CE

1.0
ANCC
CONTACT HOUR

Increasing cultural competence with LGBTQ patients

BY LIZ MARGOLIES, LCSW, AND CARLTON G. BROWN, PhD, RN, AOCN, NEA-BC, FAAN

Abstract: Many nurses practicing today lack basic education about LGBTQ (lesbian, gay, bisexual, transgender, queer) patient care. How can they better prepare to care for this population? This article provides insight on LGBTQ people, their health risks and disparities, and how nurses can work with LGBTQ patients to improve outcomes.

Keywords: bisexual, gay, gender identity, gender minorities, lesbian, LGBTQ, queer, sexual minorities, sexual orientation, transgender

GD, a 63-year-old White gay male recently diagnosed with prostate cancer, was admitted to the hospital for a radical prostatectomy. Angie is the RN working on the surgical unit where GD is recovering from surgery. Although she has worked extensively with men following prostate surgery, she worries because she has little experience caring for a gay man undergoing the same surgery. GD and his husband had many questions for Angie about the impact of the surgery on their sexual relationship. Angie appreciated their openness about their relationship and concern but was unprepared to answer any of their questions.

Key terms and concepts

LGBTQ (lesbian, gay, bisexual, transgender, queer) is an umbrella term for two distinct facets of identity: sexual orientation and gender identity. Everyone has a *sexual orientation*; lesbian and gay people are mostly attracted to people of the same sex, romantically and sexually, while heterosexuals are mostly attracted to people of the opposite sex. People who identify as bisexual (or pansexual) are capable of attractions to people of all genders. It is important to keep in mind that sexual orientation is an identity label and may not correspond to the full range of a person's sexual behavior.

Everyone also has *a gender identity*; transgender people identify as a sex

TRIFF / SHUTTERSTOCK

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

other than the one they were assigned at birth, whereas cisgender people identify with the sex they were assigned at birth. *Transgender* people include those who may identify as nonbinary, or gender queer, meaning that their gender identity is not exclusively male or female. When obtaining a sexual history, nurses should ask about both identity and behavior to better understand a patient's health risks and recommended screening tests.

The two groups under the LGBTQ umbrella (sexual orientation and gender identity) are distinct; knowing a person's sexual orientation does not imply any specific gender identity. Transgender people may identify as heterosexual, homosexual, bisexual, or none of the above. For example, a transgender woman (assigned male at birth) may identify as a lesbian (with an attraction to women) and desire to have relationships with women.

LGBTQ in the US

The lack of appropriate questions pertaining to gender and sexual identity in most national or state surveys makes it difficult to estimate the number of LGBTQ individuals and their healthcare needs. The fact that there are three major markers of sexual orientation—attraction, behavior, and identity—exacerbates the difficulty in determining exactly how many LGBTQ people currently reside in the US. Depending on which reference point one draws upon to quantify the community, the answer to "How many people are LGBTQ in the US?" varies greatly. The LGBTQ community includes people of every race, ethnicity, religion, age, and socioeconomic group. Historically, communities that have been targeted by the state for discrimination and violence are less likely to identify themselves on government surveys as LGBTQ, further confounding the search for exact numbers.[1]

The National LGBTQ Task Force Policy Institute estimates the LGBTQ population (people who identify as LGBTQ or create family or sexual affiliations that involve people of the same sex) as somewhere between 5% and 10% of the general population.[1] However, according to the Williams Institute, about 3.5% of Americans identify themselves as lesbian, gay, or bisexual, and 0.3% identify themselves as transgender.[2] With this lower number, the LGBTQ community includes over 8 million people, roughly the population of New Jersey.

As the culture becomes more accepting, an increasing number of young people are coming out. A 2017 Harris Poll found that 20% of people between ages 18 and 34 identify as LGBTQ.[3] A 2016 study by trend forecasting agency J. Walter Thompson Innovation Group found that only 48% of 13- to 20-year-olds in the US identify as "exclusively heterosexual."[4]

LGBTQ health disparities

As a group, LGBTQ people experience significant health disparities, caused by a combination of barriers to care and minority stress. The National Academy of Medicine and National Institutes of Health have formally recognized these disparities, and in 2016 *sexual minorities* and *gender minorities* (the research terms for LGBTQ people) were designated as health disparity populations for research purposes.[5]

LGBTQ people experience multiple barriers to quality and timely healthcare across the lifespan. First, they have lower rates of health insurance coverage.[6] Despite huge gains in coverage since the Patient Protection and Affordable Care Act went into effect, LGBTQ people remain twice as likely to be uninsured compared with their non-LGBTQ peers.[7,8] In addition, fewer LGBTQ people have a regular healthcare provider than their heterosexual counterparts.[9]

A long history of LGBTQ bias in the healthcare system continues to make these populations avoid or delay treatment. While explicit bias is less common today, research shows that implicit bias is still active.[10,11] A 2015 study found that heterosexual nurses held strong implicit preferences for heterosexual people over gay and lesbian people.[12] Even well-meaning healthcare providers often lack education about LGBTQ health issues. A national 2015 survey found that the estimated median time devoted to teaching LGBTQ health in nursing school was 2.12 hours.[13] In another study of practicing nurses, most reported that they had no training in LGBTQ health.[14] If nurses lack basic education about LGBTQ patient care, they may, as a result, have negative attitudes, endorse stereotypes, and/or feel uncomfortable providing care to LGBTQ people.

The minority stress model explains how chronic stress arising from living as a sexual or gender minority individual results in poorer health and earlier deaths in LGBTQ people.[15-19] These result from a combination of factors, including the stress of concealment, discrimination, and stigma, as well as institutional stigma such as noninclusive policies.[20] In one study, lesbian, gay, and bisexual respondents in states without protective policies were five times more likely than those in other states to have two or more mental disorders.[21] In fact, another study found that LGB people who live in communities with high levels of antigay prejudice die 12 years earlier than their peers in other communities.[22]

On an individual level, multiple studies have shown a direct relationship between discrimination and poor health. As a group, LGBTQ people experience higher rates of depression, suicidal ideation, anxiety,

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

heavy drinking, smoking, cardiovascular disease, and interpersonal violence than non-LGBTQ people.[23] (See *Health disparities in LGBTQ people*.) Forty percent of all homeless youth are LGBTQ.[24] Lesbian and bisexual women are less likely to receive preventive services for cancer, even if they possess one or more risk factors for breast cancer (nulliparity, tobacco use, alcohol use, and high body mass index).[25,26] Many of these health disparities begin in youth, when LGBTQ adolescents may first experience discrimination. In 2016, the Youth Risk Behavior Survey showed that 34% of LGBTQ teens were bullied in school, 18% were forced to have sex, 23% were the victims of sexual violence, and 18% experienced physical violence.[23]

The increased victimization, or bullying, of LGB youth is associated with increased rates of tobacco use.[27] Similarly, gay college students are more likely to smoke when they have to conceal their sexual orientation.[28,29] In contrast, LGBTQ youth who live in more supportive communities with LGBTQ-friendly policies and student groups have a substantially lower risk of tobacco use.[30,31] It is worth noting that a high rate of tobacco use among LGBTQ people is partly due to the aggressive marketing to LGBTQ populations by tobacco companies via community events, promotions, and direct advertising.[32]

Health disparities in LGBTQ people[23]

According to Healthy People 2020:

- LGBTQ youth are more likely to be homeless and two to three times more likely to attempt suicide.
- Lesbians are less likely to get preventive screening services for cervical cancer.
- Gay and bisexual men are at higher risk for sexually transmitted infections, especially in communities of color.
- Lesbians and bisexual females are more likely to be overweight or obese.
- Transgender individuals are at increased risk for being victims of violence and have a high prevalence of sexually transmitted infections, mental health issues, and suicide; they are also less likely to have health insurance than heterosexual or lesbian, gay, or bisexual individuals.
- Older LGBTQ individuals face additional barriers to healthcare because of isolation and a lack of social services and culturally competent providers.
- LGBTQ individuals have the highest rates of tobacco, alcohol, and drug use.

Nursing considerations

Without adequate training, nurses may think that the "I treat all my patients the same" approach will help LGBTQ patients feel safe and welcome. It does not. LGBTQ patients may use different language for their bodies, rely exclusively on their "family of choice" (people with whom they may or may not have any legal ties) for support, have distinct fertility needs, or may be estranged from their families of origin. Instead, a patient-centered approach encourages nurses to understand the unique social conditions of each person they treat. At the same time, patients need to know that their healthcare providers want to know who they really are and that the information will be respected and honored.

Several nursing interventions will directly improve the care of LGBTQ patients. In-depth cultural competence training offers more skills training and wider knowledge of LGBTQ health disparities, but some simple changes can be made immediately and signal welcome and safety to LGBTQ patients.

To start, nurses must understand that LGBTQ identities are intersectional and multilayered.[33] A patient's experience of the world in general—and healthcare in particular—is influenced by the intersection of multiple social identities, including race, age, and class, in addition to sexual orientation and gender identity. For example, an able-bodied Black lesbian patient may enter the healthcare setting with a different set of concerns and challenges than a White lesbian with a disability. Some aspects of patients' identities may be obvious or public, and others may be private or hidden. Still, patients fare better when they feel safe bringing their full selves into treatment.

Encouraging SOGI disclosure

Disclosure of sexual orientation and gender identity is rarely listed on intake forms, as most have limited options for choosing one's sex and relationship status. According to Margolies and Brown, "regardless of the institution's intake forms, nurses should make it part of their respective practice during the assessment to routinely ask their patients, at all points on the care continuum, about their SOGI (sexual orientation and gender identity)."[33] Without being directly asked on a medical intake form or being asked in person, LGBTQ people may wonder if it is safe to disclose their identities or if doing so could result in substandard care.[33] Gathering SOGI data can also increase the ability to screen, detect, and prevent conditions more common in LGBTQ (including health and risk behaviors); assist in a better understanding of patients' support systems; and provide needed data for outcome research.

Recent research suggests that clinicians and patients hold discordant views about asking questions about sexual orientation. In one study, when queried in an ED, only 10% of LGB patients reported that they would refuse to provide sexual orientation information; however, over three-quarters of the clinicians

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

thought patients would refuse to provide sexual orientation.[34] In another recent study of 544 sexual or gender minority patients seen in EDs, the participants reported improved communication and greater comfort when SOGI was collected via nonverbal self-reports, such as on registrar forms.[35]

In other words, LGBTQ people want to disclose their sexual or gender identity, but some might prefer not to do it verbally. However, in the absence of inclusive forms, nurses should not assume that all patients are cisgender and heterosexual, or that all LGBTQ patients use identical language to discuss their bodies, their pronouns, and their relationship partners. Open-ended questions allow patients to describe themselves using the words that are most relevant to their own identities. It is important to also ask if the patient is okay with the information being documented in the patient's medical record.

In the medical record, nurses can encompass both legal and preferred names as well as gender-affirming pronouns (for example, *Jennifer White, known as Jason, is a 25-year-old transgender man with a chief complaint of abdominal pain and diarrhea*).[36] Nurses could also check in with patients frequently, realizing that as identities change, the names and words that patients prefer to be referred to may change as well.[36]

Training staff in LGBTQ cultural competence

To provide the best treatment to LGBTQ patients, nurses need to understand LGBTQ culture, language, and barriers to high-quality healthcare.[33] As mentioned earlier, most nurses and healthcare providers have not been adequately trained in these areas. Nurses can spearhead the movement to bring this training to their staff; multiple organizations, national and local, offer high-quality training in various formats.

Patients need to know that their healthcare providers want to know who they really are and that the information will be respected.

Cultural competence training refers to a wide range of proficiencies, including cultural knowledge, welcoming attitudes toward diverse populations, and skills in communicating with people from different groups.[33] According to The Joint Commission, "Cultural competence requires organizations and their personnel to do the following: (1) value diversity, (2) assess themselves, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of individuals and communities served."[37]

For nurses employed by organizations where LGBTQ clinical competence is lacking or absent, several governmental and nongovernmental organizations offer this training.[38] These three nationally respected organizations offer LGBTQ cultural competence for healthcare professionals:

- GLMA: Health Professionals Advancing LGBT Equality (www.glma.org) offers a free online 3-part webinar series; the slides from the presentations can also be downloaded
- National LGBT Cancer Network (http://cancer-network.org) provides individual and agency-wide LGBT cultural competence training and a free best practices publication for health and social service agencies
- National LGBT Health Education Center (www.lgbthealtheducation.org) provides an array of learning modules, publications, and technical assistance specific to LGBT health issues.

Creating a culturally competent system of care

While it is important for nurses to establish their own individual cultural competence in LGBTQ care, it is equally important to assess for a culturally competent healthcare system. Because nurses often spend significant time with patients, they are in an ideal situation to lead healthcare organizations and other healthcare providers to improvements in LGBTQ care through nursing leadership. System change is slower than individual change and works best with an advisory committee or workgroup of other like-minded providers. Nurses should consider creating a committee that is multidisciplinary by inviting social workers, physicians, dietitians—all healthcare professionals—to the team, as well as LGBTQ community members.

Once a committee has been formed, that team can decide where to place their initial emphasis. Some areas of focus might include:

- *Organizational nondiscriminatory statement*. This statement, posted prominently in waiting rooms, should be inclusive and visible if it is going to be an effective tool for reaching and welcoming LGBTQ individuals and their families,

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

specifically mentioning sexual orientation and gender identity.[39]

• *Patient education materials.* These should reflect a diverse patient population, including LGBTQ people, and use language that is inclusive of this population.[33]

• *Transgender care.* Transgender people have additional difficulties in accessing transition-related services. Nurses can be the voice for transgender and gender-nonconforming patients; if these services are not offered within your healthcare system, find local resources and have referral information available.[33]

• *Creating an inclusive workplace for LGBTQ employees.* According to Acquaviva, "For your organization to be a place where LGBTQ individuals and their families feel safe and comfortable accessing services, it needs to be a place where LGBTQ employees feel safe, comfortable, and valued. Work with your organization's human resources department [to ensure] inclusivity in employee benefits, orientation, and training."[39]

Nurses and other healthcare professionals who are interested in working together to create culturally competent organizations must realize that this work does not happen quickly. There can be many barriers and setbacks in creating environments where LGBTQ patients and their families are willing to come for care. Nurses on diversity and inclusion committees should remain persistent, tactful, polite, and always professional as they work to transform an organization into one that clearly articulates its commitment to inclusion and nondiscrimination for all patients, including LGBTQ people.[39]

Working with LGBTQ patients

Like all other patients, LGBTQ patients should be placed in the center of care and be allowed to make decisions about their own care. Rossi and Lopez recommend that nurses work *with* LGBTQ patients, rather than *on* LGBTQ patients.[36] By forming this type of patient-provider relationship with LGBTQ patients, nurses may also increase patients' engagement in shared decision-making and trust.[36] A culturally competent (and LGBTQ-welcoming) nursing workforce will improve care to LGBTQ patients by improving communication and trust in the therapeutic relationship; giving nurses access to valuable information about patients' support systems, health risks, and psychoeducational needs; and improving shared decision-making. The journey to creating an inclusive and LGBTQ-welcoming organization may not happen overnight, but by working together as an interdisciplinary team, eventually, positive healthcare change can happen for LGBTQ patients and their families.

Care for GD

Through self-assessment, Angie determined that she did not feel completely prepared to care for GD or other LGBTQ patients. She arranged to attend an online series of webinars that focused on cultural competence for LGBTQ patients. Following that education, Angie began to ask LGBTQ patients how they wanted to be referred to specific to a preference of pronouns, body parts, and first names. She began including patients' legal and preferred names as well as gender-affirming pronouns in her individual documentation in each patient's electronic medical record.

Angie formed an LGBTQ Care Committee of other interested nurses and healthcare professionals with the goal of creating hospital-wide culturally competent education as a mandatory class requirement for all employees. In addition, the committee is reviewing the medical record intake form to include more information specific to LGBTQ patients to include the names, pronouns, relationship status, and gender identity that they prefer to use. Angie and her colleagues realize that much work needs to be done to better the care of LGBTQ patients but also feel that they have made great initial strides in that arena. ■

REFERENCES

1. Grant J. *How Big Is the LGBT Community? Why Can't I Find This Number?* Washington, DC: National Gay and Lesbian Task Force; 2010.

2. Gates GJ. How many people are lesbian, gay, bisexual and transgender? The Williams Institute, UCLA School of Law. 2011. https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/how-many-people-are-lesbian-gay-bisexual-and-transgender.

3. GLAAD. Accelerating Acceptance 2017: a Harris Poll survey of Americans' acceptance of LGBTQ people. 2017. www.glaad.org/files/aa/2017_GLAAD_Accelerating_Acceptance.pdf.

4. Wong CM. Study sheds insight into teen sexuality, and it may surprise you. HuffPost. 2016. www.huffingtonpost.com/entry/teen-sexuality-survey_us_56e827f4e4b0860f99da5ef0.

5. Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.* Washington, DC: National Academies Press; 2011.

6. Baker K, Durso LE, Cray A. Moving the needle: the impact of the Affordable Care Act on LGBT communities. Center for American Progress. 2014. www.americanprogress.org/issues/lgbt/reports/2014/11/17/101575/moving-the-needle.

7. Gates GJ. In US, LGBT more likely than non-LGBT to be uninsured. Gallup. 2014. https://news.gallup.com/poll/175445/lgbt-likely-non-lgbt-uninsured.aspx.

8. Ward BW, Dahlhamer JM, Galinsky AM, Joestl SS. Sexual orientation and health among U.S. adults: national health interview survey, 2013. *Natl Health Stat Report.* 2014;(77):1-10.

9. Gounder C. LGBT people suffer from poorer health. Doctors must work to change that. *The Guardian.* 2016. www.theguardian.com/commentisfree/2016/jun/29/lgbt-health-disparities-stigma-us.

10. Fallin-Bennett K. Implicit bias against sexual minorities in medicine: cycles of professional influence and the role of the hidden curriculum. *Acad Med.* 2015;90(5):549-552.

11. O'Hanlan KA, Cabaj RP, Schatz B, Lock J, Nemrow P. A review of the medical consequences of homophobia with suggestions for resolution. *J Gay Lesbian Med Assoc.* 1997;1(1):25-39.

12. Sabin JA, Riskind RG, Nosek BA. Health care providers' implicit and explicit attitudes toward lesbian women and gay men. *Am J Public Health.* 2015;105(9):1831-1841.

13. Lim F, Johnson M, Eliason M. A national survey of faculty knowledge, experience, and readiness for teaching lesbian, gay, bisexual, and transgender health in baccalaureate nursing programs. *Nurs Educ Perspect.* 2015;36(3):144-152.

14. Carabez R, Pellegrini M, Mankovitz A, Eliason M, Ciano M, Scott M. "Never in All My Years... ": nurses' education about LGBT health. *J Prof Nurs.* 2015;31(4):323-329.

15. Gonzales G, Przedworski J, Henning-Smith C. Comparison of health and health risk factors between lesbian, gay, and bisexual adults and heterosexual adults in the United States: results

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

from the National Health Interview Survey. *JAMA Intern Med.* 2016;176(9):1344-1351.

16. Grant JM, Mottet L, Tanis JE, Harrison J, Herman J, Keisling M. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington, DC: National Center for Transgender Equality; 2011.

17. Shipherd JC, Maguen S, Skidmore WC, Abramovitz SM. Potentially traumatic events in a transgender sample: frequency and associated symptoms. *Traumatology.* 2011;17(2):56-67.

18. Cochran SD, Mays VM. Mortality risks among persons reporting same-sex sexual partners: evidence from the 2008 General Social Survey—National Death Index data set. *Am J Public Health.* 2015;105(2):358-364.

19. Lehavot K, Simpson TL, Shipherd JC. Factors associated with suicidality among a national sample of transgender veterans. *Suicide Life Threat Behav.* 2016;46(5):507-524.

20. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull.* 2003;129(5):674-697.

21. Haas AP, Eliason M, Mays VM, et al. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *J Homosex.* 2011;58(1):10-51.

22. Garcia M. Study: antigay communities lead to early LGB death. Advocate. 2014. www.advocate.com/health/2014/02/16/study-antigay-communities-lead-early-lgb-death.

23. Office of Disease Prevention and Health Promotion. Lesbian, gay, bisexual, and transgender health. Healthy People 2020. www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

24. Choi SK, Wilson BDM, Shelton J, Gates G. Serving our youth 2015: the needs and experiences of lesbian, gay, bisexual, transgender, and questioning youth experiencing homelessness. Williams Institute, UCLA School of Law. 2015. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Serving-Our-Youth-June-2015.pdf.

25. Yancey AK, Cochran SD, Corliss HL, Mays VM. Correlates of overweight and obesity among lesbian and bisexual women. *Prev Med.* 2003;36(6):676-683.

26. American Cancer Society. Lifestyle-related breast cancer risk factors. 2017. www.cancer.org/cancer/breast-cancer/risk-and-prevention/lifestyle-related-breast-cancer-risk-factors.html.

27. Willoughby BLB, Doty ND, Malik NM. Victimization, family rejection, and outcomes of gay, lesbian, and bisexual young people: the role of negative GLB identity. *J GLBT Fam Stud.* 2010;6(4):403-424.

28. Case KR, Cooper M, Creamer M, Mantey D, Kelder S. Victims of bullying and tobacco use behaviors in adolescents: differences between bullied at school, electronically, or both. *J Sch Health.* 2016;86(11):832-840.

29. Gordon AR, Conron KJ, Calzo JP, White MT, Reisner SL, Austin SB. Gender expression, violence, and bullying victimization: findings from probability samples of high school students in 4 US school districts. *J Sch Health.* 2018;88(4):306-314.

30. Hatzenbuehler ML, Wieringa NF, Keyes KM. Community-level determinants of tobacco use disparities in lesbian, gay, and bisexual youth: results from a population-based study. *Arch Pediatr Adolesc Med.* 2011;165(6):527-532.

31. McCabe SE, Hughes TL, Matthews AK, et al. Sexual orientation discrimination and tobacco use disparities in the United States. *Nicotine Tob Res.* 2017. [e-pub Dec. 30, 2017]

32. Stevens P, Carlson LM, Hinman JM. An analysis of tobacco industry marketing to lesbian, gay, bisexual, and transgender (LGBT) populations: strategies for mainstream tobacco control and prevention. *Health Promot Pract.* 2004;5(3 suppl):129S-134S.

33. Margolies L, Brown CG. Current state of knowledge about cancer in lesbians, gay, bisexual, and transgender (LGBT) people. *Semin Oncol Nurs.* 2018;34(1):3-11.

34. Haider AH, Schneider EB, Kodadek LM, et al. Emergency department query for patient-centered approaches to sexual orientation and gender identity: The EQUALITY study. *JAMA Intern Med.* 2017;177(6):819-828.

35. Haider A, Adler RR, Schneider E, et al. Assessment of patient-centered approaches to collect sexual orientation and gender identity information in the emergency department: The EQUALITY study. *JAMA Netw Open.* 2018;1(8):e186506.

36. Rossi AL, Lopez EJ. Contextualizing competence: language and LGBT-based competency in health care. *J Homosex.* 2017;64(10):1330-1349.

37. The Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals.* Oakbrook Terrace, IL: The Joint Commission; 2010.

38. Bidell MP, Stepleman LM. An interdisciplinary approach to lesbian, gay, bisexual, and transgender clinical competence, professional training, and ethical care: introduction to the special issue. *J Homosex.* 2017;64(10):1305-1329.

39. Acquaviva KD. *LGBTQ-Inclusive Hospice and Palliative Care: A Practical Guide to Transforming Professional Practice.* New York: Harrington Park Press; 2017.

Liz Margolies is the founder and executive director of the National LGBT Cancer Network in New York City. Carlton G. Brown is a nurse consultant at Zenith Healthcare Solutions, LLC, in Portland, Ore., and a member of the *Nursing2019* editorial board.

The authors and planners have disclosed no potential conflicts of interest, financial or otherwise.

DOI-10.1097/01.NURSE.0000558088.77604.24

For more than 39 additional continuing-education articles related to cultural competence topics, go to NursingCenter.com/CE.

CE CONNECTION

Earn CE credit online:
Go to www.nursingcenter.com/CE/nursing and receive a certificate within minutes.

INSTRUCTIONS

Increasing cultural competence with LGBTQ patients

TEST INSTRUCTIONS

- Read the article. The test for this CE activity is to be taken online at **www.nursingcenter.com/CE/nursing.**
- You'll need to create (it's free!) and log in to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Professional Development online CE activities for you.
- There's only one correct answer for each question. A passing score for this test is 13 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.
- Registration deadline is **June 4, 2021.**

PROVIDER ACCREDITATION

Lippincott Professional Development will award 1.0 contact hour for this continuing nursing education activity. Lippincott Professional Development is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 1.0 contact hour, and the District of Columbia, Georgia, and Florida CE Broker #50-1223.

Payment: The registration fee for this test is $12.95.

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.