic, and constantly evolving, and therefore encompasses more than race and ethnicity. Because constructivists state that learning involves developing new knowledge ***through reflection on previous experiences and taking action***, the development of competence is continued throughout life (Garneau and Pepin, 2015).

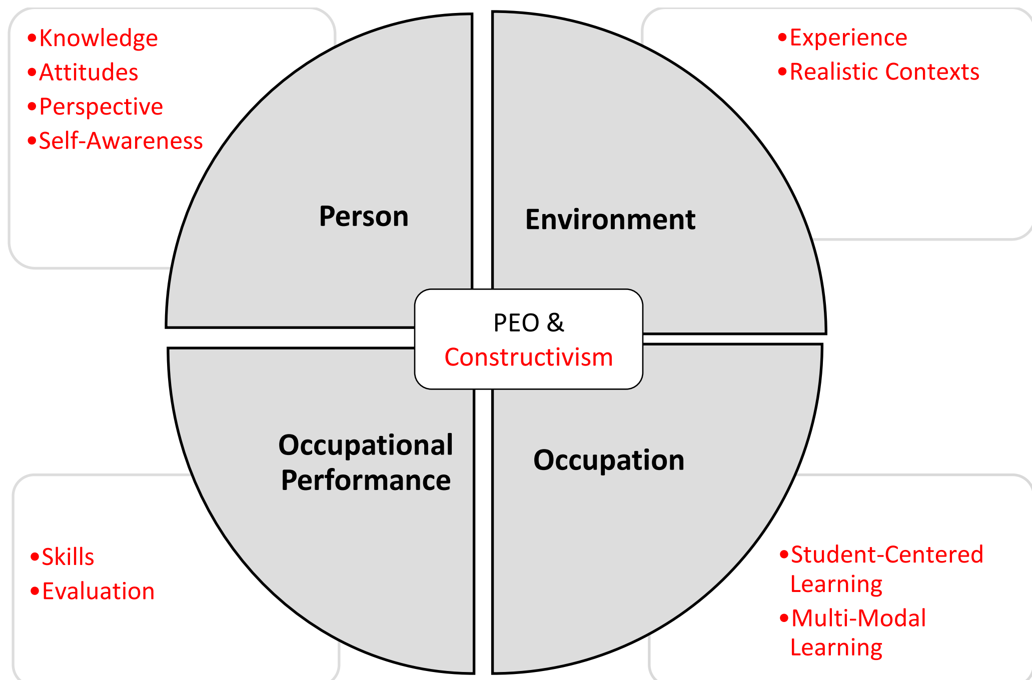
Knowledge is not simply transmitted to the learner; the learner needs to actively construct the knowledge in his/her mind. "In other words, students learn by fitting new information together with what they already know" (Bada & Olusegun, 2015, pg. 66).

The constructivist learning theory consists of three overarching concepts: knowledge, skills, and attitudes. However, for the purpose of this guide the authors followed the constructivist theory's six constructs. Honebein (1996) summarized what he described as the six pedagogical goals of constructivist learning environments as (Bada & Olusegun, 2015, pg. 68):

1. To provide experience with the knowledge construction process (students determine how they will learn).
2. To provide experience in and appreciation for multiple perspectives (evaluation of alternative solutions).
3. To embed learning in realistic contexts (authentic tasks).
4. To embed learning in social experience (collaboration).
5. To encourage the use of multiple modes of representation, (video, audio text, etc.)
6. To encourage self-awareness of the knowledge construction process (reflection, metacognition).

It should be noted that another construct was listed – "encourage ownership and voice in the learning process" - however, the authors felt this construct was embodied throughout the other six steps and represented appropriately (Honebein, 1996, pg. 68). By understanding the concepts of this theory, a curriculum can be designed to improve students' ability to learn and influence inclusive change within their future performance.

Figure 2
PEO & Constructivism Diagram



With the concepts of both constructivism and PEO in mind, this product will take in aspects of both occupational therapy theory and learning theory to adequately address the qualities of both. The authors felt that the holistic approach of the occupational model

combined with the learning theory, constructivism, would best represent an inclusive and effective curricula guide.

Organization

A literature review was conducted prior to the development of this guide, which is available upon request. The literature review includes current information regarding the LGBTQ population within the healthcare curriculum. The Guide then progresses into 3 parts:

Part I: Part I of this guide is titled *Transdisciplinary Instruction for Inclusion.* This section orients the facilitator to the guide and gives direction to how this material is meant to be implemented. It also discusses the six curricula objectives which reflect the constructs of the constructivist learning theory.

Part II: Part II of this guide is titled *General Curriculum.* This section presents a general curriculum outline and four different discipline-specific outlines that can be used for different professions.

Part III: Part III of this guide is titled *Interactive Education.* This section discusses the importance of cultural competency and gives a guideline of how to implement different activities into the session to enhance competency for the LGBTQ population.

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Utamsingh, P. D., Kenya, S., Lebron, C. N., & Carrasquillo, O. (2017). Beyond sensitivity. LGBT healthcare training in U.S. medical schools: A review of the literature. *American Journal of Sexuality Education*, 1-22. https://doi.org/10.1080/15546128.2017.1298070

PART I: TRANSDISCIPLINARY INSTRUCTION FOR INCLUSIVITY

The construction process of this guide was rooted in research and organized with the concepts, beginning with the whole and expanding to include the parts" (Olusegun, 2015, p. 68). This idea of beginning with the large concept is addressed throughout the guide through introducing a topic/concept, then providing an interactive education. The authors also found that a curriculum that provides students the opportunity for open interactions and effective communication increases the level of learning. These concepts then became the outline for the guide's introduction and education sections, which can be found in Part II and III.

Part I is represented by two sections. The first is an overarching outline of the curricula guide, found in *Table 1*. This outline will orient the facilitator to the topic and give them a better understanding of how this material was meant to be implemented. The second is a breakdown of the six curricula objectives which reflect the constructs of the constructivist learning theory. The objectives are further divided into specific learning goals and provide suggestions, activities, and resources to achieve the stated objective. Additionally, due to discipline specific education standards, definitions, policies, and procedures, each discipline has a representative perspective found in Part II.

Table 1
Facilitator Topic Guide

Topic	**LGBTQ+ health and the need for inclusivity in healthcare**
Purpose/ Objective	To educate students within medicine, nursing, and the allied health professions on the following: the foundational knowledge of the LGBTQ population, their specific needs and disparities within healthcare, and give participants resources for further education.
Preparation/ Supplies	Preparation: The facilitator will need to look over the session guide/presentation to get a feel for the intended purpose. To fully prepare the facilitator will need to do research on current literature, societal initiatives and policies, and discipline specific information and resources. We recommend that facilitators create a reading or assignment from this material for students to complete prior to class. If the facilitator does not feel comfortable with the material, they are to contact UND's pride center to set up a time for a guest speaker. Supplies needed: Overhead screen/projector for PowerPoint presentation, tables for students that facilitate group discussion, computer/access to the internet, spacious environment, and paper/pencil. ** *This may not be an all-inclusive list; materials may differ per environment and/or facilitator.*

<table>
<tr><td>Time Needed</td><td colspan="2">This guide is designed for a two-hour class session. However, the facilitator may implement sections into multiple class sessions if desired.</td></tr>
<tr><td>Rationale of Activities</td><td colspan="2">To create a guide that is holistic and inclusive, the Person-Environment-Occupation Model (PEO) was used to structure the content and activities. In conjunction, the Constructivist learning theory was used as a resource and guide for curricula objectives and content organization. These were used as a multi-layered approach and integrated in the following way:
1. Person (Client/Student) – This will challenge and build the person's knowledge, self-awareness, attitudes, and perspectives.
2. Occupation (Health Maintenance and Management/Learning) – This is the act of student-centered and multi-modal learning.
3. Environment (Healthcare Facility/Classroom) – This will support and enrich the experience, specifically using experience and realistic contexts.</td></tr>
<tr><td>Facilitation</td><td colspan="2">The curriculum was developed to be taught in a PowerPoint format with activities integrated throughout. This guide includes detailed objectives, general and discipline specific information, interactive activities, and resources. This guide was not designed to instruct, but to feed the learners' needs and to treat knowledge as an integrated whole.</td></tr>
<tr><td rowspan="4">Process</td><td>Person</td><td>The guide will be implemented by the facilitator with the learner at the center. Parts of the person to consider when preparing and facilitating the material are their physical, cognitive, and affective wellbeing, as well as spirituality.</td></tr>
<tr><td>Environment</td><td>The guide will be implemented in an institutional environment. Although the facilitator must consider the learners' cultural, social, physical, and virtual contexts as well.</td></tr>
<tr><td>Occupation</td><td>The guide targets the occupation of learning, categorized as productivity/work. As the material is designed to challenge and enhance learners' perspective, the facilitator also needs to take the occupations of self-car, leisure, and rest/sleep into consideration.</td></tr>
<tr><td>Context</td><td>As the constructivist theory indicates, research has shown that the context in which learning occurs influences the level of understanding and generalization to realistic contexts. The guide offers the facilitator learner-centered objectives to stray away from the typical instruction method of teaching, instead incorporating real contexts and focus on the needs of the learner.</td></tr>
</table>

<table>
<tr><td rowspan="3"></td><td>Connection to past experiences</td><td>As the constructivist theory indicates, knowledge is personal. This means that each learner has a unique perspective, which is based on prior knowledge and values. If the facilitator uses the constructivist principles, they can challenge and/or enhance the learners’ perspectives. This results in a positive experience, knowledge, and increased rate of that learner providing inclusive care in the future.</td></tr>
<tr><td>New Knowledge - Skills</td><td>After successfully taping into the learners’ perspective and experiences, the facilitator may integrate new information. This can be achieved by presenting new information in a way that matches the learning style of the students. This guide provides that facilitator with multi-modal teaching methods (i.e. visual, auditory, kinesthetic) to best connect with their learners.</td></tr>
<tr><td>Evaluation of knowledge & skills</td><td>As the constructivist learning theory indicates, each learner has their own process. The evaluation phase especially may look very different from person to person. This guide provides the facilitator with various ways to incorporate learner evaluation within their sessions (i.e. discussion/processing questions, post-test, follow-up assignment).</td></tr>
<tr><td>Adaptations</td><td colspan="2">This guide is designed as a base layer of knowledge for facilitation and implementation into current medicine and allied health related professions. Users may use and adapt the material to fit their needs, making sure to maintain academic integrity. Electronic copies of the full guide, activities, literature review, and PowerPoint are available upon request.</td></tr>
<tr><td>Resources</td><td colspan="2">

National LGBT Health Education Center (https://www.lgbthealtheducation.org/)
The Trevor Project (https://www.thetrevorproject.org/)
The Genderbread person (https://www.genderbread.org/)
UND Pride Center
Ally Training
“The LGBTQ+ Ally Training Program is committed to increasing understanding and awareness around how to foster an inclusive and welcoming environment for the LGBTQ+ community. These workshops are open to students, faculty, and staff.”
Dakota OutRight (http://dakotaoutright.org/css/)
National Resource Center on LGBT Aging (https://www.lgbtagingcenter.org/)
Welcoming Schools (http://www.welcomingschools.org/)
Allies in Medicine
A potential group started by Justin Schaefer, a medical student at UND.

</td></tr>
</table>

Broad Curriculum Objectives

Objective 1: Provide experience with the knowledge construction process

1a. The students will identify session expectations at the beginning of the session to facilitate a positive learning environment.

1b. The students will evaluate learning through a pre/post-test.

1c. The students will define healthcare disparities in relation to the LGBTQ population.

For the facilitator to create a positive learning environment for their students, they will first either establish or ask the students to establish expectations for the session. An example of a rule is respecting other students' questions, thoughts, and opinions. This method directly targets learning goal 1a and allows for a richer group discussion and increasing students' understanding of the topic.

The guide then moves into the introduction section of the session. The activity that is associated with this step in the learning process is a pretest found in Appendix A to be given prior to any knowledge, meeting learning goal 1b. In this pretest the large topic is presented, and students then begin to draw upon any personal/professional experience with this population to answer the questions. The authors provide a pdf version of the pretest, however, they encourage facilitators to use their creativity and student preferences to disseminate the tests, as they are designed to not be graded. For example, using a Qualtrics link to present the information through a technology platform, which may be preferred by the students. An additional benefit to this method is anonymous collection of student answers, which the facilitator can view data and establish a continued need for education.

After introducing the topic of LGBTQ health and the need for inclusivity in healthcare, the guide then branches to include all parts of this topic. The education section of the lesson plan is broken up into the following: Introduction to the population, statistics, stereotypes, health disparities, access to healthcare, providers' viewpoint of barriers, review of microaggressions, and national initiatives. This is where interactive education begins, addressing learning goal 1c, as the guide has designed activities that consist of implicit testing, case studies, group discussions, practice application, and interactive methods of learning. As the first objective of the constructivist learning theory conveys, students begin to take control of their learning and the facilitator is a resource for directing that process (Honebein, 1996). To further address this objective and learning goal 1b, the authors suggest a posttest or the facilitator to ask the students for their feedback on the session for increased development of the curriculum.

Objective 2: Provide experience in and appreciation for multiple perspectives

2a. The students will contrast their perspectives during group activities/discussion.

2b. The students will summarize main points of the material and activities as a group.

At the beginning of this guide the authors emphasize the importance of collaboration, specifically within practice as communication between disciplines has been

proven to increase client outcomes. This concept is also present within curriculum development and the constructivist theory's second objective, as "there are multiple ways to think about and solve problems. Students must engage in activities that enable them to evaluate alternative solutions to problems as a means of testing and enriching their understanding" (Honebein, 1996). To address learning goal 2a, this guide has provided many activity and curriculum options for the facilitator to choose. This aligns with a constructivist's view of the classroom, as "materials include primary sources of material and manipulative material" (Olusegun, 2015). As stated, many times throughout, this guide was created for an active education process and interactive learning.

To understand whether the students are connecting with the material being presented, the authors of this guide encourage group discussion and questions before, during, and after the session. As identified in the constructivist theory, the facilitator should encourage questions, as student interest and inquiries are valued (Olusegun, 2015). The more enriching the discussion is the easier learning goal 2b will be achieved. As not all students value in-class discussions, the authors suggest that the facilitator alter this process to fit the needs of their students. For example, this may look like a discussion board for those who need additional processing time or would like to further discuss the topic with peers. Additionally, resources can be found in table 1, which may enhance student learning. It is suggested that the facilitator makes these resources available to the students, as further education is self-directed. As stated by Olusegun (2015), "knowledge is seen as dynamic, ever changing with other experiences," allowing students to further their learning down the road when experiences lead them back to this information (p. 69).

Another benefit that is addressed in learning goal 2b is through the student's ability to summarize key points. This analysis of the material indicates that the students are functioning at a higher learning level. Which aligns with the purpose of this guide, as the authors want students to gain an understanding of inclusive healthcare for the LGBTQ population and implement these concepts into their future practice.

Objective 3: Embed learning in realistic and relevant contexts

3a. The students will practice principles learned through the material applying them to the activities.

3b. The students will identify methods to implement material while on future clinical rotations.

3c. The students will recognize available and credible online resources for the LGBTQ population.

As the objective suggests, learning within a natural context best facilitates a student's learning as they can generalize that learning to other contexts. However, bringing each student to their natural context is not feasible. To bridge this gap the guide suggests case studies and role play activities for a simulated environment within practice, fulfilling learning goals 3a and 3b. Seyyedrezaie and Barani (2017) support this concept stating, "constructivist learning environment is learner-centered, which is mainly based on problem-solving and hands on activities that require active engagement of cognitive processes" (p.128). These experiences will give students a foundational experience that

they can use to reference when out on clinicals or within future practice. The authors encourage the facilitator to create a discussion based upon what the students will take away from this material to use within practice. As the LGBTQ population is unique, as every person, setting, and situation will be individualized, the students will be able to generalize knowledge learned through this material.

In addition to presenting simulated material, this guide offers resources that can be used in any context. As addressed above, some students may use these resources as a way to self-directed learning. However, some students may also use these resources as direction within practice to increase inclusivity. The core of constructivism is meeting students' needs where they are at, celebrating their uniqueness of learners and promoting quality education through the curriculum (Seyyedrezaie and Barani, 2017). Ideally, students would then disseminate the credible sources to colleagues and the circle of inclusivity would continue to grow.

Objective 4: Embed learning in social experience

4a. The students will relate to their classmates and facilitator through discussions and asking questions.

4b.The students will describe the benefits of collaboration with other students/clients.

According to Olusegun (2015), "intellectual development is significantly influenced through social interactions," emphasizing the importance of collaboration in learning (p. 12). Just as the authors stressed the importance within a healthcare setting, collaboration within education is just as important. Through the view of a constructivist classroom, students mainly work in groups to facilitate the environment needed for communication (Olusegun, 2015). In fact, constructivists believe that students are not only responsible for their learning, but the learning of their fellow group members (Seyyedrezaie & Barani, 2017). Therefore, it is increasingly important for the facilitator to establish session/class expectations prior to presenting the material.

To address learning goals 5a and 5b, the facilitator will utilize group discussion to direct students to analyze and evaluate for a deeper understanding. This can be achieved through the activities that are listed in appendices C-G. Another way that the authors suggest increased carry-over is implementing work to be done prior or concluding the session. This may take the form of watching a video, completing a discussion board post, or turning in an assignment. No matter the media, we encourage the facilitator to continue learning about the LGBTQ population throughout the curriculum and not just present an isolated PowerPoint.

Objective 5: Encourage the use of multiple modes of representation

5a. The students will generalize information learned through lecture, videos, discussion, and activities.

5b. The facilitator will choose various learning styles to implement within the class session.

As stated within the constructivist learning theory principles, this guide represents multiple learning modes by providing interactive educational material, representing

learning goal 5a. The material is given as a foundation for the facilitator to use in various forms including lecture, group discussions, activities, or a combination of the three. However, the design was not intended to be heavy on lecture, but instead the facilitator would represent someone who "coaches, mediates, prompts, and helps students develop and assess their understanding, and thereby their learning" (Olusegun, 2015). This interactive approach allows for all student learning styles to be represented, and therefore students will gain a higher understanding of the material, increasing future inclusivity.

Each learning style is represented throughout the presentation of the material. Auditory is represented through facilitator lecture, peer discussion, and audio in videos. Visual learning is represented through a session guide that can be available for students if the facilitator chooses, PowerPoint presentation, and written material. Lastly, kinesthetic learning is represented through activities and group discussion, allowing for students to get up and move. The authors would like to encourage the facilitator to allow kinesthetic students the right to means for movement, such as fidgets, to increase attention. When developing this guide, we took careful consideration to include all learning styles to represent how unique each student is and their associated learning style. Consequently, learning goal 5b is achieved through utilizing different learning styles throughout the session material.

Objective 6: Encourage self-awareness of the knowledge

6a. The students will recognize national stereotypes, biases, and beliefs that may impact inclusive care.

6b. The students will describe how personal biases and beliefs may negatively influence inclusion within their profession.

6c. The students will generalize the effects of microaggressions on providing inclusive care.

The final objective involves student self-awareness, the outcome of the constructivist learning theory (Honebein, 1996). This guide serves as a step by step approach, which aligns with the concepts, knowledge, skills, and attitudes. Throughout this guide the facilitator presents material through various modes for a foundational knowledge. Then the students participate in activities building on that knowledge. This is presented through the activities, where students are asked to look at their prior knowledge and beliefs toward the LGBTQ population. This reflection is upon their attitudes, to personally and professionally grow throughout this material to provide inclusive care.

The students will achieve learning goal 6a throughout the knowledge stage, utilizing the social experience of group discussion to best understand negative stereotypes, biases, and beliefs. This is also the stage for reflection, representing learning goal 6b, as the student learns through the implicit testing about their own biases and beliefs. The authors hope that through the presentation of this material any negative biases, beliefs, or stereotypes will be challenged. As stated by Seyyedrezaie & Barani (2017), "conceptual growth comes from the negotiation of meaning, the sharing of multiple perspectives and changing of our internal representations through collaborative learning" (p. 128).

In relation to education about discrimination, the guide provides the facilitator with the material to explain microaggressions. As research within the past ten years has shown a shift in discrimination from explicit to microaggressions. However, even though discrimination is in a less direct manor, this does not mean that the language, environmental, and institutional microaggressions are any less detrimental to the LGBTQ population. This last piece of the puzzle encompasses not only the student and their behaviors and language, but also adds the concept of environment and institution. This is where learning goal 6c is addressed.

PEO Implementation

The PEO occupational model was used throughout the development of this guide as a tool to keep the students/clients at the center of the material. As this model is holistic in nature or person-first. It is important to note that the authors of this guide are occupational therapy students and utilized the professions language, however, careful consideration was taken to make language inclusive to all disciplines.

The person represented in this guide is multilayered, as the population represented through the material is the LGBTQ population. However, the second layer of person is the student, as this guide was created for change to occur within the student. Therefore, the authors diligently kept both person groups at the center of all material.

Aspects of the person that were addressed throughout the guide were physical, cognitive, sensory, affective, and spiritual (Baptiste, 2017). These factors influenced the types of activities and nature of group discussion topics. For example, when considering health disparities with this population, the facilitator needs to take cognition, affect, and spirituality into consideration when representing the client. The facilitator can create discussion questions that give students the opportunity to see the world through this population and empathize with what the potential client may go through. Additionally, this activity would also take the students' cognition, affect, and spirituality into consideration as this material may pose a different perspective. Allowing each population, the time and positive environment to process the activity/experience will allow for personal and professional growth.

Aspects of the environment that were considered throughout the guide development were physical, social, cultural, institutional, and virtual (Baptiste, 2017). A specific environmental factor addressed for the client population is cultural, as this is a base throughout the material. For example, this concept can best be represented with the case study and role play activities, found in appendices F and G. These include cultural nuances for students to gain a better understanding of the population's diversity. Two environmental factors played a large role within the students' environment, institutional and social. As these two factors are the current environment that they experience daily participating in a professional program. Additionally, the facilitators should also emphasize that these environments continue throughout students' personal and professional lives. As many students may find that the social environment within their future employment may not be inclusive. This situation may pose an ethical dilemma, and emphases the students' need to be aware and keep credible resources available for further education.

Lastly, PEO takes occupation into consideration, which can be broken down into self-care, productivity, and leisure (Baptiste, 2017). As an occupational therapist these would be the base of their interventions. However, to keep the perspective neutral, these are areas that the facilitator can address when considering the client or can be represented through activities/discussion. For example, these areas are daily activities that the clients do daily and need to be taken into consideration when treating the individual. A medical professional may need to know what the client does for work or how they structure their day for hormone injections. It is the facilitator's job throughout this guide to emphasize the importance of considering the person holistically. As for the students, they are engaging in these occupations by attending to this material, this course, and whatever professional degree they are pursuing. The facilitator, just as they are emphasizing the holistic needs of the clients, need to consider their students' needs as well.

References

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PART II: GENERAL CURRICULUM

Introduction

Part II of this guide presents a general session outline. The outline is to be used as a tool for facilitators to organize material for their class session(s). A PowerPoint that aligns with the session can be found in appendix H. Each section of the outline represents a topic that is needed to educate students on health disparities that the LGBTQ population is faced with. Along with current statistics and research, the facilitator is presented with a plethora of resources to continue to update information throughout the use of this guide. Specifically, the facilitator will need to change national initiatives more frequently due to societal changes.

The outline includes general learning objectives to be achieved through the material developed using Blooms Taxonomy. These are suggested as the authors recognize that disciplines may use other methods to structure their outcome objectives.

After the general session outline is presented, each discipline is represented as their own unique entities. Each perspective incorporates the discipline's standards, relevant statistics, role with the LGBTQ population, state and/or national organizations, and resources. The facilitator can incorporate specific aspects found in the respective guides into the areas of the main section that they align with. The authors acknowledge that there may be more credible information for each section specific to the disciplines and this is not an all-encompassing list. The facilitator is encouraged to stay up to date on their specific discipline's perspective using this guide for a foundation, organizational tool, and resource for course development.

LGBTQ+ Healthcare Education: General Session Outline

OVERVIEW & INTENDED AUDIENCE

To educate students within medicine, nursing, and the allied health professions on the following: the foundational knowledge of the LGBTQ population, their specific needs and disparities within healthcare, and give participants resources for further education.

EDUCATION STANDARDS

Each profession has specific educational standards they use as a guide and must meet for program accreditation. See individual perspectives for detailed education standards.

OBJECTIVES

The facilitator may create their own objectives or use the ones below. However, we encourage the facilitator to maintain PEO and the constructivist principles at the center of their objectives.

1. The learners will be able to define healthcare disparities in relation to the LGBTQ population.
2. The learners will be able to select available and credible online resources for the LGBTQ population.
3. The learners will be able to admit personal biases that may impact culturally competent care within discussion and the pretest.
4. The learners will be able to demonstrate culturally sensitive care by applying their knowledge to the case study activity.
5. The learners will be able to generalize the effects of microaggressions on providing culturally competent care.

MATERIALS NEEDED

***This is not an all-inclusive list; materials may differ per environment and/or facilitator.*

- Overhead screen for PowerPoint presentation
- Tables for group discussion
- Computer/access to the internet
- Spacious Environment
- Paper/Pencil
- Pre/Posttests

INTRODUCTION/WARM-UP

Session/Class Expectations. The facilitator will state session/class expectations at the beginning of material presentation. By creating expectations, the facilitator is creating a safe and supportive environment to encourage maximum learning potential. These expectations can either be created by the facilitator, reiterated from the student handbook from the university, or the students may create them prior to, or at the beginning of the session. If the facilitator chooses to establish expectations, the following are examples of potential session expectations.

1. Each student is to be treated and treat others with respect.
2. All information disclosed within the session does not leave the room.
3. All questions are welcome and encouraged, this is a learning environment.
4. Listen with an open mind.
5. Stay mentally and physically present.

Pretest. The facilitator will present the learners with a pretest. The pretest will encourage students to recall experiences and influence a base perspective for the session. Distribution medium of the pretest is dependent on the facilitator's preference and content can be changed to be tailored to the learning audience. A general pretest can be found in *Appendix A*. However, the following principles will be upheld across all disciplines.

1) The pretest is not for grading purposes.
2) The responses will be anonymous, as this is to determine the participants' current knowledge about the LGBTQ population

The facilitator will have the option of using the pretest as a posttest upon session completion. This will be a concrete measure of students' learning and can validate the necessity for continued session implementation in the future.

Due to the sensitive nature of the topic, the facilitator should provide resources for students that may need them (i.e. the university's counseling center).

EDUCATION

The following information is the general education portion that will be addressed within each disciplines' session presentation. This is the presentation of potential new material for the students. The facilitator is provided with interactive activities throughout the education session to encourage an increased understanding and challenge/enhance students' perspectives. Specific education related to each discipline can be found in each perspective's lesson plan.

Introduction to the Population (National LGBT Health Education Center, 2020)

Terms can be defined throughout the presentation, or students can be directed to the National LGBT Health Education Center Glossary of Terms to follow along.

1. Terms/definitions. The LGBTQ+ population is ever changing and expanding. Facilitators are encouraged to update themselves on the current terminology. The following are general and commonly known terms associated with the population's acronym.
    a. **Lesbian**: women who are primarily attracted to women
    b. **Gay**: men who are primarily attracted to men
    c. **Bisexual**: an individual who is attracted to both men and women
    d. **Transgender**: a person who identifies as the opposite gender they were assigned at birth
    e. **Queer**: an umbrella term for sexual and gender minorities who are not heterosexual or are not cisgender
    f. **Intersex**: individuals born several variations in sex characteristics
    g. **Pansexual**: an individual who is attracted to people of all gender identities and sexes
    h. **2-Spirit**: Two-spirit is a gender identity. If someone is two-spirited, their body simultaneously houses both a masculine spirit and a feminine spirit. This idea originated with Native Americans and can also mean that they fulfill both gender roles.
    i. **Asexual**: someone who experiences little or no sexual attraction to others
    j. **Agender**: no gender or without gender

2. Gender vs sexuality vs sexual orientation
    a. **Assigned sex**: Sex (sometimes called biological sex, anatomical sex, or physical sex) is assigned at birth, and is typically based on anatomical and biological characteristics.
        i. <u>Female</u>: having female genitals, chromosomes, and hormones
        ii. <u>Male</u>: having male genitals, chromosomes, and hormones
        iii. <u>Intersex</u>: individuals born several variations in sex characteristics
    b. **Gender Identity**: Your psychological sense of self. One's inner sense of being female, male, something else, or no gender.
        i. <u>Cisgender</u>: your gender identity and assigned sex align

ii. Transgender (male/female): a person who identifies as the opposite gender they were assigned at birth
iii. Transgender (masculine/feminine): anyone who identifies on the masculine/feminine side of the spectrum, but may not identify as a man/woman
iv. Non-binary: a person who identifies with or expresses a gender identity that is neither entirely male nor entirely female
v. Two-spirit: If someone is two-spirited, their body simultaneously houses both a masculine spirit and a feminine spirit. This idea originated with Native Americans and can also mean that they fulfill both gender roles.
vi. Genderqueer: spectrum of gender identities that are not exclusively masculine or feminine
vii. Agender: not identifying with either gender

c. **Gender Expression**: The way a person communicates their gender to the world through mannerisms, clothing, speech, behavior, etc. Gender expression varies depending on culture, context, and historical period.
   i. Feminine: expressing oneself in a way that is traditionally characterized by women
   ii. Masculine: expressing oneself in a way that is traditionally characterized by men
   iii. Androgynous: having a combination of both masculine and feminine characteristics
   iv. Fluid: individuals who shift between masculine and feminine expression

d. **Sexuality**: The desire one has for emotional, romantic, and/or sexual relationships with others.
   i. Gay: men who are primarily attracted to men
   ii. Lesbian: women who are primarily attracted to women
   iii. Bisexual: an individual who is attracted to both men and women
   iv. Heterosexual: men who are primarily attracted to women and vice versa (also known as straight)
   v. Pansexual: an individual who is attracted to people of all gender identities and sexes
   vi. Polysexual: an individual who is attracted to multiple genders or sexes, but not all
   vii. Asexual: someone who experiences little or no sexual attraction to others
   viii. Aromantic: someone who experiences little or no romantic attraction to others
   ix. Demisexual: someone who doesn't feel sexual attraction until there is an emotional bond
   x. Demiromantic: someone who doesn't feel romantic attraction until there is an emotional bond

Statistics

This section can be represented as an activity, see *appendix C*. When the facilitator incorporates statistics within an activity the students can better conceptualize the numbers. Additionally, this multi-modal approach increases understanding and information carry-over. The following statistics are to be represented no matter the activity. To maintain up to date on statistics the facilitator can check out the following recommended resources: National Public Radio, Robert Wood Johnson Foundation, and Harvard T.H. Chan School of Public Health.

- 90% of all LGBTQ people believe there is discrimination against the population in America today
- 57% of LGBTQ members have experienced slurs
- 51% have reported being sexually harassed
- 51% reported experiencing violence
- 34% have reported being verbally harassed in the bathroom
- 16% reported being personally discriminated against when going to a doctor or health clinic
- 22% of transgender individuals and 18% of LGBTQ Americans report that they have avoided doctors or healthcare due to concern that they would be discriminated against

Stereotypes

The facilitator will ask students what stereotypes they have heard regarding the population. This section will pull in the students' prior knowledge and potentially biases. The purpose of this section is to challenge these perspectives and biases to increase awareness and understanding. The facilitator needs to take all students' person factors into consideration within this section as the material may be contradictory from their past knowledge. The facilitator will go through the following stereotypes:

1. LGBTQ individuals are mentally ill

- **Fact**: In 1973, the American Psychological Association (APA) removed the diagnosis of "homosexuality" from the Diagnostic and Statistical Manual (DSM) (Spitzer, 1981). After reviewing theories that placed homosexuality in the DSM in the first place, the American Psychological Association declared "Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they do not indicate either mental or developmental disorders" (Glassgold, Beckstead, Drescher, Greene, Miller, Worthington, & Anderson, 2009, p. 2).

2. LGBTQ individuals look a certain way

- **Fact**: A common misconception is that men who act feminine must be gay and that women with short haircuts or are more masculine must be lesbian. This stereotype is perpetuated by the media. When seeing individuals that fit these stereotypes in movies this engages an individuals' *selective perception or* favoring information that affirms a predetermined belief (Bucher, 2015). Information that disputes this belief would be disregarded. In all reality, individuals in the LGBTQ community are in every social, racial, religious, and economic group, and only a small percentage fit the stereotype. More exposure in the media and everyday life of a wide range of individuals in the LGBTQ community may help to eliminate this myth.

3. AIDS is a "gay" disease

- **Fact**: Although HIV/AIDS is more prevalent in gay men than heterosexual individuals, anyone can obtain this disease (Centers for Disease Control and Prevention, 2019). In general, many individuals of the LGBTQ community avoid going to a healthcare provider due to fear of discrimination (Macapagal, Bhatia, & Greene, 2016; Seelman, Colon-Diaz, LeCroix, Xavier-Brier, and Kattari, 2017). If this myth is perpetuated, individuals of this population may avoid getting tested for HIV/AIDS due to that same fear. This could lead to a higher spread of the disease due to an individual not knowing he or she has the disease. By decreasing the stigma around HIV/AIDS and increasing education about the different types of prevention, individuals of this population can feel safer about seeing a doctor to meet his or her specific needs regarding this topic.

4. Sexual orientation can be changed

- **Fact**: As previously stated, the APA determined that homosexuality is a normal occurrence and does not indicate any type of disorder (Glassgold et al., 2009). Nevertheless, sexual orientation conversion efforts (SOCE) have been used to attempt to convert the sexual orientation of LGBT individuals to heterosexuality (Anton, 2010). Dehlin, Galliher, Bradshaw, Hyde, and Crowell (2014) did a study which examined SOCE by surveying 1,612 individuals. Most of the participants in the study reported little to no change in sexual orientation after going through SOCE (Dehlin et al., 2014). Instead, many reported considerable harm (Dehlin et al., 2014). Examples of harm include decreased self-esteem, increased self-shame, increased depression and anxiety, the wasting of time and money, increased distance from God and the church, worsening of family relationships, and increased suicidality (Dehlin et al., 2014). This study combined with information from the APA shows that attempting to change sexual orientation is ineffective and potentially harmful to LGBTQ individuals.

5. LGBTQ and Ally political organizations are asking for "special rights"

- **Fact**: Individuals of the LGBTQ community are not asking for special rights, many are simply asking for the same rights that heterosexual individuals already have, one of those being safety from being discriminated against. Currently, only 21 states have laws that prohibit discrimination against LGBTQ individuals in the workplace (Human Rights Campaign, 2019). In a survey conducted by the Pew Research Center, 21% of LGBTQ individuals reported being treated unfairly by an employer through pay, hiring, or promotions (2013). According to the United States Transgender Survey completed in 2015, 30% of transgender respondents who had a job in the past year reported being fired, denied a promotion, or experiencing some other form of mistreatment related to their gender identity (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). These surveys show that although some steps are being taken towards reducing discrimination for LGBTQ individuals, discrimination is still prevalent towards this population. Equal rights and non-discrimination laws should not be considered "special rights" but should be a basic human right for all people.

Health Disparities

Individuals within the LGBTQ population share the same general health risks as their heterosexual peers; however, this population does have additional health related needs that require specific care. The facilitator will go through the statistics of each disparity.

1. Substance abuse
   a. 39.1% (⅖) of the sexual minority use illicit drugs compared to 17.1% of the sexual majority (Medley et. al., 2016).
   b. 15.1% of the sexual minority had a substance use disorder compared to 7.8% of the sexual majority (Medley et. al., 2016).
2. Unhealthy weight control
   a. Due to societal pressures of body image LGBTQ individuals have higher rates of eating disorders, body dissatisfaction, and obesity (Hadland et. al., 2015).
   b. Associated behaviors of unhealthy weight control (binging, purging, misuse of laxatives, self-induced vomiting, and caloric restriction) then increase. Statistically sexual minority males are 4x more likely and females are 2x more likely to engage in these behaviors then their sexual majority peers. (Hadland et. al., 2015)
3. Smoking
   a. Cigarette use is high in this population in part due to tobacco companies and a mid-1990s marketing campaign called Project SCUM (subculture urban marketing). These companies continue to market at gay pride festivals and encourage menthol use. (CDC, 2019)
   b. 20.5% of LGBTQ individuals smoke cigarettes compared to 15.3% of straight adults. (CDC, 2019)
4. Mental health related disorders
   a. LGBTQ individuals are 2.5x more likely to experience depression, anxiety, and substance misuse. (APA, 2017)
   b. 37.4% of individuals in the sexual minority have a mental illness compared to 17.1% of the sexual majority (Medley et. al., 2016).
   c. Increase in mental health disorder consequently contributes to a higher risk for suicidal behavior and increased suicide attempts (APA, 2017).
5. Sexual Violence
   a. Due to poverty, stigma, and marginalization LGBTQ individuals suffer higher levels of sexual violence (Human Rights Campaign, 2020).
   b. The following are percentages of subgroups that experience rape, physical violence, and/or sexual violence by an intimate partner (Human Rights Campaign, 2020):
      - 44% lesbians
      - 35% heterosexual women
      - 37% bisexual men
      - 61% bisexual women
      - 26% gay men
      - 29% heterosexual men
   c. Within a transgender individual's lifetime 47% will experience sexual assault (Human Rights Campaign, 2020).

6. Sexually Transmitted Infections
    a. Socially, LGBTQ individuals are not receiving relevant or culturally sensitive sexual health education
    b. LGBTQ population are more likely than their heterosexual peers to be sexually active, have a sexually debut prior to 13-years-old, be involved with 4 or more partners, and are "about half as likely to have used a condom at last intercourse (35.8% vs 65.5%)" (Wood, Salas-Humara, & Downshen, 2016).
    c. Biologic factors, men who have sex with men are more susceptible to STIs and HIV due to their anatomy and immunology of their rectal mucosa (Wood et al., 2016).

Access to Healthcare

This section introduces the students to environmental factors that may be inhibiting or supportive for accessing healthcare. The facilitator may bridge this topic through asking the students what environmental factors they perceive as inhibiting or supportive. Material based on research can then be implemented about LGBTQ individuals' access to healthcare. LGBTQ individuals are less likely to be insured or lack a regular place of care, which in turn are also barriers for the population to obtain healthcare.

1. 31% of LGBTQ individuals report that they have no regular doctor or form of healthcare
2. 22% of LGBTQ individuals report being uninsured.
3. Researchers found that transgender and non-binary individuals were over three times more likely to choose a provider that sees LGBTQ patients
4. GLMA (previously known as the Gay & Lesbian Medical Association) has a resource on their website to find LGBTQ friendly providers in a specific area. After searching major cities in North Dakota (ND), only three LGBTQ friendly healthcare providers were found - one in Minot, ND, and two in Fargo, ND (GLMA, n.d.)
5. This means that many people in the LGBTQ will have to travel in order to see a provider that considers themselves LGBTQ friendly.

Video

To reiterate the need for inclusive care the following video has been chosen. The facilitator may choose when to show the video within the presentation (i.e. prior to, during, or following). This video is a suggestion, the facilitator may choose a different video if appropriate. The purpose of the video is exposing students to the perspectives of the LGBTQ community and offering an alternative point of view they might otherwise not be exposed to. This activity also presents another variation of context and learning mode.

- **Video Title:** LGBTIQ People Talk About Their Experiences Accessing Health Care
- Link**:** https://www.youtube.com/watch?v=Q5-7t_qBw14

Providers Viewpoint of Barriers

This section allows the students to relate with professionals that are currently practicing and assist them in understanding why this education is important. This section combines the person factors of PEO with occupation. The facilitator can express that an imbalance in either part of the transaction can negatively impact clients – specifically the LGBTQ population. Research suggests that providers are struggling with education about the LGBTQ population in order to provide culturally competent care. Specifically, inaccessibility of reliable resources, limited knowledge of appropriate referrals, inadequate medical knowledge, training, and experience (Snelgrove, Jasudavisius, Rowe, Head, and Bauer, 2012)

1. The most common barrier across all healthcare professions for giving LGBTQ culturally competent care appears to be a lack of knowledge and experience with the population.
2. Javaherian et al. (2008) found that out of 373 occupational therapists and occupational therapy assistants, only 19% received education on working with LGBTQ clients and only 11% had received training from their employers on diversity issues related to the population.
3. Other studies indicate that medical professionals in general receive limited or no education regarding LGBTQ care (Beagan, Chiasson, Fiske, Forseth, Hosein, Myers, & Stang, 2013; Utamsingh, Kenya, Lebron, & Carrasquillo, 2017).

Microaggressions Specific to LGBTQ Population

The facilitator will educate the learners on microaggression dependent on the need for the topic. If the students have not been exposed to the topic of microaggressions, the facilitator may want to create an introduction for the students based on knowledge that is needed. The facilitator will then open the floor to a group discussion about microaggressions and what the class perceives them to be. This section is again either exposing the student to new knowledge or building upon prior experience. Additionally, this section heavily emphasizes the concept and impact that environment has on a person and/or their occupation. The following list of the 3 types of microaggressions is to be included within discussion for full understanding of how these concepts impact the LGBTQ population.

Language	Environmental (Lack of diversity)	Institutional
1. Tone of voice 2. Body Language 3. Word Choice	4. Advertisements 5. Images 6. Media representation 7. Space organization 8. Lack of gender-neutral bathrooms	• Curriculum choices • Lack of education within professional schools • Policies • Regulations

The facilitator will present Solutions to each type of microaggression. An activity for language can be found appendix E.

National Initiatives

***Specific initiatives per the disciplines' associations will also be addressed within the perspective lesson plan.*

The facilitator will read the following quote from The Department of Health and Human Services (HHS): "For too long, LGBT people have been denied the compassionate services they deserve. That is now changing. HHS continues to make significant progress toward protecting the rights of every American to access quality care, recognizing that diverse populations have distinctive needs. Safeguarding the health and well-being of all Americans requires a commitment to treating all people with respect while being sensitive to thei r differences. (2012)"

This allows the students to be exposed to another context, specifically a professional context. They will then inform the class of the following additional efforts made by HHS since 2012 to improve quality of life for the LGBTQ population:

- Equal Employment Opportunity Policy
- Hospital visitation
- Internal LGBT Coordinating Committee
- Healthy People 2020, national HIV/AIDS strategy
- Tobacco control
- Anti-bullying efforts
- Improvements in foster and adoptive care
- Advanced directives
- Institute of Medicine study on LGBT health
- The Affordable Care Act
- Runaway and homeless youth services
- Aging services
- Non-discrimination Policy

PROFESSION'S ROLE

The facilitator will ask the class to discuss what they think that their role is in their profession when working with this population. This section allows for exposure to discipline specific context and allows students to better understand their role with this population. Upon completion of this section, it will allow for students to evaluate their knowledge taking new information and prior experience into consideration. Additionally, this allows for peer discussion, which encourages individuals to share perspectives. Specific roles will be discussed further in each individual outline, but some general roles include the following (Gibson, 2020):

- When talking about sex or safe sex, don't assume heterosexuality. Focus on behavior/practices not sexual identity.
- Ask patients to clarify any terms that you are unfamiliar with.
- Advocate for updating patient intake forms
- Displaying brochures and educational materials on LGBTQ Health concerns
- Patients may not be "out". If with family or friends, talk about private matters with the individual, not in front of others.
- Attend UND Ally Training (offered every month during academic year)
- Educate yourself on issues surrounding LGBTQ people (Stay current)

CLASS ACTIVITY

The facilitator will determine which class activity the participants will engage in based on the variety of activities included in part three of this guide. The activities are structured to be general and be able to be tailored to specifically address each discipline, if desired. The purpose of incorporating another interactive method of learning is to allow all students' needs to be met through the facilitation of this material.

CONCLUSION/DISCUSSION

This section is designed to facilitate further discussion and allow students the opportunity to ask questions or share their perspective. This section is based on the students' needs and the facilitator is to encourage sharing, however, not force any party to participate as some students may be still be in the processing/evaluation stage of learning. If needed, the facilitator can refer any learner to the appropriate resource for further information.

RESOURCES

***Resources may differ per discipline, as each perspective lesson plan will be tailored to the learners' resource needs.*

- National LGBT Health Education Center (https://www.lgbthealtheducation.org/)
    - "Provides educational programs, resources, and consultation to healthcare organizations with the goal of optimizing quality, cost-effective healthcare for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority (LGBTQIA+) people."
- The Trevor Project (https://www.thetrevorproject.org/)
    - "Founded in 1998 by the creators of the Academy Award®-winning short film TREVOR, The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer & questioning (LGBTQ) young people under 25."
- The Genderbread person (https://www.genderbread.org/)
    - "The Genderbread Person is a model that depicts the ways society constructs gender, and the different components that go into that. It's meant to be a digestible introduction to these ideas, for beginners, in a way that makes sense to most people."
- UND Pride Center
    - UND has a pride center on campus to support the LGBTQ+ population and allies through events, ally training, and an informative website that includes resources (i.e. gender-neutral bathroom map, gender pronouns, etc.), a mentorship program, scholarships, and many more.
- Ally Training
    - "The LGBTQ+ Ally Training Program is committed to increasing understanding and awareness around how to foster an inclusive and welcoming environment for the LGBTQ+ community. These workshops are open to students, faculty, and staff."

- Dakota OutRight (http://dakotaoutright.org/css/)
    - "Creating Safe Spaces is a resource and training project developed by Dakota OutRight. Their goal is to equip educators, counselors, and all kinds of youth-serving professionals to learn more about supporting LGBTQIA youth and creating safe spaces within their organization. The free toolkits come with an array of resources so that you can make a circle of impact, no matter how small."
- National Resource Center on LGBT Aging (https://www.lgbtagingcenter.org/)
    - "The National Resource Center on LGBT Aging is the country's first and only technical assistance resource center aimed at improving the quality of services and supports offered to lesbian, gay, bisexual and/or transgender older adults."
- Welcoming Schools (http://www.welcomingschools.org/)
    - "HRC Foundation's Welcoming Schools is the nation's premier professional development program providing training and resources to elementary school educators to embrace all families, create LGBTQ and gender-inclusive schools, prevent bias-based bullying, and support transgender and non-binary students."
- Allies in Medicine
    - A potential group started by Justin Schaefer, a medical student at UND. This is an organization for LGBTQ+ members and allies at the medical school. The plan is to host educational events about the LGBTQ+ community once a semester and attend social events. Be on the lookout for further updates on this organization.

EVALUATION OF LEARNING

The facilitator is encouraged to have the students evaluate their learning from this material. This section was designed based on the final concept of the constructivist learning theory. This can be implemented in various ways; the following is a list of ideas for the facilitator. The facilitator may use one method, a combination of the methods, or create their own method for learning evaluation.

1. *Session evaluation paper.* The facilitator may ask the students to submit a reflection paper on the session, their learning, and main takeaways that will positively influence their future practice.
2. *Post Test.* The facilitator is provided with a pretest that may be used again at the end of the session for the student and facilitator to conceptualize learning throughout the session.
3. *Discussion Board.* The facilitator may ask the learners to participate in a discussion board the week concluding the session. This will allow learners to connect with their peers and continue the conversation, knowledge, and deepen their understanding on the topic.
4. *Research.* The facilitator may ask each learner to locate a journal article relating to LGBTQ health and their field of study. The learners would then summarize the article and either share this with peers or turn in the summary to the facilitator.

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Education Standards

The following table represents the educational standards that the Accreditation Council for Occupational Therapy Education (ACOTE) has implemented to address cultural competency and inclusion in occupational therapy programs (2011):

B.1.2	Apply and analyze the role of sociocultural, socioeconomic, and diversity factors, as well as lifestyle choices in contemporary society to meet the needs of persons, groups, and populations.
B.1.3	Demonstrate knowledge of the social determinants of health for persons, groups, and populations with or at risk for disabilities and chronic health conditions. This must include an analysis of the epidemiological factors that impact public health and the welfare of populations.
B.4.1	Demonstrate therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process in both individual and group interaction.
B.4.4	Evaluate client(s)' occupational performance, including occupational profile, by analyzing and selecting standardized and non-standardized screenings and assessment tools to determine the need for occupational therapy intervention(s). Assessment methods must take into consideration the cultural and contextual factors of the client. Intervention plans and strategies must be client-centered, culturally relevant, reflective of current occupational therapy practice, and based on the available evidence.
B.4.5	Select and apply assessment tools, considering client needs, and cultural and contextual factors.
B.4.23	Identify occupational needs through effective communication with patients, families, communities, and members of the interprofessional team in a responsive and responsible manner that supports a team approach to the promotion of health and wellness
B.4.26	Evaluate and discuss mechanisms for referring clients to specialists both internal and external to the profession, including community agencies.

Statistics

1. Javaherian et al. (2008) found that out of 373 occupational therapists and occupational therapy assistants, only 19% received education on working with LGBTQ clients and only 11% had received training from their employers on diversity issues related to the population.

Occupational Therapy Policies

American Occupational Therapy Association (AOTA). The facilitator will read AOTA's inclusion statement:

"Nondiscrimination exists when we accept and treat all people equally. In doing so, we avoid differentiating between people because of biases or prejudices. We value individuals and respect their culture, ethnicity, race, age, religion, gender, sexual orientation, and capacities. Nondiscrimination is a necessary prerequisite for inclusion. Inclusion requires that we ensure not only that everyone is treated fairly and equitably but also that all individuals have the same opportunities to participate in the naturally occurring activities of society. We also believe that when we do not discriminate against others and when we do not discriminate against others and when we include all members of society in our daily lives, we reap the benefits of being with individuals who have different perspectives, opinions, and talents from our own" (AOTA, 2014).

Occupational Therapy's Role

1. Occupational therapists have a professional and ethical obligation to provide care that is client-centered best practice, which is outlined in the AOTA code of ethics (2010).
2. Additionally, the profession plays a unique role by providing interventions that target occupation, which could include the following areas: Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), rest and sleep, work, play, leisure, and social participation.
3. Dressing (Sharber, 2018)
    a. Identity confirming clothing
    b. May include form-changing garments or items
        i. Transfeminine: breast forms (used to simulate breasts), gaff (compression underwear used to tuck in genitals to achieve a more gender-affirmed look), tape (also used to tuck in genitals)
        ii. Transmasculine: binder (can be used to flatten breasts to achieve a more gender-affirmed look), bandages (also used to flatten breasts), packer (a phallic-shaped object used to give the appearance of having a penis)
4. Sexual Activity
    a. Many handouts are heterosexual based (Sharber, 2018)
    b. "Sex" doesn't always mean penis-in-vagina (PIV) sex. It could consist of oral sex, anal sex, manual sex (i.e. hand jobs, fingering, etc.), using sex toys, etc. It is important for an occupational therapist to be aware of these variations when discussing sexual activity with patients.
    c. It is important for occupational therapists to understand different sexual equipment and positions that may assist this population in having healthy and safe sexual activity (i.e. strap-ons, dildos, etc.)
    d. Remember, LGBTQ patients can still be at risk for pregnancy (e.g. if a transgender woman has a penis and is having sex with another woman) and sexually transmitted infections. Educating patients on preventative measures is always important.

5. Medication Management (Sharber, 2018)
    a. "Some transgender and gender non-conforming people choose to undergo hormone therapy, a series of self-administered injections that influence secondary sex characteristics as well as metabolism and nutritional needs." Along with hormone therapy, individuals may also be taking Pre-Exposure or Post-Exposure Prophylaxis, which are drugs used to attempt to prevent HIV. OTs may need to assist patients in managing these injections and medications.
6. Social Participation (Sharber, 2018)
    a. Coming out is a process and requires emotional and social support
    b. Social acceptance from family, peers, coworkers, etc. is a common issue
    c. Transitioning includes learning gender norms and changing behavior to match identity

OT Specific Resources

1. Network for LGBT Concerns in Occupational Therapy (AOTA)
    - The mission of the Network is to create the means for members of the occupational therapy professional community who are committed to advancing the understanding of sexual orientation issues to identify, support, and mentor one another and to promote research in occupational therapy.
2. LGBTQ + OT (https://www.lgbtq-ot.com/)
    - Connecting occupational therapy practitioners, educators, and students with the information and resources that they need to help lesbian, gay, bisexual, transgender, queer, and questioning client's live life to the fullest.

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A Physical Therapy Perspective

Education Standards

The following table represents the educational standards that the Commission on Accreditation in Physical Therapy Education (CAPTE) has implemented to address cultural competency and inclusion in physical therapy programs (2017):

6F	The didactic and clinical curriculum includes interprofessional education; learning activities are directed toward the development of interprofessional competencies including, but not limited to, values/ethics, communication, professional roles and responsibilities, and teamwork.
7D8	Identify, respect, and act with consideration for patients'/clients' differences, values, preferences, and expressed needs in all professional activities.
7D10	Apply current knowledge, theory, and professional judgment while considering the patient/client perspective, the environment, and available resources.
7D11	Identify, evaluate and integrate the best evidence for practice with clinical judgment and patient/client values, needs, and preferences to determine the best care for a patient/client.
7D34	Provide physical therapy services that address primary, secondary and tertiary prevention, health promotion, and wellness to individuals, groups, and communities.
7D39	Participate in patient-centered interprofessional collaborative practice.

Physical Therapy Policies

American Physical Therapy Association (APTA). The facilitator will read APTA's vision on cultural competence and their non-discrimination policy statements:

Vision: "The physical therapy profession embraces cultural competence as a necessary skill to ensure best practice in providing physical therapist services by responding to individual and cultural considerations, needs, and values" (2015).
Non-Discrimination Policy: "The American Physical Therapy Association opposes discrimination on the basis of race, creed, color, sex, gender, gender identity, gender expression, age, national or ethnic origin, sexual orientation, disability, or health status" (2019).

Physical Therapy's Role

1. Pelvic Floor Therapy
   a. Transgender individuals can benefit from pelvic floor physical therapy both prior to and after the procedure (Jiang, Gallagher, Burchill, Berli, & Dugi, 2019).
   b. Pelvic floor PT is often recommended for individuals considering a vaginoplasty prior to surgery because it can identify and help with concerns related to pelvic floor dysfunction (Jiang et al., 2019).
   c. After surgery, it can help maintain pelvic floor health (Jiang et al., 2019).

Physical Therapy Specific Resources

1. PT Proud (https://www.ptproud.org/)
   a. The purpose of PT Proud is to improve health care access for LGBTQIA+ patients as well as empower LGBTQIA+ students, faculty and clinicians within the physical therapy profession to influence health and well-being that is specific to sexual and gender minority populations. This will be accomplished through advocacy, networking, and promotion of cultural competency/humility education while centering the interests of the membership, the HPA, the Global Health SIG, and the APTA.
2. LGBT Inclusion in PT Podcast (https://www.integrativepainscienceinstitute.com/latest_podcast/lgbt-inclusion-in-physical-therapy-with-chris-condran-pt-dpt/)
   a. A podcast with Chris Condran, DPT, on LGBT inclusion in physical therapy. He has personally advocated for curriculum change within physical therapy education and has created training material about LGBT inclusion in physical therapy practice. His research advocacy interests are centered on providing inclusive clinical environments, transgender health issues, eliminating health disparities in the LGBT population and establishing a curriculum for LGBT cultural competency in the classroom and beyond.

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Education Standards

The following table represents the educational standards that the Liaison Committee on Medical Education (LCME) has implemented to address cultural competency and inclusion in medical programs (2019):

7.6	The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the healthcare delivery process. The medical curriculum includes instruction regarding the following: • The way people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments • The basic principles of culturally competent healthcare • Recognition of the impact of disparities in healthcare on medically underserved populations and potential solutions to eliminate healthcare disparities • The knowledge, skills, and core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society
7.9	The faculty of a medical school ensure that the core curriculum of the medical education program prepares medical students to function collaboratively on healthcare teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from other health professions.

Specific Statistics

1. Obedin-Maliver et al. (2011) determined that in undergraduate medical education in the United States and Canada, the median amount of time spent on LGBTQ related content is five hours.
2. Only 24.2% of the LGBTQ related content taught was rated as “good” or “very good” by the deans of the schools, meaning that 75.8% of the content was deemed inadequate (Obedin-Maliver et al., 2011).
3. Other studies indicate that medical professionals, in general, receive limited or no education regarding LGBTQ care (Beagan, Chiasson, Fiske, Forseth, Hosein, Myers, & Stang, 2013; Utamsingh, Kenya, Lebron, & Carrasquillo, 2017).

Medical Policies

The American Medical Association (AMA). The facilitator will read AMA's statement on LGBTQ policy:

"The American Medical Association (AMA) supports the equal rights, privileges, and freedom of all individuals and opposes discrimination based on sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age (n.d.)"

Medical Professional's Role

1. Pre-Exposure Prophylaxis (PrEP)
    a. "Pre-exposure prophylaxis (or PrEP) is a way for people who do not have HIV but who are at very high risk of getting HIV to prevent HIV infection by taking a pill every day" (CDC, 2019). It is important for medical professionals to know of this drug, how it works, and any possible side effects to give proper recommendations to patients.
2. Post-Exposure Prophylaxis (PEP)
    a. "PEP is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion. PEP must be started as soon as possible to be effective—and always within 72 hours of a possible exposure" (CDC, 2019). Medical professionals must understand the use of this drug and ensure that patients know that this is an option if it suits them.
3. Hormone Therapy
    a. Hormone therapy is completed for individuals looking to transition from one gender to another. The types of hormone therapy include testosterone, estrogen, and progesterone therapy as well as testosterone blockers (USCF, 2019). Completing this therapy can induce physical, emotional, sexual, and reproductive changes (USCF, 2019). It is important for medical professionals to be aware of this therapy, the different methods (i.e. pill, patch, injection, etc.) any risks, and whether it is a good fit for patients. It is also important for medical professionals to be able to read the hormone levels of the patient through lab tests to determine how the therapy is progressing.
4. Gender Confirming Surgery
    a. Female-to-male
        i. Certain surgeries are available to individuals who are looking to transition from females to males. Examples of possible gender-affirming surgeries include:
            - Hysterectomies: This is the surgical removal of the uterus.
            - Oophorectomies: This is the surgical removal of the ovaries.
            - Vaginectomies: This is the surgical removal of the vagina.
            - Chest reconstruction: This procedure involves removing breast tissue and augmenting the nipple to portray a more masculine chest.
            - Phalloplasty: The goal of this procedure is to create a penis from a donor site on the body that can feel sensations and releasing urine from a standing position.

(The University of Michigan, n.d.).

b. Male-to-female
    i. Surgeries that are available for individuals looking to transition from males to females include:
        - Tracheal shaving: This procedure involves shaving the trachea as much as possible without damaging the vocal box to diminish the appearance of an "Adam's Apple."
        - Breast augmentation: This procedure can involve inserting silicone or saline implants into the chest to give the individual the look of having breasts.
        - Facial feminization: This procedure is done to alter typically male features to have them look closer to typically female features in shape and size.
        - Penile inversion vaginoplasty: This procedure can involve the testicles being removed, the skin from the scrotum being used to make the labia, and the erectile tissue of the penis being used to make the neoclitoris. The urethra is preserved and functional. This gives an individual the look of having a vagina.

(The University of Michigan, n.d.)

Medical Specific Resources

1. Guidelines for Care of LGBT Patients (http://www.glma.org/_data/n_0001/resources/live/Welcoming%20Environment.pdf)
    a. The Gay and Lesbian Medical Association (GLMA) created an in-depth guide including issues to discuss with LGBT patients, intake forms, specific considerations to consider with certain populations, and resources for future assistance.
2. California Department of Public Health (https://www.cdph.ca.gov/Programs/CID/DOA/Pages/LGBT_Health.aspx)
    a. This website has many different links to resources and websites on LGBT health in multiple different areas such as aging, cancer, HIV/AIDS, mental health, and more.
3. American Medical Association (https://www.ama-assn.org/topics/lgbtq-population-care)
    a. The AMA has created an LGBTQ population care page where medical professionals can get the latest news on the LGBTQ population from AMA and other sources.

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A Nursing Perspective

Education Standards

The following table represents the educational standards that the American Association of Colleges and Nursing (AACN) has implemented to address cultural competency and inclusion in nursing programs (2008):

1	Apply knowledge of social and cultural factors that affect nursing and healthcare across multiple contexts.
2	Use relevant data sources and best evidence in providing culturally competent care.
3	Promote the achievement of safe and quality outcomes of care for diverse populations.
4	Advocate for social justice, including a commitment to the health of vulnerable populations and the elimination of health disparities.
5	Participate in continuous cultural competence development.

Specific Statistics

1. In a study done by Aaberg (2016), 44 faculty members for 44 separate programs participated in a survey on sexuality education in baccalaureate nursing programs. Aaberg (2016) found that 28.3% of the programs spent zero hours teaching on LGBT health. The mean time spent on this topic was .59 hours (Aaberg, 2016).
2. Lim, Johnson, and Eliason, (2015) completed a study that looked at the knowledge, experience, and readiness of faculty to teach LGBT health content in baccalaureate nursing programs. About 50% of respondents indicated knowledge limitations and lack of awareness with regard to LGBT health issues, and approximately 75% of respondents in the study indicated that LGBT health topics were non-existent or had limited inclusion in the courses they taught.

Nursing Policies

American Academy of Nursing (AAN). The facilitator will read the following diversity and inclusion statement from the AAN:

> "As leaders in advancing health policy to promote health for all populations, the Academy is committed to modeling diversity, inclusivity, and equity in all aspects of our organization's performance. To accomplish this effectively, the Academy must foster diversity among the fellowship, and promote inclusivity in our efforts. Inclusivity refers to the active engagement of all voices within an organization's membership, leadership, policy-setting and decision-making units, and overall profile. The Academy defines diversity as "all the ways in which people differ, including innate characteristics (such as age, race, gender, national origin, mental or physical capacities, gender identity, and sexual orientation) and acquired characteristics (such as education, socioeconomic status, religion, work experience, area of practice, language skills, cultural values, geographic location,

family status, organizational level, work style, philosophical and intellectual perspectives, etc. (2016)."

Nursing's Role

1. Pre-Exposure Prophylaxis (PrEP)
    a. "Pre-exposure prophylaxis (or PrEP) is a way for people who do not have HIV but who are at very high risk of getting HIV to prevent HIV infection by taking a pill every day" (CDC, 2019). It is important for nurses to know the properties of this drug and to educate patients on how to take it and what it is for.
2. Post-Exposure Prophylaxis (PEP)
    a. "PEP is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion. PEP must be started as soon as possible to be effective—and always within 72 hours of a possible exposure" (CDC, 2019). It is important for nurses to know the properties of this drug and to educate patients on how to take it and what it is for.
3. Hormone Therapy
    a. Hormone therapy is completed for individuals looking to transition from one gender to another. The types of hormone therapy include testosterone, estrogen, and progesterone therapy as well as testosterone blockers (USCF, 2019). Completing this therapy can induce physical, emotional, sexual, and reproductive changes (USCF, 2019). Hormone therapy can be administered in multiple ways (i.e. pill, patch, injections, etc.), so it is the nurse's role to educate the patient on how to administer the therapy is the best way for the patient.
4. Surgery Preparation
    a. Many different surgeries can be performed for patients who are looking to transition from one gender to another. These include but are not limited to: Hysterectomies, oophorectomies, vaginectomies, chest reconstruction, phalloplasty, tracheal shaving, breast augmentation, facial feminization, and penile inversion vaginoplasty (The University of Michigan, n.d.). Nurses may be utilized to help prepare these patients for surgeries. It is important that nurses understand these procedures and how to adequately prepare and educate their patients on them.

Nursing Specific Resources

1. Nurses (HEALE) Curriculum (http://www.nursesheale.org/)
    a. This website provides a six-hour cultural competency continuing education training program for nurses who serve older LGBTQ adults. This curriculum is free of charge for nurses. It addresses barriers to healthcare and disparities, sex and sexuality, legal concerns, and introduction to the population, and information on HIV and aging.

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PART III: INTERACTIVE EDUCATION

Introduction

According to LGBT Demographic Data Interactive (2019), approximately 4.5% of the world's population identifies themselves as being lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual, etc. (LGBTQ+). These numbers have increased as society has become more accepting of the population. However, they are still being underserved and are facing disparities in healthcare settings (Dean et al., 2016; Institute of Medicine, 2011). To provide a safe and culturally competent healthcare environment for the LGBTQ population, the Joint Commission (2011) requires that accredited healthcare facilities prohibit discrimination based on sexual orientation, gender identity, and gender expression. In response, healthcare facilities are beginning to include diversity training on the LGBTQ population to address healthcare disparities. However, despite this effort, many healthcare spaces are still lacking culturally competent care (Dean et al., 2016).

Cultural competency in the healthcare setting is defined as: "understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the healthcare delivery system; and, finally, devising interventions that take these issues into account to assure quality healthcare delivery to diverse patient populations" (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003, p. 297). Cultural competency is a life-long journey, and there are various levels in which it can take place. To assure that the guide is addressing multiple levels, information was broken up into three categories: introduction and foundational knowledge, application/skills, and attitudes. The introduction and foundational knowledge section will give the learner the opportunity to discover information about themselves and about the LGBTQ population. Once foundational knowledge has been established, application/skills can be addressed. In this area, learners will take the knowledge that they gained and apply it to different activities to assure that they are using the information that they received accurately. The final level of cultural competency that will be addressed is attitudes. This area allows the learner to take the knowledge and skills that they have learned and use it to guide their interactions in different case scenarios and role play situations. By addressing these multiple levels, learners can increase their cultural competency and their ability to provide quality healthcare to their patients. The following section includes different activities that the facilitator can use to address the different levels.

The authors encourage the facilitator to use interactive activities whether they are found in this guide, current course activities, or any other activity that is culturally competent and inclusive.

Activities

Note to the facilitator: Information on the LGBTQ population can be found throughout the lesson plan and in the references and resource section of each discipline-specific lesson plan. Although it is easier to facilitate these activities with a knowledge base of the population, these activities have all the information available to facilitate them effectively.

Level I: Introduction and Foundational Knowledge

Activity One: Implicit Association Test

"The Implicit Association Test measures the strength of associations between concepts (e.g., black people, gay people) and evaluations (e.g., good, bad) or stereotypes (e.g., athletic, clumsy)" (Project Implicit, 2011). The goal of this activity is for students to take a look at their own implicit biases regarding sexuality. The students will take the implicit association test about *sexuality* prior to this presentation and take note of their results so they can gain an understanding of their own implicit biases towards gay and straight individuals and discuss it at the beginning of the lesson or during the *stereotypes* section. The test is set up by Project Implicit (2011) and can be completed here: https://implicit.harvard.edu/implicit/selectatest.html.

Activity Two: General Population Statistics

This activity is meant to be completed during the *statistics* section of the lesson plan. The goal of this activity is to give students a visual representation of the barriers that the LGBTQ population faces so they can gain a better understanding of the population. For this activity, students will be asked to number off based on the number of students in the class. A certain number of people, associated with the statistic, will stand before each statistic is read (i.e. in a class of 40 people, 36 people will stand to represent 90%). The facilitator will state: "pretend that you all represent the LGBTQ population. I want students 1-36 to stand up. This represents the 90% of LGBTQ people believe there is discrimination against the population in America." Continue this with each statistic. Statistics for this activity can be found in appendix C.

Activity Three: Healthcare Population Star Statistics (Pierce, n.d.)

This activity will describe the multiple ways the "coming out" process can happen with friends, family, communities, and work for individuals in the LGBTQ community. The goal is to bring awareness to students about how many people react to individuals in this community coming out and the consequences that can result from them. Materials needed include blue, purple, red, and orange paper stars, pen/pencils for each participant, and the script for the activity (located in Appendix D). This activity can be completed any time during the general beginning portions of the lesson plan (i.e. *introduction to the population, statistics, etc.).*

Level II: Application/Skills

Activity One: Choose that Statement

This activity is meant to be completed during the *inclusive language* portion of the lesson plan. The goal of this activity is to teach students about inclusive language. The facilitator will read the first example from the chart located in Appendix E and explain how using

the term “everyone” is inclusive to all individuals versus saying “you guys” which, although a common saying, is not as inclusive of a statement. The facilitator will then read the following prompts in the “instead of saying” section of the chart and have the students come up with answers for the “try saying” section of the chart. Examples are provided for each statement, but there are other possible alternatives as well.

Activity Two: Occupational Engagement (Occupational Therapy-Based Activity)
This activity is meant to be completed before going over occupational therapy-specific content. Have the students break up into small groups, and assign them an occupation (dressing, sexual activity, medication management, or social participation will most likely yield the best/most relevant results). Have the students look up or brainstorm some occupational barriers that may be specific to the LGBTQ population, and different interventions that the students can use to be more inclusive. Examples can be found in the *occupational therapy specific lesson plan.*

Level III: Attitudes

Activity One: Case Study
This activity is meant to be completed after all education has been given. The goal of this activity is to have students use the knowledge they gained to work through multiple case studies regarding different situations LGBTQ individuals and practitioners may face when working together. Participants will be broken up into small groups, and each group will be assigned a case study (which can be found in Appendix F). At the bottom of each case study will be questions for the group to discuss. The class will then come back together as a large group to discuss each case. The questions can be tailored to fit each discipline, or they can be kept in their original, general format. *Case studies were adapted with permission from the Fenway Institute. Permission can be viewed in Appendix I.*

Activity Two: Role Play
This activity is meant to be completed after all education has been given. The goal of this activity is to have students use the knowledge they gained to role play a different experience that they may encounter during clinical rotations or as a future practitioner. There are four different role play scenarios (can be found in Appendix G). The students will be broken up into groups of about 3-4 students and each group will be assigned a role play scenario. The students will all receive a different role. Depending on the amount of time, it is ideal that each student in the small group gets the opportunity to play each role. Afterwards, the students will discuss in their small groups what went well, what they could have done differently, and their overall experience. Once everyone is completed, groups will come back together and talk about what they discovered during these interactions.

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Appendix A

Pre/Post Test

LGBTQ+ PRESENTATION PRE/POSTTEST

Please answer the following questions honestly and to the best of your ability.

1. What percent of individuals in the LGBTQ+ population have avoided medical care due to fear of discrimination?
   a. 18%
   b. 5%
   c. 90%
   d. 26%

2. Which of the following is **NOT** a healthcare disparity that individuals in the LGBTQ+ population experience?
   a. Substance Abuse
   b. Sexual Violence
   c. Smoking
   d. Unhealthy Weight Control
   e. None of the above

3. From a practitioner's perspective, what is the most common barrier for providing culturally competent care?
   a. Discomfort
   b. Lack of education
   c. Contradicts their belief system
   d. Lack of resource

4. What is **NOT** an example of a microaggression?
   a. Tone of voice
   b. Body language
   c. Physical violence
   d. Word choice

5. Which is **NOT** a common myth about the LGBTQ+ population?
   a. Individuals in this population are mentally ill
   b. Sexual orientation can be changed
   c. LGBTQ+ individuals look a certain way
   d. Same-sex relationships have been found throughout history in every culture

6. What is a way to be more inclusive within future practice?
   a. Using they/them/their with all clients
   b. Asking a client if they have a husband/wife
   c. Avoid asking questions about sex
   d. Ask a client what their preferred pronouns are
   e. Both A & D

7. In the space below, indicate how interested are you in becoming more educated about the LGBTQ+ population?

Not willing to learn | Indifferent | Ready

8. I can identify and am educated about ____/ 10 terms listed below pertaining to the LGBTQ+ population.
   - → Gender
   - → Sexuality
   - → Androgynous
   - → Cisgender
   - → Gender-Fluid
   - → Non-Binary
   - → Polyamorous
   - → Queer
   - → Two-Spirit
   - → Transgender

9. I am aware of the resources available for the LGBTQ+ population

   - ☐ Yes
   - ☐ No

10. In the space below please rate your personal comfort level when working with individuals in the LGBTQ+ population.

Extreme Discomfort | Indifferent | Comfortable

Thank you for your participation and completing this pre/posttest!

If you have any additional questions, comments or concerns please feel write down the following information and contact - ____________.

Appendix B

Key Concepts and Terms

This section represents the following key concepts that are referred to throughout this guide. The following sources were used to extract the terms:

- Human Rights Campaign: https://www.hrc.org/resources/glossary-of-terms
- New York University: https://www.nyu.edu/students/communities-and-groups/student- diversity/lesbian-gay-bisexual-transgender-and-queer-student-center/glossary-of-important-lgbt-terms.html
- National LGBT Health Education Center: https://www.lgbthealtheducation.org/wp- content/uploads/LGBT-Glossary_March2016.pdf

1. **Agender:** A person who identifies as having no gender.
2. **Ally:** A person who is not LGBTQ but shows support for LGBTQ people and promotes equality in a variety of ways.
3. **Androgynous:** Identifying and/or presenting as neither distinguishably masculine nor feminine.
4. **Asexual:** The lack of a sexual attraction or desire for other people.
5. **Binding:** The process of tightly wrapping one's chest in order to minimize the appearance of having breasts. This is achieved using constrictive materials such as cloth strips, elastic or non-elastic bandages, or specially designed undergarments.
6. **Bisexual:** A person emotionally, romantically or sexually attracted to more than one sex, gender or gender identity through not necessarily simultaneously, in the same way or to the same degree.
7. **Bottom Surgery:** Colloquial way of describing gender affirming genital surgery.
8. **Cissexism:** The belief that transgender identified genders are inferior to, or less authentic than those of cisgender.
9. **Cisgender:** A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.
10. **Closeted:** Describes an LGBTQ person who has not disclosed their sexual orientation or gender identity.
11. **Coming Out:** The process in which a person first acknowledges, accepts and appreciates their sexual orientation or gender identity and begins to share with others.
12. **Drag:** The performance of one or multiple genders theatrically. Those who perform are called Drag Kings and Drag Queens.
13. **FTM or F2M (Female to Male):** An identity for a person who was assigned female at birth, and who identifies as male, lives as a male or identifies as masculine.
14. **MTF or M2F (Male to Female):** An identity for a person who was assigned male at birth, and who identifies as female, lives as a female or identifies as feminine.
15. **Gay:** A person who is emotionally, romantically or sexually attracted to members of the same gender.
16. **Gender Binary:** A concept that everyone must be one of two genders: men or women. The term describes the system in which society divides people into a masculine or feminine gender roles, gender identities, and gender attribute.

17. **Gender Dysphoria:** Clinically significant distress caused when a person's assigned birth gender is not the same as the one with which they identify. According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), the term - which replaces Gender Identity Disorder - "is intended to better characterize the experiences of affected children, adolescents, and adults."
18. **Gender-Fluid:** A person who does not identify with a single fixed gender; of or relating to a person having or expressing a fluid or unfixed gender identity.
19. **Gender Identity:** One's innermost concept of self as male, female, a blend of both or neither - how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.
20. **Gender Non-Conforming:** A broad term referring to people who so not behave in a way that conforms to the traditional expectations of their gender, or whose gender expression does not fit neatly into a category.
21. **Gender Role:** A set of societal norms dictating what types of behaviors are generally considered acceptable, appropriate or desirable for a person based on their actual or perceived sex.
22. **Genderqueer:** Genderqueer people typically reject notions of static categories of gender and embrace a fluidity of gender identity and often, though not always, sexual orientation, People who identify as "genderqueer" may see themselves as being both male and female, neither male nor female or as falling completely outside these categories.
23. **Gender Transition:** The process by which some people strive to more closely align their internal knowledge of gender with its outward appearance. Some people socially transition, whereby they might begin dressing, using names and pronouns and/or be socially recognized as another gender. Others undergo physical transitions in which they modify their bodies through medical interventions.
24. **Heteronormativity:** The assumption that everyone is heterosexual, and that heterosexuality is superior to all other sexualities.
25. **Heterosexual (Straight):** A sexual orientation that describes women who are emotionally and sexually attracted to men, and men who are emotionally and sexually attracted to women.
26. **Homophobia:** The fear and hatred of or discomfort with people who are attracted to members of the same sex.
27. **Intersex:** Intersex people are born with sex characteristics that do not fit typical binary notions of male or female bodies. Intersex is an umbrella term used to describe a wide range of natural bodily variations. In some cases, intersex traits are visible at birth while in others, they are not apparent until puberty. Some chromosomal intersex variations may not be physically apparent at all.
28. **Lesbian:** A woman who is emotionally, romantically or sexually attracted to other women.
29. **Minority Stress:** Chronic stress faced by members of stigmatizing minority groups. Minority stress is caused by external, objective events and conditions, expectations of such events, the internalization of societal attitudes, and/or concealment of one's sexual orientation.
30. **Non-Binary:** An adjective describing a person who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman,

somewhere in between, or as falling completely outside these categories, while many also identify as transgender, not all non-binary people do.

31. **Pangender:** A person whose gender identity is comprised of many genders.
32. **Pansexual:** A person who has the potential for emotional, romantic or sexual attraction to people of any gender though not necessarily simultaneously, in the same way or to the same degree.
33. **Polyamorous:** A person who has or is open to having more than one romantic or sexual relationship at a time, with the knowledge and consent of all their partners. Sometimes abbreviated as poly.
34. **Queer:** An umbrella term to refer to all LGBTQ people as well as an identity which advocates breaking binary thinking and seeing both sexual orientation and gender identity as potentially fluid. While it has been reclaimed as a unifying, celebratory, and neutral term among many LGBTQ people today, historically it has been derogatory and can still be viewed negatively by some.
35. **Questioning:** An identity for people who are uncertain of their sexual orientation and/or their gender identity.
36. **Sexual Orientation:** An inherent or immutable enduring emotional, romantic or sexual attraction to other people.
37. **Social Stigma:** Negative stereotypes and social status of a person or group based on perceived characteristics that separate that person or group from other members of a society.
38. **Top Surgery:** Colloquial way of describing gender affirming surgery on the chest.
39. **Transgender:** An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.
40. **Tucking:** The process of hiding one’s penis and testes with tape, tight shorts, or specially designed undergarments.
41. **Two-Spirit:** A contemporary term that connects today’s experiences of LGBT Native American and American Indian people with the traditions from their culture.

Appendix C

General Population Statistics Activity

The following chart displays the statistics that are to be used in this activity:

In a survey of 3,453 LGBTQ individuals' personal experiences with discrimination…

1. 90% of all LGBTQ people believe there is discrimination against the population in America today
2. 57% of LGBTQ members have experienced slurs
3. 51% have reported being sexually harassed
4. 51% reported experiencing violence
5. 34% have reported being verbally harassed in the bathroom
6. 16% reported being personally discriminated against when going to a doctor or health clinic
7. 22% of transgender individuals and 18% of LGBTQ Americans report that they have avoided doctors or healthcare due to concern that they would be discriminated against

(National Public Radio [NPR], Robert Wood Johnson Foundation [RWJF], & Harvard T.H. Chan School of Public Health, 2017)

Appendix D

"Coming Out" Activity (Pierce, n.d.)

The following are the step-by-step directions and script for the "Coming Out" Activity

1. Let each person pick either a BLUE, ORANGE, RED, or PURPLE star and then read the following to them: Imagine that this star represents your world, with you in the center and those things or people most important to you at each point of the star. So, we'll begin by writing your name in the center of the star, making it your very own star!
2. Then, pick a side of the star to begin with. Choose a friend who is very close to you. Someone you care about very much. A best friend or a close friend, it doesn't matter. Write their name on this side of the star.
3. Next, think of a community that you belong to. It could be a religious community, your neighborhood, a fraternity or sorority, or just a group of friends. Take the name of this group that you are a part of and write it on the next side of the star moving clockwise.
4. Now, think of a specific family member. Someone that you have always turned to for advice or maybe who knows how to cheer you up when you're sad. A mother, father, aunt, or uncle … any family member who has made a large impact in your life. Please write their name on the next side of the star.
5. What job would you most like to have? It could be anything from president to dentist. Whatever your career aspiration is, write it on the next side.
6. Lastly, what are some of your hopes and dreams? Maybe you want to be a millionaire, maybe you want the perfect family. Think of a few of your hopes and dreams and write them on the last side of your star.
7. Explain that each person is now gay or lesbian and each are about to begin their coming out process. Tell them that they cannot talk for the rest of this activity.
8. You decide that it will be easiest to tell your friends first, since they have always been there for you in the past and you feel they need to know.
    a. If you have a BLUE star, your friend has no problem with it. They have suspected it for some time now and thank you for being honest with them. Luckily, they act no different toward you and accept you for who you are.
    b. If you have a ORANGE or PURPLE star, your friends are kind of hesitant. They are a little irritated that you have waited so long to tell them, but you are confident that soon they will understand that being gay or lesbian is just a part of who you are … you just need to give them some time. Please fold back this side of your star.
    c. If you have a RED star, you are met with anger and disgust. This friend who has been by your side in the past tells you that being gay or lesbian is wrong and they can't associate with anyone like that. If you have a red star, please tear off this side and drop it to the ground, this friend is no longer a part of your life.
9. With most of you having such good luck with your friends, you decide that your family probably deserves to know. So, you turn to your closest family member first so that it will be a little easier.

a. If you have a PURPLE star, the conversation does not go exactly how you planned. Several questions are asked as to how this could have happened, but after some lengthy discussion this person who is close to you seems a little more at ease with it. Fold this side of your star back, as they will be an ally, but only with time.
b. If you have a BLUE star, you are embraced by this family member. They are proud that you have decided to come out and let you know that they will always be there to support you.
c. If you have a ORANGE or RED star, your family member rejects the thought of being related to a person who is gay or lesbian. Much like some of your friends, they are disgusted and some of you are thrown out of your house or even disowned. You are now part of the 42% homeless youth who identify as gay or lesbian. If you have an orange or red star, please tear off this side and drop it to the ground.

10. Having told your friends and family, the wheels have started to turn and soon members of your community begin to become aware of your sexual orientation.
    a. If you have a PURPLE or BLUE star, your sexual orientation is accepted by your community. They continue to embrace you like anyone else and together you celebrate the growing diversity in your community.
    b. If you have an ORANGE star, you are met with a mixed response. Some accept you and some don't know what to think. You remain a part of the community, and with time, will fit in as you once did. If you have an orange star, please fold back this side.
    c. If you have a RED star, your community reacts with hatred. They tell you that someone like you doesn't belong in their community. Those who had supported you in your times of need no longer speak to you or acknowledge you. If you have a red star, tear this side off and drop it to the ground.
11. You have heard that rumors have started circulating at work regarding your sexual orientation. In the past, you have made it a point to confront these rumors as soon as they began, but now you're not sure if that will do more harm than good. But, unfortunately, you don't have the chance.
    a. If you have a BLUE star, your coworkers begin to approach you and let you know that they have heard the rumors and that they don't care, they will support you. Your bosses react the same way letting you know that you do good work and that's all that matters.
    b. If you have a PURPLE star, your workplace has become quite interesting. Everyone seems to think that you are gay or lesbian, even though you haven't mentioned it to anyone or confirmed any of the rumors. Some people speak to you less, but the environment has not seemed to change too drastically. If you have a purple star, please fold back this side.
    c. If you have a RED or ORANGE star, you continue to work as though nothing is happening, ignoring the rumors that have spread throughout your workplace. One day, you come in to find that your office has been packed up. You are called into your boss' office and she explains that you are being fired. When you ask why, she tells you that lately your work has

been less than satisfactory and that she had to make some cutbacks in your area. If you have a red or orange star, please tear off this side and drop it to the ground.

12. Now… your future lies ahead of you as a gay man or lesbian. Your hopes and dreams, your wishes for the perfect life… for some of you these are all that remain.
    a. If you have a PURPLE, BLUE, or ORANGE star, these hopes and dreams are what keep you going. Most of you have been met with some sort of rejection since beginning your coming out process, but you have managed to continue to live a happy and healthy life. Your personal hopes and dreams become a reality.
    b. If you have a RED star, you fall into despair. You have been met with rejection after rejection and you find it impossible to accomplish your lifelong goals without the support and love of your friends and family. You become depressed and with nowhere else to turn, many of you begin to abuse drugs and alcohol. Eventually, you feel that your life is no longer worth living. If you have a red star, please tear it up and drop the pieces to the ground. You are now part of the 40% of suicide victims who are gay or lesbian.

Appendix E

Choose That Statement Activity

The following is the chart used to facilitate the "Choose That Statement" activity:

Instead of saying...	**Try saying...**
How are you guys doing today?	How is everyone doing today?
Do you have a husband/wife?	Are you married? Do you have a partner?
Can you ask that guy if he has checked in?	Can you ask if the patient/client has been checked in? Can you ask if they have been checked in?
Is this your brother with you today?	Who do you have with you today?
I see that you're a fireman!	I see that you are a firefighter!

Appendix F

Case Studies – adapted with permission from The Fenway Institute

Case 1: Aarya

Aarya arrives for her urgent care appointment and appreciates when the assistant at the front desk asks for the name she goes by and her pronouns ("Aarya," and "she/her/hers"). She is disappointed later, however, when the nurse practitioner asks if she "has a boyfriend" while taking a sexual health history.

Why is Aarya disappointed?
What could the nurse practitioner have said instead?
What are some possible implications of this interaction?

Case 2: Celina

Celina is a transgender woman being examined for an infection in her hand. The nurse has never taken care of a transgender person before and finds himself very curious about Celina. He repeatedly catches himself staring at her. While taking Celina's vitals, the nurse asks, "You know, at first I thought you were a real woman. Do you take hormones? Have you had the surgery yet?" Celina angrily responds, "I don't think that has anything to do with my hand."

Why did the nurse upset Celina?

What could the nurse have done instead?

How could the nurse practitioner apologize?

Case 3: Dawud

Dawud is meeting his pregnant wife, Imran, at the health center for a prenatal appointment with the midwife. Dawud is transgender and is in the process of transitioning from female to male. The midwife, along with a midwife in training, enters the room and sees Dawud. The midwife says to Dawud: “Hi, you must be Imran’s sister, it’s nice to meet you!” Dawud, upset, responds, “No, I am her husband.” The midwife looks startled and mumbles “Oh, sorry.” The trainee notices that Dawud and Imran are visibly uncomfortable but does not say anything.

Why are Dawud and Imran upset?

What could the midwife have said instead?

What are some of the possible implications of this interaction?

Case 4: Fabian

Fabian, who identifies as gay, is a new patient in his health center's primary care department. The doctor assigned to Fabian has a moral objection to same-sex relationships, but knows he has an obligation to treat all patients. During the exam, the doctor is polite but not friendly, and he avoids eye contact by looking at his computer screen most of the time. He decides to skip asking Fabian any family or sexual history questions because it makes him uncomfortable, and because he sees that Fabian has recently been tested for HIV. Fabian leaves the health center feeling bad about his care and wondering if he will ever return. The doctor, meanwhile, feels proud of himself for agreeing to treat Fabian despite his sexual orientation, and for not saying anything that could be considered offensive or judgmental.

Why does Fabian leave the health center feeling bad about his care?

Why are the implications of the doctor's behavior?

How can the doctor shift his approach to caring for LGBTQ+ people?

Case 5: Ebony

Ebony feels out of place arriving for her neurology appointment because the medical assistant addressed her as “sir” when checking in for her appointment, an experience that is common due to her short hair, but always upsetting. While in the waiting room, she overhears staff behind the counter talking about someone they know who grew up in a “bad, hood area,” but later married into a “really good family.” Ebony becomes even more distraught because the neighborhood the staff is discussing is near where she lives.

What contributed to Ebony’s distress?

What could have been done to prevent this situation?

What are the implications of Ebony overhearing this information?

Case 6: Kiara

Kiara, who identifies as Latinx and bisexual, is in the waiting room for her OB/GYN appointment and is looking through informational pamphlets. When she is looking through the pamphlets and the posters around the clinic, she notices that there are no people of color and that every couple is portrayed as heterosexual. When she asked her provider why there are no people of color or other sexualities represented around the clinic, the provider stated, "almost all of the people that come in here are White and straight, so it makes sense."

How might Kiara be feeling?

How can the OB/GYN office make all patients feel included?

What could the provider have said instead?

Case 7: Rowan

Rowan, a college student, is dreading her annual physical appointment but musters the courage to attend. Rowan identifies as pansexual, and her primary care provider has made comments about her sexuality in the past, like "Is that what the kids are calling it these days? It's impossible to keep up with all this diversity stuff, but I'm just an old fogey!"

What did the provider do wrong in this encounter?

What could the provider have said instead?

How could the provider prepare for working with diverse patients?

Case 1 answers (Aarya):

1. **Why is Aarya disappointed?**

The nurse practitioner's question assumes that Aarya dates men and that she only has one partner, when in fact Aarya has multiple partners, including women and men. In this example, the provider has reinforced a cultural stereotype that all people are heterosexual and monogamous. This implicit bias could make Aarya feel that the provider would judge her when she shares her sexual history.

2. **What could the nurse practitioner have said instead?**

The nurse practitioner could have asked Aarya if she is sexually active, and if so, to describe her partners. This gives Aarya space to disclose that she has multiple partners, and the gender of her partners. The nurse practitioner can then ask Aarya to describe the types of sexual activities she engages in with her partners, so that she receives appropriate screening tests, if warranted.

3. **What are some possible implications of this interaction?**

Aarya could feel that the provider is judging her for her sexual history, which could make her less likely to share important information with her due to fear of discrimination. This could also decrease the patient-provider relationship and overall result in a poor experience and Aarya not getting the care she needs.

Case 2 answers (Celina):

1. **Why did the nurse upset Celina?**

Celina was in the health center for a hand infection; therefore, her history of gender-affirming medical care was not relevant in this context. The questions about hormones and surgery came from curiosity rather than from a medical need. Also, by implying that Celina is not a "real" woman, and by staring at Celina, the nurse was communicating the view that Celina is abnormal.

2. **What could the nurse have done instead?**

Confusion and curiosity are normal. Healthcare workers can avoid being overly intrusive by avoiding questions that are not relevant to clinical care. Simply acknowledging to oneself that confusion and discomfort are normal when encountering patients with identities and life experiences that are unfamiliar can help reduce anxiety. One can be honest with the patient about a lack of experience, while expressing a desire to work together and a willingness to learn. Healthcare personnel can also explicitly ask the patient to let them know immediately if they do anything that is upsetting or offensive, and then apologize if they do make a mistake.

3. **How could the nurse practitioner apologize?**

He could say, "I am so sorry for my mistake. I did not mean to offend you." It is not always possible to avoid mistakes. Simple apologies can go a long way in repairing the alliance.

Case 3 answers (Dawud):

1. **Why are Dawud and Imran upset?**

The midwife assumed that Dawud was Imran's sister based on Dawud's gender presentation. This mistaken assumption was hurtful because Dawud identifies as male. This interaction also included a bias based in heteronormativity, as the midwife assumed that Dawud was Imran's sister, as opposed to her spouse. These implicit biases made Dawud feel "invisible" and unwelcome. It is important not to make any assumptions about the relationship between the patients and the people they bring with them.

2. **What could the midwife have said instead?**

The midwife could instead have said, "Hi, nice to meet you. Tell me, what's your name and what is your relationship to each other?"

3. **What are some of the possible implications of this interaction?**

This interaction could result in less trust and comfort with the midwife. Because of this, Dawud and Imran may not feel comfortable disclosing information anymore due to fear of discrimination. The patient-provider relationship may not be tainted.

Case 4 answers (Fabian):

1. **Why does Fabian leave the health center feeling bad about his care?**

The doctor showed microaggressions towards Fabian (body language and tone of voice). He also was not asked important questions about his care. This could have made Fabian feel as though he wasn't good enough to be treated or that he was being discriminated against.

2. **Why are the implications of the doctor's behavior?**

Although the doctor did not refuse to treat a gay patient, and did not verbally admonish Fabian (all of which are not only inappropriate, but are acts of explicit bias and discrimination), his tone of voice and body language communicated enough disapproval to make Fabian feel rejected. Moreover, by avoiding a discussion of social or sexual history, the doctor was unable to determine Fabian's risk for STIs, intimate partner violence, or other areas related to sexual and social health.

3. **How can the doctor shift his approach to caring for LGBTQ+ people?**

Presumably, this physician has not received enough, if any, training in providing equitable healthcare to LGBTQ people. One technique he could be taught to use is perspective-taking—for example, he could imagine what it would feel like to have a doctor avoid eye contact with him because the doctor disliked people of his ethnic identity (or other characteristic). He can also attempt to counter his negative thoughts about gay people by thinking, "I can value gay people as human beings even if I disapprove of their actions or behaviors."

Case 5 answers (Ebony):

1. **What contributed to Ebony's distress?**

Ebony may have experienced a great deal of bias and stigma in her life because of her race, gender expression, and socioeconomic status. She is constantly on alert in unfamiliar places and has come to expect mistreatment.

2. **What could have been done to prevent this situation?**

This situation could have been prevented by training all staff to use gender-neutral terms and to always speak respectfully, as comments may easily be overheard. Such disrespectful comments create an unwelcoming environment and may result in patients feeling excluded from care.

3. **What are the implications of Ebony overhearing this information?**

After overhearing staff talk, Ebony may feel as though she is being judged for her appearance. Also, hearing staff gossip contributes to an overall negative environment, one of which many patients would feel uncomfortable with. Ebony may believe that if staff are talking gossiping about other people, they may gossip about her as well.

Case 6 answers (Kiara):

1. **How might Kiara be feeling?**

The waiting room environment may make Kiara feel invisible, as her identity is not reflected in any of the reading material in the waiting room.

2. **How can the OB/GYN office make all patients feel included?**

The office can ensure that patient brochures, displayed magazines, and posters reflect a variety of sexual orientations, gender identities, ages, races, ethnicities, and abilities. Other things the practice can do to make it more welcoming for LGBTQ people is to offer at least one all-gender restroom, and to have non-discrimination policies that include sexual orientation, gender identity, and gender expression.

3. **What could the provider have said instead?**

The provider could have recognized Kiara's concerns and not try to make excuses. The provider could tell Kiara that her concern is noted and that she will advocate for creating a more inclusive environment for all people.

Case 7 answers (Rowan):

1. **What did the provider do wrong in this encounter?**

Though Rowan's provider is trying to be casual and approachable, he may also be sending a message that Rowan's sexuality is not to be taken seriously. Rowan could interpret his words as a rejection of her identity, which can greatly diminish patient-provider trust, and can make her less likely to be open with future providers.

2. **What could the provider have said instead?**

The provider could have caught himself before commenting about something he is unfamiliar with. Rather than being dismissive about "diversity stuff," he can ask Rowan to explain in her

own words what being pansexual means to her. The provider may also want to educate himself through continuing education and reliable resources about different terms that people use to identify their sexuality.

3. **How could the provider prepare for working with diverse patients?**

The provider could attend continuing education courses, talk to coworkers, or do personal research on a population to gain a better understanding of them. It is okay if you don't know everything about a population, but it can make a positive impact on a patient when you show willingness and openness to learn.

Appendix G

Role Play Activity

Situation #1 - A coworker is refusing to use a patient's preferred pronouns.
ROLES:

Role 1: Amy - You are playing Amy, a nurse that works with Sam. You see in the charts that Sam identifies as a man, but because he looks like a female, you think it's weird to use he/him pronouns, and you have been consistently using she/her pronouns when writing notes about him and talking to him.

Role 2: Jenna - You are playing Jenna, a nurse that also works with Sam. You see in the charts that Sam identifies as a man, but you have been hearing Amy consistently using she/her pronouns when talking about him, and you see that all of Amy's notes are using the incorrect pronoun as well. Sam told you that he doesn't like all of the nurses here because he feels like they don't really care about him at all. You try to talk to Amy about how her actions are influencing Sam.

Role 3: Observer - Your job is to observe the interaction between Amy and Jenna. Think about what is being said and how effective it is. Share what you observed when Amy and Jenna are finished talking.

Situation #2 - One of your patients told you that they were pansexual, but you don't know what that means.
ROLES:

Role 1: Eric - You are playing Eric, a physical therapist who is working with Georgia. During one of your sessions, Georgia discloses to you that she is pansexual. You want to be open and welcoming to her, but you have no idea what being pansexual means. You want to keep your rapport with Georgia without being disrespectful, so you try to talk to her about it more.

Role 2: Georgia - You are playing Georgia, a young woman who is receiving physical therapy from Eric. You are talking about social support, and you disclose to him that you are pansexual (an individual who is attracted to people of all gender identities and sexes). He looks taken aback at first, and a little confused. You get worried that he's judging you and you might have made your relationship awkward now.

Role 3: Observer - Your job is to observe the interaction between Eric and Georgia. Think about what is being said and how effective it is. Share what you observed when Eric and Georgia are finished talking.

Situation #3 - You go to meet a new patient and see that another man has his arm around him. You do not know the relationship between these two patients.
ROLES:

Role 1: Abby - You are playing Abby, a doctor who is meeting a new patient, Adam, for the first time. You walk into the room and see that another man has his arm around Adam, but they quickly separate. You are curious as to who the man sitting next to Adam is, and assume he's his boyfriend, but you're not sure. Your job is to build rapport with Adam by getting to know him better.

Role 2: Adam - You are playing Adam, a gay man who is meeting a new doctor for the first time. You are nervous, so you brought your boyfriend with you. However, you are not sure if you want to disclose to your new doctor that you are gay just yet. So when you see her walk in the room, you quickly scoot farther away from your boyfriend.

Role 3: Danny- You are playing Danny, Adam's boyfriend. You are attending Adam's appointment with him today, and know he's nervous so you have his arm around him. When the doctor comes in, Adam quickly scoots away, and you understand that he might not be ready to disclose that he's your boyfriend. You go along with whatever Adam says about your relationship.

Role 4: Observer - Your job is to observe the interaction between Abby, Adam, and Danny. Think about what is being said and how effective it is. Share what you observed when Abby, Adam, and Danny are finished talking.

Situation #4 - One of your coworkers is refusing to treat a patient because they are bisexual, and it goes against their religion.
ROLES:

Role 1: Noel - You are playing Noel, an occupational therapist. You overhear Danielle, another therapist, complaining to a coworker about how she got assigned a new patient today that is bisexual. She said that she is not going to work with her because it's against her religion to be bisexual. She then said that if she's forced to work with the patient, she's going to talk to her as little as possible. You think that this is unethical and decide to talk to Danielle about it.

Role 2: Danielle - You are playing Danielle, an occupational therapist who got assigned to work with Bailey, who identifies as bisexual. Being bisexual is against your religion, so you don't want to work with her. You decide that if you have to, you'll just talk to her as little as possible, because you don't want to risk the chance of having to talk to her about her relationships or sexual activity.

Role 3: Observer - Your job is to observe the interaction between Noel and Danielle. Think about what is being said and how effective it is. Share what you observed when Noel and Danielle are finished talking.

Appendix H

LGBTQ+ Healthcare Education

A *insert discipline here* Perspective

1

Objectives

1. The learners will be able to **define healthcare disparities** in relation to the LGBTQ population.
2. The learners will be able to **select available** and credible online **resources** for the LGBTQ population.
3. The learners will be able to **admit personal biases** that may impact culturally competent care within discussion and the pretest.
4. The learners will be able to **demonstrate culturally sensitive care** by applying their knowledge to the case study activity.
5. The learners will be able to **generalize the effects of microaggressions** on providing culturally competent care.

2

Pretest

3

Introducing the Population: LGBTQQIP2SAA+

L = Lesbian	**Q =** Queer	**2S =** 2-spirit
G = Gay	**Q =** Questioning	**A =** Asexual
B = Bisexual	**I =** Intersex	**A =** Agender
T = Transgender	**P =** Pansexual	+

(National LGBT Health Education Center, 2020)

4

Gender & Sexuality Spectrum

Assigned Sex	**Gender Identity**	**Gender Expression**	**Sexuality**
★ Female ★ Male ★ Intersex	★ Cisgender (Male/Female) ★ Transgender (Woman, Man, Masculine, Feminine) ★ Non-Binary ★ Gender Nonconforming ★ Two Spirit ★ Genderqueer ★ Agender	★ Feminine ★ Masculine ★ Androgynous ★ Fluid	★ Gay ★ Lesbian ★ Bisexual ★ Heterosexual ★ Pansexual ★ Polysexual ★ Asexual ★ Aromantic ★ Demisexual ★ Demiromantic

Used with permission from Jeff Gibson, Senior Program Coordinator for LGBTQ and Cross-Cultural Programming Initiatives

5

Statistics

In a survey of 3,453 LGBTQ individuals' personal experiences with discrimination…

90% of all LGBTQ people believe there is discrimination against the population in America today

57% of LGBTQ members have experienced slurs

51% have reported being sexually harassed

51% reported experiencing violence

National Public Radio (NPR), Robert Wood Johnson Foundation (RWJF), & Harvard T.H. Chan School of Public Health. (2017)

6

Statistics cont.

34% have reported being verbally harassed in the bathroom

16% reported being personally discriminated against when going to a doctor or health clinic

22% of transgender individuals and 18% of LGBTQ Americans report that they have avoided doctors or healthcare due to concern that they would be discriminated against

(NPR et al., 2017)

7

What are some Myths/Stereotypes about the LGBTQ population?

8

Common Myths/Stereotypes

- LGBTQ individuals are mentally ill
- LGBTQ individuals look a certain way
- AIDS is a "gay" disease
- Sexual orientation can be changed
- LGBTQ and Ally political organizations are asking for "special rights"

(The University of Missouri-St. Louis, n.d.)

9

Health Disparities

- Substance abuse
- Unhealthy weight control
- Smoking
- Mental health related disorders
- Sexual Violence
- Sexually Transmitted Infections

10

Access to Healthcare

- LGBTQ individuals are less likely to be insured and lack a regular place of care (Whitehead, Shaver, & Stephenson, 2016)
- Researchers found that transgender and non-binary individuals were over three times more likely to choose a provider that sees LGBTQ patients (Whitehead, et al., 2016)
- After searching major cities in North Dakota (ND), only three LGBTQ friendly healthcare providers were found - one in Minot, ND, and two in Fargo, ND (GLMA, n.d.)

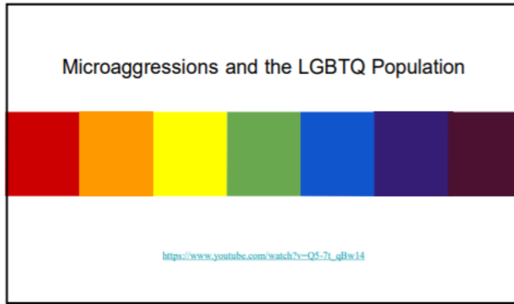
11

Provider's View of Healthcare Barriers

- Inaccessibility of reliable resources
- Limited knowledge of appropriate referrals
- Inadequate medical knowledge, training, and experience

(Snelgrove, Jasudavisius, Rowe, Head, and Bauer, 2012)

12



13

Inclusive Language

Instead of saying...	Try saying...
How are you guys doing today?	How is everyone doing today?
Do you have a husband/wife?	
Can you ask that guy if he has checked in?	
Is this your brother with you today?	
I see that you're a fireman!	

14

National Initiatives

"For too long, LGBT people have been denied the compassionate services they deserve. That is now changing. HHS continues to make significant progress toward protecting the rights of every American to access quality care, recognizing that diverse populations have distinctive needs. Safeguarding the health and well-being of all Americans requires a commitment to treating all people with respect while being sensitive to their differences. (2012)"

15

Disclipline-Specific Standards

Insert your discipline-specific standards here

16

17

CLASS ACTIVITY

select an activity

18

Resources

Add discipline-specific resources

- National LGBT Health Education Center (https://www.lgbthealtheducation.org/)
- The Trevor Project (https://www.thetrevorproject.org/)
- The Genderbread person (https://www.genderbread.org/)
- UND Pride Center
- Ally Training

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Resources cont.

- Dakota OutRight (http://dakotaoutright.org/css/)
- National Resource Center on LGBT Aging (https://www.lgbtagingcenter.org/)
- Welcoming Schools (http://www.welcomingschools.org/)
- Allies in Medicine

20

Posttest

21

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Appendix I

From: Hansen, Caelin <
Sent: Wednesday, February 12, 2020 1:51 PM
To: LGBT Health Education <
Subject: Use of Material

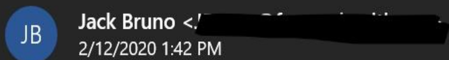
CAUTION: EXTERNAL EMAIL! This email originated from outside Fenway Health. Do not click on links or open attachments unless you recognize the sender and know the content is safe.

Hello,

My name is Caelin Hansen. I am an occupational therapy student at the University of North Dakota. My partner, Jordyn, and I are currently working on our thesis project. We are hoping to develop a curriculum to educate healthcare students on the LGBTQ+ population. We were wondering if we would be able to use and adapt the case scenarios from the guide ***Learning to Address Implicit Bias Towards LGBTQ Patients: Case Scenarios.*** We believe that they are a great resource for practicing cultural competency and would be a great addition to our product.

Thank you in advance,

Caelin Hansen, OTS
University of North Dakota



JB **Jack Bruno** <
2/12/2020 1:42 PM

To: Hansen, Caelin

Good afternoon Caelin,

Thank you so much for reaching out to us at the National LGBT Health Education center, and for your interest in our materials. Please feel free to base your work off of those case scenarios. We only ask that you attribute any used slides appropriately. Thank you again, and have a great day!

Best,
Jack Bruno
Operations Coordinator
The Fenway Institute

Jack Bruno | Operations Coordinator – Division of Education and Training | Pronouns: They, Them, Theirs

CHAPTER V

Summary

The purpose of this scholarly project was to create inclusive curriculum for professions within healthcare to effectively treat the LGBTQ population. A need was determined based on the literature review. As presented in chapter II, the LGBTQ population often avoid healthcare due to experiencing discrimination and microaggressions. Additionally, students felt that they were unprepared to work with this population upon graduation. Therefore, ***LGBTQ+ Population: A Guide for Inclusivity in Healthcare Curriculum*** was created to provide professional programs with the knowledge and tools to incorporate this population into their course content.

Proposal for Implementation

The product of this scholarly project is intended to educate healthcare students on the LGBTQ population and address cultural competency within a healthcare setting. The intent is that this product is used to guide an educational session within physical therapy, occupational therapy, nursing, and medical programs. The product includes the content necessary to adapt the session for each discipline, but also gives the option for a general session. This product is the starting point to increase education about the LGBTQ population in a classroom setting.

Project Outcomes

The plan for this product is to distribute it to the director of the occupational therapy, physical therapy, nursing, and medical departments to implement into their

curriculum. The purpose of this is to gain feedback on the product and determine its efficacy when used to teach students about the LGBTQ population. This feedback will assist in upgrading and designing the product to enhance it for future use. Lastly, this product gives resources for students and faculty to further educate themselves on LGBTQ care independently.

Limitations

A primary limitation was that the product was developed for a small percentage of healthcare professions. As the authors took consideration to make a general outline, other professions would need to do their appropriate research and adapt the product to fit their profession. A second limitation was that the authors are not a part of the LGBTQ population. Even though they consulted experts on the topic, they are not able to experience the disparities that the population faces daily.

Conclusions

In conclusion, this scholarly project is based on evidence, research, and consultation with the director of the Pride Center at the University of North Dakota. The authors hope that this product will be used effectively to help future healthcare professionals understand the LGBTQ population and the importance of cultural competency in healthcare facilities. The goal is to continually update the product to ensure its effectiveness for healthcare students and expand it to include more disciplines. Along with expanding the use of this project in multiple universities, the authors would like to present the information at national and state conferences to continually advocate for cultural competency and the LGBTQ population in healthcare.

Recommendations for Future Action

The authors of this project intend to contact the medical, occupational therapy, physical therapy, and nursing departments to encourage use of this guide within curriculum. It would be beneficial for the guide to be implemented and to develop a research study to determine the guide's efficacy. Further projects could include a guide or program implementing information with clinicians already in practice throughout all disciplines and settings. In addition, further research needs to be conducted in the areas of cultural competency and inclusivity of the LGBTQ population in healthcare, specifically within occupational therapy literature. This project has the potential to increase collaboration with organizations that are devoted to eliminating health disparities through dissemination of the guide to programs around the United States. Other recommendations are for AOTA to mandate the use of this guide throughout all entry-level programs within the country as a standard to increase all practitioner's comfortability for inclusive and ethical care of all clients. It is the duty of the profession of occupational therapy to implement a broader concept of sexuality into the curriculum. Additionally, education should take place globally with continued education regarding the LGBTQ population for practicing occupational therapists.

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