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ASSESSING TRANSGENDER INCLUSION WITHIN A VETERANS HEALTHCARE SYSTEM: A DELPHI STUDY

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ASSESSING TRANSGENDER INCLUSION WITHIN A VETERANS HEALTH CARE SYSTEM: A DELPHI STUDY

by

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Dedication

This dissertation is dedicated to my daughter Harper Katherine Lee. When you approach the world with an open mind and an open heart, you can achieve great things.

“Somebody said that it couldn’t be done, but she with a chuckle replied that maybe it couldn’t but she would be one who wouldn’t say so till she tried. So, she buckled right in with a trace of a grin on her face and she started to sing as she tackled that thing that couldn’t be done, and she did it!”- J. Bielik

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Abstract

ASSESSING TRANSGENDER INCLUSION WITHIN A VETERANS HEALTHCARE SYSTEM: A DELPHI STUDY

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Transgender veterans have specific health care needs and often experience profound health disparities, barriers to accessing care, and varying degrees of stigma and discrimination. Yet, there is a lag in research regarding transgender persons in terms of the extent and impact of diversity and inclusion within healthcare. There is a need to further define inclusion and examine how this concept is operationalized in the healthcare settings. This study addressed the gap in knowledge gained from transgender healthcare research by establishing a consensus definition of transgender inclusion as well as identified contributing factors. The study also compared the end user perspectives of both transgender veterans and direct care nursing staff for congruence and inconsistency. Included in the dissertation portfolio are three manuscripts that expound upon this issue. The first manuscript outlines the current state of science regarding transgender veteran healthcare. The second is an analysis of the concept of cultural inclusion. The final manuscript includes the results of a two round Delphi study where a combined expert panel of transgender veterans and direct care nurses ($N = 10$) reached consensus regarding defining factors, contributors, and barriers of transgender inclusion. The results yielded 10

factors that contribute to the consensus definition of transgender inclusion, and identified that knowledge, communication, training, policy, and advocacy were contributing factors to achieving transgender inclusion.

Chapter 1

Overview and Purpose of the Research Focus

Transgender veterans face a significant number of documented health disparities for reasons that are presumably complex and somewhat undefined. Current environments within healthcare have been relatively unexplored from a firsthand perspective and may not align with the end service user needs or perception of inclusion. While diversity and inclusion are often viewed as one and the same, they are unique constructs that each contribute to the achievement of equity within organizations (Moore et al., 2020). There is a need to further examine inclusion as it relates to health promotion, patient satisfaction, and reduction in health disparity among diverse gender minority populations such as transgender veterans.

The transgender veteran subpopulation remains under researched, underserved, and vastly unfamiliar to direct care providers (Kauth et al., 2014). Hence, the limited existing literature suggests that transgender veterans continue to view VHA as unwelcoming (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd et al., 2012). This research study was designed to contribute new knowledge about the construct of transgender inclusion by exploring the perspective of both transgender veterans and direct care nurses regarding the concept and existence of transgender inclusion within the VA healthcare systems, as well as barriers and facilitators to achieving inclusion. This study offers a unique approach to addressing the gap in knowledge gained from transgender healthcare research by establishing a consensus definition of transgender inclusion and outlining contributing factors from the end user perspective.

Introduction of Articles

To fully expound upon the magnitude of the problem and purpose of the research, this dissertation portfolio includes three distinct original manuscripts. The first manuscript *Transgender Veteran Healthcare: State of Science* outlines the current state of healthcare concerning transgender veterans. This manuscript was submitted for publication (Figure 1., Appendix D) and provides an overview of identified healthcare needs, barriers to care, access to care issues, and challenges concerning health outcomes specific to the transgender veteran population.

Cultural diversity and inclusion, specifically related to transgender persons has been an increasingly recognized areas of emphasis in healthcare (IOM, 2010; National Center for Transgender Equality, 2011). The second manuscript, *Cultural Inclusion: A Concept Analysis,* explores the conceptual definition of cultural inclusion in relation to healthcare, nursing implications, defining attributes, case examples, antecedents and consequences, as well as empirical referents utilizing the Walker and Avant (2011) method for concept analysis.

The third manuscript *Assessing Transgender Inclusion within a Veterans Health Care System: A Delphi Study*, describes a two round Delphi study designed to define transgender inclusion, existing facilitators, and barriers through consensus of an expert panel of transgender veterans and direct care nursing staff ($N = 10$). The manuscript also compares the perception of identified defining factors between the transgender veteran expert panel ($n = 5$) and staff nurse expert panel ($n = 5$). The overarching goal of the dissertation study was to provide insight into transgender healthcare and extent of inclusion in existing systems. The findings in the following manuscripts expand upon the limited existing evidence and offer the beginnings of a conceptual

foundation to guide future research and inform efforts to develop inclusive strategies aimed at reducing health disparities for transgender veterans that may be related to inclusion barriers.

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Chapter 2

Transgender Veteran Healthcare: State of Science

The purpose of this manuscript is to outline the current state of science regarding transgender veteran healthcare. An evaluation of peer-reviewed scientific literature revealed that transgender veterans have unique healthcare needs, barriers to care, access to care issues, and negative health outcomes. Despite increased representation of transgender veterans and recent expansion of targeted inquiry, gaps within the literature continue to exist. Provider perspective regarding culturally inclusive care and unmet needs warrant further scientific exploration.

Keywords: transgender, Veteran, gender minority, healthcare, barriers

Transgender Veteran Healthcare: State of Science

Transgender is a term used to describe individuals who self-identify with a gender that does not match their assigned birth sex ([DOD], 2016). Nearly one million people in the United States (U.S.) identify as transgender (Meerwijk & Sevelius, 2017). Not until the Don't Ask Don't Tell Repeal Act of 2010 were sexual and gender minorities such as lesbian, gay, and bisexual (LGB) persons allowed to serve openly in the U. S. armed forces. However, controversy still exists regarding whether transgender identifying persons should be allowed to serve in the military. Despite historical bans on open military service, transgender persons are still two-fold more likely to serve in the military than non-transgender individuals (James et al., 2016).

Those who identify as transgender fear disclosure of their gender identity status (Meerwijk & Sevelius, 2017). Additionally, healthcare providers, in response to prohibiting policies and political debate, do not ask about gender identity, thus making it difficult to ascertain an accurate representation of the population within the U.S. military. Furthermore, population estimates are confounded by the lack of specification for transgender identification in demographic survey questions (Meerwijk & Sevelius, 2017). For example, the term transgender may be inaccurately represented as sexual orientation when capturing demographic information or used as an umbrella label failing to capture those who do not identify with the exact terminology (Meerwijk & Sevelius, 2017). Although exact numbers are unknown, it is estimated that up to 10,790 transgender individuals are actively serving in the U.S. military (Schaefer et al., 2016). Furthermore, it is important to note that there are approximately 134,000 transgender veterans in the U.S. (National Center for Transgender Equality, 2017). The Veterans Healthcare Administrative (VHA) is one of the largest single providers of transgender healthcare, serving more than 5,000 transgender veterans (Brown & Jones, 2015).

Transgender identification has been explored in scientific literature since the early twentieth century. Early healthcare literature described transgender identity as deviant behavior and a curable condition associated with increased health concerns (Eliason, Dibble, DeJoseph, & Chinn, 2012; Snyder, 2011). Not until recent years have health disparities among transgender individuals been linked to societal stigmatization and discrimination. Transgender health has been identified as a major priority in the Healthy People 2020 initiative (U.S. Department of Health and Human Services, 2014) and VHA has increased efforts to meet the healthcare needs of the transgender veteran population ([DOD], 2016). Despite recent progress, there is still much to be discovered. Provider perspective and scientific evidence to support culturally inclusive education initiatives are limited. This manuscript outlines the current priorities for transgender veteran healthcare. Furthermore, it describes gaps in research specific to this population and recommendations for future research are presented.

Search Methods

Peer reviewed articles published in English and during the previous six years were located from five databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane Library, Psych-Info, PubMed, and Medline. The following terms were used in the search strategy: *transgender, gender minority, sexual minority, transgender veteran, veteran, transgender health, transgender healthcare*. The Boolean phrase *transgender veteran* yielded the most relevant results (n = 53). Reference lists of selected articles were also reviewed. Fourteen relevant articles were located and are described below.

State of Science

The literature was comprised of non-experimental and qualitative evidence. Four studies were qualitative in nature (Chen et al., 2017; Dietert, Dentice, & Keig, 2017; Rosentel, Hill, Lu,

& Barnett, 2016; Sherman, Kauth, Shipherd, & Street, 2014), two of which were open ended interviews (Chen et al., 2017, Rosentel et al., 2016). Four were survey research (Sherman et al., 2014; Levahot, Katon, Simpson, & Shipherd, 2017; Sherman et al., 2014; Shipherd, Mizock, Maguen, & Green, 2012), and three used mixed method approaches (Chen et al., 2017; Sherman et al., 2014; Sherman, Kauth, Shipherd, & Street, 2014). Three of the studies used retrospective chart review (Blosnich et al., 2016; Brown & Jones, 2015; Bukowski et al., 2017). The Minority Stress Model served as the framework for one study (Chen et al., 2017); the others used no theoretical framework. Additionally, transgender veterans were included as part of a larger study of sexual and gender minority veterans (Sherman et al., 2014; Sherman, Kauth, Shipherd, & Street, 2014). Four studies offered insight through partial examination of transgender veterans' experience with VHA providers (Chen et al., 2017; Levahot et al., 2017; Rosentel et al., 2016; Sherman et al., 2014). One study examined the healthcare provider point of view (Sherman et al., 2014). Barriers to care were derived from transgender veteran self-report.

Sample Description

Male-to-female transgender individuals also referred to as transgender females represented more than 55% of the participants in the identified studies (Brown & Jones, 2015; Chen et al., 2017; Dietert, Dentice, & Keig, 2017; Hill, Bouris, Barnett, & Walker, 2016; Levahot et al., 2017). Transgender females are defined as individuals who are biologically assigned male sex at birth but self-identify as female (VHA, 2017). There were no studies specifically targeting female-to-male transgender individuals, or transgender males. One study did not specify gender identification (Hill et al., 2016), and gender was not relevant for research involving healthcare providers (Sherman et al., 2014). Most transgender veteran research participants were between 40 to 50 years of age (Brown & Jones, 2015; Chen et al., 2017; Hill, et

al., 2016; Levahot, et al., 2017; Shipherd et al., 2012) and primarily identified as white or Caucasian (Brown & Jones, 2015; Chen et al., 2017; Dietert, Dentice, & Keig, 2017; Rosentel et al., 2016; Hill, et al., 2016; Levahot et al., 2017; Shipherd et al., 2012). While most studies did not report socio-economic status, two studies described transgender veteran samples as earning significantly less than $35,000 per year (Chen et al., 2017; Levahot et al., 2017).

Healthcare Needs

Veteran health needs have been well documented. However, research regarding transgender individuals as a subpopulation of veteran healthcare has only been examined within the last six years. Existing research indicated that transgender veterans experienced significant physical and mental health disparities (Table 1., Appendix A) and concerns regarding access to care (Table 2., Appendix A). These disparities are positively or negatively impacted by the healthcare milieu, culture, provider education, and minority stress.

Mental Health. Evidence suggests that transgender veterans experienced an increased prevalence of certain mental health conditions (Table 1, Appendix A). In a recent survey of transgender veterans, 69% reported receiving some form of mental health treatment; among those 51% reported receiving their mental health care through the VHA (Levahot et al., 2017). Prevalent mental health conditions among the transgender veteran population included depression (Hill et al., 2016; Levahot et al., 2017), suicide (Blosnich et al., 2013; Brown & Jones, 2015; Bukowski et al, 2017; James et al., 2016), substance abuse (Brown & Jones, 2015; Bukowski et al., 2017) and Post Traumatic Stress Disorder (PTSD) (Hill et al., 2016). Transgender veterans reported depression at 50% (Levahot et al., 2017), and 65% (Hill et al., 2016), twice the rate reported by active-duty service members (Hill et al., 2016). Furthermore, a health record review of 5135 transgender veterans utilizing VHA showed that suicidal ideation

was 10% more prevalent (Brown & Jones, 2015) and suicide attempt rates for were 20 times higher among transgender veterans than the general veteran population (Blosnich et al., 2013). While the studies did not examine the reason for suicidal behavior among transgender veterans, the reported increased rates were consistent with the results of the 2015 U.S. Transgender Survey Report, which found that nearly 50% of transgender veterans had attempted suicide (James et al., 2016).

When compared to active-duty service members, rates of PTSD were similar for transgender veterans (Hill et al., 2016). More than 40% of study participants were diagnosed with PTSD (Levahot et al., 2017), and transgender veterans residing in small rural locations were at increased risk for experiencing PTSD (Bukowski et al., 2017). Military Sexual Trauma among veterans is associated with an increased risk of PTSD and alcohol abuse (Hahn, Tirabassi, Simmons, & Simmons, 2015). The Department of Defense uses the term Military Sexual Trauma (MST) to describe sexual assault or harassment experienced during active-duty service (Title 38 U.S. Code 1720D). Military Sexual Trauma can affect a person's mental and physical health for years after the incident. Results of recent studies indicated that transgender veterans were two times more likely to report MST than their cisgender counterparts (Brown & Jones, 2015; Bukowski et al., 2017). Despite urban or rural residential designation (Bukowski et al., 2017) transgender veterans exhibited increased rates of alcohol and substance abuse (Brown & Jones, 2015; Levahot et al., 2017) at significantly higher rates than active duty service members (Hill et al., 2016).

Transgender veterans were more likely to experience homelessness (Levahot et al., 2017; Brown & Jones, 2016) nearly three times that of the general population (James et al., 2016). While homelessness is not directly linked to mental health diagnosis, it is a social determinant

that may contribute to the prevalence of health disparities identified among transgender veterans (Edens, Kasprow, Tsai, & Rosenheck, 2011). Homelessness in this population was associated with higher rates of health disparities such as mental health conditions and substance abuse (Brown & Jones, 2015).

Physical Health. Although much of the research focused on mental health, unique physical health disparities were reported among the transgender veteran population (Table 1) (Brown & Jones, 2016; Hill et al., 2016). Chronic medical conditions such as chronic obstructive pulmonary disorder (COPD), congestive heart failure (CHF), diabetes, and hypertension were prevalent in transgender veterans (Brown & Jones, 2015). Transgender veterans were five times more likely to be diagnosed with HIV than non-transgender veterans (Brown & Jones, 2015), and four times the rate of the general U.S. population (James et al., 2016). While obesity was not exclusive to transgender veterans, body mass index scores were higher (Brown & Jones, 2015; Hill et al., 2016). Furthermore, more than 50% of transgender veterans received lifetime service-connected medical diagnosis (Brown & Jones, 2015; Hill et al., 2016), diagnoses related to conditions resulting from experiences encountered while serving in the military.

Healthcare Milieu

Environments that promote psychological safety, support and inclusion are essential for promoting positive health outcomes. Yet transgender veterans continue to face multiple barriers to accessing healthcare because of discrimination, stigmatization, and associated environmental stress factors (Table 2, Appendix A). Environmental barriers such as negative reactions from healthcare providers negatively influence health seeking behavior and compliance (Dietert, Dentice, & Kieg, 2017). Fear based identity concealment among this population is a noted stress

factor (Dietert & Dentice, 2015). Distress caused by discriminatory environments and perceived need for concealment have been associated with poor health outcomes (Chen et al., 2017), and increased rates of documented depression and PTSD (Hill et al., 2016). Environmental factors for transgender veterans were categorized and examined from the perspective of both the culture of the healthcare system, access to resources, and the extent of provider education.

Culture. Healthcare providers' and transgender veterans' perceptions regarding culturally inclusive healthcare were represented. While healthcare providers endorsed a welcoming and culturally inclusive environment (Sherman et al., 2014), transgender veterans reported a lack of provider knowledge regarding transgender related healthcare issues (Rosenthal et al., 2016; Chen et al., 2017). In a recent survey, 24% of transgender veterans viewed the Veterans Administration (VA) as unwelcoming, while an overwhelming 81% of providers viewed the VA as welcoming to Lesbian, Gay, Bisexual and Transgender (LGBT) populations (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd et al., 2012). Reported barriers to accessing healthcare for transgender veterans within VHA included cost (Levahot et al., 2017; Sherman, Kauth, Shipherd, & Street, 2014), potential loss of benefits or denial of care (Sherman, Kauth, Shipherd, & Street, 2014), fear of judgement or discrimination (Levahot et al., 2017; Sherman, Kauth, Shipherd, & Street, 2014), and either harassment or knowledge of someone who had a negative experience (Rosenthal et al., 2016; Shipherd et al., 2012).

Access to Resources. Transition for transgender individuals means "the time period during which a person begins to live according to their gender identity, rather than the gender they were assigned at birth" (National Center for Transgender Equality, 2016). Transition may include counseling, hormone replacement therapy, or surgical intervention (Dietert & Dentice, 2015). Transgender veterans viewed access to these resources as affirming healthcare that

reinforced a positive sense of self (Chen et al., 2017). Although VHA does not currently provide sex reassignment or associated reconstructive surgery (VHA, 2017), transgender veterans utilized mental and medical health services through VHA (Blosnich et al., 2013; Brown & Jones, 2015; Levahot et al., 2017; Shipherd et al., 2012). In 2011 the VHA mandated the provision of medically necessary care for transgender veterans to include counseling and hormone replacement therapy (Brown & Jones, 2015; Levahot et al., 2017; Shipherd at al., 2012; Blosnich et al., 2013), as well as pre and post-operative care (Hill et al., 2016). Since then, there has been a significant increase in the number of identified transgender veteran patients (Kauth, et al., 2014). Despite VHA policy initiatives to provide culturally inclusive patient centered care, transgender veterans endorsed more barriers to medical care within the VHA than with mental health providers, because of concerns for negative reaction towards gender identity (Shipherd et al., 2012).

Provider Education. Research regarding providers caring for transgender veterans has been minimally explored. Transgender health issues are inadequately covered in most provider training programs (Lutwak et al., 2014; Sawning et al., 2018). Despite transgender specific training initiatives, many VHA providers lack adequate training and experience regarding transgender veteran specific needs (Lutwak et al., 2014). Less than half of VHA providers reported receiving education on transgender related issues and stated that gender identity and sexual orientation were rarely discussed (Sherman et al., 2014). Consequently, transgender veterans from two distinct Veterans Healthcare Systems reported never being asked about their sexual orientation (62%) or gender identity (81%) (Sherman Kauth, Shipherd, & Street, 2014). This suggests that providers may be ill prepared and uncomfortable addressing the unique health needs of transgender veterans. Lack of provider competency was indicated as a major stressor

for transgender veterans that contributed to negative health outcomes (Chen et al., 2017). Education among health providers may be crucial to decreasing health disparities and reducing barriers to transgender veteran care (Rosentel et al., 2016; Shrader et al., 2017).

Negative experiences and misunderstanding by providers can influence decisions to seek both ongoing and preventative healthcare (Dietert, Dentice, & Keig, 2017; Lutwak et al., 2014). Lack of provider education in transgender related issues causes external stressors and contributes to negative health outcomes whereas knowledgeable providers are considered a positive influence on transgender veteran health seeking behavior and experience (Chen et al., 2017). Although provider knowledge was often referred to as competency within the available literature, specific transgender healthcare competencies for providers have not been identified. Current literature also supports the need to transition beyond basic knowledge of transgender issues towards more inclusive and responsive provider practice (Kattari & Kattari, 2017). Transgender inclusive behavior is defined as implicit and explicit actions that support transgender individuals and groups (Kattari & Kattari, 2017). Transgender inclusive behavior promotes trust, and compliance with preventative care measures, in turn reducing acute care needs (Lutwak et al., 2014, Shipherd et al., 2012).

Minority Stress Theory and Transgender Veteran Healthcare

Minority stress is the high level of chronic stress experienced by members of stigmatized minority groups (Meyer, 2015). Minority stress theory suggests that both external and internal stressors such as stigma, discrimination, identity concealment, and fear of rejection negatively impact mental and physical health in transgender individuals (Meyer, 2015). Suicidal ideation and lifetime suicide attempts among transgender veterans significantly correlated with minority stress (Levahot et al., 2017). Conversely, transgender veterans residing in nondiscriminatory employment states, defined as states that prohibit discrimination based on gender under Title

VII, 29 CFR Part 1604 (U.S.EEOC, n.d.), experienced decreased mood disorders and violence (Blosnich et al., 2016).

Research Gap

Transgender veterans experience unique health needs beyond those of the general veteran or transgender population. Lack of provider education along with fear of negative experiences in the healthcare setting create barriers to accessing care and improving health disparity among this population. While the body of research regarding transgender veterans continues to grow, substantial gaps in the literature exist. Small sample sizes (Chen et al., 2017; Hill et al., 2016; Rosentel et al., 2016; Sherman, Kauth, Shipherd, & Street, 2014; Shipherd et al., 2012) and self-report measures (Bukowski et al., 2017; Chen et al., 2017; Hill et al., 2016; Rosentel et al., 2016; Shipherd et al., 2012) limits generalizability of findings. Retrospective chart reviews were limited by the availability of transgender diagnosis definitions (Brown & Jones, 2015; Blosnich et al., 2016; Bukowski et al., 2017). Four International Classification of Disease (ICD)-9 codes associated with transgender status were used to identify transgender veterans. Other transgender related diagnostic codes may have been assigned but not included. Additionally, the ICD codes are not consistent with the Diagnostic Statistical Manual of Mental Disorders diagnosis (Kauth et al., 2014). Lack of defined transgender status markers within the medical record make it difficult to differentiate health care needs of the transgender veteran population from other sexual minority groups (Mattocks et al., 2013). Clear definitions for identifying transgender status are necessary to gain a better understanding of the needs of transgender persons apart from other sexual minority groups.

A strong association has been identified between the healthcare milieu and health outcomes for transgender identifying veterans. However, only one study investigated the

perspective of the healthcare provider (Sherman et al., 2014). This is consistent with the lack of provider specific research found in transgender health literature outside of the veteran population. In an effort to decrease stereotype and establish best practice, it is important to examine how providers perceive transgender veteran health and associated care (Rowe, Ng, & O'Keefe, 2017; Mattocks et al., 2013). Multiple studies reported transgender veterans' dissatisfaction with the lack of knowledge (Chen et al., 2017; Rosentel et al., 2016), or negative interactions with the healthcare provider (Rosentel et al., 2016; Shipherd et al., 2012). Yet no study to date has examined beliefs, attitudes, knowledge, or inclusive behavior among providers of transgender veteran health care.

Conclusion

Transgender veteran healthcare continues to be under explored within scientific literature. Available research indicates that transgender veterans experience profound health disparities and unique challenges within the healthcare milieu. Stigmatization, discrimination, lack of provider education, and associated negative health outcomes are driving forces behind the call for further investigation. While efforts to improve health outcomes and access to care for transgender persons have become a priority for both the national government and VHA, further exploration into the healthcare provider perspective and interventions for promoting culturally inclusive care are necessary for advancing transgender healthcare in veteran and non-veteran populations.

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Chapter 3: Cultural Inclusion: A Concept Analysis

Abstract

The definition of cultural diversity has expanded beyond race and ethnicity and is increasingly becoming a major focus of many healthcare organizations. The need for nurses and other healthcare professionals to create culturally inclusive environments for all marginalized groups including sexual and gender minorities is critical. Yet the concept of cultural inclusion needs to be more concretely defined and examined in terms of how it is operationalized in healthcare. This article presents a conceptual analysis of cultural inclusion in relation to healthcare through the lens of sexual and gender minorities (SGM). Healthcare implications, defining attributes, case examples, antecedents, consequences, and empirical referents are identified with emphasis on the healthcare environment.

Key words: culture, inclusion, cultural inclusion, concept analysis

Cultural Inclusion: A Concept Analysis

The demographics of healthcare are rapidly changing, not only in relation to ethnic identity, but in terms of age, gender identity, and socio-economic status. According to the U.S. Census Bureau population report, by the year 2060, the majority status of any one racial and ethnic group will no longer exist, due to the significant increase in minority populations (Colby & Ortman, 2015). Health disparities are significantly more prevalent among demographic groups disadvantaged by discrimination and inequitable access to healthcare (U.S. Department of Health and Human Services, 2015). Therefore, it is imperative that healthcare providers are able to provide patient-centered care to diverse populations within a culturally inclusive environment.

The purpose of this paper is to present an analysis of the concept cultural inclusion utilizing the Walker and Avant's (2011) method. This manuscript explores the conceptual definition of cultural inclusion in relation to healthcare, defining attributes, case examples, antecedents and consequences, as well as empirical referents in the context of sexual and gender minorities (SGM). Concept clarification can provide both explanation and justification to support implications for and application to practice (Toulmin, 1972).

Significance to Healthcare

Patient populations within healthcare systems are becoming increasingly culturally diverse. The idea of cultural diversity expands beyond race and ethnicity to include factors such as gender, sexual orientation, age, religion, education, and family structure (Kaakinen, Coehlo, Steele, & Robinson, 2018), allowing for heightened visibility and identification of cultural minority groups within the context of healthcare. Yet, minority groups continue to experience profound health disparities (AHRQ, 2014). Many culturally diverse groups have encountered varying degrees of discrimination and alienation. For example, sexual minority groups such as transgender identifying persons have been identified as at-risk populations, due to the history of

stigma and discrimination (U.S. Department of Health and Human Services, 2014), while race-based discrimination continues to be linked to poor health outcomes (Kaakinen, Coehlo, Steele, & Robinson, 2018). Increased emphasis on diversity recognition in healthcare from organizations such as the Institute of Medicine (2010) and the National League for Nursing (2013) has resulted in the adoption of terms such as cultural sensitivity, cultural competency, and more recently, cultural humility.

Cultural sensitivity, an attribute of cultural competency (Sharif, Adib-Hajbaghery, & Najafi (2019), appreciates how cultural viewpoints contribute to health behaviors and attitudes (Burchum, 2002). According to Foronda (2008), knowledge, understanding, respect, awareness, and culturally appropriate intervention are defining attributes of cultural sensitivity. While the development of cultural sensitivity is fluid, it is also dependent on individual perception (Bennett, 1986).

Historically, cultural competency has been the primary focus for addressing diversity within healthcare systems (Borden, 2018; Daugherty & Kearney, 2017; Govere & Govere, 2016), with insufficient results. Definitions and perspectives of cultural competency vary but imply that a person has mastery level understanding (Borden, 2018). Furthermore, emphasis on competency has the potential to perpetuate stigma and social stereotypes (Kirmayer, 2012; Tervvalon & Murray-Garcia, 1998). Cultural competency alone only accounts for how cultural belief factors influence health behaviors (Daugherty & Kearney, 2017). Furthermore, while cultural competency training has been linked to increased cultural awareness among healthcare providers, findings linking cultural competency to improved patient outcomes or satisfaction are inconclusive (Govere & Govere, 2016).

Cultural humility is not only seen as more politically correct, but also promotes a shift from pure knowledge attainment to increased self-reflection and awareness (Forondo, Baptiste, Reinholdt, & Ousman, 2016). In contrast to a content-oriented cultural competency approach, cultural humility incorporates interpersonal and intrapersonal components (Lekas, Pahl, & Lewis, 2020) yet clear conceptualization and measures of effectiveness are lacking (Agner, 2020; Hook, Davis, Owen, & Worthington, 2013).

Cultural inclusion implies a more well-rounded practice application compared with other concepts. Inclusive environments and communication standards are vital aspects of culturally relevant care for gender minority groups (McNair & Hegarty, 2010). The application of cultural competency and cultural humility both aim to foster inclusive healthcare environments, yet no analysis of cultural inclusion exists in the context of culturally diverse patient populations. It is necessary to advance beyond existing culture models in an effort to improve patient satisfaction and decrease health disparities among diverse cultural minority groups. Heightened sensitivity and policy alone do not change practice culture (Kauth & Shipherd, 2016). Additional reflection and critical analysis are needed to achieve sustained change and global accountability. A conceptual analysis of cultural inclusion stands to contribute to advancing research efforts and clinical practice initiatives to address these shortcomings.

Concept Identification

Merriam Webster (2018) defines culture as a set of beliefs, values, practices, or characteristics associated with a specific group. People's thinking, decisions, and behaviors are influenced by culture (Cai, 2016). In turn, culture impacts both health seeking and healthcare delivery behaviors (Doherty et al., 2017). While the simplistic definition of culture is relatively understood, the application is expansive. Culturally normative practices are not unique to age,

race, religious or socioeconomic groups. Gender identification is one recently highlighted group that precipitates a unique cultural perspective (Rowe, Chye, & O'Keefe, 2017).

The term inclusion is less universally defined within the literature. The dictionary definition of inclusion refers to the act or state of being included (Merriam Webster, 2018). From a socio-political standpoint, inclusion is also associated with social determinants of health in regard to either equitable access to resources or deprivation based on discrimination and stigmatization (O'Donnell, O'Donovan, & Elmusharaf, 2018). Additionally, definitions within the context of healthcare, human resources, and education extend a connotation of empowerment and equity. Inclusion in this context is further defined as the act of creating a welcoming, supportive, and respectful environment or climate in which all parties are valued (Berkley Diversity, 2018). Inclusion is the formal and informal experience of acceptance of identity and ideas at all levels of decision making (Mor Barak et al., 2016). An inclusive workforce promotes productive relationships and effective communication amongst diversity (Tavakoli, 2015).

Cultural inclusion is often depicted in education institutions from both an environmental and curriculum viewpoint. Cultural inclusion is described as an interactive strategy aimed at acknowledging, valuing, and supporting cultural diversity (USC, n.d.). According to the United Nations Educational, Scientific, and Cultural Organization (UNESCO) (2017), cultural inclusion "Promotes laws and policies that ensure cultural participation, access, and the right to express and interpret culture. From an urban policy perspective, cultural inclusion calls to mixing the best problem-solving creative, innovative and entrepreneurial practices".

Defining Attributes

Defining attributes, or repeated and differentiating characteristics, (Walker & Avant, 2011) for the concept of cultural inclusion have not been clearly delineated. The following defining attributes for the concept cultural inclusion were derived from associated definitions and

terminology within the literature. Defining attributes for cultural inclusion include: knowledge, self-awareness, skill, environment, and engagement.

1. **Knowledge** refers to the attainment of information. To achieve cultural inclusion, a basic knowledge of cultural differences and values must exist (Foronda, 2008). Basic knowledge of cultural values, beliefs, and norms can prevent unintended cultural offenses and help establish trust (Cai, 2016). Lack of knowledge regarding SGM specific health issues, services, and terminology is a reported barrier to effective healthcare delivery (Lee, & Kanji, 2017).
2. **Self- awareness** of personal beliefs and bias is essential to cultural inclusion. Self-awareness is the personal process of getting to know yourself (Anderson, 2015). Healthcare providers should reflect on their knowledge, assumptions and presumed biases as well as unconscious bias in relation to cultural groups. Cultural or normative assumptions manifested in provider communication and clinical environments can hider trust and relationship building (Lee & Kanji, 2017).
3. **Skill** is the ability to elicit pertinent historical information and cultural context (Munoz, DoBroka, & Mohammad, 2009) through effective communication (Sharifi, Adib-Hajbaghery, & Najafi, 2019). The use of culturally inclusive communication skills includes the ability capture individual perceptions of health and treatment preference (Kripalani, Bussey-Jones, Katz, & Genao, 2019). The American Psychological Association (APA) has published Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (APA, 2012) as well as with Transgender and Gender Non-conforming People (APA, 2015), to develop rapport building skills based on a better understanding of SGM experiences (Hendricks &

Testa, 2012). A lack of culturally inclusive skill may result in a lack of disclosure or unwillingness of to fully engage in health promoting behavior.

4. **Environment** refers to the conditions or surroundings of the healthcare system. Inclusive environments are those where participants feel valued and that their needs are supported (Cornell University Center of Teaching Excellence, 2018). Environments should promote involvement, respect, and connection. Participants are more likely to engage in activities and open communication when they are comfortable in their environment (Anderson, 2015). According to the Gay and Lesbian Medical Association Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients (2006), clinical environments should undergo evaluation and display SGM friendly symbols, nondiscriminatory statements, and SGM related health disparity education materials.
5. **Engagement** is a critical and defining attribute of cultural inclusion. Patient involvement improves health outcomes by promoting informed decision-making and mutual accountability and understanding (WHO, 2016). Negative outcomes and decreased productivity occur when people are not engaged (Tavakoli, 2015).

Model Case

Defining attributes can be exemplified in the form of a model case. A model case is a real or fictitious exemplar used to illustrate and enhance concept identification (Walker & Avant, 2011). The following exemplar is provided to reflect the defining attributes of cultural inclusion: Nurse Jane works in the primary care clinic of All-Inclusive Hospital. Annually, she participates in a cultural awareness training offered through the hospital education department. The training includes information concerning cultural values, healthcare issues, and associated

terminologies for diverse cultural patient populations (knowledge). Nurse Jane uses this knowledge to reflect on her personal cultural values and possible misconceptions or biases she may have regarding other cultural groups (self-awareness). She asks open ended questions about patient history and listens to the patient's opinion about health problems and goals (skill). Nurse Jane notices that positive SGM affirming signage has been posted in the clinic waiting room and that intake forms offered multiple gender options and pronoun preference. Informational pamphlets provided in the lobby were also available in multiple languages (environment). Nurse Jane makes sure to ask all patients about their concerns and goals of care before reviewing the care plan to ensure a mutual understanding has been reached (engagement).

Contrary Case

While model cases present ideal examples of a concept, contrary cases are examples of inadequate instances (Walker & Avant, 2011). This second case is incongruent with the concept of cultural inclusion. Nurse Jane has recently started working for Standardized Care Hospital. She has not received any training on the various cultural groups within the healthcare system (lack of knowledge) and assumes veterans are older male persons who have fought in a war (lack of self-awareness), because that is what she has seen in movies. Nurse Jane suspected her patient is transgender based on physical appearance but does not know how to how to talk about gender identity in a sensitive manner, so does not address gender identity or sexual orientation issues with the patient (lack of skill). There are no women's or gender minority health information pamphlets or posters displayed in the hospital waiting areas (lack of environmental cues). When nurse Jane visits with a patient, she performs a routine assessment and asks the patient why they have come to the hospital today. She avoids asking questions that are outside of her comfort zone (lack of patient engagement).

Antecedents and Consequences

Antecedents are aspects that precondition the occurrence of a concept (Walker & Avant, 2011). In order for cultural inclusion to occur, cultural diversity must also exist. A broad definition of diversity is all aspects of a person that make them unique (Office of Diversity and Inclusion, 2018). Increasing cultural diversity within the healthcare setting enhances the need for cultural inclusion. Interaction or encounter with another culture is also an antecedent (Cai, 2016; Foranda, 2008). Finally, for cultural inclusion to occur, there must be a desire or value placed on the attainment of inclusion.

Concept occurrence in turn generates consequences of the concept (Walker & Avant, 2011). Cultural inclusion stands to result in positive consequences. Cultural inclusion would establish effective communication channels between healthcare providers and patients (Cai, 2016; Foranda, 2008), and promote an environment of safety (Lee & Kanji, 2017). Positive affirming encounters that establish trust and open-communication increase the degree to which individuals feel valued (Lee & Kanji, 2017). Consequences of increased patient satisfaction and improved patient outcomes as a result of cultural inclusion is implied but has not been tested.

Empirical Referents

Identifying how to measure a concept by means of its attributes is the final step in the concept analysis process (Walker & Avant, 2011). A tool specific to cultural inclusion within healthcare was not evident within the literature. Cultural competency assessment tools were located; however, seven tools demonstrated a high degree of inconsistency and variability (Govere & Govere, 2016). Another tool, the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Student Version, lacked sufficient consistency in minimal detectable change (MDC) between sample groups across subscales necessary to validate the use of this measure (Fike, Denton, Esparza, & Palombaro, 2016). Further development of a

tool to measure provider knowledge and skill specific to the cultural inclusion of SGM groups is warranted.

Perceptions of organizational culture, individual value, and opportunity for engagement are required to evaluate the extent of inclusion (Tavakoli, 2015). Due to the subjective nature of the concept cultural inclusion, a self-assessment tool is needed to gauge provider self-awareness, evaluation of environment and engagement factors. It may also be possible to assess patient perceptions of cultural inclusion and correlate with patient satisfaction and health disparity outcomes among at risk minority groups.

Conclusion

The cultural composition of healthcare is becoming increasingly diverse. Knowledge alone is not enough to ensure that healthcare systems provide quality patient-centered care. Policies and programs that promote contribution and acceptance by both patients and staff must be initiated (Kauth & Shipherd, 2016). However, scientific evidence to guide strategies to promote cultural inclusion, drive education initiatives or create effective measurement tools is lacking. Analysis of the concept of cultural inclusion is merely a starting point in the journey to provide affirmative and welcoming care to cultural minority groups in a manner that improves patient outcomes. Additional research is needed to examine the perceived existence of cultural inclusion and facilitating factors within the healthcare setting.

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Chapter 4: Assessing Transgender Veteran Inclusion within a Veterans Health Care System: A Delphi Study

Abstract

Significance of Problem. There are approximately 134,000 identified transgender veterans in the United States and more than 5,000 are reported as receiving healthcare through the Veterans Healthcare Administration (VHA). Despite inclusion initiatives, transgender veterans continue to experience significant health disparities and barriers to care as a result of stigmatization and discrimination. Yet, there is a lack of research targeting the extent of inclusion versus discrimination within the healthcare setting. Furthermore, the viewpoint of the veteran and direct care stakeholders remains absent from the literature.

Purpose. The purpose of this study is to explore transgender inclusivity by seeking a consensus definition of transgender inclusion within a veteran's healthcare system and identify factors that contribute to inclusion.

Research Questions. (1) How is transgender inclusion in veteran's healthcare defined? (2) What facilitators and barriers to transgender inclusion exist within a Veterans Health Care System? (3) How do transgender veterans and direct care nursing staff group responses compare?

Methods. A purposeful sample of transgender veterans and direct care nurses from the Central Texas Veterans Health Care System ($N = 10$) were recruited to participate in a two-round Delphi process. During round 1, participants responded to open-ended questions designed to elicit defining characteristics of transgender inclusion in the healthcare environment, as well as mediating and mitigating factors related to stigma and discrimination. Identified themes were

presented to participants in a subsequent round for ranking on a 5-point Likert scale and convergence of opinion.

Results: Initial open responses were categorized into 57 items presented for agreement. Panelists reached consensus on 10 factors that defined transgender inclusion. Poor communication and lack of knowledge were barriers to healthcare and training by knowledgeable staff and patient-led communication served as facilitators.

Keywords: transgender, veteran, inclusion, Delphi, barriers,

Assessing Transgender Inclusion within a Veterans Health Care System: A Delphi Study

Transgender is a term used to describe individuals who self-identify with a gender that does not match their assigned birth sex (United States Department of Defense ([DOD]), 2016). Nearly one million people in the United States (U.S.) identify as transgender (Meerwijk & Sevelius, 2017). Despite historical bans on open military service, transgender individuals are two times more likely to serve in the military than the general population (James et al., 2016). Although exact numbers are unknown, it is estimated that up to 10,790 transgender individuals are currently serving in the United States military in either active duty or reserve status (Schaefer et al., 2016). Furthermore, there are approximately 134,000 transgender veterans in the U.S. (National Center for Transgender Equality, 2017), and more than 5,000 transgender veterans have been identified as utilizing Veterans Health Administration (VHA) services (Brown & Jones, 2015), making the VHA one of the largest single providers of transgender healthcare.

Transgender veterans have unique health care needs. Despite recent efforts by the VHA to implement transgender inclusive policies, and extend availability of healthcare services, transgender veterans continue to experience profound health disparities and barriers to accessing care as a result of stigmatization and discrimination. Transgender veterans continue to view VHA as unwelcoming (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd et al., 2012). Thus, this study aims to evaluate the meaning of transgender inclusivity by seeking consensus on the definition of transgender inclusive environments in a Veterans health care system and prioritize strategies to support a model of inclusive healthcare based on feedback from transgender veterans and direct care nurses.

Review of Literature

A review of literature was conducted utilizing the following databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane Library, Psych-Info, PubMed, and Medline. Search criteria was limited to peer reviewed articles published in English within the last 10 years. Entry terms used in the search strategy included: *transgender, gender minority, sexual minority, transgender veteran, veteran, transgender health, transgender healthcare*. Additional literature noted in the reference list of selected articles and meeting the previously denoted limitations of the search criteria was also reviewed for relevance. Articles were employed as part of the review if they were current, specific to transgender veteran health or healthcare systems, and based on scientific evidence.

It is evident that transgender veterans have unique healthcare needs including psychological, physical and socio-cultural care. Additionally, they face multiple barriers to care and addressing these needs. Discrimination and barriers to care have negative implications on the overall health of the transgender veteran.

Healthcare Needs

Due to the increasing evidence of health disparities and poor health outcomes among the transgender population, a priority goal of the healthy People 2020 initiative is to "Improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals" (U.S. Department of Health and Human Services, 2014). Evidence of the unique health needs of the transgender veteran are examined from a psychological, biological, and socio-cultural needs perspective.

Psychological needs. Compared to other veteran and non-veteran groups, an increased prevalence of certain mental health conditions were documented within the transgender veteran

population. In a study by Levahot et al. (2017), over 69% of transgender veteran participants indicated that they received treatment for at least one mental health condition, and more than half reported receiving mental health services from the VHA (Levahot et al., 2017). Depression (Hill et al., 2016; Levahot et al., 2017), suicide attempt or ideation (Blosnich et al., 2013; Brown & Jones, 2015; Bukowski et al., 2017; James et al., 2016), substance abuse (Brown & Jones, 2015; Bukowski et al., 2017) and Post Traumatic Stress Disorder (PTSD) (Hill et al., 2016) were among the mental health conditions most frequently reported by transgender veterans across studies.

Transgender veterans were significantly more likely to experience incidents of depression, suicidal ideation, or attempted suicide than other groups. More than 50% of the 298 transgender veteran participants in a survey by Levahot et al. (2017), and nearly 65% of respondents in a similar study by Hill et al. (2016) reported experiencing some form of depression, double the rate of depression found in active-duty service members (Hill et al., 2016). Suicidal ideation was noted to be 10% higher in veterans with documented diagnosis associated with transgender identification (Brown & Jones, 2016), such as transvestic fetishism, transsexualism, or Gender Identity Disorder. Note that Gender Identity Disorder was the terminology used at the time of Brown and Jones' (2016) study; the term has since been replaced with *Gender Dysphoria*. Although contributing factors were unknown, suicide rates among transgender veterans were significantly higher than those reported throughout VHA and the U.S. population (Blosnich, et al., 2013). The U.S. Transgender Survey Report (2015) similarly found that suicide attempts were nearly 50% higher among transgender veterans (James et al., 2016).

Veterans who identify as transgender were more likely to experience post-traumatic stress disorder (PTSD), military sexual trauma (MST), and higher rates of alcohol and substance

abuse. Similar to reports of active-duty service members (Hill et al., 2016), more than 40% of transgender veterans had documented PTSD diagnoses (Levahot et al., 2017). The mental and physical implications of MST, assault, or harassment experienced by transgender veterans while on active-duty, were reported at twice the rate of non-transgender veterans (Brown & Jones, 2015; Bukowski et al., 2017), and were linked to an increased risk for PTSD and substance abuse (Hahn, Tirabassi, Simons, & Simons, 2015). Overall, transgender veterans reported higher rates of alcohol and substance abuse (Brown & Jones, 2015; Levahot et al., 2017) than other service members (Hill et al., 2016), regardless of residential location (Bukowski et al., 2017). Transgender veterans residing in rural areas showed increased likelihood of experiencing PTSD symptoms (Bukowski et al., 2017).

Biological/ physical needs. In addition to an increased prevalence of mental health conditions, transgender veterans exhibited unique physical health disparities (Brown & Jones, 2015; Hill et al., 2016). An increased prevalence of chronic conditions such as chronic obstructive pulmonary disorder (COPD), congestive heart failure (CHF), diabetes, and hypertension were frequently documented in the transgender veteran population (Brown & Jones, 2015). Increased incidence of high body mass index (BMI) scores indicative of obesity were also noted (Brown & Jones, 2015; Hill et al., 2016). While only 42% of non-transgender veterans reported medical diagnoses related to military service experiences (Brown & Jones, 2015), more than half of transgender veterans had documented military service-connected diagnoses (Brown & Jones, 2015; Hill et al., 2016). Furthermore, HIV diagnoses were five times higher in transgender veterans compared to other veterans (Brown & Jones, 2015), and four times higher than reported in the U.S. census (James et al., 2016).

Transgender individuals may desire to transition from male to female or female to male with the assistance of counseling, hormone replacement therapy and surgical intervention (Deitert & Dentice, 2015). Although sex reassignment and reconstructive surgery are not covered under transgender care within the VHA, hormone replacement therapy, preoperative evaluation, and medically necessary postoperative care are provided (VHA, 2017). Access to transition related care was perceived as affirming and had a positive impact on veteran self-esteem related to gender identity and body image (Chen et al., 2017).

Socio-cultural. Transgender veterans are significantly economically and socially disadvantaged (Levahot et al., 2017). While some transgender veterans report having a college education (Chen et al., 207), many earn less than $35,000 per year (Chen et al., 2017; Levahot et al., 2017). Transgender veterans are also three times more likely to experience homelessness (Brown & Jones, 2016; Levahot et al., 2017) than the general population (James, et al., 2016). Homelessness among transgender veterans has been linked to substance abuse and higher incidents of mental health disparities (Brown & Jones, 2015).

Transgender patients experience unique discrimination in social settings such as the workplace (Blosnich et al., 2016). Until 2016 (DOD, 2016) individuals were prohibited from military service if their transgender status was known. Identity concealment among this population is a noted stress factor (Mattocks et al., 2014). Distress associated with concealment was associated with poor health (Chen et al., 2017) and reports of depression and PTSD (Hill et al., 2016).

Barriers to Meeting Healthcare Needs

Transgender veterans are often misunderstood and face multiple barriers to accessing healthcare. These barriers influence health seeking behavior and compliance (Dietert, Dentice,

& Keig, 2017). Reported barriers to accessing healthcare for transgender veterans within VHA included cost of care (Levahot et al., 2017; Sherman, Kauth, Shipherd, & Street, 2014), potential loss of benefits or denial of care (Sherman, Kauth, Shipherd, & Street, 2014), fear of judgement or discrimination (Levahot et al., 2017; Sherman, Kauth, Shipherd, & Street, 2014), and harassment or knowledge of someone who had a negative experience (Rosenthal et al., 2016; Shipherd, et al., 2012). Furthermore, these barriers and incidents of discrimination were examined from a health system policy, healthcare environment, and provider education perspective.

Health system policy. VHA does not currently provide sex reassignment or associated reconstructive surgery (VHA, 2017); however, transgender veterans still utilize mental and medical health services throughout VHA (Blosnich et al., 2013; Brown & Jones, 2015; Levahot et al., 2017; Shipherd et al., 2012). A notable increase in identified transgender representation was seen following the 2011 VHA directive which mandated medically necessary care for transgender veterans (Kauth et al., 2014). However, more barriers to accessing medical care were described compared to mental health care experiences within the VHA. Substantial concerns related to possible negative reactions towards gender identity (Shipherd et al., 2012) were reported despite VHA initiatives to improve care for transgender veterans.

Healthcare environment. Veterans and / or healthcare providers' perspectives regarding transgender inclusion in the healthcare setting is lacking. However, polarizing differences between healthcare providers' and transgender veterans' perceptions concerning barriers to inclusive healthcare access were apparent. While healthcare provider perspective was limited, most believed that VHA environments were inclusive and welcoming to sexual and gender minorities (Sherman, Kauth, Shipherd, & Street, 2014; Sherman et al., 2012). Conversely,

transgender veterans perceived that VHA providers lacked adequate knowledge and communication skills to address transgender veteran health issues (Rosenthal, et al., 2016; Chen, et al., 2017), and described VHA facilities as unwelcoming, as providers neither acknowledged or accepted their gender identity (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd et al., 2012). Literature did not address the inclusivity of physical surroundings. However, these findings are not suggestive of a transgender inclusive environment.

Provider education. Transgender health issues are inadequately covered in most provider education programs (Lutwak et al., 2014; Sawning et al., 2018). Evidence suggests that despite transgender specific education initiatives by VHA, healthcare providers are ill prepared and lack the knowledge and skills necessary to address the healthcare needs of transgender veterans (Lutwak et al., 2014). Less than half of providers from two VHA facilities indicated that they received transgender specific education (Sherman et al., 2014). Furthermore, more than 80% of transgender veterans reported never being asked about gender identity, and 62% denied discussing sexual orientation with their provider (Sherman, Kauth, Shipherd, & Street, 2014), consistent with provider responses that they avoided asking gender and sexual orientation specific questions (Sherman et al., 2014). Improved provider knowledge can promote better health management, improved outcomes related to health disparities, and more inclusive veteran care (Rosentel et al., 2016; Shrader et al., 2017).

Relationship Between Barriers and Healthcare Needs

Minority stress theory suggests that prejudice and stigma towards minority persons result in stressors that ultimately impact mental and physical health (Meyer, 2015) and can be applied to transgender individuals. These stressors can be experienced on a continuum from discriminatory interpersonal interactions to internal cognitive processes such as the expectation

of rejection or purposeful identity concealment (Meyers, 2015). Minority stress had significant correlation to suicidal ideation and lifetime suicide attempts among transgender veterans (Levahot et al., 2016). States with laws against workplace discrimination saw decreased incidents of mood disorders reported among transgender veteran residents (Blosnich et al., 2016).

Discrimination and lack of provider competency cause unnecessary stress (Lutwak et al., 2014) that may contribute to the avoidance of health seeking behavior and increased prevalence of health disparity among transgender veterans (Dietert, Dentice, & Keig, 2017; Lutwak et al., 2014). Conversely informed and culturally inclusive care is critical to reducing incidents of discrimination, promoting patient-provider trust and thereby influencing positive health behaviors (Chen et. al., 2017; Shipherd et al., 2012) and reducing acute health care needs (Lutwak et al., 2014, Shipherd et al., 2012). Given the limited and incongruent perspectives, understanding what inclusion means to both the transgender veteran and the healthcare provider may be useful for driving future research, policy, and education initiatives.

Theoretical Framework

Increased visibility and changing attitudes towards transgender persons have highlighted the prevalence of health disparities within this population. While the growing body of research related to transgender health care suggests a link between stigma and negative health outcomes, the interactive pathways for reducing stigma and promoting inclusion are relatively unexplored. Furthermore, no standard definition or framework for transgender inclusion exists. Social ecological models have been utilized in public health practice to depict environmental and individual characteristics that lead to certain health outcomes (Golden & Earp, 2012). The socio-ecological model first developed by Bronfenbrenner (1994) describes how human development

is shaped by multiple systems. The systems or concepts within these models are described as concentric but not distinct from one another (Edwards, Goodwin, & Neumann, 2019); levels are also interactive and reinforcing (Stokols, 1992; 1996). As a framework, the system levels are nested to depict the multifaceted and bidirectional relationship between each level. A modified socio-ecological framework was used to operationalize the structural, interpersonal, or individual levels of transgender based stigma, based on type of experience (White Hughton, Reisner, & Pachankis, 2015). Even when one form of stigma is addressed, the existence of stigma in other forms will continue to negatively impact transgender health outcomes (White Hughton, Reisner, & Pachankis, 2015).

Based on this rationale, the modified socio-ecological model adapted by White Hughton, Resiner, and Pachankis (2015) was used as the theoretical framework to evaluate panel responses to the open-ended questions posed in round one of the Delphi process (Figure 1. Appendix F). In this model, stigma is operationalized by the level it is experienced: *structural, interpersonal, and individual*. Use of this framework also allowed the researcher to further identify which themes elicit more attention from expert panelists.

Theoretical Definitions

The structural level of the model is composed of cultural norms, institutional policies or practices, and organizational expectations that impose either a positive or negative message regarding transgender individuals or associated groups (Edwards, Goodman, & Neumann, 2019; White Hughto, Reisner, & Pachankis, 2015). An example of structural level stigma is the reinforcement of a binary gender in society and the healthcare system. Gender binary norms force transgender persons whose gender identity does not align with their biological sex characteristics to be classified as “other” (Link & Phelan, 2014; Schilt & Westbrook, 2009).

Reversely, the recent removal of gender identity disorder from the DSM suggests that nonbinary gender identity in no longer considered a deviant behavior or mental disorder (APA, 2013; White Hughto, Reisner, & Pachankis, 2015).

The interpersonal level interaction can be direct or endorsed as a result of explicit or implicit bias towards a person or associated group (White Hughton, Resner, & Pachankis, 2015). Cultural norms or information passed down from the structural level can influence interpersonal level interactions (Edwards, Goodman, & Neumann, 2018). Interpersonal stigma can often take the form of verbal harassment or physical assault based on transgender identity or expression (White Hughto, Reisner,& Pachankis, 2015). Overt scrutiny and frequent use of incorrect language in the healthcare setting are common forms of interpersonal level stigma experienced by transgender individuals (White Hughto, Reisner, & Pachankis, 2015).

The individual or intrapersonal level refers to a person's biological or socio-cultural identity that shapes how a person presents themselves or is treated by others (Edward, Goodman, & Neumann, 2019). Age, gender or sexual identity, religious affiliation, racial and ethnic origin, social class, and physical ability are some commonly identified individual level components (Edwards, Goodman, & Neumann, 2019). Additionally, stigma at the interpersonal or structural level can impact behavioral or psycho-social aspects at the individual level (White Hughto, Reisner, & Pachankis, 2015). For example, transgender persons who report mistreatment in the healthcare setting may avoid medical care (Grant, 2011; Resiner et al., 2015) or conceal their transgender identity to prevent negative reactions (Cruz, 2014; Dewey, 2008; Mizock & Mueser, 2014).

Methods

Research Questions

The following research questions were posed: (1) How is *transgender inclusion* in the healthcare environment defined? (2) What are major facilitators and barriers for transgender inclusion within the veteran health care system? (3) How do transgender veterans, and direct care nursing staff responses compare?

Design and Rationale

The research study employed a Delphi design. Originally used as a method for predicting military warfare outcomes (Clibbens et al., 2012; Dalkey & Helmer, 1962; Dalkey, 1969; Helmer, 1967; Keeney, Hassan, & McKenna, 2011), the Delphi technique uses a sequential series of survey rounds to achieve group consensus through controlled feedback (Dalkey & Helmer, 1963; Keeney, Hassan, & McKenna, 2011). The process is founded on the assumption that group opinion is superior to individual belief (Keeney, Hassan, & McKenna, 2011). This technique offers a way to structure and consolidate individual responses across various groups (Powell, 2002). While the Delphi method has been used in a variety of settings, it can be aptly applied to under-researched areas to bring together diverse views on issues where opinion is vital, yet little evidence exists (Thangaratinam & Redman, 2005).

The extent of the research problem and need for group decision making determines the appropriateness of a Delphi approach (Hassan, Keeney, & McKenna, 2000). The Delphi design is ideal for consensus building because of the ability to elicit underlying assumptions and multiple perspectives (Delbecq, Van de Han, & Gustafson, 1975). Rowe and Wright (1999) suggested that the anonymity and structure of the Delphi Technique may result in a more accurate assessment compared to other approaches where individual response may be inhibited. Furthermore, the sharing of responses and attempts to achieve group consensus elicited in the Delphi approach may be reassuring and encourage participants to objectively share (Lindeman,

1975). Given the historical stigma and sensitive nature of the topic, combined with the lack of individual or collective viewpoints present within the existing literature, a Delphi design provided an innovative way to obtain a consensus opinion regarding transgender inclusion in the veterans' healthcare system.

Population and Sample.

In order to achieve the objectives of this study, it was necessary to employ expert panel participants. The term expert within the Delphi design implies that participants have extensive knowledge, perspective, and current experience with the topic or condition under investigation (Keeney, Hassan, & McKenna, 2011; Powell, 2002). Furthermore, Skulmoski et al. (2007) add that criteria for expertise also include willingness, time to participate, and adequate communication skills. A heterogenous sample of the target population is crucial to obtaining a comprehensive viewpoint and increased external validity (Keeney Hassan, & McKenna., 2011; Vernon, 2009). Therefore, purposeful and snowball sampling were used to recruit a mix of transgender veteran and direct care nursing staff expert panel members from the Central Texas Veterans Health Care System (CTVHCS) population. Nursing staff (n = 5) were recruited through facility wide email announcements, and word of mouth. Recruitment flyers (Figure 2. Appendix F) distributed to primary care clinics and Lesbian Gay Bisexual and Transgender (LGBT) Veteran Care Coordinators at CTVHCS, along with announcements at LGBT special interest community outreach groups were used to recruit Transgender Veteran (n = 5) participants. Table 1. Appendix C displays the demographic composition of both groups.

Although the size of the panels is limited, this study benefits from an expert sample that included a mix of transgender veterans and direct care nursing staff participants, diverse levels of experience, and two distinct geographic locations within the healthcare system. Representation

of the sample is derived from the qualifications of the expert panel rather than the sheer number of panel members (Powell, 2003). No standard guidelines exist to suggest the exact number of participants needed. Opinion on panel sizes range anywhere from less than 10 to upwards of 500 (Keeney, Hassan, & McKenna, 2011). However, Delbecq and colleagues (1975) reported that increased panel sizes beyond 30 experts have not resulted in improved results. Based on what is known about Delphi studies, the participant sample size ($N = 10$) was deemed sufficient to gain a consensus that may be explored in the larger population to a larger sample.

Inclusion and Exclusion Criteria

All study participants were between the ages of 18 and 89 years old, citizens of the United States, and proficient in English. To protect the anonymity and identification of participants, persons over the age of 89 were excluded. Transgender veteran panel members were currently enrolled and receiving primary care through CTVHCS for a minimum of one year and self-identified as a transgender person. Direct care nurse staff panelists held a current Registered Nurse (RN) or Licensed Vocational Nurse (LVN) license, were permanent employees of the CTVHCS for a minimum of one consecutive year and had provided direct patient care to one or more transgender veterans in their CTVHCS position within the last six months.

Protection of Human Subjects.

Final study approval was granted by the University of Texas at Tyler Institutional Review Board (IRB) and the CTVHCS IRB with the CTVHCS IRB as the IRB of record (Figures 3A &3B, Appendix F). Guidelines for human subject research was maintained throughout the study. Study participation was strictly voluntary. The purpose, objectives, and minimal risks pertaining to the study were disclosed during the informed consent process. All participants were instructed to read and acknowledge informed consent (Figure 4, Appendix F) prior to starting each round of

the study. Prior to dissemination, approval for the survey questions was obtained from the Union (Figure 5A, Appendix F) in accordance with the American Federation of Government Employees (AFGE) Master agreement and a memorandum of support to recruit nursing staff was solicited from nursing leadership within the CTVHCS healthcare system (Figure 5B, Appendix F).

A key feature of the Delphi design is participant confidentiality (Keeney, Hassan, & McKenna, 2011; Rowe, 1991); therefore, only the principal investigator had access to participant names and email information for the purposes of survey distribution. No other personal information directly linked to the participant was collected. Survey responses were collected via a secure SurveyMonkey link where data was compiled in a password protected electronic format. SurveyMonkey did not collect identifying information such as name, email address, or IP address; therefore, responses remained unidentified. All data pertaining to this study was stored in a secure password protected file on the primary investigator's computer and will be maintained in accordance with VA and IRB policy. Disseminated findings were combined to protect the identification of participants. The potential identification of a participant based on demographic information within the survey posed only minimal risk to study participants.

Data Collection.

Self-identified transgender veterans receiving care at CTVHCS and direct care nursing staff meeting the expert panel inclusion criteria were invited via email to complete a series of surveys. The same participants from each expert panel were invited to participate in both rounds of the Delphi process. At the beginning of each round, participants received an emailed link to access the survey. SurveyMonkey (2019) software was used to disseminate and collect survey data. Survey rounds were open for 14 calendar days for response submission. The open

timeframe for Round 1 was extended by 21 calendar days for the purpose of recruitment and to allow enough participants to respond. A reminder email was sent at seven days and again one day prior to the close of each round. Additionally, at the start of each round, participants were given instructions for completing that round and provided a current definition of the term transgender.

Round One. After confirming inclusion criteria was met and acknowledging informed consent, participants answered six demographic questions (Figure 6A, Appendix F). They responded to three open-ended questions designed to determine how they defined transgender inclusion in a veteran healthcare setting, and to identify factors they felt enforced or prevented the actualization of transgender inclusion within the veteran's health care system (Figure 6B, Appendices F). At the end of the survey, participants received a reminder to participate in the subsequent survey round.

Round Two. During round two, panel responses and themes derived from content analysis of round one data were presented in a 57-item survey (Figure 7, Appendix F). All participants from round one received an email invitation to participate in round two. Participants were again asked to acknowledge informed consent and given directions for completing the survey. Participants were asked to rank each of the consolidated 57 items using a five-point Likert scale with 1 being "completely disagree" and 5 being "completely agree".

Round Three. After data analysis from round two, items that did not reached consensus were reassessed. Based on this analysis, participants were not asked to re-rank items from the subsequent round. For transparency, participants were presented with the median score and range of the overall group response. Additional opportunity to provide qualitative feedback was provided but no additional data was collected.

Analysis.

Round One. Content analysis of open-ended responses from round one was used to group expert statements into themes using the Social Ecological Model as a framework. Participant responses were read by the primary investigator and transferred into a Microsoft Excel worksheet. Similar statements were grouped into themes. Duplicate statements or statements with the same meaning were collapsed into one statement. All attempts were made to maintain original wording or response meaning. Derived themes were also compared between expert panel groups. Preliminary descriptive analysis was conducted to determine the frequency and distribution of the demographic characteristics of the expert panels.

Round Two. Themes from round one responses were used to create the 57 survey items (Figure 8, Appendix F) in round two and presented to participants to rank on a 5-point Likert scale. Based on the statistical level of data being collected descriptive statistics were used to quantify response rates by frequency, and percentage (Salkind, 2017). Overall and comparison panel group mean, standard deviation and distribution of scores were analyzed using SPSS. Because there is no standard level of consensus (Keeney, Hassan, & McKenna, 2011), consensus was set at 70% to allow for convergence without sacrificing variance in scores. This cut-off percentage was suggested by Sumsion (1998) and McKenna et al. (2002) and most frequently cited as the level of consensus for healthcare related Delphi studies (Vernon 2009). Consensus was achieved if 70% of responses fell within either two categories for agreement or two categories for disagreement on a five-point Likert scale. Consensus was achieved when 70% of panelists indicated agree or strongly agree for defining factors, barriers, and facilitators of

transgender inclusion. To account for described experiences, consensus disagreement was also when 70% of panelists indicated disagree or strongly disagree for items related to experience.

Results

Ten expert panel members were invited via email to participate in Round 1. Panel demographics characteristics represented an equal mix of transgender veteran (n = 5) and nurse expert panelists (n=5) (Table 1, Appendix C). Ages of panel participants ranged from 26 to 63 (M = 45.9). Gender designation among participants was mixed with the majority identifying as female (40%), followed by male (20%), other (20%), transgender male (10%), and Gender Queer (10%). In regard to sexual orientation, the majority of participants identified as heterosexual (60%). Other panelists identified as bisexual (30%) or queer (10%). Racial identity was mixed between white (50%), other (30%), black or African American (10%) and Hispanic or Latino (10%). All transgender veteran panelist indicated Austin as their primary healthcare location compared to two nurse panelists designating Austin and three designating Temple as their primary work location. Number or years working at the VA for nurse panelists ranged from one to four years (M = 2.2). Transgender veterans reported receiving healthcare at a VA facility between one and twenty-five years (M = 10).

Round One Item Identification

The purpose of round one was to extract themes or phrases that defined transgender inclusion and identified contributing factors related to inclusion. Raw data from both panel groups was combined in an attempt to create an exhaustive list of potential items. Analysis of round one responses and derived themes resulted in identification of 57 items posed for reevaluation by expert panelists. Of the combined items, 14 were linked to the definition of transgender inclusion and the remaining 43 items were exemplars describing existing barriers

and facilitators to achieving transgender inclusion, as well as related experiences and perceptions that surfaced in response to the open-ended questions posed.

Participants shared opinions regarding the current state of transgender inclusion and described experiences. One expert panelist remarked that "it's very fringe barely exists". Another stated that "its current standings are on the border of 'fair and good' it needs improvement overall". These responses were comparable to a response from a nurse panelist stating, "I do not feel prepared to handle the unique needs of a transgender patient". Even though these themes did not directly identify defining characteristics of transgender inclusion, they were included as round two survey items to assess the level of consensus.

Round Two Item Consensus

Mean, Standard Deviation and consensus percentage were calculated collectively and within panel groups (Table 2 and Table 3, Appendix C). Results from round two revealed that defining indicators of transgender inclusion with consensus of ≥80% included: provision of treatment based on gender identity ($M = 4.4$, $SD = 0.66$), use of preferred names ($M = 4.8$, $SD = 0.4$), use of preferred pronouns ($M = 4.8$, $SD = 0.4$), use of preferred titles ($M = 4.8$, $SD = 0.4$), sensitivity to transgender specific challenges ($M = 4.5$, $SD = 1.2$), treating all persons with dignity and respect ($M = 4.3$, $SD = 0.92$), and provider awareness of healthcare options available to transgender persons ($M = 4.4$, $SD = 0.64$). Transgender inclusion was also defined as not making judgements about identity ($M = 4.4$, $SD = 0.64$) or assumptions about medical decisions based on gender identity ($M = 4.5$, $SD = 1.2$). Transgender inclusive healthcare systems were described as welcoming and supportive of all persons. Consensus on these defining characteristics was achieved at ≥80% comprehensively as well as within expert panel groups. Panelists did not agree that transgender inclusion was non-existent ($M = 2.7$, $SD = 0.9$) but did cohesively agree that it needed improvement ($M = 4.3$, $SD = 0.64$) and was something people

were still getting used to within the Veterans healthcare system ($M = 3.9$, $SD = 0.7$). They also agreed that VA providers were unprepared to meet the needs of transgender Veterans ($M = 4.2$, $SD = 0.6$).

Panel scores in round two also indicated that barriers to transgender inclusion where related to lack of provider knowledge ($M = 4.9$, $SD = 0.3$) with 100% agreement consensus, and poor communication ($M = 4.7$, $SD = 1.37$) 90% agreement. Panelists agreed that inclusion was facilitated when providers allowed the veteran to guide conversation ($M = 3.7$, $SD = 1.49$). All participants agreed that diversity training ($M = 4.2$, $SD = 0.98$) facilitated transgender inclusion followed by 70% agreement that transgender allies ($M = 3.7$, $SD = 0.78$) promoted inclusion in the healthcare system. The panel felt that training led by LGTBQ knowledgeable staff promoted inclusion ($M = 4.2$, $SD = 1.08$) with 100% consensus. The majority of combined panelists neither agreed nor disagreed that national guidelines for transgender healthcare promoted inclusion ($M = 3.2$, $SD = 0.6$) indicating a neutral stance.

Differences Between Veterans and Nurses

Based on frequency distribution and mean scores for each panel group, further analysis revealed parallels and divergence of opinion between groups (Table 2, Appendix C). Both groups responded cohesively to the defining characteristics of transgender inclusion and overall existence of inclusion within the healthcare system. However, less agreement occurred in response to items related to the experience of barrier and facilitator themes identified by the collective group. Since these items were more reflective of the environmental state of the health system specific to inclusion, identified barriers, and facilitators rather than the identification of a defining characteristic, the items were not redistributed for panel consensus but instead were only compared between groups.

Even though an overwhelming 100% of panelists agreed that lack of knowledge was a barrier to transgender inclusion, 60% of nurses perceived that providers in the healthcare system had a basic knowledge of transgender health issues ($M = 3.6$, $SD = 0.49$), opposed to 80% of transgender veterans who disagreed ($M = 2.2$, $SD = 0.8$). Among transgender veteran panelists 80% indicated that providers often questioned their gender identity (Veteran $M = 3.6$, $SD = 1.36$) compared to only 20% of nurse panelists ($M = 2.8$, $SD = 0.98$). Differences were also noted in the perception of whether providers often confused gender identity with sexuality (veterans $M = 4.4$, $SD = 0.8$; nurses $M = 2.8$, $SD = 0.98$), or avoided discussing gender identity (veterans $M = 4.4$, $SD = 0.8$; nurses $M = 2.8$, $SD = 0.98$). Perceptions that providers sometimes ask inappropriate questions (veterans $M = 4.4$, $SD = 0.8$; nurses $M = 2.4$, $SD = 1.02$) were inconsistent between groups. Similarly, opinions diverged regarding whether transgender persons were pre-judged based on media portrayal (veterans $M = 4.6$, $SD = 0.8$; nurses $M = 1.4$, $SD = 1.4$) or that they have heard derogatory or offensive comments about transgender persons (veterans $M = 4$, $SD = 0.63$; nurses $M = 2.4$, $SD = 1.74$). In these cases, transgender veterans trended in the direction of agreement and nurses towards disagreement. Direct care nurses reported 80% consensus that poor behavior towards transgender persons was not tolerated in the healthcare system ($M = 4.6$, $SD = 0.8$); however, 60% of transgender veteran panelists disagreed ($M = 2.6$, $SD = 1.46$).

Discussion of Findings

This study examined how both transgender veterans and direct care nursing staff defined transgender inclusion and identified key facilitating factors and barriers to creating transgender inclusive environments. Based on responses to the open-ended questions posed in round one and consensus agreement achieved in round two, transgender inclusion was defined as treating

transgender veterans with dignity and respect by being sensitive to their unique experiences and needs and engaging in dialog about healthcare options without assumption or judgement. Transgender inclusion incorporates the use of preferred names, pronouns, and titles. Barriers and facilitators to transgender inclusion were described at the interpersonal level of the modified Social Ecological Model, and reinforced that there is a lack of knowledge, skill and cultural awareness in the provision of transgender veteran care (Rowe, Ng, & O'Keefe, 2017). Barriers included a lack of provider education and poor communication. To facilitate transgender inclusion, panelists felt that it was important to let the veteran guide the health conversation. Patient involvement encourages mutual accountability, understanding, and informed decision making on both sides (WHO, 2016). Other identified facilitators of transgender inclusion included diversity training, training by LGBT knowledgeable persons, and the presence of transgender allies within the healthcare system.

Data was analyzed in the context of the modified Social Ecological Model. Findings support that transgender inclusion is shaped by multiple levels of stigma and interaction, there is a bidirectional and reinforcing relationship between levels, and addressing one level of stigma without addressing other levels negatively impacts achievement of transgender inclusion. Participants reported both interpersonal and structural levels of stigma; however, examples of individual level stigma were not shared. Data indicated an interconnected relationship between levels, and further suggested that while efforts have been made to address structural level stigma, the prevalence of interpersonal level stigma continues to create barriers to transgender inclusion.

Evidence of interpersonal level stigma was present in the data reflecting provider bias experienced. Previous studies noted that transgender veterans were cautious about seeking medical care within the VA because of discrimination or negative provider interactions

(Shipherd et al., 2012). Findings from this study support that some level of provider bias towards transgender persons (M = 3.4, SD = 0.64) continues to exist in the present healthcare system. Providers should reflect on their personal beliefs and biases and normative assumptions that may hinder communication and patient relationship building (Lee & Kanji, 2017). Furthermore, both panel groups indicated that providers often make assumptions based on physical appearance (M = 3.9, SD = 1.14), thus reinforcing the multifaceted and bidirectional relationship between individual and interpersonal levels of stigma.

Interpersonal level stigma, specifically communication barriers, were prevalent throughout survey responses. Efforts to improve patient-provider communication through information sharing and skill building will be a key factor in facilitating transgender inclusion within the veterans healthcare system. Findings from this study suggest that both veterans and nurses viewed communication as an area for improvement. Based on combined panel scores, providers in the healthcare system avoided discussing gender identity (M = 4.1, SD = 1.04) and sexuality or sexual orientation (M = 3.8, SD = 0.75). Open discussion about sexual identity and sexual orientation is not only important to identifying health risk factors and disparities associated with transgender populations (Sherman et al., 2014), but it also influences identified defining factors of inclusion such as being sensitive to transgender persons' unique needs, not making assumptions about medical decisions, and exploring all healthcare options with the patient. The absence of culturally inclusive skills negatively impacts interpersonal levels of stigma such as willingness to disclose and participate in health promoting behavior (Hendricks & Testa, 2012), and may result in poor health outcomes (Chen, et al., 217). Findings suggest that providers may not know how to ask these questions.

Improper language and unsolicited inquiry are common forms of interpersonal level stigma encountered by transgender persons (White Hughto, Reisner, & Pachankis, 2015). Transgender panelists reported that they had overheard derogatory comments about transgender persons ($M = 4$, $SD = 0.63$) or witnessed negative non-verbal gestures ($M = 3.6$, $SD = 0.8$). These negative experiences were less obvious to nursing staff; additional examination of implicit bias and influence of individual level stigma among providers may be warranted.

Findings imply that lack of training and interpersonal level stigma may be influenced by structural levels of stigma in that the organization does not prepare providers with skills to meet transgender veterans' healthcare needs. Despite lack of knowledge being a barrier to transgender inclusion, 70% of transgender respondents indicated that providers lacked a basic knowledge of transition services ($M = 2.5$, $SD = 1.02$) or even general healthcare services offered by the VA ($M = 2.4$, $SD = 1.2$). A basic knowledge of cultural must exist to achieve inclusion (Forondo, 2008), prevent unintended stigma, and establish trust (Cai, 2016). Among all panelists, agreement about providers having a basic knowledge of transgender specific services was split ($M = 2.6$, $SD = 0.92$). This is consistent with previous suggestions that providers are not adequately trained (Lutwak et al., 2014; Sawning et al., 2018) and lacked experience caring for transgender patients (McNair & Hegarty, 2010). These findings imply that providers need additional training concerning availability of services and transgender specific issues. When asked whether the healthcare system provides transgender related training to staff, the combined panel mostly disagreed ($M = 3.8$, $SD = 1.25$; nurses $M = 2.6$, $SD = 0.8$; transgender participants $M = 2.8$, $SD = 0.98$). Findings also indicate that training led by LGTBQ knowledgeable staff facilitated inclusion ($M = 4.2$, SD = 1.08) but that this was not presently occurring within the healthcare system ($M = 1.9$, $SD = 0.94$). Transgender allies were also regarded as transgender

inclusion facilitators (M = 3.7, SD = 0.7) but most participants were not aware of transgender allies within the healthcare system (M = 2, SD = 0,89). According to the Gay and Lesbian Medical Association (2006), clinical environments should display sexual and gender minority friendly materials and resource information. Future training initiatives may benefit from the involvement of LGBTQ knowledgeable staff and the identification of transgender allies. It is less obvious but may be implied that the socio-cultural identity of LGBT friendly staff and transgender allies at the individual level stand to positively reinforce interpersonal and structural level concepts. Additional evaluation of the healthcare environment is warranted.

Data also suggested the existence of structural level stigma. The use of preferred pronouns, titles, and names were identified as defining factors of transgender inclusion, yet both veterans and nurses indicated that the healthcare record did not reflect the veterans' preferred gender identity (M = 2.2, SD = 1.08), suggesting structural level barriers and room for improvement in the health record beyond the gender binary norms. Nurse participants disagreed that the veterans' preferred name was evident in the health record (M = 1.8, SD = 0.49); however, transgender participants responded neutrally (M = 3.2, SD = 0.95). Some nurse panelists (M = 3.8, SD = 0.98) and transgender veterans (M = 2.4, SD = 0.49) indicated that providers ask transgender veterans for their "real" name or name given at birth. These experiences could also be linked to the inconsistent or neutral responses regarding the impact of national guidelines for transgender healthcare. Nurses in this study were unclear, and most transgender veterans disagreed, as to whether providers in the healthcare system were familiar with national guidelines (veterans M = 2, SD = 0.63; nurses M = 3, SD = 0.63) or if guidelines were being used consistently (veterans M = 1.6, SD = 0.8; nurses M = 3.4, SD = 1.6). It is

possible that even though structural level guidelines have been published, the influence of other levels of stigma impair the clear and consistent application of these guidelines.

Strengths and Limitations

Although the study provides new insight into the perspectives of transgender veterans and front-line staff, it is not without limitations. Some of the limitations were attributed to recruitment constraints. Purposeful sampling techniques utilized in the study limited generalizability of findings to all transgender veterans or the entire transgender population. Threats may have existed based on the level of exposure and experiences of individual panel members. Different healthcare facility locations might have unique cultures. This the participation of nurse and transgender panelists from two distinct location may have been a limitation in this study. The voluntary nature of the study may have posed a threat to internal validity, as selection bias may limit generalizability. However, clear inclusion criteria and optimal participation from knowledgeable and experienced panel experts enhanced content validity (Goodman, 1987). The study was also conducted during the COVID-19 pandemic. Clinic closures and staff details to other work areas made advertisement and contact with potential participants more difficult. Although it was not possible to recruit a larger sample as originally intended, the use of two distinct expert panels increased efficacy of the study.

The use of successive Delphi rounds and achievement of consensus stand to increase validity (Hassan, Keeney, & McKenna, 2000). Validity may have also been strengthened by the consistent response rate from participants. Employment of knowledgeable participants with a vested interest in the topic can enhance concurrent validity within the Delphi method (Hassan, Keeney, & McKenna, 2000). A minimum response rate of 70% for each round is suggested to maintain rigor when utilizing a Delphi approach (Sumsion, 1998). Response rates in this study

were maintained at 100% for each survey round. The use of subsequent rounds and controlled feedback to participants also accounted for enhanced reliability throughout the process. Credibility of the study is dependent on the researcher's self-awareness (Houghton et al., 2013). Personal bias was assessed and monitored throughout the study to avoid influencing data interpretation (Campbell, 2015) and selection of participants.

The study panel was able to reach consensus on 10 defining attributes of transgender inclusion, as well as identify two distinct barriers, and five facilitators. However, the use of an online survey tool limited the ability to expand on the qualitative meaning behind some themes derived from the open-ended questions. While all responses were meaningful, additional opportunity for discussion with individual participants may have resulted in additional items or exploratory themes.

Historical threats surrounding transgender military service and fluctuating political climate posed potential threats to internal validity. Threats to content validity also existed within the use of current transgender specific terminology within the survey. Terminology may not have identical or meaningful definition for all study participants. Provision of a glossary of terms within the survey accounted for this factor.

Summary and Implications

There are more than 5,000 identified transgender veterans utilizing VHA healthcare services (Brown & Jones, 2016). Despite the fact that VHA is one of the largest single healthcare providers of transgender healthcare, transgender veterans continue to experience significant health disparities and barriers to care. Existing literature has only begun to examine the full extent of this problem. Additional research is needed to understand the state of transgender inclusion in healthcare and drive necessary actions to ensure the needs of the transgender veteran, healthcare provider, and associated infrastructures are being met. This is

the first study to simultaneously examine and compare the perspective of both transgender veterans and direct care providers in regards to how they define and experience transgender inclusion.

This study employed a unique approach to reaching a consensus definition of transgender inclusion and identify facilitators and barriers to achieving transgender inclusiveness within a veteran healthcare setting. Findings from this study can be used to further examine the current climate of transgender inclusion within the healthcare system, as well as identify priorities for improvement and further training and policy initiatives. Improved transgender inclusion stands to promote positive interactions, thus reducing barriers and improving health outcomes (James, et al. 2016). While the findings are restricted by the limitations of this study, assessing, and comparing the perspectives of both the transgender veteran and front-line provider offers valuable information in shaping future efforts. Replication of the study on a larger scale within and outside of the veteran healthcare system is supported. Future research may examine the perspective of other health care disciplines and administrative front line staff. While consensus for defining characteristics of transgender inclusion was achieved, the results of this study indicated that improvement is needed in regards to provider knowledge of transgender health issues, veteran-provider communication, and tolerance for discrimination. The development and testing of targeting interventions to address the experienced barriers identified in this study is warranted. Continued involvement and direct dialog with the transgender veteran community is recommended to inform and promote culturally inclusive research initiatives.

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Chapter 5: Summary and Conclusion

Diversity and inclusion in healthcare are continuously expanding beyond the constructs of race and ethnicity (Kaaiken, Coehlo, Steele, & Robinson, 2018). Likewise, transgender visibility in the United States, the military and in healthcare has grown exponentially in recent years (Billard, 2016; National Center for Transgender Equality, 2017; VHA, 2017). However, information and measures regarding the extent of cultural inclusion towards this diverse population are extremely limited. While the exact number of transgender veterans is unknown, many receive care through the Veterans Healthcare Administration (VHA) (Kauth et al., 2014). Evidence has shown that transgender veterans experience profound health disparities and barriers to accessing care (Blosnich et al., 2013; Bukowski et al, 2017), which may contribute to high rates of discrimination and societal stigmatization (Shipherd et al., 2012; Lutwak et al., 2014). Policy and visibility alone are not sufficient to address these concerns. It is important that not only does research occur, but that the perspective of both the transgender individual and direct care provider are included. Findings from these manuscripts offer an initial step towards the examination of and achieving transgender inclusion in healthcare.

Overview and Findings

Transgender Veteran Healthcare: A State of Science examined the current state of transgender veteran healthcare based on an evaluation of peer-reviewed scientific literature. Despite increased representation of transgender veterans and recent expansion of targeted inquiry, gaps within the literature continue to exist. Findings from 14 studies revealed that transgender veterans have unique healthcare needs including psychological, physical, and socio-cultural care. Mental health disparities included increased rates of depression (Hill et al., 2016; Levahot et al., 2017), suicide (Blosnich et al., 2013; Brown & Jones, 2015; Bukowski et al,

2017; James et al., 2016), substance abuse (Brown & Jones, 2015; Bukowski et al., 2017), Post Traumatic Stress Disorder (PTSD) (Hill et al., 2016) and Military Sexual Trauma (MST) (Brown & Jones, 2015; Bukowski et al., 2017). Increased prevalence of physical conditions such as HIV, congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD), diabetes, hypertension (Brown & Jones, 2015), and increase body mass index (BMI) (Brown & Jones, 2015; Hill et al., 2016) were also documented. Additionally, findings suggested that transgender veterans face multiple barriers to care such as discrimination (Chen et al., 2017), unwelcoming environments (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd et al., 2012), lack of knowledge by providers (Chen et al., Lutwak et al., 2014; Rosenthal et al., 2016), limited services, and cost (Levahot et al., 2017; Sherman, Kauth, Shipherd, & Street, 2014) and addressing these barriers is warranted. Discrimination and other barriers to care have negative implications on the overall health of the transgender veterans (Dietert, Dentice, & Keig, 2017; Lutwak et al., 2014).

Provider perspectives regarding culturally inclusive care and unmet needs were overwhelmingly lacking, thus warranting further scientific exploration. Limited reports suggested that some healthcare providers endorsed a welcoming and culturally inclusive environment (Sherman, et al., 2014), contrary to transgender veterans who reported lack of provider knowledge regarding transgender related healthcare issues (Chen et al., 2017; Rosenthal, et al., 2016), and unwelcoming environments (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd et al., 2012).

Cultural Inclusion: A Concept Analysis presented an analysis of the concept, cultural inclusion in health care through the lens of sexual and gender minorities (SGM). Analysis of cultural inclusion suggested a concept that is beyond cultural competency and humility. Cultural

inclusion is relevant to addressing health disparities in SGM groups and may be applicable to other marginalized groups.

Cultural inclusion is attributed to knowledge, self-awareness, skills, environment, and engagement factors. In order for cultural inclusion to occur, diversity, interaction, and the desire to attain inclusion must first exist. Achievement of cultural inclusion promotes open and effective communication between patients and providers, fosters psychological safety, and enhances trust. There is also reason to suggest that cultural inclusion may also positively impact patient satisfaction and health outcomes, but further evaluation is needed.

Assessing Transgender Inclusion within a Veterans Healthcare System: A Delphi Study reported consensus definition of the construct of transgender inclusion and related barriers and facilitators. Defining characteristics were derived from an expert panel ($N = 10$) consensus using a Delphi method. Expert panel participants consisted of both transgender Veterans and front-line nursing staff who had direct patient care interactions with at least one transgender Veteran within the last six-months.

During round one of the Delphi process, expert panel participants were asked to respond to three open ended questions about how they defined transgender inclusion, and what barriers or facilitators to transgender inclusion existed in the healthcare system. Responses were analyzed and consolidated into themes, resulting in the creation of 57 items. The same expert panel participants were asked to evaluate the 57 items for agreement in a subsequent survey round. Findings indicated that the panel met consensus ($\geq 70\%$) agreement on 10 defining indicators of transgender inclusion. Defining factors include included: provision of treatment based on gender identity, use of preferred name, use of preferred pronouns, use of preferred titles, sensitivity to transgender specific challenges, treating all persons with dignity and respect, provider awareness

of healthcare options available to transgender persons, not making judgements about identity, not making assumptions about medical decisions based on gender identity, and be welcoming and supportive of all persons. Additionally, the panel identified lack of provider knowledge and poor communication were barrier. Identified facilitators included: providers allowing the veteran to guide conversation, diversity training, transgender allies, and training led by LGTBQ knowledgeable staff. Additional comparison between transgender veteran and nurse panel groups revealed differing perceptions pertaining to the existence or exposure to inclusive facilitators and barriers such as training, bias, negative encounters, and policy . Findings suggested that some level of inclusion exists, but improvement and further investigation is needed policy.

Recommendations

Transgender Veterans represent a culturally diverse yet marginalized population that is vastly under researched and underserved. Knowledge regarding transgender inclusion remains in a developmental stage that warrants additional research. Results of this study reinforced that there is a disconnect between transgender veterans' and providers' perceptions regarding inclusion. Lack of provider knowledge, adequate training, poor communication, and bias continue to have negative impact on access to inclusive patient centered care. Given the exploratory design of this study and the lack of existing research surrounding this topic, findings from this study can be used as a framework to guide future meaningful research with transgender populations and direct care providers across diverse healthcare environments. Findings can help inform efforts designed to develop and test appropriate strategies to promote inclusivity and reduce health disparities for transgender veterans that may be related to inclusion barriers.

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Appendix A. Chapter 2 Tables

Table 1. Prevalent Health Disparities Among Transgender Veterans

Mental Health	**Physical Health**
Post-Traumatic Stress Disorder (PTSD)	HIV
Depression	Chronic Obstructive Pulmonary Disorder
Suicidal Ideation/ Suicide Attempt	Congestive Heart Failure
Substance Abuse / Alcohol Abuse	Diabetes Meletus
Military Sexual Trauma (MST)	Hypertension
	Increase Body Mass Index (BMI)

Table 2. Documented Barriers to Transgender Veteran Healthcare Access

Internal Barriers	**External Barriers**
Identity Concealment Fear (Discrimination, Harassment, Loss of Services, Denial of Care)	Lack of Provider Knowledge Unwelcoming Environment Discrimination/Stigmatization Negative Reactions Transgender Specific Service Limitations Cost of Care

Appendix B. Chapter 3 Tables

Table 1: Cultural Inclusion Concept Analysis

Cultural Inclusion	
Conceptual Definition	
• Culture	• Set of beliefs, values, practices, or characteristics associated with a specific group • Influence thinking, decision making, and behavior
• Inclusion	• Act or state of being included • equitable access to resources • Act of creating a welcoming, supportive, and respectful environment or climate in which all parties are valued • Experienced acceptance for ideas and identity
Defining Attributes	• Knowledge • Self-Awareness • Skills • Environment • Engagement
Antecedents	• Diversity • Interaction/ Encounter • Desire to attain inclusion
Consequences	• Additional • Effective Communication • Open Communication • Safety • Trust • Increased Patient Satisfaction * • Improved Patient Outcomes * * implied but not tested

Appendix C. Chapter 4 Tables

Table 1. Expert Panel Demographics Round 1 and Round 2

Expert Panel Demographics				
		Combined (*N* = 10)	**Veterans (*n* = 5)**	**Nurses (*n* = 5)**
Gender				
	Male	2 (20%)	1 (20%)	1 (20%)
	Female	4 (40%)	1 (20%	3 (60%)
	Transgender Male	1 (10%)	1 (20%)	0 (0%)
	Transgender Fema	0 (0%)	0 (0%)	0 (0%)
	Genderqueer	1 (10%)	1 (20%)	0 (0%)
	Other	2 (20%)	1 (20%)	1 (20%)
Age Range				
		28-63 (M=45.9)	28-63 (M=48.6)	29-58 (M=43.2)
Race				
	White	5 (50%)	3 (60%)	2 (40%)
	Asian	0 (0%)	0 (0%)	0 (0%)
	Black/ African American	1 (10%)	0 (0%)	1 (20%)
	American Indian/ Alaska Native	0 (0%)	0 (0%)	0 (0%)
	Hispanic/ Latino/ Spanish	1 (10%)	0 (0%)	1 (20%)
	Middle Eastern/ North African	0 (0%)	0 (0%)	0 (0%)
	Pacific Islander/ Native Hawaiiian	0 (0%)	0 (0%)	0(0%)
	Other	3 (30%)	2 (40%)	1 (20%)
Sexual Orientation				
	Lesbian	0 (0%)	0 (0%)	0 (0%)
	Gay	0 (0%)	0 (0%)	0 (0%)
	Queer	1 (10%)	1 (20%)	0 (0%)
	Bisexual	3 (30%)	3 (60%)	0 (0%)
	Heterosexual	6 (60%)	1 (20%)	5 (100%)
	Pansexual	0 (0%)	0 (0%)	0 (0%)
	Questioning	0 (0%)	0 (0%)	0 (0%)
	Prefer not to Answer	0 (0%)	0 (0%)	0 (0%)
Primary Care Site				
	Austin		5 (100%)	2 (40%)
	Temple		0 (0%	3 (60%)
Years at VHA				
		1-25 (M=6.1)	4-25 (M=10)	1-4 (M=2.2)

Appendix C Chapter 4 Tables

Table 2. Round 2 Definitions and Existence of Transgender Inclusion

	Transgender Veterans (*n* =5)			Nurses (*n* =5)			Combined (*n* =10)		
	M	SD	Cns %	M	SD	Cns %	M	SD	Cns %
healthcare treatment based on gender identity.	4	0.63	80	4.8	0.4	100	4.4	0.66	90
use of preferred name.	4.8	0.4	80	4.8	0.4	100	4.8	0.4	90
use of preferred pronouns	4.8	0.4	100	4.8	0.4	100	4.8	0.4	100
use of person's preferred title	4.8	0.4	100	4.8	0.4	100	4.8	0.4	100
being sensitive to transgender persons' challenges.	4.2	1.6	80	4.8	0.4	100	4.5	1.2	90
not making assumptions about medical decisions.	4.2	1.6	80	4.8	0.4	100	4.5	1.2	90
not judging or questioning a person's identity.	4.6	0.8	80	4.8	0.4	100	4.4	0.64	90
being treated with dignity and respect.	4.4	1.2	80	4.8	0.4	100	4.3	0.92	90
making aware of all healthcare options.	4.6	0.8	80	4.8	0.4	100	4.4	0.64	90
welcoming and supportive of all persons.	4.8	0.4	100	4.2	1.6	80	4.5	1.2	90
inclusion does not exist.	2.8	1.17	*60	2.6	0.49	*40	2.7	0.9	*50
exists but needs improvement.	4.2	0.75	80	4.4	0.49	100	4.3	0.64	90
new thing that people are getting used to	4	0	100	3.8	0.98	80	3.9	0.7	90
VA providers feel unprepared	4	0.63	80	4.4	0.49	100	4.2	0.6	90
* indicates % disagree									

Appendix C Chapter 4 Tables

Table 3. Round 2 Barriers, Facilitators, Experiences, and Group Comparison

	Transgender Veterans (*n* =5)			Nurses (*n* =5)			Combined (*n* =10)		
	M	SD	Cns %	M	SD	Cns %	M	SD	Cns %
Lack of knowledge is a barrier	5	0	100	4.8	0.4	100	4.9	0.3	100
basic knowledge of transgender health issues.	2.2	0.8	*80	3.6	4.9	60	3	0.89	40
basic knowledge of transition related services.	2	0.99	*80	2.8	0.98	*60	2.5	1.02	*70
basic knowledge of transgender specific services	2.4	0.8	*60	2.8	0.98	*60	2.6	0.92	*60
basic knowledge about healthcare services	2.6	1.36	*60	4.2	0.98	*80	2.4	1.2	*70
Poor communication is a barrier	4.4	0.8	80	5	0	100	4.7	1.37	90
providers do not respect transgender persons	3.4	0.49	40	3.4	1.36	60	3.4	1.12	50
Providers are biased towards transgender persons.	3.6	1.02	60	3.2	1.17	60	3.4	0.64	60
providers question gender identity	3.6	1.36	80	2.8	0.98	20	3.2	1.02	50
providers confuse gender identity with sexuality.	4.4	0.8	80	2.8	0.98	20	3.6	1.11	50
providers ask inappropriate questions	4.4	0.8	80	2.4	1.02	*60	3.4	1.36	40
providers avoid discussing gender identity.	4.4	0.8	80	3.8	1.17	60	4.1	1.04	70
orientation.	4	0.63	80	3.6	0.8	60	3.8	0.75	70
portrayal	4.6	0.8	80	1.4	0.63	*80	3.3	1.49	0
heard derogatory or offensive comments	4	0.63	80	2.4	1.74	*60	3.2	1.54	60
seen negative non-verbal gestures	3.6	0.8	40	2.4	1.74	*60	3	1.48	40
Providers often make assumptions on appearance.	4.4	0.8	80	3.4	1.2	80	3.9	1.14	80
Providers are welcoming and supportive.	3	0.63	20	3.2	0.4	20	3.1	0.54	40
treat transgender Veterans with dignity and respect.	3	0.63	20	4	0.63	80	3.5	0.81	50
attempt to use preferred pronouns when addressing	3	0.63	20	3.8	0.98	80	3.4	0.92	50
argue about preferred pronoun usage.	2.4	0.49	*60	1.8	0.4	*100	2.1	0.54	*80
The health record reflects preferred gender identity.	2.8	1.17	*60	1.8	0.49	*100	2.2	1.08	*80
The healthcare record reflects preferred name.	3.2	0.98	20	1.8	0.49	*100	2.4	1.11	*60
ask transgender Veterans for "real" name.	2.4	0.49	*60	3.8	0.98	80	3.1	1.04	10
Poor behavior is not tolerated in my healthcare syst	2.6	1.46	*60	4.6	0.8	80	3.7	1.49	50
Transgender inclusion is promoted when providers allow the Veteran to guide the conversation.	4	0.63	80	4.2	0.4	100	3.7	0.78	90
Providers allow Veteran to guide the conversation.	2.4	0.49	*60	3.4	0.8	20	2.5	0.67	*30
provides transgender related training to staff.	2.8	0.98	20	2.6	0.8	*60	3.8	1.25	*40
Training by LGBTQ knowledgeable staff helps facilitate transgender inclusion.	5	0	100	4.8	0.4	100	4.2	1.08	100
healthcare system has LGBTQ knowledgeable staff	2.8	1.36	20	3.4	1.02	40	2.3	0.9	30
providers receive training led by LGBTQ knowledge	2	1.26	*60	1.8	0.4	*100	3.4	1.69	*80
Diversity training enhances transgender inclusion.	5	0	100	4.8	0.4	100	4.2	0.98	100
Diversity training is encouraged in my healthcare sy	3.2	1.17	60	3.4	0.8	60	3.3	1	60
LGBTQ advocates promote transgender inclusion ir	3.2	1.17	60	3.6	1.02	60	3.4	1.11	60
LGBTQ advocates are visible in my healthcare syst	2.8	1.36	20	2.4	1.02	*60	2.6	1.02	*40
Transgender Allies facilitate transgender inclusion i	3.8	0.4	80	3.6	1.02	60	3.7	0.78	70
I am aware of Transgender Allies in my healthcare s	2.4	1.02	*60	1.8	0.49	*100	2	0.89	*80
Providers are affirming of a person's gender identity	3.2	1.17	60	3.6	0.49	60	3.4	0.92	60
National guidelines help promote transgender inclus	2.8	0.4	*20	3.6	0.49	60	3.2	0.6	30
Providers are familiar with national guidelines for tra	2	0.63	*80	3	0.63	20	2.8	1.17	*50
National guidelines are used consistently across the	1.6	0.8	*80	3.4	1.36	60	2.5	1.43	*50
unisex restrooms help promote transgender inclusio	4	0.63	80	3	1.26	20	3.5	1.12	50
Unisex restrooms are available and easily accessibl	3.8	0.75	60	2	1.26	*60	2.9	1.37	0
* indicates % disagree									

Appendix D Chapter 2 Figures

Transgender Health <onbehalfof@manuscriptcentral.com>
Thu 12/6/2018 10:48 PM
To: Kathy-Jo Lee
06-Dec-2018

Dear Mrs. Lee:

Your manuscript entitled "Transgender Veterans Healthcare: State of Science" has been successfully submitted online and is presently being given full consideration for publication in Transgender Health.

This journal is fully open access and carries a 1000.00USD article publication charge which will be due if and when the manuscript is accepted.

Your manuscript ID is TRGH-2018-0064.

Please mention the above manuscript ID in all future correspondence or when calling the office for questions. If there are any changes in your street address or e-mail address, please log in to Manuscript Central at https://mc.manuscriptcentral.com/trgh and edit your user information as appropriate.

You can also view the status of your manuscript at any time by checking your Author Center after logging in to https://mc.manuscriptcentral.com/trgh.

Ensure you stay informed. Register to receive email alerts for the Journal(s) that are critical to advancing your work: www.liebertpub.com/liebertconnect (copy/paste the link into your browser).

Thank you for submitting your manuscript to Transgender Health..

Sincerely,
Transgender Health Editorial Office

Figure 1. SOS Manuscript Submission Acknowledgement Letter

Appendix D. Chapter 3 Figures

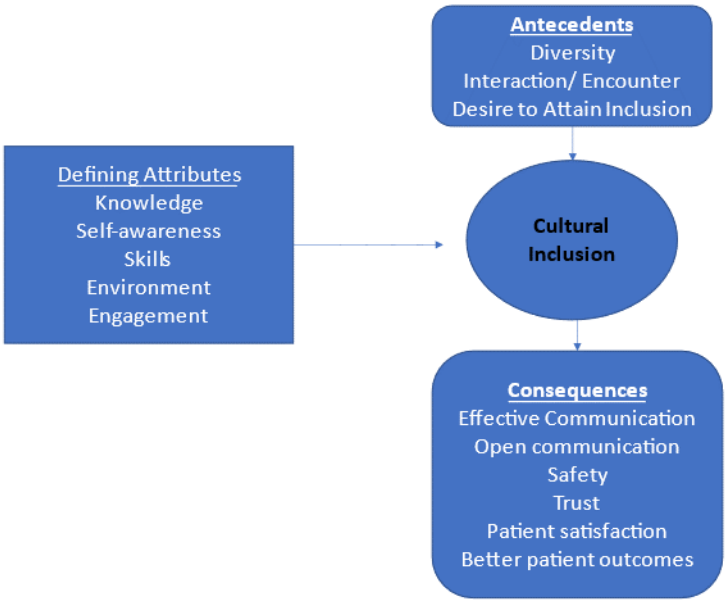


Figure 1. Cultural Inclusion: Relationship of Antecedents, Defining Characteristics, and Consequences

Appendix E. Chapter 4 Figures

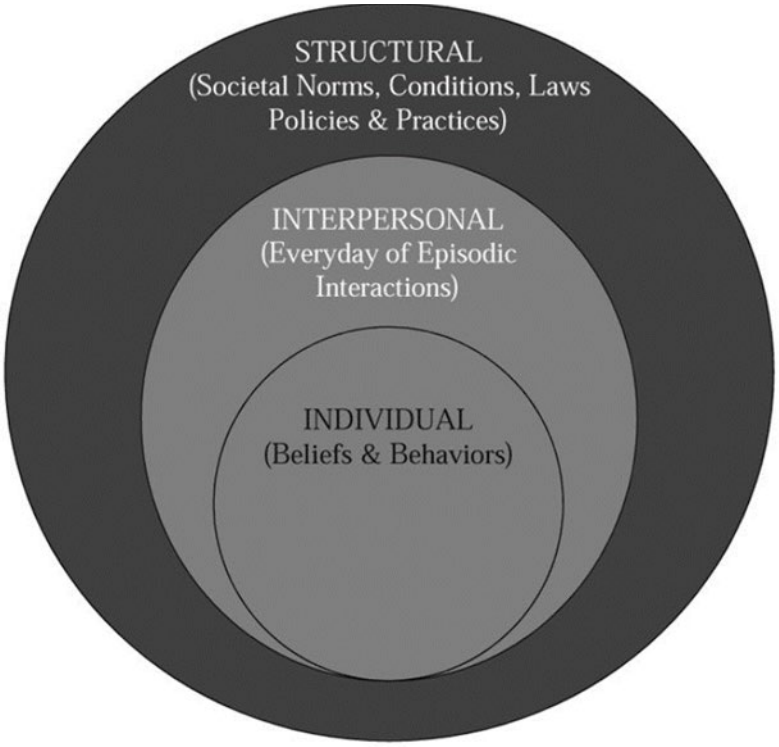
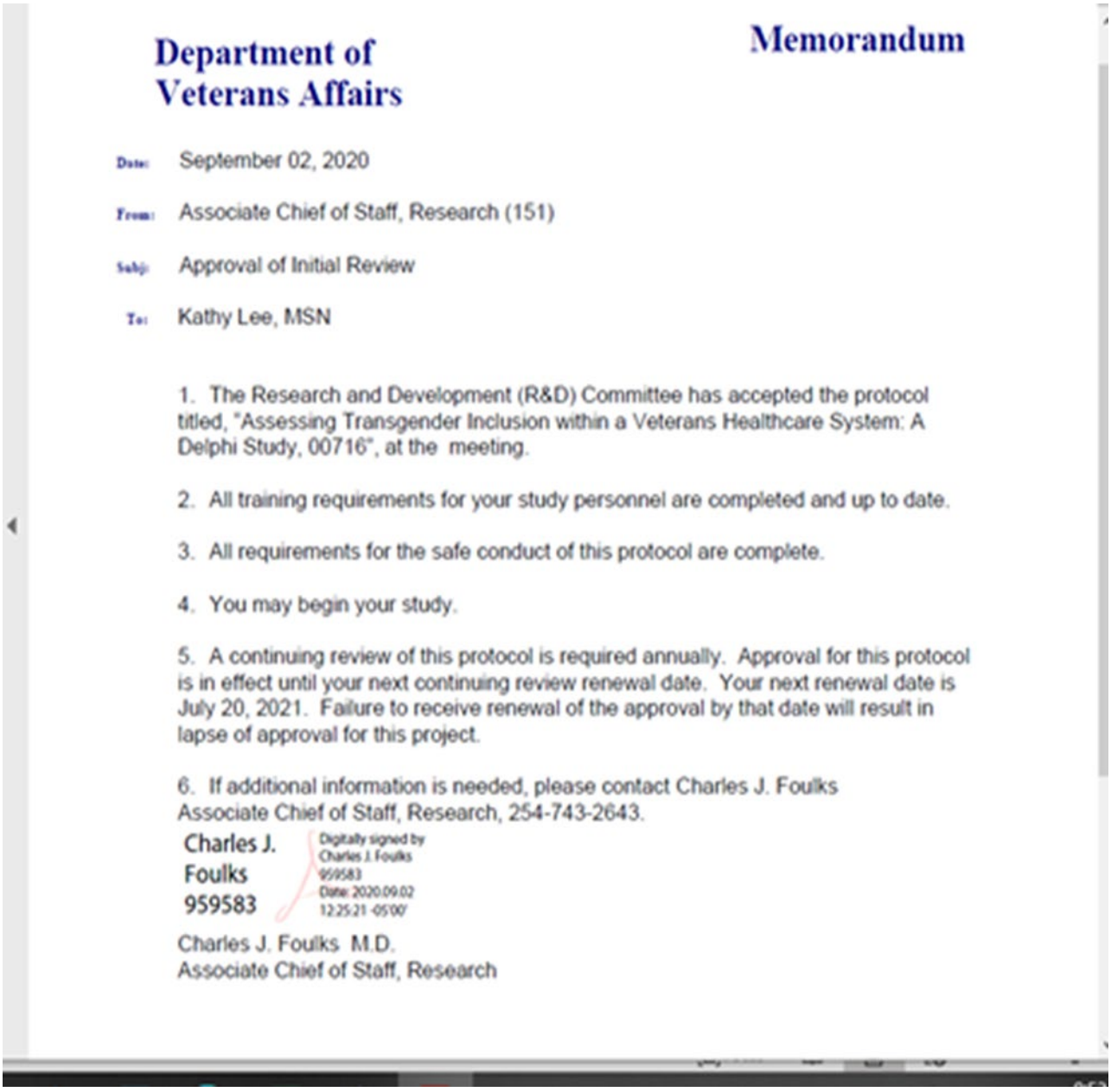


Figure 1 Modified Socio-ecological Model of Transgender Stigma and Stigma Interventions. The model illustrates the concentric and interactive relationship between the individual, interpersonal, and structural levels of transgender related stigma. Used with permission from White Hughton, J., Reisner, S., & Pachankis, J. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science and Medicine, 147*, 222-231.

Figure 2. Transgender Veteran Recruitment Flyer



Department of Veterans Affairs

Memorandum

Date: September 02, 2020

From: Associate Chief of Staff, Research (151)

Subj: Approval of Initial Review

To: Kathy Lee, MSN

1. The Research and Development (R&D) Committee has accepted the protocol titled, "Assessing Transgender Inclusion within a Veterans Healthcare System: A Delphi Study, 00716", at the meeting.

2. All training requirements for your study personnel are completed and up to date.

3. All requirements for the safe conduct of this protocol are complete.

4. You may begin your study.

5. A continuing review of this protocol is required annually. Approval for this protocol is in effect until your next continuing review renewal date. Your next renewal date is July 20, 2021. Failure to receive renewal of the approval by that date will result in lapse of approval for this project.

6. If additional information is needed, please contact Charles J. Foulks Associate Chief of Staff, Research, 254-743-2643.

Charles J. Foulks 959583

Digitally signed by Charles J. Foulks 959583 Date: 2020.09.02 12:25:21 -05'00'

Charles J. Foulks M.D.
Associate Chief of Staff, Research

Figure 3A. CTVHCS IRB/ R&D Approval Letter

Appendix F Chapter 4 Figures

The University of Texas at TYLER
Office of Research and Scholarship

INSTITUTIONAL REVIEW BOARD
uttyler.edu/research ▪ Fax: 903-565-5858

IRB Authorization Agreement When The University of Texas at Tyler is not the IRB of Record

Name of Institution or Organization Providing IRB Review (Institution A): Central Texas Veterans Health Care System Research Service Institutional Review Board; IRB Registration #: IRB00001630. Abbreviated CTVHCS RS (151)
OHRP Federal Wide Assurance (FWA) : **FWA00001125**

Name of Institution Relying on the Designated IRB (Institution B): The University of Texas at Tyler
OHRP Federal Wide Assurance (FWA) #: 00009775

The officials signing below agree that ***Institution B*** may rely on the designated IRB for review and continuing oversight of its human subject research described below: (choose one)
_____ This agreement applies to all human subject research covered by Institutions B's FWA.
__X__ This agreement is limited to the following specific protocol: **IRB-FY2020-138** ***Assessing Transgender Inclusion within a Veterans Healthcare System: A Delphi Study***

Name of Research Project: ***Assessing Transgender Inclusion within a Veterans Healthcare System: A Delphi Study***
Name of Principal Investigator: Kathy Lee, RN, MSN
Sponsor or Funding Agency: Unfunded
Award Number (if any): N/A
Other (describe):

The review and continuing oversight performed by the IRB Institution A will meet the human subject's protection requirements of the IRB Institution B. The IRB at Institution A will follow written procedures for reporting its finding and actions to appropriate officials at Institution B, with the exception of meeting minutes. Institution A remains responsible for ensuring compliance with the IRB's determinations and with the terms of its IRB Review Board. This document must be kept on file at both institutions and provided to OHRP and funding agencies upon request.

Signature of Signatory Official (CTVHCS RS (151)
Charles J. Foulks 959583 Digitally signed by Charles J. Foulks 959583 Date: 2020.09.15 09:02:26 -05'00'
Date: 09/15/2020
Charles J. Foulks, M.D.
Associate Chief of Staff for Research, CTVHCS RS (151)

Signature of Signatory Official (Institution B):
Kouich Mokhtari
Date: 9-17-20
Print Full Name Here:
Institutional Title:

Figure 3B UT Tyler IRB Authorization Agreement

Appendix F Chapter 4 Figures

Electronic Informed Consent

Information Page/Agreement to Participate in Research Study

You are being asked to take part in a research study led by Kathy Lee, a student at the University of Texas at Tyler in partnership with the Central Texas Veterans Healthcare System (CTVHCS). This form provides you with information about the study. Your participation is completely voluntary and none of your answers will be linked to your name or any other identifying information; this study is confidential. You may refuse to take part in the research or exit the survey at any time. You are free to choose to not answer any question you do not wish to answer for any reason.

The purpose of this study:

- To better understand the transgender veteran healthcare experience and identify any related issues.
- This study is for transgender veterans receiving health care through the CTVHCS and CTVHCS nursing staff providing direct care to transgender veterans, ages 18-89, and who can speak and read English.

If you agree to be in this study, we will ask you to do the following things:

- Complete the survey in one sitting.

Total estimated time to participate:

- You will be invited to participate in three separate online surveys over the course of three months. Each survey will be open and available for 14 days.
- Each survey will take about 10 minutes to complete.

Risks of being in the study:

- Please note that some of the questions may cover sensitive topics. Some of the questions may remind you of a difficult, challenging, or uncomfortable experience(s) in your life. You can always choose to not answer a question or stop participation in the study at any time.
- If you need to access supportive services during or after completing the questions, please contact your local Veterans Affairs office for assistance, or, you can contact the national Veterans Crisis Line at 1-800-273-TALK (8255) or call 911 for immediate assistance.

Benefits of being in the study:

- Your participation will help us to improve healthcare for veterans and increase healthcare provider awareness.

Confidentiality and Privacy Protections:

- The information collected during this study is confidential. Your responses will be sent to a link at SurveyGizmo.com where they will be stored on a password protected computer. Survey Gizmo does not collect personal information such as your name, email address, or IP address. Your responses will remain anonymous. No one will be able to identify you or your answers, and no one will know whether you participated in the study.
- No personal information will be linked to your responses.

- The data from this study will be kept confidential. Approved persons from the Central Texas Healthcare System Institutional Review Board and University of Texas at Tyler may review your answers but your name will not be included.
- Any reported findings from this study will be combined to protect the identity of the study participants.

Contacts and Questions: If you have questions at any time about the study or procedures, you may contact the Principal Investigator, Kathy Lee, RN, MSN (254-743-2910) klee12@patriots.uttyler.edu or University of Texas at Tyler research advisor Beth Mastel-Smith, RN, PhD BMastel-Smith@uttyler.edu. As a participant in this study, if you have a complaint about any issue about the study, or the research investigator; or, if you have questions about your rights as a participant, you may contact Katerine Getchell., Chairperson, CTVHCS Institutional Review Board at (254) 743-2609 katerine.getchell@va.gov.

Please select the "print" tab if you would like to print this agreement for your records.

PRINT TAB

If you agree to participate please click the "I agree" tab to continue, otherwise use the X at the upper right corner to close this window and disconnect. If you wish to discontinue participation at any point during the study, you may use the X at the upper right corner to close this window and disconnect.

ELECTRONIC CONSENT: Please select your choice below. Clicking on the "Agree" button indicates that

- You have read the above information
- You voluntarily agree to participate
- You are 18-89 years of age
- You are a current enrolled veteran or employee of the CTVHCS

☐ Agree

☐ Disagree

Figure 4. Informed Consent

Department of Veterans Affairs

Memorandum

Date: January 21, 2020

From: Kathy Lee, RN, MSN; Education Service (14)

Subj: Employee Survey for Research Study

To: President AFGE Local 1822
Thru: Human Resources Labor Relations

1. This memorandum is to inform you that I will be conducting a research study to examine the state of transgender inclusion within the veterans healthcare system.

2. The purpose of this study is to explore transgender inclusivity by seeking a consensus definition of transgender inclusion within a veteran's healthcare system and identify factors that contribute to inclusion. As part of this study, I plan to dessiminate a series of short surveys to both transgender veterans enrolled in the Central Texas Veterans Healthcare System (CTVHCS) and current nursing employees who have provided direct care to these veterans.

3. Participation in the study and associated surveys is completely voluntary. Recruitment for this study is anticipated to begin late February 2020 through early March 2020 pending local Institution Review Board (IRB) Approval, followed by projected administration of the survey to participants in late March 2020 through May 2020. Employees who wish to participate in the study will be provided informed consent and emailed a link to the survey through SurveyMonkey https://www.surveymonkey.com/r/RJSYNRQ .

4. Only the Primary Investigator, myself will have access to study participant names and email addresses, for the sole purpose of survey distribution and validation of study inclusion criteria. Actual participation in the study will remain anonymous. Survey responses are confidential and cannot be linked to the participant. Completed surveys will be distributed and collected through a password protected SurveyMonkey account, which is only accessible to the primary investigator of this study.

5. The Initial survey will consist of six standard demographic questions and three open ended questions specific to transgender inclusion in healthcare. The survey will be open for a duration of two weeks. All responses from the survey will be compiled and consolidated into themes or phrases. These themes or phrases will then be used to generate and disseminate via email a second survey. Participants in the second survey will be asked to rank the complied group

x F

Employee Survey for Research Study

responses on a 5 point likert scale with 1 being " completely agree" and 5 being " completely disagree". The second survey will be disseminated two weeks following the close of the first survey and will remain open for an additional two weeks. A third survey will only be distributed to reassess compiled response items that did not reach consensus agreement in survey two. The same likert scale rating will be used. Again participation in each survey round is completely voluntary and anonymous.

6. If you have any questions, please contact the undersigned at extension 42910.

Kathy Lee, RN, MSN
Clinical Faculty/ Student Coordinator
254-743-2910

Attachement
Copy of survey questions

Figure 5A. AFGE Union Notification

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: 11/04/2019

From: Kathy Lee, RN, MSN, Principal Investigator

Subj: Service Support for Research Project entitled:
Assessing Transgender Inclusion within a Veterans Healthcare System: A Delphi Study

To: Deputy Nurse Executive (118)

1. The cooperation of Nursing Service is requested to accomplish the goals of the above research project. I will need the support of Nursing Service as detailed below:

   Time from beginning of subject recruitment to end of subject recruitment: 3 to 4 months

   Planned number of subjects to be recruited: 10 to 15 nurses (RN or LVN)

2. Additional Information: Plan to recruit RN or LVN permanent employees who have provided direct patient care to at least one transgender identifying veteran within the last year.

3. The research study **will not** require support from VA patient care services that is above and beyond those necessary to the patient care treatment needs for which the subjects are eligible. The procedures include (name service, then procedure):

   Participation is voluntary, confidential and would entail responding to a maximum of three short surveys over the course of 2-3 months. Each survey should take no more than 15 minutes to complete.

3. If you need any further information, my phone number is: 254-743-2910 . Please do not hesitate to contact me.

Principal Investigator's Signature

VA FORM
MAR 1989 **2105**

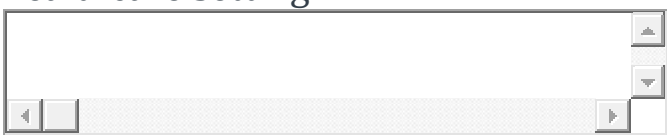
Figure 5B. Nursing Service Memo of Support

Transgender Inclusion Survey Round 1

Please answer the following questions in your own words. There are no right or wrong answers.

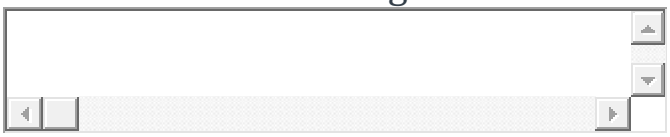
Question Title

8. How would you describe or define transgender inclusion in the healthcare setting?



Question Title

* 9. What are some things that create barriers or lessen transgender inclusion in the existing veterans' healthcare setting?



Question Title

* 10. What are some things that facilitate or increase inclusion of transgender veterans in the existing veterans' healthcare setting?

Figure 6. Round 1 Open-ended Survey Questions

Appendix F Chapter 4 Figures

Q3. On a scale of 1-5, please indicate your level of agreement with the below statements about "Transgender Inclusion". 1 being "completely disagree" and 5 being "completely agree"					
	Completely Disagree	Disagree	Neutral	Agree	Completely Agree
Transgender inclusion in veterans healthcare does not exist.					
Transgender inclusion in veterans healthcare exists but needs improvement.					
Transgender inclusion is a new thing that people are getting used to in the veterans healthcare system.					
VA healthcare providers feel unprepared to meet the needs of transgender Veterans.					
Transgender inclusion involves providing treatment options based on a person's gender identity.					
Transgender inclusion includes using a person's preferred name.					
Transgender inclusion includes using preferred pronoun(s) when addressing someone.					
Transgender inclusion includes using a person's preferred title (Sir, Ma'am, Ms., Mr., etc) to address them.					
Transgender inclusion involves being sensitive to the challenges faced by transgender Veterans.					
Transgender inclusion means not making assumptions about medical decisions.					
Transgender inclusion means not judging or questioning a person's identity.					
Transgender inclusion means being treated with dignity and respect.					
Transgender inclusion in healthcare includes making Veterans aware of all available healthcare options.					
A transgender inclusive healthcare system is one that is welcoming and supportive of all persons.					

Figure 7A. Round 2 Transgender Inclusion Consensus Questions

Appendix F Chapter 4 Figures

Q4. On a scale of 1-5, please enter your level of agreement with the following statements about barriers and facilitators to transgender inclusion.					
	Completely Disagree	Disagree	Neutral	Agree	Completely Agree
Lack of knowledge is a barrier to transgender inclusion in healthcare.					
Providers in my healthcare system have a basic knowledge of transgender health issues.					
Providers in my healthcare system have a basic knowledge of transition related healthcare services.					
Providers in my healthcare system have a basic knowledge of transgender specific services offered by the VA.					
Providers in my healthcare system have a basic knowledge about general healthcare services offered by the VA.					
Poor communication is a barrier to transgender inclusion in the VA healthcare system.					
Providers in my healthcare system do not respect transgender persons.					
Most providers in my healthcare system are biased towards transgender persons.					
Providers often question the gender identity of transgender Veterans.					
Providers sometime confuse gender identity with sexuality.					
Providers sometimes ask inappropriate questions because of transgender identity.					
Providers avoid discussing gender identity.					
Providers avoid discussing sexuality or sexual orientation.					
Transgender Veterans are pre-judged by healthcare providers based on portrayal of transgender persons in the media.					
I have heard derogatory or offensive comments made about transgender persons by providers or other VA healthcare staff.					
I have seen providers make negative non-verbal gestures or facial expressions towards transgender persons.					
Providers often make assumptions based on physical appearance.					
Providers are welcoming and supportive.					
Providers treat transgender Veterans with dignity and respect.					
Providers attempt to use preferred pronouns when addressing Veterans.					
Providers argue about preferred pronoun usage.					
The health record reflects the Veteran's preferred gender identity.					
The healthcare record reflects the Veteran's preferred name.					
Some providers in my healthcare system ask transgender Veterans for their former or "real" name.					
Poor behavior towards transgender persons is not tolerated in my healthcare system.					
Transgender inclusion is promoted when providers allow the Veteran to guide the conversation.					
Providers in my healthcare system allow the Veteran to guide the conversation.					
My healthcare system provides transgender related training to staff.					
Training by LGBTQ knowledgeable staff helps facilitate transgender inclusion.					
My healthcare system has LGBTQ knowledgeable staff.					
Healthcare providers receive transgender related training led by LGBTQ knowledgeable staff.					
Diversity training enhances transgender inclusion.					
Diversity training is encouraged in my healthcare system.					
LGBTQ advocates promote transgender inclusion in healthcare.					
LGBTQ advocates are visible in my healthcare system.					
Transgender Allies facilitate transgender inclusion in the healthcare system.					
I am aware of Transgender Allies in my healthcare system.					
Providers in my healthcare system are affirming of a person's gender identity.					
National guidelines for transgender health promote transgender inclusive healthcare environments.					
Providers are familiar with national guidelines for transgender healthcare within the VA healthcare system.					
National guidelines are used consistently across the VA healthcare system(s).					
The availability of unisex restrooms help promote transgender inclusion in the healthcare setting.					
Unisex restrooms are available and easily accessible at my healthcare facility.					

Figure 7B Round 2 Transgender Inclusion Barriers and Facilitators Consensus Questions

BIOGRAPHICAL SKETCH

NAME: Kathy-Jo Bielik Lee

POSITION TITLE: Deputy Associate Chief of Staff Education

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	Completion Date MM/YYYY	FIELD OF STUDY
Community College of the Air Force	A.A	01/2005	Foreign Language (Persian Farsi)
University of Mary Hardin Baylor Belton, TX	B.S	12/2008	Nursing
University of Texas at Arlington Arlington, TX	M.S	05/2015	Nursing (Administration)
University of Texas at Tyler	PhD	Present	Nursing Philosophy and Research

A. Personal Statement

I have six years' military service experience followed by over twelve years of nursing service in the Veterans Healthcare Administration (VHA). I have a broad background in acute and critical care, with specific training and expertise in nursing leadership, clinical staff development, and education of nursing and allied health trainees. Over the last few years, I have sought out experiences to enhance my knowledge and practice related to research and related policies.

B. Positions and Honors

Positions and Employment

1999-2005	Persian Farsi Cryptologic Linguist – USAF Active Duty
2007-2008	VALOR Nurse Student Intern ICU- CTVHCS
2009-2012	Staff RN ICU – CTVHSC
2012-2012	Assistant Nurse Manager ICU – CTVHCS
2012-2016	Clinical Education Instructor – CTVHCS
2016-2019	RN Clinical Documentation Improvement/ Clinical Faculty- Student Coordinator- CTVHCS
2020-present	Deputy Associate Chief of Staff for Education-CTVHCS

Other Experience and Professional Memberships

2012-present	Member, Texas Nurses Association/ American Nurses Association
2013-2016	Member, Texas Nurse Association Continuing Education Committee
2018-present	Voting Member CTVHCS IRB
2020-present	Chair of CTVHCS IRB Research Information and Data Security Workgroup

Honors

2015	VISN 17 Leadership Development Institute Graduate