THE NURSE’S ROLE IN GENDER IDENTIFICATION

by

Melissa K. Haworth

MATTIE BURTON, PhD, Faculty Mentor and Chair

JENNIFER GREEN, DNP, ARNP, CPNP-AC, Committee Member

KIMBERLEY SUTTER, MSN RN Preceptor, Committee Member

Patrick Robinson, PhD, Dean, School of Nursing and Health Sciences

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Abstract

Individuals identifying as gender non-conforming are members of a minority culture underserved by the current lack of guidelines for nursing care. This project developed due to a practice gap at the public health clinic with the nurse’s ability to provide care to gender non-conforming patients. The purpose of this project was to work with nurses at a rural health clinic to provide culturally competent, holistic care to individuals who identify as gender non-conforming. The PICOT question that guided this project was: For public health nurses in a rural health clinic (P), will a quality improvement project aimed at providing education related to the care of gender non-conforming patients and implementation of gender self-identification (I) improve the nurses perceived cultural competency and identification of transgender individuals (O) compared to current practice (C) over 6 to 10 weeks (T)? Methodology was a quality improvement project guided by Campinha-Bacote’s theory of cultural competency. The project assumed nurses would lack competency and be willing to participate in the project. Limitations included the absence of nursing specific data, small sample size, and rural location. The Inventory for Assessing the Process of Cultural Competence Revised survey was given before and after project implementation. Results showed increased levels of cultural competency among nurses after project completion. The small sample size eliminated any statistical significance. This project has improved nurse’s ability to provide culturally competent, holistic care to gender non-conforming patients and implementation at other health clinics within the State of Michigan is anticipated.

Key words: nursing, gender identification, gender non-conforming, perception on cultural competency
The Nurse’s Role in Gender Identification

Individual gender identity that differs from biologically assigned gender has become more common in general culture today. Increased awareness of alternate gender identities were brought to light through popular celebrity Caitlyn (Bruce) Jenner’s public transition from male to female (Henig, 2017). Individuals who have an alternative gender identity are at increased risk for adverse outcomes, partially due to lack of education on proper care for this population to nurses and other health care providers. The nurse’s role in gender identification was a quality improvement project completed at a northern Michigan public health clinic that sought to improve the quality of care to gender non-conforming patients.

Project focus. The focus of this project was to work with the nurses and staff at the rural northern Michigan health clinic to provide culturally competent, holistic care to individuals who identify as gender non-conforming. The gender non-conforming individual is a member of a minority culture who is at risk for adverse outcomes due to self-identification. Current practice did not mandate that nurses assess for alternate gender identities other than male or female. Currently, there is a lack of formal guidelines from the American Nurses Association (American Nurses Association, 2017) and the American Psychiatric Nurses Association (Lantrip, 2017) related to providing care to individuals who identify as gender non-conforming. The clinic setting provides service to patients of all ages. Adolescent and adult individuals who identify as gender non-conforming are at an elevated risk of avoiding care due to perceived lack of provider knowledge as well as a higher risk for self-harm including suicide attempts (Almeidia, Johnson, Corliss, Molnar, & Azrael, 2009).

Interventions included with this project provided an intake form for the clinic nursing staff to utilize to have patient’s self-identify gender in accordance to the recommendations from the
Fenway Institute (Bradford, Cahill, Grasso, & Mackadon, 2010) along with education on best practice care for gender non-conforming patients. Nurses at the clinic site completed a survey that assessed the nurses’ perceived level of competency to provide care to this population. Following the survey, the nursing staff was provided education on best practice care of the gender nonconforming individual.

**Significance**

This project was significant because as of the time of this project the American Nurses Association and the American Psychological Nurses Association did not have guidelines for nurses to provide care to individuals who identified as gender non-conforming. Further significance was the lack of tool to assess the comfort of the nurse in working with members of the LBGTQ community. The Fenway Institute in 2010 recommended that patients be given an opportunity to self-identify gender including accounting for gender non-conforming status along with preferred pronoun. The State of Michigan, through the Department of Education has mandated that schools allow for individuals, including minors, to be able to identify gender and preferred pronoun without notifying parents or guardians. Educators and school professionals received related training through the Department of Education. Some school based health centers have also implemented practices regarding gender identity, however the rural northern Michigan health clinic which utilized some forms from the State of Michigan allowed only for male/female identification. Furthermore, this information was often collected by office staff through verbal interview or based on physical presentation.

The Fenway Institute, a national center to promote care for Lesbian, Gay Bisexual, Transgender, and Questioning (LBGTQ) individuals reported that gender identity in the clinical setting should be assessed by allowing the patient to self-identify (Bradford, Cahill, Grasso, &
Mackadon, 2010). This practice recommendation came in response to data that showed individuals who identified as a member of the community had elevated risks for adverse health outcomes. Further study noted that individuals who identify as members of the LBGTQ community are more likely to be the subject of abuse and discrimination even when seeking healthcare from healthcare providers (Grant, et al., 2011). The evidence of adverse outcomes including substance abuse, depression, suicide, and being the victim of abuse was so great that the Office of Disease Prevention and Health Promotion added goals for improved care for the LBGTQ population to the Healthy People 2020 goals (Office of Disease Prevention and Health Promotion, 2018). Despite these recommendations no formal practice guidelines were available for the nursing profession. The American Nurses Association, one of the largest professional nursing organizations in the United States did not publish a position related to the care of the LBGTQ population until April 19, 2018 (American Nurses Association, 2018). This position statement was published without formal practice guidelines for the nursing profession.

**Project AIMS and Relationship to PICOT**

For public health nurses in a rural health clinic (P), will a quality improvement project aimed at providing education related to the care of gender non-conforming patients and implementation of gender self-identification (I) improve the nurses perceived cultural competency and identification of transgender individuals (O) compared to current practice (C) over 6 to 10 weeks (T)? The project aim was to seek a baseline level of cultural competence for the nurse working at a rural public health clinic in providing care to individuals that identify as gender non-conforming. After the baseline was obtained, the project intervention was to provide a tool for the rural public health nurse to allow for patient self-identification of gender non-conforming status. In conjunction with the implementation of the intervention, the nursing staff
and other clinic staff received education on how to provide care to the individual who identified as gender non-conforming. The clinic utilized the tool for 49 days (6 weeks) and nurses completed the survey again to assess the level of cultural competence in working with the gender non-conforming population.

**Relationship to PICOT**

The project related to the PICOT through an assessment of the nurses perceived level of cultural competency in providing care to the gender non-conforming population. Prior to the implementation of this quality improvement project the nursing staff at this rural, public health clinic were not assessing for gender identity outside of male or female. The intervention was directed at both improving the ability of the patient to self-identify and also improving the nursing staff in the ability to provide appropriate care to this population within the time frame. Project design incorporated education to the nursing and clinic office staff on the gender non-conforming patient population. The timeframe of the project, six weeks, allowed for the self-identification tool to be utilized enough to see if this was a sustainable practice for the clinic.

**Relevance to Nursing and Public Health Practice**

At this clinic the nursing staff had limited knowledge of the needs of the gender non-conforming according to the needs assessment conducted with the Director of Nursing. This information agreed with research data stating that nursing education programs in prior years have had little to no time directed to education on the gender non-conforming population (Ard, Keuroghlian, & Markadon, 2017). The individual who identifies as gender non-conforming is part of a minority group that are at high risk for poor health outcomes due to perceived lack of confidence in health providers (Grant, et al., 2011). Gender non-conforming individuals have a
unique culture, and knowledge of this culture is limited in the general population. The American Nurses Association and American Psychiatric Nurses Association both lack official guidelines for nurses to utilize when working with the gender non-conforming population. The Campinha-Bacote theory of cultural competence best addressed the needs of this project with the clinic nursing and patient population.

Project Description

The Nurses Role in Gender Identification is a quality improvement project designed to address the practice gap that currently exists at the rural, public health clinic in northern Michigan. This practice gap of nursing provider knowledge on how to provide care to the gender non-conforming patient exists throughout the United States in part due to lack of formal education on the needs of this patient population (Ard, Keuroghlian, & Markadon, 2017).

Significance of Problem

Gender non-conforming refers to any individual who identifies as a gender that is not congruent with the biologically assigned gender. Gender identity is how an individual perceives themselves as male or female (Moleiro & Pinto, 2015). On a biological level, the majority of individuals have either two X chromosomes (female) or one X and one Y chromosome (male). Gender identity is often expressed through dress and mannerisms. There are many cultural influences on gender identity and roles of individuals within gender identity. In the United States, it is estimated that two percent of the population identify as gender non-conforming. The actual number of individuals who identify as gender non-conforming is uncertain due to lack of accurate data.
The gender non-conforming individual is a member of a unique culture that is different from that of the rest of the population (Meerwijk & Sevelius, 2015). The gender non-conforming, also referred to as transgender, population is a minority culture that is subject to discrimination and abuse compared to other cultures within the United States. This discrimination occurs in many forms from obtaining medical care or benefits in the gender that the individual identifies as (Grollman & Miller, 2015). Gender non-conforming individuals are typically placed in the Lesbian, Gay, Bisexual, Transgender, and Questioning (LBGTQ) category. It should be noted that lesbian, gay, and bisexual refer to sexual orientation, not gender identity, but as a whole the LBGTQ community is represented as a single culture or entity in many studies and publications (Meerwijk & Sevelius, 2015). This project was a quality improvement project and used existing knowledge and data, which included the gender non-conforming individual as a member of the LBGTQ community and culture. The LBGTQ community remains a minority population that is underserved by the nursing profession and health care profession which is most prominently illustrated by the reluctance of these individuals to seek care due to perception of providers not being able to understand the needs of this population (Haas & Rodgers, 2014). Patients who identify as transgender, gender neutral, or a gender identity other than biological assignment are at a high risk for mental illness, suicide, and substance abuse. The patient with a gender identity that is not congruent with the biological identity are at risk for lack of gender specific assessments (annual pap smear, mammogram, Prostate Specific Antigen (PSA) testing, etc.) due to many not being prompted to report the variant gender identity status and providers that are not educated to ask.

Organizations Current Practice
The Director of Nursing identified that the clinic was not meeting the best practice needs to provide care to the individual who identifies as gender non-conforming prior to the start of this project. The Director of Nursing reported that the clinic nursing staff needed education on how to provide care to gender non-conforming patients. At the Family Planning clinic in northern Michigan the intake assessment did not ask or prompt the individual to identify as any gender other than male or female. Due to the lack of assessment prior to implementing this project, the exact number of patients who self-identify with a gender other than male or female was unknown due to the lack of patient self-identification forms. The current forms did not allow for the patient to self-identify gender for Sexually Transmitted Disease (STD) or contraceptive planning. The clinic’s HIV screening did prompt the provider to ask the patient for gender identity, including non-conforming status, but that was separate from the family planning, STD, and the patient had to request HIV testing before encountering this opportunity. This practice is not the recommended practice according to the Fenway Institute which recommends that patients be given the opportunity to self-identify gender (Bradford, Cahill, Grasso, & Mackadon, 2010). Prior to the project, the nursing staff at the clinic are relied on the clerical staff to identify gender, which was sometimes completed by verbally asking the patient to disclose or physical appearance of patient on arrival. Stakeholders in this project include the clinic’s nursing staff who provide care to the patients, patients and the caregivers of the patients, as well as community members. Discussion with the Director of Nursing regarding the concerns of the clinic, nursing staff, and community led to the discovery that the clinic has at least one known transgender individual who receives care. The Director of Nursing and nursing staff at the clinic met with this learner regarding the concerns of providing holistic care to all of the clinics patients.
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Implemented Changes

The community health nurse in the rural northern Michigan clinic, according to the Director of Nursing of the clinic, was thought to be inadequately prepared to care for the gender non-conforming patient due to lack of exposure and education on how to provide culturally competent care to this minority population. This differed from the current practice which was to have clerical staff ask the patients to report gender identity or it was assigned based on physical presentation to the reception area. This quality improvement project implemented a patient intake self-identification form (Appendix A) for all patients to complete on each visit to the clinic. The self-identification form asks patients to identify own gender identity, preferred pronoun use, as well as biological gender assignment which aligned with recommendations by the literature (Cortez, Divan, Keatley, & Smelyanskaya, 2016). Nursing staff and clerical staff received education on how to utilize the patient intake self-identification form. Policy and procedure information (Appendix B) along with community resources (Appendix C) were provided to the clinic for use during the project. Education also addressed nursing care of the gender non-conforming patient.

Available Knowledge

Knowledge related to care of the gender non-conforming patient is extremely limited. The community of gender non-conforming individuals has existed for many years, yet only recently has gained mainstream awareness due to media attention to celebrities like Kaitlyn (Bruce) Jenner who have publicly disclosed gender non-conforming status (Henig, 2017). Political attention to the gender non-conforming population has also resulted in a broader public awareness and debate to the needs of these individuals. Currently there is some guidance for physicians regarding best practice to provide care to this population, though this is not
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standardized throughout the United States health care system at this time (Cortez, Divan, Keatley, & Smelyanskaya, 2016).

**Key Terms and Databases Used in Literature Review**

The topic of nursing care related to the individual who identifies as gender non-conforming is limited in the literature. To research the topic of gender non-conforming individuals needs as a patient several databases were utilized including CINHAL (Cumulative Index of Nursing and Allied Health Literature), PubMed, LBGT Life, Psych Info, and Medline. The search consisted of several phrases and words. Terms used were *gender dysphoria, gender identity disorder, transsexualism, transgender, gender identity, transgenderism, sex reassignment*, and *nursing care*. Thousands of results were found until the search was refined for inclusion of nursing practice or nursing care. Search criteria included age range for 13 to adult, to include peer reviewed works, and to be in English. The addition of nursing care limited results from thousands to under 35 articles. 40 total sources were utilized for this project. The references that were retained from the exhaustive search were kept due to the relevance of the material. These articles directly addressed the gender non-conforming or transgender individual, the outcomes for the gender non-conforming individual with current practices, or recommendation for future practice.

**Review Process**

Literature review was conducted by utilizing several professional data bases. Data bases used included CINHAL, PubMed, LBGT Life, Psych Info, and Medline. All of these data bases allowed for a comprehensive search by allowing selection of variables. The topic of gender non-conforming individuals had many articles and references that did not meet criteria to be included in a scholarly work. For this project, the literature review was refined to articles that were
published in the past ten years. Information and awareness of the topic of gender non-conformity has increased greatly in the past several years partly due to a change in the political climate, celebrity publicity, and improved awareness of the plight of members of the LBGQT community. Search terms included the terms transgender, gender non-conforming, LBGQT, gender dysphoria, and gender identity. These terms were utilized in the data base search engines individually and in the following phrases: gender non-conforming patient needs, nursing care of gender non-conforming, nursing care of transgender, nursing care of LBGQT patients, care needs of LBGQT individuals, gender dysphoria and nursing care, gender dysphoria and patient needs, cultural care of the LBGQT community, and cultural needs of the LBGQT community. The limited number of articles that meet scholarly criteria when using only gender dysphoria, transgender, or gender non-conforming required the inclusion of the LBGQT community. The individual who identifies as transgender is included in the LBGQT community and culture (Ard, Keuroghlian, & Markadon, 2017). It is important to note that identifying as gender non-conforming or transgender is how the individual identifies personal gender identity, whereas lesbian, gay, and bisexual identification does not refer to gender identity, but sexual orientation. Due to the lack of nursing specific information regarding the care of the gender non-conforming individual in the literature contact via email was initiated to the American Nurses Association (ANA), American Psychiatric Nurses Association (APNA), and the Fenway Institute to obtain further information.

Results of Literature Review

The literature related specifically to gender non-conforming, gender dysphoria, and transgender individuals is limited. The gender non-conforming, gender dysphoria, and transgender individuals are included in the literature regarding the LBGQT community (Ard,
Keuroghlian, & Markadon, 2017). This population represents a unique culture with needs that vary from that of the non-LGBTQ or heterosexual community. Nursing-specific education and information related to care of the LGBTQ population is limited and a lack of education within training programs for nurses is also noted. The results of the interview with the American Nurses Association and American Psychological Nurses Association supported the lack of nursing presence and guidance related to the care of the gender non-conforming patient. The American Nurses Association (American Nurses Association, 2017) and American Psychological Nurses Association (Lantrip, 2017) do not have formally adopted guidelines to provide care for the gender non-conforming patient. In April 2018, the American Nurses Association (ANA) published a position statement regarding the LGBTQ population in which the ANA recognized the LGBTQ community as a separate culture and called for culturally appropriate care and cultural awareness regarding this population. This new publication supports this project in that the ANA officially has recognized the need for nursing to be involved with the LGBTQ population (American Nurses Association, 2018). The Joint Commission on Accreditation for hospitals and other health care organizations also calls for culturally competent care for all and distinguishes the LGBTQ population as a separate culture (The Joint Commission, 2011).

The Fenway Institute, a leading nationally recognized facility for care of the LGBTQ community, did not have a survey instrument to assess nursing or provider knowledge of care of the gender non-conforming patient. This lack of specialized assessment regarding provider knowledge of care needs for the gender non-conforming patient supports the lack of information related to this population (Bruno, 2018). Cortez, Divan, Keatley, and Smelyanskaya (2016) also noted the gender non-conforming individual is often the victim of discrimination even in obtaining healthcare and as a result, individuals who identify as gender non-conforming often
avoid medical care. The authors stated the need for healthcare professionals, which includes nursing, to become involved in improving the current status. In another large study, Grant, Mottet, Tanis, Harrison, Herman, and Keisling (2011) reported several adverse findings that apply to the Lesbian, Bisexual, Gay, Transgender, or Questioning (LBGTQ) community. Findings from the survey of 7500 individuals who identified as LBGTQ included an attempted suicide rate of 41%, which is above the 1.6% rate of the population who identify as non-LBGTQ (Grant, et al., 2011). The study was and remains the largest survey of this population and is utilized as reference in several of the other articles cited in this project. It was found that members of the LBGTQ community were more likely to live in poverty, lack adequate housing, and also noted that the population felt that medical providers did not understand the unique healthcare needs of this population. Grollman and Miller (2015) looked for trends in literature in terms of discrimination from data reported on the survey conducted by Grant, et.al (2011). The authors found significantly higher levels of perceived discrimination among those identifying as LBGTQ compared to the non-LBGTQ population. This work also defined gender non-conformity and noted the increased use and abuse of harmful substances such as tobacco, alcohol, and other drugs. Another study completed by the UCLA American Foundation for Suicide Prevention confirmed the elevated risk of suicide for gender non-conforming individuals (Haas & Rodgers, 2014). This study included over 6,000 voluntary participants that answered questions about mental health, race, discrimination, and health behaviors. The results found that individuals with a gender non-conforming identity felt a lack of understanding of the patient’s needs by health providers and an avoidance of care. The study analyzed the risk of self-harm or suicide related to other factors including racial discrimination, age, income, and biological gender. All of these articles support the at-risk minority cultural status of the gender non-
conforming patient and highlight the special needs of this population, as well as the barriers to
care including feeling misunderstood by providers. These articles support the elevated risk of
suicide, self-harm, depression, and substance abuse that is affecting this population.

Improvement in care and awareness for the health professionals to provide appropriate
care to individuals identifying as members of the LBGTQ population, which includes gender
non-conforming individuals, is needed. Part of the 2020 Healthy People initiative includes
recognition of the LBGTQ community including gender non-conforming individuals and sets
goals for improvement in provision of care for this population (Office of Disease Prevention and
Health Promotion, 2018). The Healthy People 2020 goals recognized that individuals who
identify as members of the LBGTQ community have higher rates of disease and illness, are less
likely to seek care, and that current practice is not meeting the needs for this population. Another
study looked at the LBGTQ population, which includes gender non-conforming individuals, and
found that the need to change current practice for providing medical care is great (Ard,
Keuroghlian, & Markadon, 2017). Ard, Keuroghlian, and Markadon (2017) also found that
health care facilities were the perfect place to begin educating medical professionals about the
needs of this population. This work confirmed that the LBGTQ and gender non-conforming
individual are members of a unique culture that differs from the mainstream culture. The work
also highlighted the lack of training for medical professionals in the needs of the LBGTQ and
gender non-conforming population with the average provider receiving about five hours of
training throughout all schooling. Both of these resources support improvement in practice to
provide care to the LBGTQ community. The above articles reference and support that the care
and professional training currently received is not adequate to meet the needs of this population
which includes gender non-conforming.
Information on the biological and psychological development of gender identity was found in several resources. Gender identity development begins during childhood and is not always congruent with biological gender (Hastings, Olson-Kennedy, Rosenthal, & Wesp, 2017). The development of gender identity as male or female is typically established for children by age four. Characteristics of gender identity along with an individual’s sense of gender identity can vary from the typical norms society expects (Moleiro & Pinto, 2015). This may include style of dress, toy preference in young children, use of makeup or accessories in adolescence, or social activities. The Center for Disease Control (CDC) noted that adolescents are at a higher risk to engage in behaviors such as unsafe sexual practices, use illegal substances like tobacco, alcohol, marijuana, or other drugs when they also identity as member of the LBGTQ community (Centers for Disease Control and Prevention, 2015). This study confirms that even at younger ages the individuals who identify as part of the LBGTQ culture have elevated levels of substance abuse (including alcohol, tobacco, and illegal drugs), unsafe sexual practices (not using condoms or birth control, multiple partners), and are more than double the risk of self-harm (suicide attempt, self-mutilation) compared to those who identify as heterosexual adolescents. Adolescent individuals who identify as gender non-conforming have been documented with a perceived lack of provider understanding and perceived discrimination by health providers (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009). This perception of discrimination and lack of provider ability to provide care at the adolescent age leads to increased health risks in adulthood. The health care needs of individuals who identify as gender non-conforming is a world-wide issue, though the scope of this project is limited to the United States. Individuals who vary in gender identity exist throughout the world (World Health Organization, 2017).
Currently identifying as gender non-conforming or transgender is a medical disorder known as gender dysphoria. Listing this as a mental illness further isolates individuals from care (Byrne, 2018). Many avoid care due to fear of being labeled mentally ill. Patients who identify as gender non-conforming have specific psychological and physical needs that are often unmet by current practice. This has been well documented in the literature, with elevated rates of substance abuse and suicide noted in the LBGTQ population. Individuals have described the lack of provider understanding and knowledge first hand and report feeling like they had to direct the nursing staff and that the staff was uncomfortable in providing care to them (Cicero & Black, 2016).

Cultural competency theory and need to address the cultural needs of the LBGTQ community, which includes gender non-conforming were reviewed. The Campinha-Bacote theory of cultural competence states that the nurse must be aware of personal culture, along with any bias felt toward others. There is need for continued assessment and education in the cultures of others to provide care that allows for holistic care to be provided in a manner that best suits the individual patient. The Campinha-Bacote theory includes the Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) tool to assess for perceived cultural competency in providing care to a minority or specific population. This tool was selected for this project due to multiple studies involving nursing care of minority or at risk populations. The tool was validated in studies related to providing nursing care to racial minority in a rural health setting (Grice-Dyer, 2010). The tool was also validated by implementing a practice change in a geriatric clinic (Easter, et al., 2007). A complete analysis of the tool compared to others found that the tool was successful in providing accurate measurement of nurses’ perception of cultural competency (Branson, Hartin, Loftin, & Reyes, 2013). A fourth study was completed using the
Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) to assess the perception of cultural competency between RN to BSN students. This survey noted that age and educational level had a large impact on the level of cultural competency among participants (Riley, 2010).

Textual reference material provided insight and information on how to complete the project. Texts included information related to statistics (MacMillan, 2007). Information on nursing diagnosis was obtained from NANDA, which is the North American Nursing Diagnosis Association (NANDA International, 2015). Textbooks were also referenced for information on evidence based practice (Brown & Schmidt, 2015) and how to understand nursing research (Burns & Grove, 2011). The plan-do-study-act process utilized in this project is described as assessing for a need, planning the project, completing project, studying the impact, and acting on the results (Thompson, 2015). Scholarly references from experts in the field helped to strengthen the work of this project.

With any project involving education of staff or student there is a need to assess if objectives were obtained. This assessment was completed through formative and summative assessment. The use of formative assessment to quickly assess learning and analyze areas that require further education was determined the best fit to be completed in this project (DuFour, Dufor, Eaker, Matos, & Many, 2016). Nurses who participated in this project completed formative learning assessments prior to and after the education provided by this learner. The formative assessment (Appendix E) was designed by this learner to assess if learning occurred by the participants in the project.

The literature related to the LBGTQ community is conclusive in that this population is experiencing negative outcomes as a result of the lack of provider training, knowledge, and
understanding of the needs of this community. Research concludes that action is needed, that the population will remain at-risk for complications if current practice is unchanged. Despite these conclusions, a lack of formalized nursing care guidance exists and education on the needs of this population remains inadequate (Ard, Keuroghlian, & Markadon, 2017). Until 2018 the nursing profession had been left out of the discussion, but the American Nurses Association recognized the LBGQT population as a separate culture in April 2018 calling for cultural competency in providing nursing care to these individuals (American Nurses Association, 2018). The Joint Commission for Accreditation of Hospitals concurs that culturally competent care improves outcomes for all patient populations (The Joint Commission, 2011) supporting the position of the American Nurses Association and Campinha-Bacote theory of cultural competency for the theoretical framework of this project.

Rationale

For this project, several theories and potential ideas were visited. The nursing profession has a practice gap and knowledge gap in the care of the gender non-conforming population. As a profession, nursing is also a system which corresponds to the Neuman theory of nursing systems that states if a system is stressed negative outcomes will result (Parker, 2001). Further evidence supported that the problem is related to the cultural difference between the gender non-conforming minority population and the nursing profession. The Campinha-Bacote theory of cultural competence has been utilized in multiple studies of minority patients and nurses ability to provide culturally competent care to diverse populations.

Framework Description

Currently, the nursing profession has a gap in practice regarding caring for gender non-conforming individuals. Nursing is one of the largest professions within the healthcare industry,
working in multiple inpatient and outpatient settings. As a profession, nursing is guided by both legal and ethical standards that direct actions. There is a deficiency in the ability to assess, identify, and support individuals who are presenting as gender non-conforming. In order to begin, the perception of nurses regarding personal level of cultural competence to provide care to the gender non-conforming patient will need to be assessed. A formative assessment of the nurses’ perceived understanding of the individual who is identifying as gender non-conforming needed to be established as well.

Since the gender non-conforming individual is a member of the LBGTQ community, which is a minority community and also culturally unique from other communities, the nurse’s cultural competence to provide care was assessed. Specific study regarding the nurse’s perceived ability to provide care specifically to the gender non-conforming population is not possible due to lack of validated instrument to survey the nurse. This lack of instrument was verified not only through exhaustive literature review, but by direct contact with National LBGTQ Health Center which is part of the Fenway Institute (Bruno, 2018).

The Campinha-Bacote theory of cultural competence was used to guide this project. The theory of cultural competence states that the individual must constantly evaluate the individual’s level of comfort in working with populations and must have a desire to do so (Campinha-Bacote, 2007). The desire to achieve a greater understanding of the needs of a patient population has to be present and if present will lead to a desire to know more about a culture. This theory states that nurses must have an awareness of various cultures, knowledge of the culture, and skill to provide care within a culture. The individual who identifies as gender non-conforming is a member of a minority culture and the lack of cultural awareness, knowledge, and skill in providing care for individuals within this culture is great (Ard, Keuroghlian, & Markadon, 2017).
Individuals who identify as gender non-conforming often avoid care because they feel that the needs and status are not understood by nurses or other providers (Haas & Rodgers, 2014). Addressing this gap in practice should lead to improved practice at the rural public health clinic in northern Michigan, and hopefully could lead to the implementation of consistent guidelines throughout nursing practice in other settings (White & Dudley-Brown, 2012). The Campinha-Bacote theory of cultural competency states that the nurse (or other health professional) has a desire to gain greater understanding of the cultures they serve (Campinha-Bacote, 2007). This desire leads to the nurse questioning his or her awareness, knowledge, and skill to provide care to a culture. This theory of cultural competence and the corresponding validated instrument Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) was used to assess the nurses perceived level of competence in providing culturally appropriate care to the gender non-conforming population underpinned the project.

Current practice is to treat all individuals similarly regardless of sexual or gender identity (American Nurses Association, 2017). However, the increased rate of self-harm, suicide, and substance abuse suggests that this practice is not the best practice. The gender non-conforming population has a suicide attempt rate of 41%, which is significantly higher than that of the rest of the population (Grant, et al., 2011). Currently there are no formal recommendations specific for nursing regarding how to assess, identify, and support these individuals. This creates a stress on both the profession and patient. Furthermore, a study regarding training of health professionals, again lack of nursing specific material, has shown that the average professional receives only five hours of training regarding the needs of the entire LBGTQ population (Ard, Keuroghlian, & Markadon, 2017). This does not include nurses or professionals that completed schooling outside of the past decade, for those clinicians the amount of education was less than five hours
or non-existent. The concept of gender non-conforming has been viewed as a mental illness, gender dysphoria, until recently (World Health Organization, 2017). Encountering a minority population, gender non-conforming individuals, without standardized practice guidelines and only five hours of education is a major stressor on the nursing profession (system) as a whole. This leads to fragmented care for these individuals. Gender non-conforming individuals report not seeking care due to the lack of provider knowledge related to the individual needs (Grant, et al., 2011). Campinha-Bacote’s (2007) theory of cultural competency states that nurses have a desire to improve awareness, knowledge, and skills related to working with individual cultures. The gender identity non-conforming population has unique needs that are not being addressed currently. Use of the Campinha-Bacote theory of cultural competency is also supported for this project by the American Nurses Association’s direction that all nurses should provide culturally appropriate care to the LGBTQ population (American Nurses Association, 2018).

Looking also at relationship between nursing and population health, there is a direct correlation between nursing actions and the overall health of a population. If the nurse is unable to provide appropriate (culturally specific) care to the gender identity non-conforming patients, then the entire patient population as a whole is underserved. Nurses have various personal backgrounds united by a desire to provide care to others. There are many religious and cultural beliefs that are linked with gender identity and expression of gender identity (Grollman & Miller, 2015). In American culture gender has traditionally been a binary concept allowing for only male and female identity though this has changed dramatically in the past several years; many still have strong belief that there are only the two options. Pervasive stereotypes exist in mainstream culture that the individual’s sense of gender identity is related to parenting or religious affiliation. The expression of gender identity through dress and behavior is also misunderstood.
Traditional American gender roles indicate that flowers and dresses are for female, whereas males should not wear dresses or makeup. These stereotypical beliefs provide a barrier for understanding and providing care to the individual with a gender non-conforming identity. These individuals experience higher rates of abuse and discrimination because of this. The gender non-conforming individual is also at a higher risk for substance abuse, mental illness, and self-harm which relates to poor long-term health outcomes.

Variables

The outcome variable measured in this project was the nurses perceived level of cultural competency as recorded by the IAPCC-R 2002 pre and post-test completion. The nurse’s perception is a dependent variable, and was expected to change with the implementation of the project. Dependent variables react or change based on the action of an independent variable (White & Dudley-Brown, 2012). Independent variables have an effect on the dependent variable; without independent variables, dependent variables would not change. The interventions of the Patient Self-Assessment form and educational seminar on the needs and care of the gender non-conforming population are the independent variables in this quality improvement project.

Study Assumptions

The study assumed that the nurses would be willing to participate in the project. The study also assumed that the nurses who participated would be honest with all responses. A risk with Likert type questions is that participants sometimes answer what they think the researcher is asking for. The study also made assumptions related to the pre-test results on the IAPCC-R 2002 in that it would show a lack of perceived cultural competency by the nursing staff at the clinic. This assumption was based on the Director of Nursing’s report and in person meeting with the
nursing staff at the clinic regarding the project. The majority of the nursing staff reported having no additional or specialized training in working with the gender non-conforming population.

**Specific Aims**

The overall goal of this project was to improve the care of the patients who sought services at this rural, public health clinic in northern Michigan. Through use of a patient identification form (Appendix B) and nursing staff education on best practices for care of the gender non-conforming population it was anticipated patient care would improve. The Director of Nursing supported the project by requesting that both nursing and non-professional clinical staff participate in the education to avoid any gaps in administration of the patient self-identification assessment form.

**Project AIMS and Relationship to PICOT**

This project aimed to obtain a baseline level of cultural competence for the nurse working at a rural public health clinic in providing care to individuals that identify as gender non-conforming. After the baseline was obtained the project intervention was to provide a tool for the rural public health nurse to allow for patient self-identification of gender non-conforming status. In conjunction with the implementation of the intervention, the nursing staff and other clinic staff received education on how to provide care to the individual who identifies as gender non-conforming. Clinic staff and nurses utilized the tool for six weeks. Nurses then completed the IAPCC-R 2002 survey again to assess the level of cultural competence in working with the gender non-conforming population. It was anticipated that the nursing staff would have an improved level of competence in providing care following the intervention.
Relevance to Nursing and Public Health Practice

At this clinic the nursing staff had self-reported limited knowledge of the needs of the gender non-conforming patient. The individual who identifies as gender non-conforming is part of a minority group that are at high risk for poor health outcomes due to perceived lack of confidence in health providers. Gender non-conforming individuals have a unique culture, and knowledge of this culture is limited in the general population. The Campinha-Bacote theory of cultural competence best addressed the needs of this project and population. The theory of cultural competence states that the individual must constantly evaluate the level of comfort in working with populations and must have a desire to do so (Campinha-Bacote, 2007). The desire to achieve a greater understanding of the needs of a patient population has to be present and if present will lead to a desire to know more about a culture. This theory states that nurses must have an awareness of various cultures, knowledge of the culture, and skill to provide care within a culture. The individual who identifies as gender non-conforming is a member of a minority culture and the lack of cultural awareness, knowledge, and skill in providing care for individuals within this culture is great. Individuals who identify as gender non-conforming often avoid care because of feeling that the physical and psychosocial needs are not understood by nurses or other providers (Haas & Rodgers, 2014). Addressing this gap in practice should lead to improved practice at the rural public health clinic in northern Michigan. The Director of Nursing for the clinic would like to implement this project at all clinic sites throughout the State of Michigan. The broader goal of the project is to establish the implementation of consistent guidelines throughout nursing practice (White & Dudley-Brown, 2012).

Problems Addressed Through the Project
This project addressed multiple issues within the nursing profession. The first problem was the clinic site did not have consistent practices in place to assess gender non-conforming status. Secondly was the lack of cultural competency by the clinic staff in the ability to provide care to the gender non-conforming population. Additional problems included the lack of formal guidance on practice from the American Nurses Association (American Nurses Association, 2017) and the American Psychiatric Nurses Association (Lantrip, 2017). Through this project the clinic site has implemented a patient self-identification intake form that continues to be utilized for every patient on every encounter. This allowed the individual to express chosen gender identity, preferred name and pronouns, along with biological gender which is in alignment with best practice for provider recommendations since 2010 (Bradford, Cahill, Grasso, & Mackadon, 2010). The clinic staff and nursing staff also received education on the unique needs of the gender non-conforming patient, how to implement the information on self-identification patient intake form into the routine assessment, and follow up strategies based on responses to assessment questions. This improved the knowledge and understanding that the staff and nursing staff had related to care of the gender non-conforming population. Due to the age and experience level of the clinic staff it is unlikely they received more than five hours of education while in nursing school regarding the care of this minority culture (Ard, Keuroghlian, & Markadon, 2017). The final improvement made through this project was to implement standard responses and protocol for the gender non-conforming patient. The utilization of the self-identification patient intake form led to the nurse being prompted to address the patient’s biological needs while addressing the patient according to the preferred gender identity. Through this process the nursing staff is also screening for depression, risk for or attempted self-harm, and is able to explain the need for screening for preventative health measures (i.e. cervical cancer screening,
prostate examination, etc.). Care was able to be individualized in a manner not previously possible due to lack of patient ability to express chosen gender identity and biological gender identity. Care is now truly holistic for the gender non-conforming patient who seeks care at the clinic.

**Context**

The State of Michigan Department of Education in collaboration with the Centers of Disease Control had implemented *A Silent Crisis* program to provide education on the needs of the LBGTQ population for educators and school counselors (Michigan Department of Education, 2015). This program was available to all educators and counselors to attend. Through the Department of Education, the State Superintendent published recommendations that public schools are required to recognize the students (regardless of age) chosen gender, preferred pronoun, utilize preferred identity for restroom or locker room facilities. These students have a mandated right to confidentiality and, if requested, guardians do not have to be notified. The State of Michigan did not implement similar practices in public health clinics and continue to utilize standard male or female gender identification as the only choice for patients.

**Setting**

The public health clinic is located in northern Michigan in a rural community. According to census data the population of the county that the clinic serves is under 25,000 and mostly Caucasian. The majority of residents are between the ages of 18 to 44 years of age and report being married. The 2010 census also reported that the average household income is under $35,000 United States Dollars (USD) per year with 14% living below the federal poverty line. This northern Michigan community has also been designated a high risk area for opioid abuse. The clinic provides care to individuals seeking care for reproductive health, sexually transmitted
disease (STD) testing and treatment, and other health services. The clinic has participated in projects and programs related to providing treatment or testing for HIV, clean needle exchange programs for those who use drugs, and increasing access to services for all.

The clinic accepts patients of all ages. Most of the population served by this clinic are on state funded insurance (i.e. Medicaid), are without insurance, or very low income. It is a non-profit, state funded clinic. The clinic serves all genders and provides reproductive health services along with other health services. The Director of Nursing determined there was a need to have education and intervention related to the topic of gender non-conforming individuals. The Director of Nursing has worked with many special populations, and has shared that concerns for the clinic’s patient population include heroin abuse, HIV, and that the staff was currently not educated on how to assess for gender identity outside of male and female. The rural community provides several limitations for the clinic and the project. Concerns about privacy, perceived perception of not having problems with drug use or HIV or gender non-conforming residents are noted as some of the limitations that exist. The clinic is small, with only four nurses on staff full time (includes the Director of Nursing). The Director of Nursing oversees all of the clinic’s operation. All of the staff are working in multiple roles within the clinic to service the needs of the patients. The Director of Nursing has a master’s degree, with experience in mental health, reproductive health, home health, and mentoring nurses.

According to clinic records, 314 patients were seen in the 2016-2017 year. The patients ranged in age from under 15 to over 44 years old. Patients sought services for family planning, HIV screening, and STD treatment. All of the patients were at least 100% below the federal poverty level, and did not utilize private insurance. 92% of the patients identified as being white, non-Hispanic with the remaining 8% identified as black, Asian, or other. The majority of patients
identified as female, however the option to identify as gender non-conforming or transgender was not provided.

**Needs Assessment**

The Director of Nursing identified that the clinic had not met the best practice needs to provide care to the individual who identified as gender non-conforming. The Director of Nursing reported that the clinic nursing staff needed education on how to provide care to gender non-conforming patients. At the Family Planning clinic in northern Michigan assessment did not ask or prompt the individual to identify as any gender other than male or female. Therefore, the exact number of patients who would self-identify gender other than male or female is unknown due to the lack of patient self-identification forms. The current forms did not allow for the patient to self-identify gender for STD or contraceptive planning. The clinic’s HIV screening did prompt the provider to ask the patient for gender identity, including non-conforming status, but this was separate from the family planning and STD, and patients had to request HIV testing before they would encounter this opportunity. This practice is not the recommended practice according to the Fenway Institute which recommends that patients be given the opportunity to self-identify gender (Bradford, Cahill, Grasso, & Mackadon, 2010). At the beginning of the project the nursing staff at the clinic was relying on the clerical staff to identify gender, which is sometimes completed by verbally asking the patient to disclose or on appearance on arrival. Stakeholders in this project include the clinic’s nursing staff who provide care to the patients, patients and the caregivers of the patients, as well as community members. The Director of Nursing and nursing staff at the clinic met with this learner regarding the concerns of providing holistic care to all of the clinics patients.

**Current Practice Problem**
The community health nurse in the rural northern Michigan clinic, according to the Director of Nursing of the clinic, were deemed probably not competent in providing care to the gender non-conforming patient due to lack of exposure and education on how to provide culturally competent care to this minority population. Current practice was that the patients are asked to report gender (male or female) or it was assigned based on physical presentation on admission.

**Organization Information**

The clinic site is a public health clinic in northern rural Michigan. It is funded by the State of Michigan. Some funding comes to the clinic through participation in grant programs. This quality improvement project did not receive funding from the clinic or other source. The site offers multiple programs in addition to the health clinic, including Women Infant and Children (WIC) services. All services provided at the health clinic are overseen by the Director of Nursing and patient care is rendered by registered nurses, nurse practitioners, and physicians.

The Director of Nursing and the other three nurses who are on staff at the public health clinic were supportive of this project. The Director of Nursing also serves as a member of the State of Michigan Family Planning committee and would like to share the outcome of this project with this committee. The Director of Nursing feels that the implementation of the assessment form and education would benefit similar clinics throughout the State of Michigan.

Clinic nurses, clinic staff, and the Director of Nursing are all supportive of projects to improve the health of the overall community. Recently the clinic obtained a grant to provide needle exchanges to individuals who utilize Heroin and other IV drugs. Despite being in a rural community, the general population is also supportive of the needle exchange and other programs
including the reproductive health clinic. There have been no barriers to overcome related to this project.

Evidenced Based Guidelines

The problem to be addressed is that since 2010 the Fenway Institute, a leading provider in care for LBGTQ health, has recommended that patients be allowed to self-identify sexual orientation and gender identity including choices for non-conforming gender identity (Bradford, Cahill, Grasso, & Mackadon, 2010). In 2017 there were still no guidelines from the American Nurses Association (American Nurses Association, 2017) or from the American Psychiatric Nurses Association (Lantrip, 2017) for nurses to assess for non-conforming gender identity. This lack of standardized assessment is leading to fragmented and inconsistent nursing practice regarding the care of the patient who has a non-conforming gender identity.

Intervention

The intervention for this quality improvement project was to implement a patient self-identification form (Appendix B) at the clinic site. The self-identification form was designed to be easily implemented into the clinic workflow without creating additional paperwork burden to the staff. Multiple public health clinics exist throughout the State of Michigan and the Director of Nursing anticipated that this would be implemented statewide at some point in the future.

Project Design

This was quality improvement project which, by definition, focused on improving an identified problem (Dixon-Woods, Portella, Pronovost, & Woodcock, 2015). The quality improvement process differs from that of other project designs. Traditional research designs
often involve a hypothesis which is tested. Through traditional research new knowledge is often discovered. Quality improvement projects focus on an identified problem in a single practice or institution. The quality improvement project is designed to correct or improve existing gaps in practice within the facility and does not typically generate new knowledge. Quality improvement projects can use the Plan, Do, Study, Act (PDSA) process to address a problem or gap in current practice, implement an intervention to correct the practice gap, study the impact of the intervention, and finally implement the solution throughout the institution.

This design was chosen because the Director of Nursing of the clinic assessed that the clinic nursing staff would benefit from education and a tool to improve identification and care of gender non-conforming individuals. The setting is a rural community, and the clinic provides care to mainly low income individuals or patients without medical insurance of all ages. Data indicates that many individuals who identify as gender non-conforming are more likely to suffer from poverty and lack insurance compared to other patient populations (Grollman & Miller, 2015). The Director of Nursing reported that the nursing staff has not had formal education on identifying and providing care for gender non-conforming individuals. In discussion regarding the patient population that the clinic serves, the staff providing the service, and current practices with the Director of Nursing, it was determined that the clinic would be better able to provide care to the patients if the staff could identify such individuals and be educated on how to care for the gender non-conforming population.

The gender non-conforming individual is a member of a unique culture that is different from that of the rest of the population (Meerwijk & Sevelius, 2015). The gender non-conforming, also referred to as transgender, population is a minority culture that is subject to discrimination and abuse compared to other cultures within the United States. This
discrimination occurs in many forms from obtaining medical care or benefits in the gender that
the individual identifies as (Grollman & Miller, 2015). Gender non-conforming individuuals are
typically placed in the Lesbian, Gay, Bisexual, Transgender, and Questioning (LBGTQ)
category. It should be noted that lesbian, gay, and bisexual refer to sexual orientation, not gender
identity, but as a whole the LBGTQ community is represented as a single culture or entity in
many studies and publiciations (Meerwijk & Sevelius, 2015). This project was a quality
improvement project and therefore used existing knowledge and data, which includes the gender
non-conforming individual as a member of the LBGTQ community and culture. The LBGTQ
community remains a minority population that is underserved by the nursing profession and
health care profession which is most prominently illustrated by the reluctance of these individuals
to seek care due to perception of providers not being able to understand the needs of this patient
population (Haas & Rodgers, 2014).

The project began with the nursing staff taking the IAPCC-R 2002 survey for cultural
competence. Cultural competency is defined as the nurse (or health provider) being able to
provide care to a patient from a culture different from the providers (Campinha-Bacote, 2007). In
order to achieve cultural competence, the nurse must be aware of other cultures than that of the
nurse’s own, have a willingness to learn about the other cultures and the needs of patients from
other cultures (Campinha-Bacote, 2007). Nurses working at the clinic have had no formal
training in the culture of the gender non-conforming individual.

The patient who identifies as gender non-conforming is a member of a minority culture,
which is currently underserved by the nursing profession due to a lack of guidelines and
consistency in care practices (Grant, et al., 2011). This allowed for a baseline measurement of
the nursing staff’s level of cultural competence to provide care to the gender non-conforming
patient. The study design used an uncontrolled before and after assessment with the IAPCC-R 2002 tool to measure the effect of the quality improvement project. Uncontrolled before and after assessments protect the participants by allowing anonymous participation (Dixon-Woods, Portella, Pronovost, & Woodcock, 2015). The IAPCC-R 2002 is a Likert type questionnaire, which can be prone to bias by participants who fear reprocussion for answering poorly or incorrectly, through the use of the uncontrolled before and after design, anonymity of the participants in this project were insured, thus limiting the risk for bias.

Following the administration of the IAPCC-R 2002 the nursing and medical office staff took a knowledge-based pre-test to assess understanding of the needs of the gender non-conforming patient. Afterwards the nursing and medical office staff had an educational seminar, which took approximately one hour to complete. The office staff were included in the education and implementation of the instrument. Non-professional office staff did not participate in the assessment of cultural competence after discussion with Dr. Camphina-Bacote, who stated that the IAPCC-R 2002 would not be appropriate for non-professional staff. The staff have interaction with patient and nursing professionals, to exclude them from the education could lead to a deficit of knowledge and care consistency throughout the clinic. This education introduced the new assessment form (Appendix B) that was to be given to all patients upon arrival at the clinic. This form (Appendix B) was created in collaboration with the Director of Nursing after a complete review of the clinic’s current patient assessment forms. Patient’s are currently not self-identifying gender, and this is not in alignment with best practice recommendation from the Fenway Institute (Bradford, Cahill, Grasso, & Mackaden, 2010). The Fenway Institute is a nationally recognized health clinic and research center in Massachusetts that focuses on the health needs of the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) population. After
completing the educational program the nursing and medical office staff took a knowledge-based post-test. This allowed for formative evaluation of the participants to see if objectives were met.

The clinic utilized the patient intake form (Appendix B) for a period of six weeks, after using the form for six weeks the nursing staff at the clinic repeated IAPCC-R 2002 assessment to assess perception of cultural competency in providing care to patients who identify as gender non-conforming. The Director of Nursing believed that the project design should be able to be utilized at similar clinics throughout the State of Michigan, to improve assessment and care for patients that identify as gender non-conforming.

**Project Setting**

The setting is a rural northern Michigan health clinic that accepts patients of all ages. Most of the population served by this clinic are on state funded insurance (i.e. Medicaid), are without insurance, or very low income. It is a non-profit, state funded clinic. The clinic serves all genders, and provides reproductive health services along with other health services. The Director of Nursing for the clinic felt there was a need to have education and intervention related to the topic of gender non-conforming individuals. The Director of Nursing has worked with many special populations, and has shared that concerns for the patient population include heroin abuse, HIV, and that the staff is currently not educated on how to assess for gender identity outside of male and female. The rural community provides several limitations for the clinic and the project. Concerns about privacy, perceived perception of not having problems with drug use or HIV or gender non-conforming residents are noted. The clinic is small, with only four nurses on staff full time (includes the Director of Nursing). The Director of Nursing oversees all of the clinic’s operations, all of the staff is working in multiple roles within the clinic to service the needs of the
patients. The Director of Nursing has an MSN, with experience in mental health, reproductive health, home health, and mentoring nurses.

**Inclusion and Exclusion Criteria**

The participation of the nursing staff was voluntary and was in no way tied to the individual’s employment, licensure, or professional associations. Participation was anonymous in order to further protect participant responses and provide confidentiality. Surveys were not assigned an identifying number or name, and were be collected following administration by having the responder place it in an unmarked envelope. Registered Nurses, including Advanced Practice Nurses who work at the clinic were allowed to participate. Individuals who were not registered nurses were excluded from participation, this includes medical assistants or nursing assistants. Participants who did not want to participate were excluded. Surveys that are incomplete, though there were none, would have been excluded.

**Intervention Description**

The plan for this project is to assess the clinic nurses perceived level of competency in providing culturally competent care to the individual who identifies as gender non-conforming. As a quality improvement project the plan also includes the implementation of a new assessment form (Appendix B) to allow for patient self-identification of gender identity, and includes non-conforming options consistent with best practice recommendations (Bradford, Cahill, Grasso, & Mackadon, 2010). The plan includes education regarding the use of the assessment form (Appendix B), and how to provide best practice care to patients who identify as gender non-conforming.
Do: The intervention in this case is to utilize an assessment form to allow for self-identification of gender (See Appendix B.) This form was created in collaboration with the Director of Nursing to fit the needs of the clinic based on best practice recommendations from the Fenway Institute (Bradford, Cahill, Grasso, & Mackadon, 2010). The Director of Nursing noted that the clinic had several different forms that allowed the nurse to document, but these did not allow or prompt for gender identification other than male or female. The assessment form (Appendix B) allowed the patient to specify if they identify as male, female, or other gender identity. It also allows for the patient to identify the biological gender and preferred pronoun use. The intervention included comprehensive education with the nurses and clinic staff regarding the care of the gender non-conforming patient with implementation of an assessment form to allow for self-identification of gender identity.

The steps to complete this intervention are as follows:

1. Learner conducted a survey of nurses and advanced practice nurse’s perception of cultural competency in providing care for the gender non-conforming patient. Survey was conducted using the Inventory for Assessing Provider Cultural Competence Revised (IAPCC-R 2002) tool (Appendix C and Appendix D).

2. Pre-test of all participants on learning objectives related to education on providing care for gender non-conforming patients with learner designed formative assessment (Appendix E).

3. Provide education on care of gender non-conforming patients and use of new self-identification assessment form (Appendix B), which was designed based on literature (Bradford, Cahill, Grasso, & Mackadon, 2010) and Director of Nursing support.
4. Post-test all participants against learning objectives to providing care to gender non-conforming, analyze results for learning with learner designed formative assessment (Appendix E). Compare to pre-test, provide additional education and support if needed for any objectives that were not met.

5. Implement assessment form (Appendix B) into practice at clinic for one month. Patients were given this form to complete every time they presented to the clinic. Gender identity can change for some individuals, and therefore must be assessed on each visit to the clinic (Moleiro & Pinto, 2015).

6. Follow up after one month of supported use of assessment form with post-test on cultural competency, using the IAPCC-R 2002 tool (Appendix C and Appendix D). Analyze the results, compare to pre-test.

The implementation of an assessment form for the patient to use independently, allowed the patient to identify gender identity, biological gender, and preferred pronoun use. This was in alignment with the recommendations from the Fenway Institute (Bradford, Cahill, Grasso, & Mackadon, 2010). The form was created in collaboration with the Director of Nursing based on the Fenway Institute guidelines. The form is titled Patient Intake Information and includes seven questions. Questions include name, birthdate, preferred name, age, gender identity, preferred pronoun use, and biological gender assignment at birth. The Director of Nursing decided that it would be best for the clinic to have one form for all patients to use, and to include the demographic data that was already being collected (name, date of birth, age) on a different form. The patient self-identification form (Appendix B) incorporates the information of name, birthdate, and age as well as the gender identification options with preferred name and pronoun use into one form. This lessened the burden of additional paperwork for the clinic nursing staff.
The Director of Nursing also wanted to make sure that the patient had options to identify outside of the current gender non-conforming labels (male to female, female to male). The form was given to the patient by the nursing or office staff on arrival to the clinic for service. All patients who present for service used the form on each visit, regardless of reason for visit. The form is included in Appendix B.

Prior to implementation of this assessment form a survey of the nursing staff on the nurse’s individual perception of competence in providing care for the individual who identifies as gender non-conforming. This survey of cultural competency in providing care was conducted using the Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) tool (Appendix C) to assess cultural competency (Campinha-Bacote, 2007). This survey was completed both before and after the implementation of the assessment form. The Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) tool to assess cultural competency has been tested in prior works related to nursing care of minority population. The Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) is a copyrighted tool. Dr. Josephina Campinha-Bacote has given permission to utilize this tool (Appendix C) for IRB and committee approval through December 31, 2018. Additional authorization to utilize the tool for the project was obtained to survey four nurses before implementing the project and upon completion of the project.

The Campinha-Bacote theory of cultural competency provides an exceptional platform for this project as Director of Nursing is seeking to gain knowledge for the nursing staff on how to improve care for minority cultures who may seek care at the clinic. As her theory notes the nurse must desire to have knowledge and understand that the nurses’s personal culture is not always congruent with that of the patient.
The nurses and medical office staff also received education on providing care to the individual who identifies as gender non-conforming. This was done after the administration of the Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) and knowledge based pretest. The knowledge based pre-test asked questions related to learning objectives to provide care to gender non-conforming patients. While the office staff did not participate in the IAPCC-R 2002 assessment, they did participate in the formative assessment of knowledge regarding care of the gender non-conforming patient. The Director of Nursing and this learner feel that it was critical for the success of the assessment form that all clinic staff were trained in the use and needs of the gender non-conforming population. Once the training had been completed, a knowledge based post-test was administered. This was a formative assessment that assessed if the education was effective or if remediation needed to occur (DuFour, Dufor, Eaker, Matos, & Many, 2016). It was critical to be able to accurately assess if learning had occurred before the nurses utilized the new self-identification assessment form.

Following the planning and implementation of the project the next step was to study the results from the pre and post testing of the educational objectives (Thompson, 2015). Also studying and analyzing the results of the IAPCC-R 2002 survey that the nursing staff completed to assess the nurse’s individual perception of cultural competency in caring for the individual with gender non-conforming identity was completed before and after the implementation of the project.

The final phase was to Act. It was anticipated that this quality improvement project would be successful. After data from the project was analyzed to confirm if the anticipated success was achieved, then the Director of Nursing would like to bring this work to other clinics throughout the state.
Learner Role In Project

The project was completed under the direction of the Doctor of Nursing Practice (DNP) learner. The learner has conducted extensive research and met with the Director of Nursing to assess the needs of the clinic. The learner requested appropriate permissions to utilize the copyrighted tool, Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) from Dr. Campinha-Bacote included in Appendix C. Learner conducted the survey of the nursing staff, and analyzed data collected through the survey process with the IAPCC-R 2002. The learner designed a formative assessment (Appendix E) which the learner administered to the staff and analyze the results. The learner provided the educational seminar to the clinic staff, and launched the implementation of the patient assessment form (Appendix B). The learner collaborated with the Director of Nursing to best meet the needs of the clinic and the nursing staff at the clinic.

Clinical Team Work

The population to be addressed is the community health nurse who provides care for individuals who may identify as gender non-conforming. The nursing staff at the rural health clinic consists of four full time nurses. They are all female registered nurses ranging in age from early thirties to late fifties. The level of education varies from BSN to MSN. The nursing staff has experience in providing community health care, but did not receive education related to providing care to the gender non-conforming patient as part of the nursing school curriculum. No formal training has been completed by the nurses related to care of gender non-conforming patients. All of the nurses have been with the clinic for at least one year and are full time employees of the clinic.
Gender non-conforming is a broad term to include all individuals that present as gender questioning, genderless, transgender, or any other gender identity that differs from the biological assigned gender (Hastings, Olson-Kennedy, Rosenthal, & Wesp, 2017). According to clinic records 314 patients were seen in the 2016-2017 year. The patients ranged in age from under 15 to over 44 years old. Patients sought services for family planning, HIV screening, and STD treatment. All of the patients were at least 100% below the federal poverty level, and did not utilize private insurance. 92% of the patients identified as being white, non-Hispanic the remaining 8% identified as black, Asian, or other. The majority of patients identified as female, however the option to identify as gender non-conforming or transgender is not given. Currently the number of patients that the clinic serves who would identify as gender non-conforming is unknown. This is due to the practice gap that exists. The clinic provides many services, including reproductive health, vaccination, Women Infant and Children (WIC) health visits, screening programs, and substance use assistance. The patient population meets federal or State criteria to be considered low income and eligible for Medicaid or free health services. Currently the only gender identification options are male and female, though this changed with the implementation of the assessment form (Appendix B) through this project. Data regarding patient name or identifying information was not collected through this project. Patient completion of the assessment form (Appendix B) was completed by all patients upon arriving at the clinic and added to the medical record. This was a change from the current practice of having the clerical staff ask a patient verbally or basing gender identity on appearance at the clinic.

The nurses who work at the clinic are the targeted population for this project. The current lack of assessment form to allow for patient self-identification of gender identity as recommended by the Fenway Institute (Bradford, Cahill, Grasso, & Mackadon, 2010), is the
problem that this project is seeking to address. The implementation of a self-identification form (Appendix B) would not be effective unless the nursing staff received education on how to utilize the form. The nursing staff was also assumed to have a perceived lack of competence in providing culturally competent care to the individual who identified as gender non-conforming due to the lack of training and education that the clinic nurses have reported.

**Problem**

The problem addressed was that since 2010 the Fenway Institute, a leading provider in care for LBGTQ health, has recommended that patients be allowed to self-identify sexual orientation and gender identity including choices for non-conforming gender identity (Bradford, Cahill, Grasso, & Mackadon, 2010). In 2017 there are still no guidelines from the American Nurses Association (American Nurses Association, 2017) or from the American Psychiatric Nurses Association (Lantrip, 2017) for nurses to assess for non-conforming gender identity. This lack of standardized assessment is leading to fragmented and inconsistent nursing practice regarding the care of the patient who has a non-conforming gender identity. The community health nurse in the rural northern Michigan clinic, according to the Director of Nursing of the clinic, may not be competent in providing care to the gender non-conforming patient due to lack of exposure and education on how to provide culturally competent care to this minority population.

**Intervention Plan**

Plan: The plan for this project was to assess the clinic nurses perceived level of competency in providing culturally competent care to the individual who identifies as gender non-conforming. As a quality improvement project the plan also includes the implementation of a new assessment form (Appendix B) to allow for patient self-identification of gender identity,
and includes non-conforming options consistent with best practice recommendations (Bradford, Cahill, Grasso, & Mackadon, 2010). The plan includes education regarding the use of the assessment form (Appendix B), and how to provide best practice care to patients who identify as gender non-conforming.

Do: The intervention in this case was to utilize an assessment form to allow for self-identification of gender (See Appendix B.) This form was created in collaboration with the Director of Nursing to fit the needs of the clinic based on best practice recommendations from the Fenway Institute (Bradford, Cahill, Grasso, & Mackadon, 2010). The Director of Nursing noted that the clinic had several different forms that allowed the nurse to document, but these did not allow or prompt for gender identification other than male or female. The assessment form (Appendix B) allowed the patient to specify if they identify as male, female, or other gender identity. It also allowed for the patient to identify the biological gender and preferred pronoun use. The intervention included comprehensive education with the nurses and clinic staff regarding the care of the gender non-conforming patient with implementation of an assessment form to allow for self-identification of gender identity.

The steps to complete this intervention were as followed:

1. Learner conducted a survey of nurses and advanced practice nurse’s perception of cultural competency in providing care for the gender non-conforming patient. Survey was conducted using the Inventory for Assessing Provider Cultural Competence Revised (IAPCC-R 2002) tool (Appendix C)

2. Pre-test of all participants on learning objectives related to education on providing care for gender non-conforming patients with learner designed formative assessment (Appendix E).
3. Provide education on care of gender non-conforming patients and use of new self-identification assessment form (Appendix B), which was designed based on literature (Bradford, Cahill, Grasso, & Mackadon, 2010) and Director of Nursing support.

4. Post-test all participants against learning objectives to providing care to gender non-conforming, analyze results for learning with learner designed formative assessment (Appendix E). Compare to pre-test, provide additional education and support if needed for any objectives that were not met.

5. Implement assessment form (Appendix B) into practice at clinic for one month. Patients were given this form to complete every time they presented to the clinic. Gender identity can change for some individuals, and therefore must be assessed on each visit to the clinic (Moleiro & Pinto, 2015).

6. Follow up after six to eight weeks of supported use of assessment form with post-test on cultural competency, using the Inventory for Assessing Provider Cultural Competence Revised (IAPCC-R 2002) tool (Appendix C and Appendix D). Analyze the results, compare to pre-test.

The implementation of an assessment form for the patient allows the patient to identify gender identity, biological gender, and preferred pronoun use. This practice aligned with the recommendations from the Fenway Institute (Bradford, Cahill, Grasso, & Mackadon, 2010). The form was created in collaboration with the Director of Nursing based on the Fenway Institute guidelines. The form is titled Patient Intake Information and includes seven questions. Questions include name, birthdate, preferred name, age, gender identity, preferred pronoun use, and biological gender assignment at birth. The Director of Nursing determined that it would be best for the clinic to have one form for all patients to use, and to include the demographic data that
was already being collected (name, date of birth, age) on a different form. The patient self-
identification form (Appendix B) incorporates the information of name, birthdate, and age as
well as the gender identification options with preferred name and pronoun use into one form.
This lessened the burden of additional paperwork for the clinic nursing staff. The Director of
Nursing also wanted to make sure that the patient had options to identify outside of the current
gender non-conforming labels (male to female, female to male). The form was given to the
patient by the nursing or office staff on arrival to the clinic for service. All patients who
presented for service used the form on each visit, regardless of reason for visit. The form is
included in Appendix B.

Prior to implementation of this assessment form a survey of the nursing staff on the
individual nurse’s perception of competence in providing care for the individual who identifies
as gender non-conforming. This survey of cultural competency in providing care was conducted
using the IAPCC-R 2002 tool to assess cultural competency (Campinha-Bacote, 2007). This
survey was completed both before and after the implementation of the assessment form. The
IAPCC-R 2002 tool to assess cultural competency had been tested in prior works related to
nursing care of minority population. The IAPCC-R 2002 is a copyrighted tool. Dr. Campinha-
Bacote has given permission to utilize this tool (Appendix C) for IRB and committee approval
through December 31, 2018. Dr. Campinha-Bacote approved the use of four copies of the
IAPCC-R 2002 tool to be hand administered to the clinic nursing staff prior to the
implementation of the intervention and following the intervention. Permission to attach a copy of
the IAPCC-R 2002 in the manuscript as an appendix was not granted. The IAPCC-R 2002 asks
questions related to the nurse’s perception of cultural competency. Questions are based on a
Likert type scale and scored according to the tools criteria. The Campinha-Bacote theory of
cultural competency provides an exceptional platform for this project as Director of Nursing is seeking to gain knowledge for the nursing staff on how to improve care for minority cultures who may seek care at the clinic. As the theory notes a nurse must desire to have knowledge and understand that the nurses’s personal culture is not always congruent with that of the patient.

The nurses and medical office staff also received education on providing care to the individual who identifies as gender non-conforming. This was done after the administration of the IAPCC-R 2002 and knowledge based pretest. The knowledge based pre-test asked questions related to learning objectives to provide care to gender non-conforming patients. While the office staff did not participate in the IAPCC-R 2002 assessment, they did participate in the formative assessment of knowledge regarding care of the gender non-conforming patient. The Director of Nursing and this learner thought that it was critical for the success of the project and to achieve consistent use of the assessment form that all clinic staff were trained in the use and needs of the gender non-conforming population. Once the training had been completed, a knowledge based post-test was administered. This formative assessment assessed if the education was effective or if remediation needed to occur (DuFour, Dufor, Eaker, Matos, & Many, 2016). It was critical to be able to accurately assess if learning objectives were met before the nurses utilized the new self-identification assessment form.

Clinical Site Team

The clinic has a small yet dynamic team of nurses and office (clerical) staff. The nursing staff are all Registered Nurses who have a BSN degree with the Director of Nursing having a MSN degree. The nurses and clerical staff were very supportive of the project. The project was a success in part to the commitment of the nursing and office staff to consistently utilize the patient intake information tool (Appendix B). With any quality improvement project staff support is an
essential element in recognizing a need, addressing the need through a change in practice, and implementing the change in an on-going process (Thompson, 2015). Participation was initiated through the Director of Nursing and remained optional for nursing and clerical staff to participate with. All of the nursing staff and clerical staff choose to participate in this project. The nursing staff provided valuable input on the additional needs through this project. The nursing staff requested a policy and procedure (Appendix D) to accompany the trial of the patient intake self-identification form following the presentation and education. Nursing staff also had input into the needs of the community, which included a request for resource guidance (Appendix F) (i.e. list of resources) to provide support to patients who are identified via the intake form.

**Study of the Intervention**

Interventions must be analyzed in order to determine effectiveness in the given situation. This project utilized both quantitative and qualitative data. The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals Revised (IAPCC-R 2002) a validated tool utilized quantitative data (Campinha-Bacote, 2007). Data was gathered from the participants in this project.

**Assessment of Intervention**

The intervention was assessed in three components. First the participants completed the formative assessment (Appendix E). The formative assessment provided information directly related to the educational objectives that corresponded to the project implementation. Formative assessment data is informal and not part of a validated assessment tool for the quality improvement project and was only utilized to provide data on participants needs before and after the education (DuFour, et.al., 2016). The second assessment involved the use of the validated IAPCC-R 2002 which was given to the four clinic nurses prior to the implementation and after
completion of the project. The IAPCC-R 2002 was designed by Dr. Campinha-Bacote to measure the perceived level of cultural competence among healthcare professionals and is based on her theory of cultural competency (Campinha-Bacote, 2007). This tool has been validated in prior studies. One of these studies by Grice-Dryer in 2010 analyzed the healthcare provider from a rural area that was providing care to a minority population (Grice-Dyer, 2010). Similarly, this project looked to assess the clinic nurse’s level of cultural competency in providing care to the minority population of the gender non-conforming individual. The IAPCC-R 2002 utilized twenty five Likert type questions to analyze the healthcare professionals’ level of awareness of cultural needs within a population (Campinha-Bacote, 2007). Clinic nursing staff took the IAPCC-R 2002 prior to the implementation of this quality improvement project. The results of the pre-test indicated that the majority of the clinic nursing staff was not culturally competent.

The project was conducted from October 12, 2018 through November 30, 2018 during which time the clinic met one hundred percent compliance in use of the patient self-identification intake form (Appendix B). Throughout the project communication between the clinic site and this learner took place with the Director of Nursing and this learner. Verbal feedback from the clinicians was positive and receptive to the project. After the initial education and implementation, a clinic nurse had requested additional information on where to refer and what process to follow if a patient self-identified as gender non-conforming. To address this need policy and procedure guidance was created and implemented with the self-identification patient intake form (Appendix B). On November 30, 2018 the clinic site completed the quality improvement project. Charts were audited by the Director of Nursing to avoid any concerns related to patient privacy. Compliance with the self-identification patient intake form (Appendix B) was the third evaluative measure of this project. In order to fully assess if the project was
successful compliance with the patient self-identification intake form (Appendix B) had to be
evaluated. Names and birthdate were removed from the responses, by the clinic staff, and then
reviewed by this learner. All of the patients were female at time of appointment and were all
born female. It was anticipated that the clinic might not have any gender non-conforming
patients during the trial period due to the rural nature of the clinic. It does need to be noted that at
the time of this project the clinic is aware of one patient that is transgender. The Director of
Nursing also contacted the local support group for transgender people in the community to let
them know that the clinic was available and would be supportive of the needs of the gender non-
conforming population.

The IAPCC-R 2002 was given to the four clinic nurses again on November 30, 2018
following the completion of the project. This was repeated to assess for change following the
project within the clinic nursing staff. Scores on the IAPCC-R 2002 increased significantly from
the pre to the posttest indicating growth among all clinic nurses. This increase appears to be
related to the education provided during the implementation of the project. Questions on the
IAPCC-R 2002 ask about biological differences among cultures, which participants
acknowledged more on the posttest in comparison to the preliminary test. Other questions asking
about awareness that other needs exist also increased in awareness on the posttest compared to
the pre-test. The nursing staff also reported that the physicians working with the clinic were very
excited to see the self-identification form being utilized. Additional feedback from the clinic
nurses included that the one clerical staff member for a satellite clinic who had not attended the
training was not receptive to the self-identification intake form (Appendix B), but did comply
with the Director of Nursing’s request to give all patients the form on arrival. Nurses reported
that patient feedback was also receptive. Patient comments included “I wondered when someone
would ask this.” No one reported feeling uncomfortable or upset by being asked to complete the self-identification patient intake form (Appendix B). There were no unintended or unexpected outcomes as a result of this project. The clinic clerical staff member who opposed the project did comply with providing all patients the form on arrival to the clinic, in future work it is highly recommended that all staff attend the educational presentation to avoid this reaction.

The clinic plans to continue to utilize this form for all patients on every encounter. The Director of Nursing also reported that the clinic has future plans to merge from a separate family planning and HIV to one clinic that provides all services. She anticipates an increase in male patients when this change occurs. The clinic site also plans to continue outreach communication to local Lesbian, Gay, Bisexual, Transgender, and Questioning (LBGTQ) support groups that understanding care is available. As previously noted one of the largest barriers to the LBGTQ population which includes gender non-conforming, is the patient perceived lack of provider understanding of health care needs (Grant, et al., 2011)

Measures

The project is designed as a quality improvement project. Quality improvement projects are useful in nursing practice to target identified problems (Brown & Schmidt, 2015).

Design

This was a quality improvement project. A quality improvement project allowed for focus improvement on an identified problem (Dixon-Woods, Portella, Pronovost, & Woodcock, 2015). The quality improvement process differs from that of other project designs. Traditional research designs often involve a hypothesis which is tested. Through traditional research new knowledge is often discovered. Quality improvement projects focus on an identified problem that was identified in a single practice or institution. The quality improvement project was designed to
correct or improve existing gaps in practice within the facility and does not typically generate new knowledge. Quality improvement projects can use the Plan, Do, Study, Act (PDSA) process to address a problem or gap in current practice, implement an intervention to correct the practice gap, study the impact of the intervention, and finally implement the solution throughout the institution.

This design was chosen because the Director of Nursing of the clinic thought that the clinic would benefit from education and a tool to improve identification and care of gender non-conforming individuals. The clinic site is one that provides care for patients of all ages. The setting is a rural community, and the clinic provides care to mainly low income individuals or patients without medical insurance. Data indicates that many individuals who identify as gender non-conforming are more likely to suffer from poverty and lack insurance compared to other patient populations (Grollman & Miller, 2015). Currently the Director of Nursing reports that the nursing staff has not had formal education on identifying and providing care for gender non-conforming individuals. The American Nurses Association (American Nurses Association, 2017) and the American Psychological Nurses Association (Lantrip, 2017) also report not having policy or recommendations in place to address the gender non-conforming patient. In discussion of the patient population that the clinic serves, the staff providing the service, and current practices with the Director of Nursing, it was felt that the clinic would be better able to provide care to the patients if the staff was better able to identify such individuals and be educated on how to care for the gender non-conforming population and had a tool to allow for patient self-identification of gender identity.

The gender non-conforming individual is a member of a unique culture that is different from that of the rest of the population (Meerwijk & Sevelius, 2015). The gender non-
conforming, also referred to as transgender, population is a minority culture that is subject to discrimination and abuse compared to other cultures within the United States. This discrimination occurs in many forms from obtaining medical care or benefits in the gender that the individual identifies as (Grollman & Miller, 2015). Gender non-conforming individuals are typically placed in the Lesbian, Gay, Bisexual, Transgender, and Questioning (LBGTQ) category. It should be noted that lesbian, gay, and bisexual refer to sexual orientation, not gender identity, but as a whole the LBGTQ community is represented as a single culture or entity in many studies and publications (Meerwijk & Sevelius, 2015). This project is a quality improvement project and will therefore use existing knowledge and data, which includes the gender non-conforming individual as a member of the LBGTQ community and culture. The LBGTQ community remains a minority population that is underserved by the nursing profession and health care profession which is most prominently illustrated by the reluctance of these individuals to seek care due to perception of providers not being able to understand the needs of this patient population (Haas & Rodgers, 2014).

Nursing staff working at the clinic participated in this project. The project began with the nursing staff taking the Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) survey for cultural competence. Cultural competency is defined as the nurse (or health provider) being able to provide care to a patient from a culture different from the providers (Campinha-Bacote, 2007). In order to achieve cultural competence, the nurse must be aware of other cultures than that of the nurse’s own, have a willingness to learn about the other cultures and the needs of patients from other cultures (Campinha-Bacote, 2007). Nurses working at the clinic have had no formal training in the culture of the gender non-conforming individual.
The patient who identifies as gender non-conforming is a member of a minority culture, which is currently underserved by the nursing profession due to a lack of guidelines and consistency in care practices (Grant, et al., 2011). This allowed for a baseline measurement of the nursing staff’s level of cultural competence to provide care to the gender non-conforming patient. The study design used an uncontrolled before and after assessment with the IAPCC-R 2002 tool to measure the effect of the quality improvement project. Uncontrolled before and after assessments protected the participants by allowing anonymous participation (Dixon-Woods, Portella, Pronovost, & Woodcock, 2015). The IAPCC-R 2002 is a Likert type questionnaire, which can be prone to bias by participants who fear reprocussion for answering poorly or incorrectly, through the use of the uncontrolled before and after design, anonymity of the participants were insured thus limiting the risk for bias.

Following the administration of the IAPCC-R 2002 the nursing and medical office staff took a knowledge-based pre-test to assess their understanding of the needs of the gender non-conforming patient. Afterwards the nursing and medical office staff participated in an educational seminar, which took approximately one hour to complete. The office staff were included in the education and implementation of the instrument. Non-professional office staff did not participate in the assessment of cultural competence after discussion with Dr. Camphina-Bacote, who stated that the IAPCC-R 2002 would not be appropriate for non-professional staff. The staff have interaction with patient and nursing professionals, to exclude them from the education could lead to a deficit of knowledge and care consistency throughout the clinic. This education introduced the new assessment form (Appendix B) that was given to patients upon arrival at the clinic. This form (Appendix B) was created in collaboration with the Director of Nursing after a complete review of the clinic’s current patient assessment forms. Prior to this
project patient’s did not self-identify gender, and that practice was not in alignment with best practice recommendation from the Fenway Institute (Bradford, Cahill, Grasso, & Mackadon, 2010). The Fenway Institute is a nationally recognized health clinic and research center in Massachusetts that focuses on the health needs of the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) population. After completing the educational program the nursing and medical office staff took a knowledge-based post-test. This allowed for formative evaluation of the participants to see if objectives were met.

The clinic utilized the patient intake form (Appendix B) for a period of six weeks, after six weeks of using the form the nursing staff at the clinic repeated the IAPCC-R 2002 assessment to assess perception of cultural competency in providing care to patients who identify as gender non-conforming. The Director of Nursing believed that the project will be able to be utilized at similar clinics throughout the State of Michigan, to improve assessment and care for patients that identify as gender non-conforming.

**Desired Outcomes**

The desired outcomes of this project were that the public health nurses working in a northern Michigan health clinic would improve in the nurse’s perceived cultural competency to provide holistic care to the gender non-conforming patient. Additional outcomes include improved nurse knowledge of the specific needs of the gender non-conforming patient and implementation of the Patient Self-Assessment form to allow for individual patients to self-identify gender status.

The IAPCC-R 2002 is an instrument designed to assess nurses’ perception of cultural competence in providing care to other cultures (Campinha-Bacote, 2007). This instrument uses
quantitative data from a total of 25 Likert type questions. The nursing staff took the IAPCC-R 2002 survey prior to the implementation of the new patient intake form (Appendix B). The nursing and clinic staff then received education on how to use the new patient intake assessment tool, along with education on best practice for care of gender non-conforming patients. The IAPCC-R 2002 survey can only be utilized to measure nurses’ level of perceived cultural competency in providing care to the minority culture population of gender non-conforming patients.

Educational outcomes related to the care of the gender non-conforming patients that may use the clinic for care were measured using the formative assessment designed by the learner based on current literature. The desired outcomes for the learners (nurses and clinic staff) were that the learners would be able to utilize the patient intake information form (Appendix B) for all patients who seek care at the clinic and understand the unique needs of the gender non-conforming patients. Educators utilize literature and best practices to design curriculum along with measurable objectives that allow to assess for learning (DuFour, Dufor, Eaker, Matos, & Many, 2016). The formative assessment utilized both quantitative and qualitative data to assess for learner needs and outcomes. The quantitative questions are Likert type questions, the total score of the quantitative questions indicate if the learner had met desired objective related to the care needs of the gender non-conforming patient. The qualitative questions allow for learners to respond to open ended questions. The questions address common stereotypes found in the literature related to the gender non-conforming patient (Grant, et al., 2011). It was important to assess for participant needs related to stereotypes or misconceptions regarding this population so that education can be provided to address these prior to the implementation of the patient intake information form (Appendix B).
The Director of Nursing and this learner plan for the following outcomes:

1. Improvement in nurses perceived level of cultural competency as measured on the IAPCC-R 2002 survey (Appendix C)

2. Utilization of patient intake information form (Appendix B) for all patients on each visit to the clinic
   a. Improvement in identification of patient gender identity

3. Nurses and clinic staff would meet educational outcomes for the education provided on care for the gender non-conforming patient as measured with the formative assessment (Appendix E)

4. Patients now have the opportunity to self-identify gender.

5. Clinic will now be able to identify and track patient gender identity, including gender non-conforming identities.

**Measurement of Outcomes**

In order to measure outcomes nurses will take IAPCC-R 2002 survey to assess nurse’s perception of cultural competency in providing care for the gender non-conforming patient (Campinha-Bacote, 2007). The Director of Nursing and this learner anticipate that initial (pre-test) scores would indicate a lack of competency. In order to obtain baseline data, the nursing staff took the IAPCC-R 2002 survey prior to implementation of the patient information intake form (Appendix B) and educational seminar. Six weeks after the implementation of the project the nursing staff took the IAPCC-R 2002 survey again. Data collected through the IAPCC-R 2002 survey is quantitative data, and was scored using the scoring guide that accompanied the IAPCC-R 2002 tool. The cumulative scores of the initial survey were compared to the final
survey scores, a T-Test was utilized to assess for statistical significance in a change in the scores (MacMillan, 2007). Participants remained anonymous, participation remained voluntary.

The educational seminar included a formative assessment (Appendix F) that was designed by the learner based on best practice and literature research. This assessment was given before and immediately after the educational seminar to objectively measure if learning objectives were met. The formative assessment included both quantitative and qualitative questions. The quantitative data was collected, and the sum of the Likert questions were tallied. It was anticipated that the pre-test scores would be lower than the post-test scores. Post-test scores should show an eighty percent accuracy related to the learning objectives to consider the educational seminar effective. The qualitative questions looked for learner misconceptions regarding care of the gender non-conforming patient. Qualitative data is not numerical, and it was anticipated that responses would vary from individual participants. The literature reports many stereotypes, along with patient perceptions of discrimination and lack of provider understanding related to the needs of the gender non-conforming patient (Almeidia, Johnson, Corliss, Molnar, & Azrael, 2009).

**Data From Formative Assessment**

The formative assessment (Appendix E) was designed to quickly assess learner educational needs prior to the education on care of the gender non-conforming patient. This assessment was created by this learner based on research of best practice care for gender non-conforming individuals. This formative assessment also utilized desired outcome information, such as improving level of knowledge in how to provide care to the gender non-conforming patient and need to differentiate care for this population, to assess the learner for growth by
completing the assessment after the education was provided. This assessment was designed due to a lack of existing instrument to use and has not been validated by prior research. Pre and post testing of all participants, regardless of academic or professional status, was conducted on commencement of the project on October 12, 2018.

**Pre-Test Formative Assessment Data**

The pre-test formative assessment was completed by all participants at the clinic. The participants included five registered nurses and one clerical staff member. The formative assessment (Appendix E) was designed with both qualitative and quantitative questions. Qualitative results for questions six through eleven were discussed with the Director of Nursing upon completion of the formative assessment.

The qualitative data for the pre-test showed that the participants had needs in understanding what gender non-conforming is. Data also showed that participants had a knowledge deficit in the care needs of gender non-conforming patients as well as deficits in how individuals develop gender identity. Participants responded with uncertainty in the role of the nurse related to care of this patient population and that it was possible for upbringing (i.e. allowing girls to play with tractors or boys to play with dolls) to influence gender identity. In addition to the qualitative data, quantitative data was also collected in the formative assessment. The quantitative pre-test data responses are represented in the following graph for questions one through five on the formative assessment (Appendix E).

In the pre-test the majority of respondents agreed that individuals who identify with gender identity questions (Question 1) are at high risk for self-harm, with two individuals reporting they strongly agreed with that statement. The total score for question one on the pre-
test was 18. When asked if patients with gender identity questions were seeking attention (Question 2) the responses varied from agree to strongly disagree indicating a lack of knowledge regarding this patient population. The total score for question two was 11. All participants reported disagree or strongly disagree when asked if gender identity disorder was a mental illness that required treatment (Question 3). The total score for question three was nine, an ideal score for this question would be six, indicating that all respondents strongly disagreed with this. Responses varied from agree to strongly disagree when asked if patients who have gender identity disorders could have low self-esteem (Question 4), again indicating a lack of knowledge on the needs of this patient population. The total score for question four was 20. Finally, the participants responded from agree to strongly disagree when asked if they felt prepared to provide holistic care to the patient with gender identity questions (Question 5) which indicates a need for education among the participants. The total score for question five was 12. This result confirms the research that nurses do not receive enough training or education in providing care to the gender non-conforming or LBGTQ population (Ard, Keuroghlian, & Markadon, 2017). These responses are detailed in the following chart.

Formative Assessment Pre-Test Results
Post-Test Formative Assessment Data

The same formative assessment (Appendix E) that was given to the participants prior to the project implementation was conducted after presenting the educational material to the clinic staff. The participants remained the same with five registered nurses and one clerical staff member completing the post-test formative assessment. Qualitative results for questions six through eleven were discussed with the Director of Nursing. The responses on the post-test changed from the pre-test. Following education respondents reported concern related to the number of gender identity options, being able to find appropriate resources to use to support patient care, being able to make patients feel comfortable and understood. On post-test respondents reported that nurses could have an impact on patient outcomes for gender non-conforming individuals, that care should be differentiated to meet patient needs, and that upbringing (i.e. dolls for boys or tractor toys for girls) did not impact individual gender identity. These responses indicated a change in the participants understanding of the gender non-conforming population. After reviewing the data with the Director of Nursing additional information was implemented to provide staff with policy and procedure for the project along with a resource guide for patient resources (Appendix F).

The responses to the quantitative questions on the formative assessment (Appendix E) indicate a change in learner understanding of the gender non-conforming patient. Responses changed in question one from a cumulative score of 18 to a cumulative score of 29, which indicated a greater number of respondents strongly agreeing patients with a gender identity question have an increased risk of self-harm. Responses for question two did not change from the pre-test to the post-test. Question two asked if the participant believed that individuals who have gender identity questions are attention seeking. Responses in the pre-test ranged from neutral to
disagree to strongly disagree; the response frequency did not change following education. This indicates further work regarding this is needed as the ideal response would be strongly disagree from all respondents. Question three, gender identity disorder is a mental illness that requires treatment on post-assessment a shift in responses occurred. On the pre-test the participants choose disagree and strongly disagree with this statement, following education the responses changed to three strongly disagreeing with the statement, two neutral, and one agreeing with this. This indicates further education and clarity is required. Currently, gender dysphoria remains a mental illness in the International Classification of Diseases and Related Health Problems tenth edition (ICD-10). The World Health Organization is working to have this removed from the upcoming International Classification of Diseases and Related Health Problems eleventh edition (ICD-11) which would come into effect in 2022 (Belluck, 2016). Individuals responding that they agree with the statement, a gender identity disorder is a mental illness that requires treatment could be considered to be correct based on the current ICD-10 classifications. On question four the responses indicated a greater understanding of the needs of the gender non-conforming patient. On question four, patients with gender identity questions could have low self-esteem the respondents answered agree and strongly agree, which was a shift from the pre-test where the responses were strongly disagree to agree. The final quantitative question asked if the respondents felt prepared as a RN to provide holistic care to the patient with gender identity questions. Responses to question five increased from a cumulative score of twelve (12), with one not responding to twenty (20), also with one not responding. Only five registered nurses participated in the project out of six total participants. It is assumed that the clerical staff member did not answer this question due to not being a registered nurse. The number of nurses who strongly disagreed on the post-test was zero which was an improvement from the pre-test
responses. This shift from strongly disagree to the neutral, agree, strongly agree responses on the post-test indicate the education helped to improve the nurses perceived ability to provide holistic care to this patient population. The quantitative data is summarized in the following graph.

**Formative Assessment Post-Test Data**

![Graph showing data distribution](image)

**Evaluation of Compliance**

Additionally, the implementation of the patient intake information form found in Appendix B, resulted in a clearer identification of patients regarding the demographics of gender. The clinic had no way of measuring the number of patients who currently identified as gender non-conforming, as this was not being assessed prior to this project. Following the implementation of the project which includes using the patient intake information form for all patients’ charts will be checked for use of the form. Patient charts were audited for the presence of the patient intake information form through a chart review process. No patient identifying information was collected by this learner. All regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) were adhered to in accordance with clinic policy and federal law.
Validity of Tool

In 2007, a study was conducted regarding nurses working with geriatric population in two hospitals in New York to assess the effect of education on the cultural competency of the nursing staff (Easter, et al., 2007). This study showed an increase in cultural competency following education in comparing pre and post test results.

Another study utilized the Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) tool to assess the cultural competency of healthcare staff providing care to black (a minority population) patients in Rock Island County, Illinois (Grice-Dyer, 2010). This study found that black patients were not seeking care due to the patient perception that the care would not be equal. Through the use of the IAPCC-R 2002, the study found that nurses with less education and experience were more likely to not be competent to provide culturally appropriate care to the minority population.

In 2013, an integrative review study of cultural competency assessment for nurses compared eleven tools including the IAPCC-R 2002 for reliability, applicability, and validity (Branson, Hartin, Loftin, & Reyes, 2013). This review found that the IAPCC-R 2002 was able to measure nurses perceptions of cultural competency. It also noted that the cultural diversity of the United States is rapidly changing and that minority populations and cultures are at greater risk for mistreatment and avoid seeking care due to lack of culturally competent providers.

In 2010 the IAPCC-R 2002 was utilized to assess the cultural competency with RN to BSN students (Riley, 2010). This study noted a difference in age and educational level between the students perception of cultural competency related to nursing.
Due to the lack of tool to specifically address the nursing perception of working with gender non-conforming the IAPCC-R 2002, which has been validated in multiple nursing studies and projects was utilized. The gender non-conforming population is a separate culture from that of main-stream, cisgender (identifies as biologically assigned gender) that often avoids medical care due to provider lack of knowledge on how to provide care to them (Haas & Rodgers, 2014). Contact was made to the Fenway Institute to seek an instrument specifically related to the gender non-conforming population, or at very least the LBGTQ community. The response was that there was not a validated tool that was available (Bruno, 2018). The current guidance from the American Nurses Association is to treat the gender non-conforming “the same” as all other patients, which disregards the special needs of this minority culture (American Nurses Association, 2017). The above mentioned studies confirm the reliability and validity of the Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) and provide prior context for use regarding care of minority populations by nurses and other health providers.

**Analysis**

Analysis of the project was completed to determine if interventions were successful. Analysis of a quality improvement project has to be objective and non-biased. Data from the Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) was utilized for this analysis.

**Data Analysis**

The Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) survey utilizes Likert type questions. This study utilized quantitative data. Quantitative data is useful because it is number based which allows for comparison to be made between pre and post testing (MacMillan, 2007). The results of the Inventory for Assessing Cultural Competence Revised
(IAPCC-R 2002) were recorded from the pre-test and post-test. Mean (average) score of the pre-test was compared to the mean (average) score of the post-test. A t-test compared the difference between the pre and post-test to see if there is a statistical significance. Due to the small sample size of only four participants it was anticipated that no statistical significance would be found in the T-test results. Data was protected by utilizing a sealed envelope transported in a locked box to and from the clinic site. Responses were recorded on a password protected Excel spreadsheet. Participants remained anonymous as no identifying information was collected.

**Formative Assessment**

Formative assessment data was utilized to assess for learner needs and learner outcomes before and after the planned education regarding use of the patient intake information form (Appendix B) intervention. A formative assessment can be created to rapidly assess the learner knowledge of select objectives (DuFour, Dufor, Eaker, Matos, & Many, 2016). Contact with the Fenway Institute in the literature review process revealed that there is currently no tool or assessment that has been validated for this purpose (Bruno, 2018). Due to lack of standardized tool the formative assessment tool (Appendix E) was created based on the literature for best practices related to the care of the gender non-conforming population. Data collected on the formative assessment (Appendix E) includes quantitative data from Likert type questions. The desired response for questions one, four, and five are strongly agree (5). The desired response for questions two and three are strongly disagree (1). It is important to note that a score for the assessment as a whole cannot be utilized to assess outcomes. Individual questions must be analyzed individually to see if participants met the desired outcomes. The formative assessment also has several open ended questions designed to address common misconceptions and stereotypes related to the gender non-conforming population (Almeidia, Johnson, Corliss,
Molnar, & Azrael, 2009). Qualitative data is not numerical and cannot be measured statistically. However, the qualitative data allowed for this learner to address if any of the project participants have needs or questions that the participants may not feel comfortable asking. The qualitative questions also directly addressed some stereotypes including gender identity formation is related to parent choice of toys for children (Moleiro & Pinto, 2015). The responses to these questions was assessed for trends, such as everyone believes gender identity is related to parents’ choice of toys children are allowed to play with. Comparison was made between the pre and posttest responses to see if changes occurred. The qualitative data was also utilized to focus education as needed to address learner needs related to objectives.

Data from the patient intake information form (Appendix B) was utilized only by clinic nurses to prompt for assessment and patient care. This study did not utilize patient information to compare as no prior data regarding alternative gender identity or gender non-conforming status had previously been collected by the clinic. Charts were reviewed to assess compliance with change in practice, giving each patient the patient intake information form (Appendix B) on arrival to the clinic. Both this learner and the Director of Nursing were unsure of the number of gender non-conforming individuals that would present at the clinic during the timeframe of the project due to the rural northern Michigan location. Data has shown that urban areas are more likely to have higher populations of gender non-conforming individuals (Meerwijk & Sevelius, 2015).

**Ethical Considerations**

Research regarding human participants is regulated by federal law. Prior to this regulation many abuses occurred that resulted in harm to the participants (Ashcraft, 2004). In this quality
improvement project the human participants included the full time nursing staff, which consisted of four registered nurses, and supportive office personnel.

**Human Subject Protection**

The learner has taken the required course on protecting participants. Minority populations such as the gender non-conforming patient are at high risk for mistreatment, discrimination, and adverse outcomes. It is important to recognize that human subjects, especially minorities are at risk anytime research is conducted. This project did not collect any data from actual patients, and was designed to implement an assessment form designed in collaboration with the Director of Nursing to allow for nursing providers to have a more comprehensive picture of the patient. No patient data or patient identifying information was collected for data analysis. Normal HIPAA applications and measures to protect patient confidentiality remained at the clinic through the clinic approved policy and procedures.

The nursing staff and clinic staff that participate in the project are also human subjects. While these subjects are not a minority population that is already at high risk for complications, consideration must be given to potential risks related to participation in the project. The staff participation in this project is voluntary. Staff was not identified by name or number to protect individual identity. The project also went through an Internal Review Board (IRB) approval process to assess risk to human participants. This additional review further protected the staff.

**Inclusion and Exclusion Criteria**

The participation of the nursing staff remained voluntary and was in no way tied to the individual’s employment, licensure, or professional associations. Participation was anonymous in order to further protect participant responses and provide confidentiality. Surveys were not
assigned an identifying number or name, and were collected following administration by having the responder place it in an unmarked envelope. Registered Nurses, including Advanced Practice Nurses who work at the clinic were allowed to participate. Individuals who are not registered nurses are excluded from participation, this included medical assistants or nursing assistants. Participants who did not want to participate could also be excluded. Incomplete surveys were to be excluded.

Institutional Review Board

Per Capella University policy this project was reviewed by the Capella Institutional Review Board (IRB). IRB is used to analyze research projects to see if they could cause harm to the participants and is required by law (Ashcraft, 2004). The IRB committee at Capella University conducted a thorough review of this project. The IRB committee determined that oversight of this project is not required due to no potential risk to the participants. The clinic site does not require an additional review.

Results

Data was generated from this quality improvement project. Results from data analysis were utilized to determine if statistical significance existed. Data gathered from the project came from both the Inventory for Assessing Cultural Competence of Health Care Professionals (IAPCC-R 2002) and the formative assessment designed for use in this project based on educational objectives.

Findings

This quality improvement project began with the implementation of the patient self-assessment identification tool (Appendix B) at the clinic site. The project included education to the clinic nursing staff and clerical staff on care of the gender non-conforming patient. Prior to
the education a formative assessment was utilized and the nursing participants also took the IAPCC-R 2002 (Campinha-Bacote, 2007). The IAPCC-R 2002 has 25 Likert style questions to assess the participants’ level of cultural competence. Due to copyright restrictions the tool is not allowed to be attached to this manuscript. The IAPCC-R 2002 was given before the project was started and after the project was completed.

Pre-test data from the IAPCC-R 2002 showed that the majority of the participants, all registered nurses, were not culturally competent in providing care to the gender non-conforming population. The lack of cultural competence by the registered nurses was expected, as the literature noted that training for care of the LBGTQ population as a whole, which includes gender non-conforming, is inadequate (Ard, et.al., 2017). The education provided in the quality improvement project identified the gender non-conforming patient as a member of the LBGTQ population which is an underserved, at risk, minority culture. Results from the formative assessment (Appendix E) given before and after the education was provided confirmed the lack of cultural competency. The formative assessment provided real-time feedback on the participants level of understanding, which led to the implementation of a resources guide (Appendix F) along with a policy and procedure for the clinic (Appendix D). Nursing staff had reported on the formative assessment post-test that they wanted more guidance. Implementing the policy and procedure (Appendix D) and resource guide (Appendix F) were not in the original plan but were added to meet the needs of the clinic staff to ensure optimal use of the patient intake form (Appendix B).

Data from the IAPCC-R 2002 showed that most of the respondents did not feel adequately trained (before education) on the care of cultural needs of patients. Due to copyright restrictions the actual questions may not be reproduced in this manuscript. The IAPCC-R 2002
assesses the respondents perceived level of competency in five areas which are cultural awareness, desire, encounters, knowledge, and skill (Campinha-Bacote, 2007). The process of becoming culturally competent requires that an individual desires to have more knowledge about cultures that vary from the nurse’s own. Acquiring awareness, knowledge, skill, and encounters in many situations requires deliberate immersion into the topic. In the case of this quality improvement project many of the participants have had no encounters with the gender non-conforming patient. They have had some exposure to the topic of gender non-conforming and the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community through training for the clinic’s Human Immunodeficiency Virus (HIV) services, but not all staff participate in this program. On the IAPCC-R 2002 individuals can score as culturally incompetent (25 to 50), culturally aware (51 – 74), culturally competent (75-90), or culturally proficient (91-100). Each level indicates a higher level of self-awareness about other cultures. Three of the four registered nurses scored 65 out of 100 possible points, which corresponds to being culturally aware. One scored 79 out of 100 possible points which corresponded to being culturally competent, though this is on the lower end of the scale (75-90). The mean or average score of the nurses who participated in this survey was 68.5 indicating a lack of cultural competency. According to these results seventy-five percent (75%) of the nursing staff at the clinic are not culturally competent. Based on the pre-test results of the IAPCC-R 2002 from the four registered nurses there was room for growth for all participants in acquiring awareness of the gender non-conforming culture.

The majority of respondents reported a lack of knowledge and awareness on the IAPCC-R 2002 tool regarding the existence of genetic differences within cultural groups (Campinha-Bacote, 2007). This response is especially important when applied to the gender non-conforming patient due to the potential that the genetic gender may not match the gender identity of the
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Part of the education was to provide awareness to the nursing staff that individuals may vary in biological (genetic) and identified gender. This education included making the clinic nurses aware of the need to advocate for biologically appropriate care while meeting the identified gender needs of the patient (i.e. Prostate examination for a male to female patient).

After completing the project the clinic nurses completed the IAPCC-R 2002 again. On the posttest clinic nurses showed growth compared to pre-test results. The individual scores on the posttest ranged from 66 to 90 out of 100 possible points. This corresponded to a range of culturally aware to competent. The mean or average score on the post test was 77 which corresponds to a culturally competent result. This indicated growth as the pre-test mean score was 68.5 which corresponded to being culturally aware. On the posttest two of the four respondants scored in the culturally competent range, 78 and 90 respectivley. The other two respondants scored in the culturally aware range, 66 and 74 respectivley. This also showed growth as on the pre-test only 25% of the clinic nurses scored in the culturally competent range compared to 50% on the posttest.

The project was designed to improve the quality of care that the clinic provides to the gender non-conforming population. Based on the initial data, this project was successful. The clinic had 100% compliance with utilization of the self-identification patient intake form (Appendix B). The staff and patient verbal feedback was mostly receptive, and there was a measurable growth in the nursing staff’s perception of the ability to provide culturally competent care to the gender non-conforming patient. Further evaluation of the data was conducted by use of a paired T-test. A paired T-test is used to analyze data for statistical significance (MacMillan, 2007). To conduct the paired T-test the mean (average) result from the pre-test using the IAPCC-R 2002 was compared to the mean (average) result on the posttest using the IAPPC-R 2002. The
results of the T-test were 2.4. Lower T-test results indicate less of a significance when compared to higher T-test scores.

Sustainability

The clinic plans to continue use of the patient intake information self-assessment form (Appendix B) upon completion of the project. The form was designed be used by all patients on every encounter. Chart audits following the implementation of the project indicated one hundred percent compliance with use of the form. Input from the Director of Nursing in the design of the form allowed it to be used in place of prior intake forms. The information is completed by the patient, which did not require any additional work load to be placed upon nursing or non-professional clinic staff. The clinic staff reported throughout the project that the form was useful, and that it improved the ability to better assess patient needs.
The Director of Nursing also plans to pursue implementation of this project at other similar clinics throughout the State of Michigan. This plan was shared with the members of the Michigan Department of Health and Human Services Family Planning Advisory Council Meeting where this project was presented on October 23, 2018. Within the State of Michigan there has been an increased incidence of Human Immunodeficiency Virus (HIV) infections especially through male to male transmission (Michigan Department of Health and Human Services, 2018). The Michigan Department of Health and Human Services report on the epidemiology of HIV for 2018 also noted that within the state the incidence of HIV infection in transgender individuals is 17% compared to less than 1% of the general population. The increased risk of HIV infection in addition to the other health risks incurred by those identifying as gender non-conforming further support the need for the expansion and continuation of this project.

**Future Practice**

The clinic planned to continue to utilize the patient self-identification intake form (Appendix B). It is anticipated that this project will be implemented at other public health clinics throughout the State of Michigan. The project plan was shared with the Family Planning Advisory members during an annual meeting where participants reported interest in the results when completed. The State of Michigan has a noted increase in HIV infections specifically from male to male transmission (Michigan Department of Health and Human Services, 2018) it is not known how many of the male to male transmissions are the result of gender non-conforming individual encounters.
Further research on this topic is needed. The lack of current research from the nursing profession related to the gender non-conforming population combined with the lack of nursing specific surveys related to this population provides several venues for future projects. The quality improvement type project is useful for implementing evidence based practice solutions to meet immediate needs of the particular setting. However further study to create nursing specific care pathways, diagnosis, and interventions are needed. In the future the nursing profession needs to implement an across the board practice of allowing the patient to self-identify gender including non-conforming status at all clinics, hospitals, and other care locations. Increased education for nurses regarding the needs of the gender non-conforming population must also be included for nurses. Through increased education and utilization of best practices such as the patient self-identification intake form (Appendix B) it is anticipated that the gender non-conforming patient population will have a reduced avoidance of care, and that care received will be appropriate to the cultural needs of the patient.

Summary

The quality improvement project was designed to improve practice at a rural public health clinic for public health nurses. There were a total of four registered nurses that work at this clinic in northern Michigan which includes the Director of Nursing. Prior to the project the clinic did not have patients self-identify gender status and the gender status options to clinic staff were limited to male and female only. The clinic did offer HIV testing services on request and the federally mandated paperwork for the HIV clinic had a section for the one clinician to ask the patient about gender non-conforming status. None of the clinic staff had received formal training on the care of gender non-conforming patient. After discussing the project, the Director of Nursing became aware of one patient who identified as transgender and self-disclosed this to the
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clinician. The project consisted of implementing a patient self-identification intake form (Appendix B), assessing the clinic nursing staff’s perception of cultural competency in relation to the gender non-conforming patient, in addition to providing education to all clinic staff regarding the use of the intake form and needs of the gender non-conforming patient population.

The project was implemented on October 12, 2018 and concluded on November 30, 2018. Results from the Inventory for Assessing the Process of Cultural Competency Among Healthcare Providers Revised (IAPCC-R 2002), which was given to all four nursing participants prior to implementation of the project, resulted in 75% of the clinic staff scoring as not culturally competent. Lower scores were anticipated on the pre-test. Following the project, the IAPCC-R 2002 was given again to the four nursing participants. All participants showed growth from pre-test scores, though since scores were not assigned to participants and all participation was anonymous there was no way to track individual performance. At completion 50% of the clinic staff scored as culturally competent and all staff showed growth in cultural competency.

The clinic had 100% compliance with use of the patient self-identification intake form (Appendix B). The form was designed in collaboration with the Director of Nursing. It was designed to avoid increasing the paperwork burden of the clinic and to utilize best practice as recommended by the Fenway Institute for patients to be given the chance to self-identify (Bradford, Cahill, Grasso, & Mackadon, 2010). Clinic nurses and patients had positive feedback regarding the form and project in general. One nursing staff member had requested additional information and guidance, which was provided through a policy and procedure document and patient resource handout (Appendix D).

The project had several strengths. First was the use of the validated IAPCC-R 2002 tool. The IAPCC-R 2002 allowed for comparison of the nursing staff’s perceived level of cultural
competence in providing care to a population before and after project completion. Secondly was the ease of use with the patient self-identification intake form (Appendix B). The patients completed the form on arrival to the clinic and nurses were able to review quickly on each visit due to the one-page design. The anonymity of participants added additional strength to this project because it reduced the risks associated with Likert questions and participants desiring to answer the correct way. Patient anonymity was also a strength to this project. By not collecting patient identification information the project protects the patient. Patients who identify as gender non-conforming already report feeling that the medical community lacks understanding of the needs and concerns about discrimination (Almeidia, et.al., 2009) since the project is anonymous, (no patient identification information collected) this concern was eliminated.

**Interpretation**

The results of this project show a correlation between the interventions of this quality improvement project and the changes in the nurses perceived level of cultural competency as measured on the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals Revised (IAPCC-R 2002). The results lack statistical significance in part due to the extremely small sample size of only four nurse participants, and secondly due to the T-test score of 2.4 which is a low result. The clinic did have full compliance with implementing the patient self-identification assessment tool (Appendix B) and all patients identified biologic gender and identified gender status. At the time of this project no gender non-conforming patients presented to the clinic. Currently there are no projects to compare this quality improvement project to.

There remains a lack of knowledge and data regarding the nurses’ role in the care of the gender non-conforming patient. This lack of knowledge has had a negative impact on patient care which has been noted by poor patient outcomes including increased risk of suicide and self-harm (Haas
& Rodgers, 2014). The quality improvement project has a positive impact on the gender non-conforming patient population in that it allows them to self-identify status in a discrete, professional manner while still allowing them to receive culturally appropriate care. Project outcomes met the expectations of the project in that initial scores on the IAPCC-R 2002 were lower indicating a lack of cultural competency and following the project scores on the IAPCC-R 2002 showed growth across the board.

**Limitations**

The study is limited in several ways. First the small sample size of the survey participants is a limitation as there are only four full time nurses on staff, which includes the Director of Nursing. The clinic does have several non-nursing paraprofessional and clerical staff that will participate in the education and project, however due to lack of professional credentials are ineligible to participate in the Inventory for Assessing Cultural Competence Revised (IAPCC-R 2002) measure of perceived cultural competency to provide care for the gender non-conforming patient. The lack of nursing specific resources for the care of the gender non-conforming patient requires that resources for other disciplines in the health profession and education profession are utilized. This is an underserved population for nursing care, and the nursing profession is currently undereducated in how to provide culturally competent care to the gender non-conforming patient. This is evidenced by the position of the American Nurses Association to treat all patients “the same” (American Nurses Association, 2017). Third is the location of the clinic is in a rural northern Michigan area, and the gender non-conforming individual population is larger in more urban areas, the gender non-conforming individual is also not likely to seek non-emergent care due to perceived lack of understanding by medical staff.
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(Grant, et al., 2011). This means that the staff may not encounter a gender non-conforming patient during the month the project is being conducted.

Conclusions

This quality improvement project was designed to answer the PICOT question for public health nurses in a rural health clinic (P), will a quality improvement project aimed at providing education related to the care of gender non-conforming patients and implementation of gender self-identification (I) improve the nurses perceived cultural competency and identification of transgender individuals (O) compared to current practice (C) over 6 to 10 weeks (T)? The project was designed to implement a patient self-identification assessment form that allowed patients to choose gender identity including non-conforming identities. It also included education for nursing and clinic staff regarding the needs of the gender non-conforming patient. The project utilized the IAPCC-R 2002 tool to assess the nurses’ perception of cultural competency in providing care to the gender non-conforming population. Gender non-conforming individuals are a member of the LBGTQ population which is a minority population that are currently underserved by the nursing profession. Data from the IAPCC-R 2002 showed that the nurses lacked cultural competency on the initial assessment, growth was noted on the post assessment by all participants. The results lacked statistical significance, with a T-test result of 2.4 in comparing the pre and posttest results. There were some limitations to the study including a small samples size and rural location. Future study is recommended due to the lack of nursing specific data to provide care to the gender non-conforming patient. This lack of information was especially noted in the literature review process for this project. Gender non-conforming individuals have an elevated risk of depression, self-harm, and suicide. They also report avoiding care due to providers not understanding the needs of the patient culture. This project sought to
address nursing provider understanding. The project was successful in that the intake information form was utilized by all clinic patients, clinic nursing staff showed growth in perceived ability to provide culturally competent care, and anecdotal information was affirmative of the positive impact the project had on the clinic. The Director of Nursing and this learner would like to have this project implemented at all clinic sites across the State of Michigan.
REFERENCES


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Appendix B - Assessment Form

Patient intake information

Name: ______________________________________   Birthday: ___________________

Preferred name: _______________________________   Age: ______________________

Gender (circle all that apply): Male Female Transgender (specify below)

Male to Female   Female to Male   No gender identity Other

Specify other: __________________________________

How do you prefer to be addressed: He/Him   She/Her   You/Your   legal name only   preferred name only

Gender assigned at birth select one: Male   Female
Appendix C – Permission Request and Approval

Initial Permission Request
Melissa K. Haworth MSN RN

Dear Dr. Josepha Campinha-Bacote;

My name is Melissa Haworth, I am a DNP student at Capella University. I am in the process of completing my practice immersion project which is a quality improvement project regarding the public health nurse working with individual’s who identify as gender non-conforming. This project is called “Nurse’s role in patient gender identification” and focuses on the nurses working in public health at a rural northern Michigan clinic.

As part of this project I would like to utilize your IAPCC-R (2002) tool to assess the cultural competency of the nurse and staff. The project will include survey using the IAPCC-R (2002) tool prior to implementation of a tool to allow for the nurses and clinic staff to have the patient self-identify gender and preferred pronoun association. The nurses and staff will receive education based on culturally competent care for the gender non-conforming patient and implementation of the tool with supportive education will occur for a period of one month. Following the month the nurses and clinic staff will be surveyed again using the IAPCC-R (2002) tool to assess for growth in the level of cultural competence the nurses and clinic staff report.

I would like to request one copy of the tool to submit electronically for IRB approval of the project between April 23, 2018 and June 30, 2018. As mentioned in our call, my professor and mentor Dr. Mattie Burton anticipates that we will have be able to obtain approval by the end of
May, 2018 if everything goes as planned. Upon IRB approval I will then request a total of 16 copies to utilize for the professional staff at the clinic nurses and advanced practice nurses for pre and post intervention testing.

I appreciate your willingness to allow me to utilize your IAPCC-R (2002) tool for the completion of my DNP practice immersion project.

Sincerely,

Melissa K. Haworth DNP candidate

Request for Additional Use for DNP Committee and IRB

June 21, 2018
Melissa K. Haworth

Dr. Josepha Campinha-Bacote

Dear Dr. Josepha Campinha-Bacote,

Thank you again for the previous permission to utilize one copy of the IAPCC-R (2002) tool for electronic submission to submit to IRB electronically for approval. My project received topic level approval on June 13, 2018 from the DNP Committee at Capella University. However, the committee required additional revisions and has requested to also see the IAPCC-R (2002) tool prior to being released to IRB for review.

I am writing to request approval to allow for electronic submission of the IAPCC-R (2002) tool to submit to my DNP committee for final project approval and an extension to the approval to utilize one copy of the IAPCC-R (2002) tool for electronic submission to the IRB committee for approval of my DNP project.
I would like to request this approval for the time period of 6/22/2018 through 7/22/2018 for electronic submission to the DNP committee and then to IRB for final project approval. I understand if additional fees are required and am happy to submit payment for the use of this tool.

Thank you in advance for assisting me in the pursuit of my DNP by allowing me to utilize the IAPCC-R (2002).

Sincerely,

Melissa K. Haworth

Request for Use in Project

Melissa K. Haworth MSN RN

Dr. Josepha Campinha-Bacote

September 11, 2018

Dear Dr. Josepha Campinha-Bacote;

My name is Melissa Haworth, I am a DNP student at Capella University. I am in the process of completing my practice immersion project which is a quality improvement project regarding the public health nurse working with individual’s who identify as gender non-conforming. This project is called “Nurse’s role in patient gender identification” and focuses on the nurses working in public health at a rural northern Michigan clinic.

As part of this project I would like to utilize your IAPCC-R (2002) tool to assess the cultural competency of the nursing staff. The project will include survey using the IAPCC-R (2002) tool prior to implementation of a self-identification form that will allow for the nurses and clinic staff to have the patient self-identify gender and preferred pronoun association. The nurses and staff
will receive education based on culturally competent care for the gender non-conforming patient and implementation of the tool with supportive education will occur for a period of one month. Following ten weeks the nursing staff will be surveyed again using the IAPCC-R (2002) tool to assess for growth in the level of cultural competence the nurses and clinic staff report.

I would like to request eight copies of the tool to utilize for hand delivery of the initial testing (before the intervention) and then again after completion of the project (10 weeks after start date). The tentative dates are September 24 through December 31, 2018. I appreciate your willingness to allow me to utilize your IAPCC-R (2002) tool for the completion of my DNP practice immersion project.

Sincerely,

Melissa K. Haworth DNP candidate
Date: April 23, 2018

To: Ms. Melissa Haworth
From: Dr. Josepha Campinha-Bacote
        President, Transcultural C.A.R.E. Associates

RE: Contractual Agreement for Limited Use of the IAPCC-R

This letter grants permission to Ms. Melissa Haworth to use my tool, "Inventory for Assessing the Process of Cultural Competence Among Professionals-Revised (IAPCC-R)" to submit to the IRB Committee. I have received payment of $20 for 1 tool to be used in this electronic submission.

TIME FRAME: Permission to copy/use the IAPCC-R is granted for a one-time use before June 30, 2018. **Upon July 1, 2018, any copies must be destroyed.** If Ms. Melissa Haworth receives approval to use the IAPCC-R, another formal letter of request for permission to use the IAPCC-R in the actual study and payment for the cost of additional tools will be required.

ADMINISTRATION: This permission only grants submitting the IAPCC-R for her IRB proposal submission and therefore does not grant any form of administration of the IAPCC-R to any individuals/participants.

RESTRICTIONS OF COPYING: Ms. Melissa Haworth agrees that the IAPCC-R cannot be copied or reproduced in its entirety nor can any of the 25 items of this tool be copied for any reason. This includes, but not limited to, being copied in formal or informal publications, in a dissertation or thesis, in an academic paper/project, as handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic formats. The IAPCC-R is only to be used for the above purpose of submitting it to be reviewed the IRB Committee.

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.
ATTORNEY’S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney’s fees and costs.

Thank you for complying with the requests of using this copyrighted tool. I look forward to the possibility of hearing from you if you’re your proposal is accepted. Best of luck in your submission.

Name: [Redacted]
Date: 4/23/18

Name: [Redacted]
Date: 4/23/2018

Ms. Melissa Haworth
Date: August 6, 2018
To: Ms. Melissa Haworth
From: Dr. Josephine Campinha-Bacote
RE: Contractual Agreement for Limited Use of the IAPCC-R

This letter grants permission to Ms. Melissa Haworth to use my tool “Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) to submit to the DNP Committee and IRB Committee. I have received payment of $40 for two tools to be used in this electronic submission.

TIME FRAME: Permission to copy/use the IAPCC-R is granted for a onetime use only during the months of August 10, 2018 through December 31, 2018. If Ms. Melissa Haworth receives approval from the Committees she will have to submit another formal letter of request for permission to use the IAPCC-R in the proposed study and submit payment for the cost of additional tools.

ADMINISTRATION: This permission only grants submitting the IAPCC-R to the IRB and DNP Committees and therefore does not grant any form of administration of the IAPCC-R to any individuals/participants.

RESTRICTIONS OF COPYING: Ms. Melissa Haworth agrees that the IAPCC-R and any of its 25 items cannot be copied or reproduced for any other reason. This includes, but not limited to, being copied in formal or informal publications, in a doctoral paper/project, DNP project, dissertation or thesis, in any academic paper, handouts for presentations, in any Powerpoint or Poster presentations or in any hard copy or electronic formats. The IAPCC-R is only to be used for the above purpose of submitting it in a proposal to be reviewed by the DNP and IRB Committees.

GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court seated in the County of Hamilton, Ohio.

ATTORNEY’S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded
Date: September 19, 2018

To:  Ms. Melissa Haworth 

From: Dr. Joeapa Campinha-Bacote 
President, Transcultural C.A.R.E. Associates 

RE: Contractual Agreement for Limited Use of the IAPCC-R 

This letter grants permission to Ms. Melissa Haworth to use my tool, Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R), to assess the level of cultural competence of 4 healthcare providers. I have received $64 for 8 tools for this pre/posttest study. 

TIME FRAME: Permission to use the IAPCC-R is time-limited to be used from October 1, 2018 through December 31, 2018. Upon January 1, 2019, all unused tools must be destroyed. 

ONSITE ADMINISTRATION: This onsite permission only grants administration of the IAPCC-R via an onsite pencil and paper administration in which Ms. Melissa Haworth personally hand-administers the tool to each participant and immediately collects these tools following its completion. Ms. Melissa Haworth agrees that the IAPCC-R cannot be administered in an offsite format such as in an online course, internal or external mailings, or via an Internet website offering without granted permission. 

RESTRICTIONS OF COPYING: Ms. Melissa Haworth agrees that the IAPCC-R nor any of its 25 items cannot be copied or reproduced for any other reason. This includes, but not limited to, being copied in any formal or informal publications or presentations, a dissertation, a DNP project/paper, Capstone project, or thesis, in any academic papers, as handouts for presentations, nor for any PowerPoint or Poster presentations or in any hard copy or electronic formats. The IAPCC-R is only to be used for the above purpose of administering this tool in this above study to only these 4 participants. 

PUBLICATIONS: Ms. Melissa Haworth agrees that any publications (formal or informal) or presentations of the findings of the study using my tool will be shared with me. 

www.transculturalcare.net 
11108 Huntwick Place 
Cincinnati, Ohio 45241
GOVERNING LAW: All parties acknowledge that this Contractual Agreement for Limited Use of the IAPCC-R is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

ATTORNEY’S FEES AND COSTS: In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney’s fees and costs.

Signature
Date 9/19/20

Signature
Date 9/24/2018

Ms. Melissa Haworth
Appendix D

Suggested Policy and Procedure for Gender Identity QI project

**Purpose:** Participation in gender identification project with DNP student from Capella University to improve identification and care for individual gender identity among patients at the clinic. Currently patients who enter the clinic are not able to express gender identity aside of male or female (unless seeking HIV testing). Research has shown that individuals who identify as gender non-conforming are at higher risks for substance abuse, mental illness, suicide attempts, self-harm, and may not be receiving appropriate care based on biological needs versus gender identity.

**Definitions:**

- Androgynous: Having both male and female sex characteristics
- Biological gender: Gender assigned at birth, male XY chromosome, female XX chromosome, some individuals are born androgynous (rare).
- Cisgender: An individual who identifies as their biologically assigned gender
- Female to Male: Biological female identifying as male
- Gender fluid: An individual whose gender identity may change from male to female or both
- Gender non-conforming: Any individual who has a gender identity that is not congruent with their biological assigned gender
- HIV: Human Immunodeficiency Virus
- LBGTQ: Lesbian, Bisexual, Gay, Transgender, Questioning
- Male to Female: Biological male identifying as female
- Pangender: Identifies as more than one gender
- Other: Any other form of gender identification not previously mentioned
- STD: Sexually Transmitted Disease
- Transsexual: Identifying as opposite of the biological assigned gender
- Questioning: Undecided about gender identity

**Policy:**
To provide best care to all patients the participation in a quality improvement project to implement a patient self-identification intake form will occur from October 12, 2018 through November 30, 2018. Patients will complete the form on arrival to clinic for all services on all visits. Nursing staff will assess form and implement procedure when individuals who identify as gender non-conforming or other.

**Procedure**

1. On arrival at the Personal Health Clinic desk the clerk will provide the patient with the new intake form.
2. Patient will complete the intake form.
3. Nurse will assess the patient intake form when patient is taken to the room for care.
4. If patient has NOT identified as gender non-conforming (transgender, other, etc.)
   a. Nurse will continue with patient care, no further action required.
5. If patient HAS identified as gender non-conforming (transgender, other, etc.)
   a. Nurse will implement further assessment practice
      i. Document and utilize preferred pronoun/name
      ii. Review medication(s)
         1. Is the patient taking hormone therapy?
      iii. Review physical history
         1. Surgical procedures?
      iv. Assess patient for depression, anxiety, self-harm, or substance abuse (rationale patients who identify as gender non-conforming have elevated risk for this).
      v. Assess patient for abuse (rationale patients who identify as gender non-conforming are at higher risk for abuse).
      vi. Assess all systems pertinent to the reason for visit (be sure to address biological gender needs/systems as well).
6. Provide patient education and support for all patients
   a. Resource list for support services including counseling
   b. Education on health (including biological health needs)
   c. Acknowledge the patient as their preferred gender identity and name
   d. Ask the patient if they have questions, needs, or concerns
7. Inform physician of patient status
   a. Current guidelines are that patients should have counseling for a minimum of 2 years prior to surgical alteration
   b. Medications such as hormonal replacements or suppressants
      i. Patients will need to be informed of the risks and effects (i.e. increased risk of blood clot, cancers, changes in bone mass, physical appearance, etc.)
   c. Assessment requires both the biological gender and physical gender are addressed
      i. Preventative care screenings such as PSA, mammogram, PAP smear
      ii. Reproductive health counseling
1. STD testing annually
   a. Males (even Male to Female transgender) who have sex with males are at elevated risk for HIV, and other STD.

   Be understanding and address patient by identified gender status and preferred name/pronouns.
Appendix E- Formative Assessment

Formative Assessment of Educational Objective

1. Patients with gender identity questions are at higher risk for self-harm
   a. Strongly agree
   b. Agree
   c. Neutral
   d. Disagree
   e. Strongly disagree

2. Patient’s with gender identity questions are seeking attention
   a. Strongly agree
   b. Agree
   c. Neutral
   d. Disagree
   e. Strongly disagree

3. Gender identity disorder is a mental illness that requires treatment
   a. Strongly agree
   b. Agree
   c. Neutral
   d. Disagree
   e. Strongly disagree

4. Patients with gender identity questions could have low self-esteem
   a. Strongly agree
   b. Agree
   c. Neutral
   d. Disagree
   e. Strongly disagree

5. As a RN I feel prepared to provide holistic care to the patient with gender identity questions
   a. Strongly agree
   b. Agree
   c. Neutral
   d. Disagree
   e. Strongly disagree
6. Describe what concerns you have related to providing care to the patient with a gender identity question.

7. Do you feel that nurses can have an impact on the patient who has a question about their gender identity?

8. Gender identity is related to an individual's upbringing? (I.e. parents letting boys play with dolls, girls playing with tractors, etc.)

9. What do you think is the cause of gender identity questions in patients?

10. Do you feel that a nurse should differentiate care for individuals who identify as members of the LBGTQ community? Why or why not?

11. Describe what you think a gender non-conforming patient is?
Appendix F – Resources for patients

Counseling:
Behavioral health services at Alpena Regional Medical Center 989-356-7242 or 800-288-7242
Blooming Consultants in West Branch, MI 989-702-2792
Great Lakes Bay Health Center in Bay City, MI 989-671-2000
MPA Group in Bay City, MI 989-667-9661
Timothy Paul Bronson in West Branch, MI 810-479-5074

Support groups:
PFLAG – Bay City, MI [http://www.pflagtricities.org/contact-us.html]
  - Monthly meetings
  - Clothing services, family support
Perceptions- Midland, MI 989-891-1429
  - Meetings 2 times monthly
  - Access to multiple resources for legal help, mental health, support groups
Transgender Michigan- [http://www.transgendermichigan.org/]
  - Crisis line -855-345-8464
  - Information and support

Social Groups:
Facebook - Ogemaw County Transgender Support and Awareness