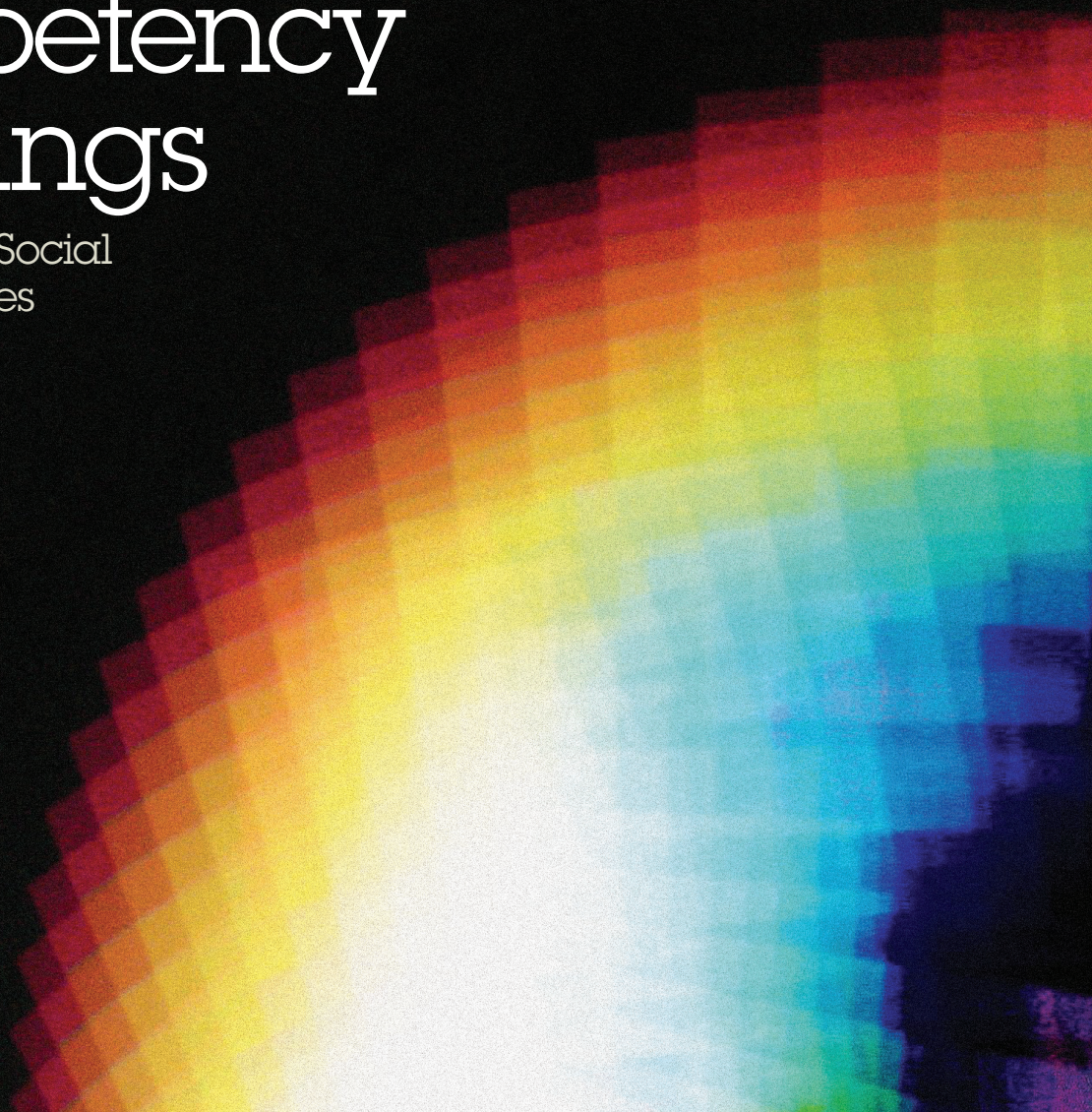# C3 | Cultural Competency Coordination

Best Practices in Creating and Delivering

LGBTQ Cultural Competency Trainings

for Health and Social Service Agencies

Contents

Cover image:
Rainbow by elray
https://www.flickr.com/photos/elray/95739274/

1
Introduction

LGBTQ cultural competency training is widely used and highly recommended for staff working in healthcare settings and social service organizations. Indeed, the federal Department of Health and Human Services encourages new and existing human services programs to include LGBTQ cultural competency curricula, as "the lack of culturally competent providers is a significant barrier to quality health care for many LGBTQ people, particularly those who identify as transgender."[1] Funding for this project from the AIDS Institute of the NY State Department of Health reflects a similar commitment.

While there is broad agreement that LGBTQ cultural competency training is valuable, there is no standardized definition of what cultural competency training should entail for a culturally competent provider of health and human services. There cannot be a permanent standard of cultural competency, as communities, language and policies shift over time and the requirements for culturally competent care may differ, based on job responsibilities. Despite the inevitability of change, we need to create current standards for "culturally competent care," even as we understand the limitations of such a designation.

> Is an increase in knowledge about this population enough?

> Can attitudes about LGBTQ people be changed through cultural competency training?

> Are modifications in the ways LGBTQ people are treated by providers, i.e., behavior change, the only change that matters?

> What personal and institutional changes are needed to reduce LGBTQ health disparities and increase access to care?

[1] U.S. Department of Health and Human Services (U.S. DOHHS). (2012). U.S. Department of Health and Human Services recommended actions to improve the health and well-being of lesbian, gay, bisexual and transgender communities. Retrieved from http://www.hhs.gov/lgbt/health.html

Across the country, curricula have been developed with one or more of these goals in mind, but without grounding in evidence-based research. Various individuals and agencies have created their own set of slides, lectures, handouts, group exercises and evaluation tools. Having analyzed approximately two dozen separate cultural competency training curricula, we have found that there is a striking similarity between them all in terms of content, suggesting that exposure to previous trainings, either in person or online, has guided new developments. Or, perhaps there is unstated national concurrence on the shape of the wheel each agency has independently created.

Research on the effectiveness of LGBTQ-specific cultural competency training is extremely limited and mostly addresses changes in providers. This does not necessarily translate into better health outcomes for LGBTQ people.[2] Some intended changes, e.g., increase in knowledge about LGBTQ terms, can be more easily measured using pre- and post-test surveys. Others, like changes in provider behavior when working with LGBTQ patients or clients, are more difficult and expensive to gauge.

In the absence of solid outcome data, how do we measure and define best practices in LGBTQ cultural competency trainings? Two separate foundations ground this manual.

> First, we use well-established theories of how adults learn and change, as we delineate the steps in constructing a curriculum.
>
> Second, we rely on community wisdom and experience.

This manual reflects the collected years of LGBTQ cultural competency training of over 60 different organizations and individuals, especially those in the New York State LGBTQ Health and Human Services Network who provided an estimated 2,500 LGBTQ cultural competency trainings in 2013.[3]

This manual does not contain a training curriculum, but is instead intended to be a guide for those who plan to create and deliver LGBTQ cultural competency trainings to health and human service providers. It was created as a technical assistance tool for LGBT health and human service providers in New York State, but it may also be of benefit to anyone beginning the work of LGBTQ cultural competence training across a wide range of agencies, organizations, schools and facilities.

The manual offers a conceptual framework that coordinates learning theory, training skills, content and evaluation. The manual is also useful for assessing existing curricula and for guidance when making routine updates. All sections are interrelated, and it is recommended that the manual be read in its entirety. The design is intended to make it simple for later reference to the information, as needed.

2
Defining Cultural Competency

Cultural competency training has been popularized and widely used across diverse fields including the healthcare sector, academic institutions and government and social service agencies. The term has been used interchangeably with diversity education, cultural sensitivity training and multi-cultural workshops. Cultural competency is commonly understood as a set of congruent behaviors, knowledge, attitudes and policies that enable effective work in cross-cultural situations.[4]

Cultural competency training, therefore, aims to increase knowledge and skills to improve one's ability to effectively interact with different cultural groups.[5]

LGBTQ cultural competency training has been developed and implemented to improve healthcare and social service delivery to LGBTQ patients and clients and, therefore, decrease LGBTQ health disparities. Some of these barriers to care include refusal of care, delayed and/or substandard care and lack of inclusion in health outreach or education on risks that affect LGBTQ people.

> LGBTQ cultural competency training has been supported and recommended by multiple federal agencies, including the Joint Commission.[6]

Some people have argued that cultural competency trainings are too focused on a prescriptive way of teaching "culture," challenging the implicit assumption that culture is a discrete body of knowledge that can be learned in one setting. Cultural norms and language are constantly changing, and there are large individual variabilities within LGBTQ communities. The intersectionalities of people's identities (e.g., race, ability and sexual orientation) resist a narrow definition of "culture."

"Cultural Humility" is an approach to cultural competency trainings that proposes change through a lifelong process of learning, including self-examination and refinement of one's own awareness, knowledge, behavior and attitudes on the interplay of power, privilege and social contexts.[7]

[2]Porter, K. E., & Krinsky, L. (2014). Do LGBT Aging Trainings Effectuate Positive Change in Mainstream Elder Service Providers?. Journal of homosexuality, 61(1), 197-216.
[3]Empire State Pride Agenda. (2011) New york state LGBT health and human services network. Retrieved from http://www.prideagenda.org/sites/default/files/pictures/2012%20LGBT%20HHS%20Network%20Report.pdf

[4]Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). Towards a culturally competent system of care. Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
[5]Beach, M.C., Price, E.G., & Gary, T.L. (2005). Cultural competence: a systematic review of health care provider educational interventions. Medical Care, (43), 356–373.
[6]The Joint Commission. (2011). Advancing effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community. Retrieved from http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf
[7]Tervalon, M. & Murray-Garcia, J. (1998) Cultural humility versus cultural competence: A critical distinction in defining physician-training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9(2), 117.
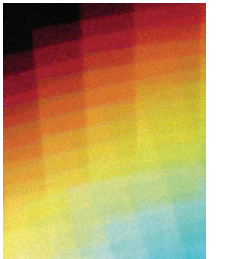
When incorporating cultural humility into practice, participants are invited to challenge their own unique set of biases and privileges that impact the LGBTQ patients and clients they work with.

People often use the word 'presentation' interchangeably with the word 'training'. However, there are important distinctions between the two methods. Presentations are a form with more emphasis on instruction and slides, requiring trainer skills of public speaking, slide development and group engagement.[8] They are best for short time frames and very large groups.[9] Trainings are more focused on facilitating group and individual activities and fit will with the cultural humility model. In reality, most cultural competency workshops include aspects of both presentations and trainings.

In this best practices manual, we will continue to use the terms "cultural competency" and "training" as they are the words most used by agencies and healthcare facilities, but we expand the definitions to take in the complexities that the cultural humility approach offers and understand that most cultural competency work involves both training and presentations. We will define cultural competency not as an end goal but as a commitment to an ongoing engagement with LGBTQ-affirming behaviors, knowledge, attitudes and policies. LGBTQ cultural competency presentations and trainings are understood to be a beginning and important step in learning to work more effectively with LGBTQ clients/patients, but they are not the only required step. Profound change also requires time, practice and self-reflection.

NOTE We will use the term "trainer" to refer to the people who lead both cultural competency presentations and trainings, and we will refer to those who attend them as "participants."

3
The Goals of LGBTQ Cultural Competency Training

Most cultural competency trainings share similar goals: to bring about positive, LGBTQ-affirming change in the participants' knowledge, attitude and behavior towards LGBTQ patients and clients. The priority placed on each separate goal may differ with the audience and setting, but it is critical to be intentional in goal setting. The specific goals of a cultural competency training will inform the topics covered, the training methods used, the choice of exercises and/or case examples and, most importantly, the evaluation approach.

While it is tempting to try to cover as many LGBTQ topics and goals as time will allow, participants become overwhelmed when given a great deal of new information, resulting in a loss of interest and/or mental withdrawal. Training goals are best when they are realistic and attainable for the specific audience and time permitted.

Bias and prejudice tend to function at many levels, including personal, interpersonal and institutional. The strategies proposed here focus primarily on the personal and interpersonal levels, with an understanding that transformation at these levels can exercise an influence on institutions. Also, few participants in LGBTQ cultural competency trainings have the authority to make major institutional changes, even as it is understood that such changes may have the greatest impact on eliminating LGBTQ barriers to quality care. Separate trainings for administrative and policy staff may better achieve the goals of institutional change.

Goals vs. Objectives

The terms "goals" and "objectives" are often considered synonymous, but they are not identical. Goals are broad desired outcomes for the trainings, while objectives are more specific, concrete and easily measured targets for achieving the goals.[10] Each goal may have multiple objectives.

The goals and objectives of the cultural competency training will determine the evaluation measures, optimal teaching methods and training content.

[8]Bowhay, S. Training vs. presenting. British Counsil. Retrieved from http://lndpost.files.wordpress.com/2012/07/training-versus-presenting.pdf
[9]Meyerson, D. (2013). The key differences between presenting, training and facilitating. Management Consultancy International. Retrieved from http://mci.edu.au/article/the-key-differences-between-presenting-training-and-facilitating

[10]Bogue, R. Use S.M.A.R.T. goals to launch management by objectives plan. Retrieved from http://techrepublic.com/article/use-smart-goals-to-launch-management-by-objectives-plan/#.

Common LGBTQ Cultural Competency Training Goals Are:

1. To increase **knowledge** about LGBTQ health/social service needs.

2. To increase LGBTQ-affirming **attitude**

3. To increase LGBTQ-affirming **behavior**

TO CHANGE:

knowledge   attitude/behavior

EASY ———————————————————— DIFFICULT

Generally, knowledge-based goals are the easier to change than attitude or behavior-based goals.
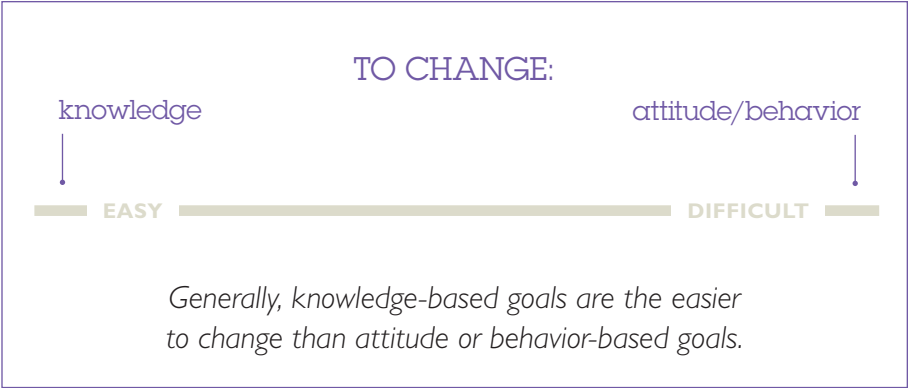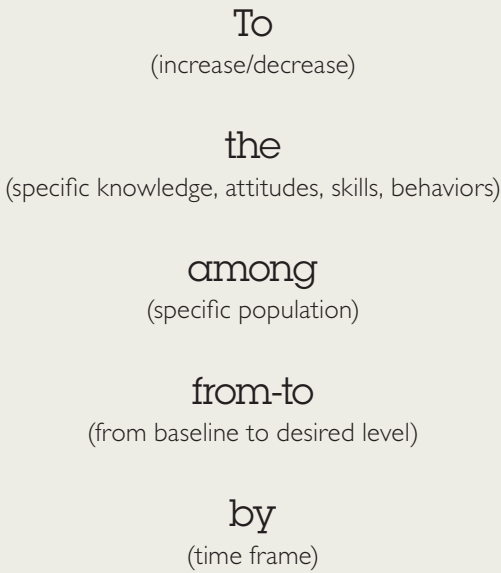
SMART Concept

One of the most effective ways to create training goals and objectives is to apply the SMART concept.[11] SMART is an acronym for the criteria used to set objectives that are specific (S), measurable (M), attainable (A), relevant (R) and timely (T).

In many grant deliverables, this type of evaluation may be referred to as "performance measures" and will also include specificity in terms of number of people reached, etc.

How to write a SMART Objective using a formula:[12]

To
(increase/decrease)

the
(specific knowledge, attitudes, skills, behaviors)

among
(specific population)

from-to
(from baseline to desired level)

by
(time frame)

Example 1

Goal: To increase knowledge about LGBTQ health and social service needs.

Unmeasurable objective: To understand risk factors that account for LGBTQ health disparities.

SMART objective: By the end of the 1.5-hour training, participants will be able to identify at least 3 risk factors that contribute to LGBTQ health disparities.

Possible training methods: Lecture/PowerPoint slides, group exercises, film clips/media.

Possible content: Lack of provider knowledge about LGBTQ health, homophobic and transphobic structural (institutional) systems, high rates tobacco and alcohol use in LGBTQ people.

Example 2

Goal: To increase LGBTQ-affirming attitudes.

Unmeasurable objective: Decrease negative attitudes toward LGBTQ elders.

SMART objective: By the end of the Part II training, participants will be able to convey at least one bias or stereotype they had about LGBTQ seniors.

Possible training methods: Individual reflective exercises, guest speakers/panel discussion, small group discussions.

Possible content: Ageism in LGBTQ communities and broader society, LGBTQ elder isolation and lack of intergenerational interactions in the LGBTQ community.

Example 3

Goal: To increase LGBTQ-affirming behavior.

Unmeasurable objective: To effectively interact with transgender and gender non-conforming clients/patients.

**SMART objective:** Participants will be able to enact at least two ways to affirm gender non-conforming clients/patients using gender-neutral language by the end of a 3-hour training.

Possible training methods: Case studies, partner role-plays, media/video clips.

Possible content: Social and health care barriers experienced by transgender people, health benefits of forming a trusting relationship with a provider.
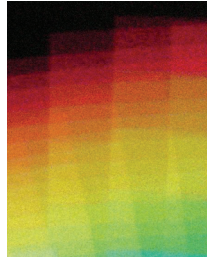
4

Preparing for a Training

The success of cultural competency training is not determined solely by the quality of the slides, videos and handouts. The skills of the trainer are of equal or greater importance than the content or methods in bringing about the changes outlined in the Goals section. A trainer can deliver well-designed slides in an incompetent or dull way or, conversely, bring life to mediocre slides.

If small group exercises and discussion are part of the curriculum, as in many trainings, the trainer must also be a skilled facilitator. The best trainers consciously employ a theory of change to the planning of their training, as well as the goal and audience being trained. Two theories of adult learning and change are described below, including recommendations for interventions that best bring about desired outcomes.

While some trainers are naturally gifted and intuitively understand the principles of adult learners and change, the skills are best taught in a Train the Trainer workshop, where participants have an opportunity to practice with peers after learning the content and concepts.

Professional Use of Self

Professional use of self refers to how the trainer serves as a role model, a guide, a coach, an advocate and/or a partner with the training participants.

Ideally, the trainer is a member of the LGBTQ community or comes to the work as an ally with a wealth of lived experience with the population. For some training participants, the trainer will be the first LGBTQ person they have ever met. Trainers often judiciously offer stories from their past to clarify concepts and offers up personal experience as a first-hand answer to some of the questions posed by participants. Trainers, however, are not required to speak about themselves or their personal experiences. In trainings (vs. presentations), where the focus is more on participants' self-disclosure, the trainer may offer fewer personal examples, as these may imply that there are right and wrong feelings or attitudes and can interfere with the willingness of participants to expose their own biases. Good trainers model acceptance of difference and encourage the expression of curiosity in participants.

Professional use of self includes:

- Strong awareness of one's own prejudices and stereotypes and a commitment to exploring them. For those working with a cultural humility approach, this personal work is critical.

- Comfort with one's own background and an understanding of how that background, as well as one's own life experiences, affect one's worldview and perceptions of other groups.

- Respect for the power of leadership and the exposure of participants, combined with a commitment to develop a reciprocal dynamic of shared intimacy and vulnerability.

- Ability to be a facilitator, in addition to being an instructor, encouraging a process of learning that begins with the participants' own histories and experiences.

- Comfort with modeling "not-knowing," coupled with a commitment to continuous learning.

Applying Appropriate Theories of Change to Cultural Competency Training

Adult Learning Theory (also known as "Andragogy")[13,14]

Adult learners are not like young students who may be more accustomed to passively accepting new information and later reproducing the content for a test. Adults are internally motivated. They enter the room with a strong sense of self, firmly attached to their beliefs, ethics and style. An approach that respects the history and experience they bring into the room will encourage them to learn. If, on the other hand, they feel information, ideas or actions are being imposed on them, adults will often be resistant.

Adult Learning Theory can be a particularly useful underpinning in cultural competency trainings that:

- focus on changing knowledge or skills

- have a short time frame

- are for a very large audience

Adult learners:

- Are motivated to learn things that help them cope. In other words, they are problem-centered rather than content-centered and are hungry to learn things that will that have an immediate relevance to their job or personal life. Whenever possible, use examples that apply to their type of organization and/or job description.

- Bring a wealth of experience into the room and will have a tendency to mask what they don't know. They want an opportunity to apply their existing foundation of knowledge and experience to what they are learning. They will also want to know WHY something is so.

- Have well-established values and attitudes that they developed over time and life experiences.

[13]Fidishun, D. (2000). Andragogy and technology: integrating adult learning theory as we teach with technology. In Proceedings of the 2000 Mid-South Instructional Technology Conference.
[14]Knowles, M. S. (1968). Andragogy, not pedagogy. Adult leadership, 16(10), 350-352.0.

Transformative Learning Theory[15-17]

Transformative learning is often described as learning that changes the way individuals think about themselves and their world. Unlike adult learning theory that views knowledge as something outside the person to be taken in through a learning process or presentation, transformative learning theory believes that change comes about through a process of dialogue and critical self-reflection. This theory asserts that personal change is based on a deeper understanding of one's own culture, values and history. Whereas in adult learning theory, participants are motivated to receive new knowledge and skills in order to adapt better to the demands of their environment, transformative learning understands change to come about as a process of disrupting old patterns of meaning and creating new understanding of themselves and the world. Motivation to change behavior follows from the new understanding.

- In order for participants to engage in the self-reflection required for transformative learning, they need accurate information about the topic for discussion, adequate time and an environment of acceptance, empathy and trust.

- Transformative learning theory can be a useful foundation for cultural competency trainings that:

  —focus on changing attitudes

  —have a longer time frame

  —and a small audience (fewer than 20 participants)

- Transformative learning theory fits with the cultural humility approach discussed in the Definitions section.

Knowing the Audience and Setting

Experts prefer to listen to others who are also experts in their own field. Partnering with a member of the profession being trained can also be useful in building a trainer's credibility. Advanced research about the job descriptions and occupational stressors of those being trained can be used to best determine the content and training methods to be used. For example, it is futile to make the strong case for policy change when training clerical staff who have no authority over such changes.

Some suggested questions to discuss with the contact person at the agency or facility can include:

- What led your organization to schedule this training?

- Have there been any previous LGBT trainings conducted? If so, how were they received?

- Was there a recent incident involving an LGBTQ client or staff person?

- Did the staff request the training or is it mandatory?

- How many people will be trained?

- Will they all be from the same department?

- Are there out LGBTQ staff at the facility?

- Does the staff believe they rarely encounter LGBTQ clients or patients?

- Will staff be trained with their supervisors, which may be an inhibiting force?

The answers to each of these questions should be used to structure the content and training methods employed in the training.

Accessibility should also be a consideration when planning a training. Some participants may be unable to see, hear or move easily, and training methods will have to be adapted accordingly. Notes on inclusion and accessibility are provided in the Training Components section and in the resources list at the end of this manual.

Finally, the time allotted to the training will also determine the structure, content and goals of the workshop. Agencies and facilities often have unrealistic expectations of what can be accomplished in the amount of time they are allocating. It is okay to advocate for more training time and/or let the organizer know the limits of what can be accomplished in the time allotted. Shorter trainings may only be able to focus on a change in knowledge about LGBTQ patients and clients and are best accomplished with a presentation method, relying primarily on the trainer to deliver material.

Making Use of the Range of Experience with LGBTQ Issues in a Group

- If possible, ask all participants about their experience with LGBTQ people/health disparities (using 1-10 scale, 1 = little experience, 10 = a great deal of experience) during introductions, letting them know in advance that a broad range is both normal and desirable. This range of experience with the LGBTQ community is probably a reflection of the range within the staff in their agency or healthcare facility and contributes to the wariness LGBTQ patients/clients feel in new encounters. The participants at both extremes enhance the training in different, but valuable, ways.

- Participants with extensive experience with LGBTQ patients/clients can be both respected and engaged by being asked at the beginning of the training to point out whenever the trainer has forgotten to mention something and/or to help with explanations if the trainer needs assistance.

- Participants with little prior exposure or experience with LGBTQ people can be respected and engaged by being asked to point out when the trainer is moving too quickly or fails to explain a concept clearly.

Some Challenges of This Material for Adult Learners

- Admitting that they don't know something when they may be experts at their jobs

- Dealing with the discomfort of sexual material and new language/terms

- Accepting that their usual and well-thought-out way of treating patients might actually be offensive or rejecting to some people

- Fear of being exposed as homophobic or transphobic

- Potential conflicts between participants' personal beliefs and the responsibilities of their jobs

Working with Difficult Participants in a Training

Trainers need to be skilled in handling both difficult participants and unproductive group dynamics that can derail a training.

There are multiple types of difficult participants and group dynamics, and most trainers are better at managing some of these behaviors than others. Difficult participants may be hostile, tangential, negativistic and/or skeptical about every suggested change. Some participants may have been mandated to attend the training and will remain disengaged. Difficult group dynamics include conflict between participants, withdrawal and challenging the trainer. Remember, there are people whose attitude or style cannot be changed through even a high-quality, well-delivered training.

[15]Mezirow, J. (2002). Transformative learning: theory to practice. New directions for adult and continuing education, 1997(74), 5-12. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/ace.7401/abstract
[16]Cochran-Smith, M., Feiman-Nemser, S., McIntyre, D. J., & Association of Teacher Educators. (2008). Handbook of research on teacher education: Enduring questions in changing contexts. New York: Routledge.
[17]Freire, P. (1993). Pedagogy of the oppressed (Rev. ed.). New York: Continuum, 197

Regardless of the type of difficulty, the most effective strategies all involve combining an expression of respect for the participant with a calm determination to carry out the agenda in a timely way. For example, hostile people and complainers need to feel listened to before their issues can be addressed. All questions are valid, even if there is not time to address the answers during the planned training. Try to maintain control over the agenda, timeframe and needs of other participants.

Some strategies that can be effective are:

• Listen to what the participant has to say, giving them, if necessary, a limited timeframe to speak

• Show that you take them and their concerns seriously

• Maintain eye contact and respect for their position

• Acknowledge and paraphrase to ensure perceptions are correct. Identify common ground; there may be a shared goal. e.g., we both want all clients to feel safe here

• It is not necessary to argue your own point. You have probably already made it clear to most of the group

• Switch to problem solving

  —"Parking Lot." This is a technique to honor and recognize the existence of important non-agenda items, without interrupting the focus and goals of the training agenda. The "parking lot" is a "place" to record the issues, with a plan to address them later

  —Suggest a private discussion after the training

  —Ask the group for suggestions to address the issue raised

5
Training Components

There are many possible components to include in an LGBTQ cultural competency training. The topics will be determined by multiple variables, including:

• the length of the proposed training

• the number of participants

• the level of prior experience participants have with this population

• and, most importantly, the goals of the training

Trainings need to be regularly updated to reflect current health policies, laws, research, LGBTQ statistics and recommendations for health. The following methods will help ensure that important news reaches your desk.

1
Read the Huffinton Post's LGBT Wellness page, including a weekly LGBT health roundup, http://www.huffingtonpost.com/news/LGBT-wellness/

2
Subscribe to Google Alerts for relevant topics ("LGBTQ," "LGBTQ Health," "Transgender Health," "gay health", etc.)

3
Follow LGBTQ health organizations on Facebook, Twitter and RSS Feeds

4
Join GLMA's weekly Health Digest and/or the Coalition for LGBTQ Health

NOTE A pre-training survey is administered to participants BEFORE the training. See Section 7, Evaluation, for more information.

The list below provides some information and guidelines on potential topics.

CORE Topics (Included in Most Presentations and Trainings)

Introduction of Trainer and Trainer's Organization

Most trainings begin with the trainer(s) introduction and welcoming remarks. While there are many possible components of the introduction, they generally include:

- Thanking the audience for coming

- Introducing the trainer and that person's credentials for giving the training

- Listing the goals of the training, what trainers want participants to leave with

- Stating the ground rules and getting group agreement on them, such as:

—Confidentiality. Ask participants to agree not to share personal information learned about any other individual or their learning process during the session. But encourage the sharing of other learned information with colleagues, friends and family

—The time allotted for the training and any proposed breaks

—Cell phones and texting usage

—The location of bathrooms, including gender-neutral options

Introductions of Participants

Whenever size and time allow, have participants introduce themselves individually. This can include participants' job titles, preferred gender pronouns, one or two things they hope to learn from the training, etc. If possible, write the items down for later reference. As described in the last section, asking participants about their experience with LGBTQ people and health disparities can help the trainer tailor the training to the group's needs and give permission/welcome for all levels of experience.

Icebreaker Exercises

Icebreaker exercises are facilitated activities that are often used at the beginning of a training to warm up the group and help form the participants into one working team. In LGBTQ cultural competency trainings, they can be particularly useful in dispelling initial anxiety about discussing topics of sex, gender and sexuality which can be discomforting, even to many healthcare professionals. Icebreakers usually take no more than 15 minutes.

In a smaller training group, an icebreaker activity can be led by the trainers and include all participants. In larger rooms, the participants can be broken into small groups. The activities selected for an icebreaker are most effective when the pre-existing group dynamics have been considered.

NOTE If a group of participants is already very familiar with one another, "getting-to-know-you" activities may not be the best use of time and can even derail the training.

Examples:

- Ask people to tell the group what pronoun they prefer to describe themselves. This may be an unfamiliar activity for cisgender (non-transgender) people but can help the room start to think about gender perceptions and assumptions. It can also be a talking point to return to later during a discussion about gender. One limitation of this exercise is that it asks transgender people to out themselves to their colleagues. It may be helpful to point out here that outing oneself requires safety and that participants may "pass" on any question that feels uncomfortable or unsafe to answer.

- Break the participants into small groups or dyads and ask them to find out three less obvious things they share in common, e.g., that they were the first person in their family to go to college, that they were both adopted, that they recently took up yoga. This exercise is a way to introduce the concept of hidden identities. Also if using a cultural humility approach, this icebreaker sets the stage for examining one's own history, culture, privilege and discrimination.

- Lead a short discussion about a current and/or local LGBTQ news item, such as a hate crime, a youth suicide, a new federal policy, etc.

Introduction/Review of LGBTQ Terminology

Some trainers prefer to start with this section; others do it after laying out the health disparities. While most people have heard the LGBTQ acronym and understand the meaning of some of the words used to describe this population, few understand the difference between gender identity and sexual orientation. Fewer still know the range of language under the transgender umbrella or have heard of DSD. It is best to go over every term, even if no one has asked a specific question about any of them.

When presenting this section, remind participants that terms and cultures are continually changing, and that participants may hear a term in their work that isn't on the list. The important thing is to listen to patients/clients and reflect back the terminology they use to identify themselves.

Some trainers also include information on the difference between sex, gender, gender expression and gender identity. For people with limited prior exposure to this population, these concepts may prove too hard to grasp at first and may require more time for participants to process this new information or risk leaving them confused.

The terms most often presented are:

- Sexual orientation (including the difference/overlap between identity/behavior/attraction)

- Gay

- Lesbian

- Bisexual/Pansexual

- Two spirit

- MSM/WSW

- Gender Identity

- Transgender/cisgender

- Queer

- DSD/Intersex

- Gender non-conforming/genderqueer/gender variant

Structural Systems of Oppression & Intersectionality

It is not enough to just know the correct terminology; ideally, we should also be able to place lived experiences within the social, historical and political contexts that shape how disenfranchised groups, including LGBTQ communities, experience social and health inequity.[18] Oppressions based on gender identity and sexual orientation, as well as race, ethnicity, class, immigration status, religion, mental health status, ability and age form a system of interlocking oppressions that are embedded in the dominant culture and social institutions in a way that is so pervasive that they are often invisible and affect everyone.

An anti-oppression model offers a way to understand the multiple visible and invisible structures of oppression.[19] Participants may be unaware of how they themselves reinforce their own social power and privilege in ways that can inadvertently perpetuate health disparities among their clients/patients.[20] Cultural competency trainings offer an opportunity for participants to critically examine their own biases and privileges.

Similar to the anti-oppression model, intersectionality addresses the relationship between privilege and oppression within individuals, explaining the great variability within LGBTQ communities and within each subgroup. Intersectionality focuses on the crossroads of multiple systems of oppression

[18]Joo, R. (2013). Moving towards trans-affirming practice: cultural humility curriculum for frontline medical providers. (Master's thesis, Columbia University).
[19]Burke, B., & Harrison, P. (2003). Anti-oppressive practice. Communication, Relationships and Care: A Reader, 131.
[20]Barnes, L.L. (2004, May). Culturally Competent Care. Concept paper presented at Consensus Building Meeting for the Culturally Competent Nursing Modules (CCNM) project..

and privilege. These do not function independently from one another, nor can these be understood simply as additive or hierarchical. Instead, the threads of discrimination and privilege are interwoven to create a unique system in which individual identities are shaped by one another.[21] For example, the compound identities of an abled-bodied, black, cisgender lesbian interact with and affect each other. She cannot be understood as the simple sum of being abled-bodied, black, cisgender, lesbian and a woman. She may experience homophobia within the larger black community and racism within the LGBTQ community, while she unknowingly navigates both of these communities with able-bodied and cisgender privileges.

LGBTQ Health Disparities

While some trainers prefer that LGBTQ health disparities come at the beginning of the training, others prefer to address this section following the discussion of structural oppression as a way to provide a context to the statistics. Some information about LGBTQ health and healthcare can include:

- Access to care issues

    —Lower rates of health insurance coverage

    —Lack of provider knowledge about LGBTQ health

    —Previous discrimination in healthcare

    —Lack of identifying information in intake forms

- The relationship between discrimination and poor health, i.e., the health consequences of LGBTQ stigma.

    —Studies that show that victims of hate crimes are more likely to suffer poor health

    —The increase in mental health problems in states without LGBTQ protections

    —The shorter lifespans of LGBTQ people who live in places without LGBTQ legal protections

    —LGBTQ rights are a patchwork across the country

- Specific health concerns of LGBTQ communities

    —Tobacco: increased use in all subpopulations

    —Alcohol/drugs: increased use/abuse

    —STDs: increased incidence, lack of knowledge

    —HPV: including cervical PAPS and anal PAPS

    —HIV: incidence, especially in trans women of color

    —Obesity/high BMI: much higher in lesbians/bisexual women

    —Mental Health: including anxiety, depression, suicidality

    —Cancer: including risks, screening behaviors and survivorship

    —MSM health concerns

    —Transgender health concerns

- Protective factors

    —LGBTQ community support (e.g., GSAs, support groups, etc.)

    —Family acceptance

    —Communities of faith

Whenever possible, include statistics and current LGBTQ health facts. Always include citations and sources for the information presented on slides and handouts. Multiple resources and examples have been included in Section 8.

Adapting or Expanding Core Elements for Specific Audiences

Depending on the need and clientele of the organization receiving the training, additional modules that address specific population and social issues can be incorporated into the training. Some examples include:

- LGBTQ Elders

- LGBTQ Youth

- LGBTQ Homelessness

- LGBTQ People of Color

- Prison/Probation/Surveillance

- Sexuality and Sexual Health

Creating a Welcoming Environment

After learning about the stigma and health disparities LGBTQ people face, providers are often eager to know specific action items that will make a difference in the healthcare and social service experience of their patients/clients. More than conceptual guidelines, they request precise and detailed suggestions.[22] The main categories for systemic and personal change include:

- Signage

    —Consider the LGBT community's "first" potential view of the providers, e.g., the website, educational materials

    —Post a nondiscrimination policy that includes sexual orientation and gender identity

    —Ensure that public areas include wall art with LGBTQ images and contain LGBTQ publications

    —Place rainbow stickers or pins on staff and posters

    —Include LGBTQ images and language in all printed materials/brochures

    —Designate gender-neutral bathrooms

- Documentation

    —Collect and analyze data on LGBTQ health

    —Change intake forms to ask for "relationship status" rather than marital status and include options such as "partnered"

    —Differentiate between "gender" and "sex assigned at birth" on patient intake forms, if your agency is a medical care setting. Otherwise, asking "sex assigned at birth" can be unnecessary and an invasive question that "out" people of trans experience who do not identify as trans. Add a "transgender" option to the gender section, allowing people to fill in more than one box and add another word that may feel more accurate[23]

    —Create spaces on forms for "preferred pronoun" and "preferred name"[24]

- Communicating with LGBTQ patients and clients

    —How to ask about gender identity and sexual orientation

    —How to record information with respect and confidentiality

    —How to respond to an error in language or pronoun

    —Developing an LGBTQ-friendly referral list

- Partnering with LGBTQ community members and organizations

    —Working with LGBTQ staff and employee groups

    —Partnering with LGBTQ organizations for outreach

    —Inviting LGBTQ community members onto advisory boards

- Summarize key points

- Questions and discussion

Evaluation

Evaluation should be factored into the training agenda, leaving time for both a pre-training questionnaire/survey and post-training questionnaire/survey. See section 7 for more information.

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[21]Knudsen, S. (2006). Intersectionality—a theoretical inspiration in the analysis of minority cultures and identities in textbooks. Caught in the Web or Lost in the Textbook, 61–76

[22]Gay and Lesbian Medical Association (GLMA). Guidelines for care of lesbian, gay, bisexual and transgender patients. Retrieved from http://www.glma.org/_data/n_0001/resources/live/Welcoming%20Environment.pdf
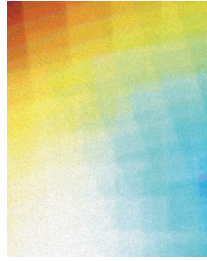
[23]American Academy of Family Physicians (AAFP). Recommended guidelines for family medicine residents -lesbian, gay, bisexual, and transgender health. Retrieved from http://www.aafp.org/dam/AAFP/documents/medical_education_residency/program_directors/Reprint289D_LGBT.pdf

[24]The Fenway Institute. Asking patients questions about sexual orientation and gender identity in clinical settings: a study in four health centers. Retrieved from http://thefenwayinstitute.org/wp-content/uploads/COM228_SOGI_CHARN_WhitePaper.pdf

6
Training Methods

A variety of different training methods can be used alone or in conjunction with one another to deliver LGBTQ cultural competency trainings. A study published in 2012 suggested that the ideal length of a training is just 20 minutes.[6] This is unreasonable for LGBTQ cultural competency trainings, considering the broad range of information to present. Also, training length is often dictated by the organization requesting the training. Instead, consider what is called "pattern interrupt," introducing changes in style, format or content every 20 minutes. Also, limit group activities and exercises to 20 minutes. Include planned breaks every 60-90 minutes.

Cultural competency trainings are best when they rely on a variety of different methods to deliver information and bring about change in the participants. The most common methods are: lecture, PowerPoint slides, personal anecdotes, small group and large group activities/discussion, media and case studies. Having opportunities to practice using new language and skills will reinforce learning. Tying the data back to participants' professional roles will increase motivation to learn and change behaviors.

Alternating between methods increases interest and also ensures that all participants have an opportunity to process information in their preferred learning style. There are three main learning styles: visual, auditory and kinesthetic.

A VISUAL LEARNER

is someone who learns best by seeing. This participant will take in new information most easily via slides, demonstrations and video components. They tend to remember things that are written down.[25]

AN AUDITORY LEARNER

is someone who learns by hearing and speaking. This participant best retains information through lecture, discussion and audio components.

A KINESTHETIC LEARNER

is someone who learns best by doing. This participant learns the most in case studies, role-plays and other hands-on demonstration components.

While some methods work well for imparting facts and knowledge, like slides and lecture, we know that whichever theory of learning is being employed, opportunities for participation allow participants to make the information their own, figure out their personal response to it and practice new skills and language.

As most participants represent diverse populations of people with varying abilities, all materials should be presented with accessibility in mind. Some participants may not be able to see, hear, speak, or move well or at all, and the most effective trainings make accommodations for these differing levels of ability. To prepare for an audience with varying abilities, the following are a few examples that can increase access:

- Provide captioning for audio and media
- Use easy-to-read fonts on handouts and slides
- Describe pertinent graphics or other visual information verbally
- If the curriculum includes activities/exercises that require standing up or walking around, consider making the exercise more accessible by having everyone sit and have them use candy pieces (like Kisses) pieces to "take steps."

More information on training accessibility can be found in the resources list or through the Web Accessibility Initiative, www.w3.org/WAI/training/accessible

Lecture with PowerPoint Slides

This is the most commonly used method of delivering cultural competency training and is best suited for presenting to very large groups and when conveying facts and statistics. Most presentations rely primarily on slides.

Slides serve as visual representation of the content spoken by the trainer. A well-crafted slide deepens the participant's understanding of the topic being discussed, rather than echoing the speaker's exact words.[26] When used well, slides can offer an emotional punch to the material being presented.

To create high quality slides, highlight a key concept from the notes, using a few words, a phrase or an image. Or, use charts to illustrate data being presented. Slides should be a companion to your training or presentation, not the training itself.

Pros:

- Both trainers and participants are accustomed to the method
- Slides can incorporate a great deal of information into a short amount of time and space
- Inexpensive to produce

Cons:

- Slides are often paired with lecture, a less interactional method of training
- High quality slides require familiarity with best practices in slide development
- There is likelihood of delivering too much information at once and losing participants' attention
- There is a tendency to read slides and rely on them as sole method

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[6]Murphy, M. (2007). Improving learner reaction, learning score, and knowledge retention through the chunking process in corporate training. (Doctorate dissertation, University of North Texas). Retrieved from http://digital.library.unt.edu/ark:/67531/metadc5137/
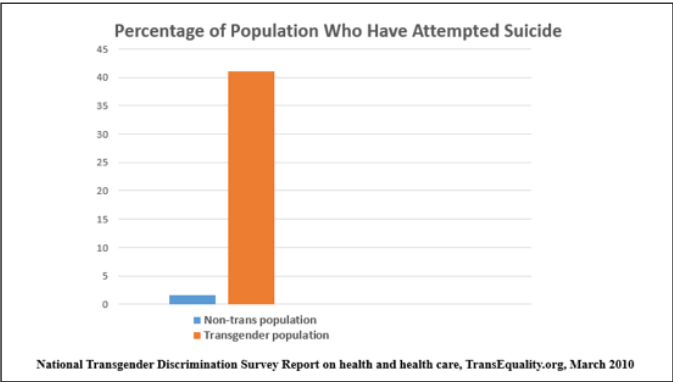
[25]University of Pennsylvania (2009). Visual learners convert words to pictures in the brain and vice versa, says psychology study. ScienceDaily. Retrieved from http://www.sciencedaily.com/releases/2009/03/090325091834.htm

[26]Cobalt Communication. Presentation skills for senior IT managers. Retrieved from http://cobaltcommunication.com/qualitiesofagoodslide/
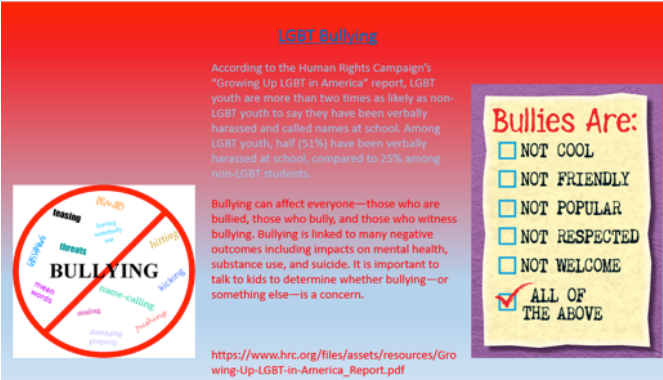
Some guidelines for slide creation:

- **Use the 6x6 rule** (maximum of six words per line, six lines per slide), as participants should be able to read and comprehend a slide in 10 seconds or less. Otherwise, they are reading when they could be listening to the trainer or other participants.
- **Use a minimum 18pt font**, serif style. Decorative fonts are hard to read and colorblindness can make certain type colors harder to decipher on a colored background.[27]
- When using statistics or a borrowed image, always include the citation on the slide.

Examples of successful slides

Among LGBT youth, 51% have been bullied at school, compared to 25% of non-LGBT students.

Human Rights Campaign, "Growing Up LGBT in America"

Percentage of Population Who Have Attempted Suicide

■ Non-trans population
■ Transgender population

National Transgender Discrimination Survey Report on health and health care, TransEquality.org, March 2010

Less successful PowerPoint slides on the same topics:

Guest Speaker(s)/Panel Discussion

Panel discussions and guest speakers enable a training to include multiple viewpoints of LGBTQ people's lived experiences and/or various areas of expertise on a particular topic. After deciding on the goal of the guest or panel, the trainer organizes the time, invites speakers from diverse backgrounds and acts as a moderator.

Pros:

- Opportunity for participants to hear people from multiple professions
- Offers humanized perspectives from multiple LGBTQ people
- Q & A allows participants to pose questions and get clarity

Cons:

- Most panel discussions take more than 20 minutes (usually an hour or longer)
- Requires more planning time and coordination (for recruiting panelists)
- Participants can become disengaged if they are expected to listen passively for an extended period

Media

Rarely used alone, multimedia can deliver a stronger and more emotionally charged message than is possible with PowerPoint slides or lecture. Media can introduce participants to multiple LGBTQ experiences and, if well made, are more captivating than a lecture. Media appeal to kinesthetic learners and work well to affect changes in attitude. They can also demonstrate new skills. However, as with lectures and panel discussions, there is no interaction with a media presentation, so participants must be offered other means of engaging with the material.

Pros:

- Media bring experts and/or LGBTQ people into a training who could not be there in person
- Media can be more stylized, interesting and engaging than lecture

Cons:

- Viewing media is a passive activity
- Media may be expensive to produce or rent

[27]Office Microsoft. (2007). Tips for creating and delivering an effective presentation. Retrieved from http://office.microsoft.com/en-us/powerpoint-help/tips-for-creating-and-delivering-an-effective-presentation-HA010207864.aspx

Interactive Participation

Interactive methods keep participants engaged with the material being delivered, as well as informing the trainer about the participants' level of understanding. Involve the participants early and often in trainings. Beginning the training with a question for the audience or an icebreaker lets them know that they will be expected to participate in the training. Interactive exercises also match adult learners' needs to find ways to incorporate the material into their own professional roles.

Pros:

- Provides an opportunity for participants to engage with the materials and make it their own

- Provides an opportunity for participants to safely make mistakes by practicing new skills and language

Cons:

- Fruitful interactive activities require the trainer to also be a competent and experienced facilitator, both encouraging participation and permitting people to not contribute to the discussion, based on their individual comfort level

- Disruptive participants can make it difficult to keep participants on task or complete the activity productively

Some examples:

- 1-on-1 paired activities: Participants are paired up with each other and asked to role-play or discuss a topic from the training, e.g., an intake with an LGBTQ youth.

- Group exercises: Small or whole-group exercises ask participants to engage with the other people in the room to reinforce understanding of the topics being discussed and find ways to incorporate the new knowledge into their work. Examples include fishbowl, role-plays, small/large group discussions (where groups can be asked to strategize new outreach methods to the LGBTQ community), etc.

- Case studies: Case studies are an excellent way for participants to be exposed to real life scenarios of LGBTQ people's challenges in accessing services, and practice strategies that would help alleviate the barriers they face. Descriptions should be short and allow for multiple group interpretations of the facts.

- Individual reflective exercises: The cultural humility approach encourages participants to examine their own lives, values and experiences of privilege and discrimination. To engage in honest and open conversations, participants must feel safe to share their experiences based on their comfort level, not as a training requirement. One example would be distributing a sheet showing the continuum of sex, gender and sexual orientation and asking participants to circle the spot that best represents them.

Print Materials and Learning Aids

Because of the wealth of information presented in most trainings, participants benefit from written materials they can take away for later reference.[28]

- Ensure that handout reflects the training. Everything contained within your handouts should relate to the material discussed during the training.

- Augment and expand on information shared during training.

- Include references and additional resources. Cite the articles, websites or studies referred to in the training. Be sure to include a link to your organization's website and the best way to contact you.

- Provide space for notes. If handouts are given before the training begins, leave space for notes.

- Include examples of inclusive intake forms.

Pros:

- Participants can take materials home with them and refer to concepts long after training

- Handouts can expand on concepts that couldn't fit within training scope or time limits

- Printed materials can include contact information for participants to stay in contact with the trainer and/or the presenting agency

Cons:

- Participants may never view the materials

- Creating and printing handouts is time consuming and can be costly

- Handouts and links need to be regularly updated

Web-based Learning

The Internet can be used to augment trainings in multiple ways.

Through web-based polls (for example, Poll Everywhere (www.polleverywhere.com) participants with cell phones can post anonymous answers to questions. The real-time results of the poll will show up on a webpage or screen. The Internet can also be effectively employed to make a live demonstration on how to research local LGBTQ organizations for future partnering and/or outreach efforts.

Pros:

- Ability to integrate real-time results into training

- Allows audience members to participate anonymously

Cons:

- Venue must have wireless networking

- Participants must have internet-enabled devices

- Participants must be comfortable with the technology to use the polling software

[28]Mitchell, O. (2010). 13 Best practice tips for effective presentation handouts. Retrieved from http://www.speakingaboutpresenting.com/delivery/presentation-handouts/

7

Training Evaluation

Evaluation is a critical element of training. It is important that every LGBTQ cultural competency training program conduct a basic training evaluation regardless of the training content, duration or number of participants. There are 3 primary benefits to be gained from conducting training evaluation:

- Greater ability to improve future trainings so that training impact is strong. The current training may be your only chance to change the knowledge, attitudes and skills of those attending, as they may not seek training again. To improve and refine future trainings, feedback is essential.

- Evidence that the training goals and objectives were accomplished. Specifically, effective evaluations will provide information on whether the training(s) made a difference by improving participants' knowledge, attitudes and skill set in providing care to LGBTQ clients.

- To assure a positive impact of the training on the care of LGBTQ patients or clients. This is the ultimate goal of training—to assure high quality care for LGBTQ clients/patients.

Trainings are more likely to be successful if they have clear goals and objectives closely aligned with the content of the training itself. Knowing WHAT is being evaluated and WHY it is being evaluated will help determine HOW best to conduct the evaluation. A widely used model for evaluating the success of a training program is Kirkpatrick's Four-Level evaluation model.[29] The following diagram shows each of the four levels, what each level evaluates and the central questions being asked at each level.

Kirkpatrick Model (Pyramid) of Evaluation[30]

As you move up the pyramid, the intensity of evaluation increases, as each new level assumes that the prior levels below are also included. In other words, the process of evaluation moving up the pyramid is cumulative—each higher level requires that the lower levels be conducted as well. Second, moving up the pyramid, the complexity of the evaluation process increases. Level 1 evaluation may entail a brief survey with items asking about satisfaction with the training, but Level 2 includes those survey items, but also a pre- and post-training survey of attitudes, knowledge and other participant characteristics that the training was targeting to change for the better. More time and resources are needed as you go up the pyramid. Below is a description of each level of the Kirkpatrick evaluation model as shown in the pyramid figure.

Level 1, at the base of the triangle, captures the reactions of participants to the training experience, i.e., their satisfaction with different components of the training, such as the content and the trainer's communication skill, and the usefulness of the training to their work. Level 1 evaluation gives the trainer feedback on how well the training met the needs of the participants, but it does not provide information on how much the participants learned from the training. For this information, Level 2 evaluation is needed.

Level 2 is the evaluation of learning itself (i.e., how much did people learn?). This level of evaluation is often accomplished by pre- and post-training test of knowledge of the training content as well as pre- and post-survey of participants' change in intentions, attitudes and self-efficacy for enacting the knowledge and skills.

EVALUATION INTENSITY

Level 4
Evaluation of Results
Evaluation of client/patient outcomes

Did the changed behavior of participants affect clients/patients?

Level 3 ▪ **Evaluation of Behavior**
Evaluation of the application of knowledge (and attitude & self-efficacy)

Did the participants use what they learned from the training at their workplace?

Level 2 ▪ **Evaluation of Learning**
Evaluation of change in knowledge (and attitude & self-efficacy)

Did the participants learn from the training?

Level 1 ▪ **Evaluation of Reaction**
Evaluation of training experience

Were the participants satisfied with the training?

[29]Kirkpatrick, D.I. (1967). Evaluation of training. In: Craig R, Bittlel, I, eds. Training and development handbook. New York: McGraw Hill.

[30]Dick, W., & Johnson, R. B. (2002). Evaluation in instructional design: The impact of Kirkpatrick's four-level model. RA Reiser & JV Dempsey Trends and Issues in Instructional Design and Technology, 145-153.

Level 3 is focused on evaluating behavior of the participants (i.e., whether participants' behavior changed based on what they learned). Many cultural competency trainings measure only Levels 1 and 2 because it is much more challenging to see and measure behavioral change of participants. Level 3 could involve rating audio- or videotapes of the participants interacting with an LGBTQ patient/client or simulated patient, or by conducting a 360 feedback from participants' subordinates, co-workers, supervisors and clients/patients.

Finally, **Level 4** takes the evaluation to the ultimate outcome—the LGBTQ patient/client. Did that participant's behavior lead to improved patient/client quality of life, adherence to treatment, or other patient/client outcomes where you would expect to see an impact?

Please refer to EVALUATION APPENDIX: "Kirkpatrick's Model of Evaluation," "Tips on Evaluation," "Sample Training Fidelity List," and "Sample Survey Items."

How to decide which evaluation approach to use

Although there are four valuable levels of evaluation, most organizations do not have the resources (time, staffing) to assess their LGBTQ cultural competency training programs beyond levels 2 or 3. The following chart describes the considerations for implementing different levels of the Kirkpatrick evaluation model and its levels or evaluation intensity. It is recommended that the Basic Evaluation Intensity or comprehensiveness be conducted, at minimum. Some organizations providing training may have resources and time to implement Level 3 and Level 4.

A more detailed step-by-step approach to developing measures to evaluate training impact at the different levels of the Kirkpatrick model is included in the Evaluation Appendix.
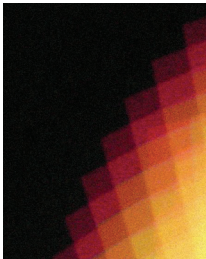
Evaluation Planning Chart

Kirkpatrick Evaluation Level	Content	Methods	Resource Considerations
BASIC EVALUATION INTENSITY			
Level 1: Reaction	**Evaluation of participants' training experience:** *Were the participants satisfied with the training?*	• **Post-training questionnaire** with quantitative and open-ended questions. *Complementary formats: Group discussion*	• Time for development of questionnaire(s) • Time for photocopying or input into web-based administration (e.g, Survey Monkey) Participant time: • Level 1 Evaluation of Reaction: 5-7 minutes, AFTER training is completed. • Level 2 Pre-test: 5-10 minutes, BEFORE training begins. Post-test: 5-10 minutes, AFTER training is completed. *More time should be allotted if complementary formats are also used.*
Level 2: Learning	**Evaluation of change in knowledge, attitudes, self-efficacy, behavioral intentions:** *Did the participants learn from the training?*	• **Pre- and post-training questionnaires** with quantitative and open-ended questions. *Complementary formats: Self-reflection exercises and group discussion.*	• Input of questionnaire data into database (e.g., Excel, SPSS) and data entry checking • Analysis of questionnaire data calculated and summarized across participants (e.g., mean values on items or scales and pre- to post-training changes) • Trainer interpretation of evaluation data and integration of findings into quality improvement of training curriculum
INTERMEDIATE EVALUATION INTENSITY			
Level 1: Reaction Level 2: Learning **Add Level 3:** Behavior*	See above **Evaluation of behavior** (or behavioral intentions): *Did the participants use what they learned from the training at their workplace?*	See above • **Direct observation of participant in work environment** (e.g., via videotaped client interaction) • **360 feedback survey** • **Pre- and post-training survey** of participants' behavioral intentions	See above • In addition to Basic evaluation above, evaluation of behavior adds more time and resource commitment. Videotaping of participants' interaction with clients/patients would be done on the job and their performance would be scored on a scale. • A 360 feedback survey would entail a standard measure of the trainee's performance as evaluated by a number of informed work colleagues, supervisors, subordinates and clients. • Intentions to perform, enact or change are reasonably good predictors of actual behavior, as long as they are assessed specifically and state a time frame.

*Note: Level 3 evaluations cannot be done if ONLY presentation (and no training) was delivered (see page 4-5 for more information on the distinction between "training" and "presentation"). Do not expect to see any behavioral changes of participants IF you only provided presentations and not trainings.

Level 1: Reaction	See above	See above	See above
Level 2: Learning	**Evaluation of results**	• **Survey of patient satisfaction with communication and care**	• This level is typically not evaluated by the trainer, given that it would require access to the clients or patients of the participants.
Level 3: Behavior	*Did the changed behavior of the participant affect his/her patients/clients?*	• **Measurement of quality of life or medical outcomes** (e.g., adherence to medical treatment)	• Surveys or other indicators of patient-level outcomes would need to be developed.
Add Level 4: Results			• The institution employing the participants might conduct this evaluation, or independent evaluators can be contracted to conduct a Level 4 evaluation.

8
Resources and Examples

General LGBTQ Health Resources for Updating Curricula

- The National LGBT Health Education Center http://www.LGBThealtheducation.org/publications/top/

- U.S. Department of Health and Human Services Recommended Actions to Improve the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Communities http://www.hhs.gov/LGBT/health.html

- The Coalition for LGBT Health http://LGBThealth.webolutionary.com/

- For current LGBTQ health updates

  —Subscribe to Google Alerts for relevant topics ("LGBT," "LGBT Health," "LGBT Health," "Transgender Health," "gay health", etc.

  —Follow LGBTQ health organizations on Facebook, Twitter and RSS Feeds

  —Join GLMA's weekly Health Digest and/or the Coalition for LGBT Health

  —LGBT Wellness page of Huffington Post, including a weekly LGBT health roundup, http://www.huffingtonpost.com/news/LGBT-wellness/

Improving the LGBTQ-friendliness of a Healthcare Facility

- Sample "New Patient Intake Form" (Fenway Institute) (http://www.fenwayhealth.org/site/DocServer/Handout_2-B_References.pdf?docID=4762)

- Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients (GLMA) (http://www.glma.org/_data/n_0001/resources/live/Welcoming%20Environment.pdf)

- Out for Health (http://www.outforhealth.org/)

- Samples of nondiscrimination policies (http://www.hrc.org/resources/entry/sample-patient-non-discrimination-policies)

- Creating inclusive spaces: Gender neutral bathrooms (http://www.westernstatescenter.org/tools-and-resources/Tools/creating-inclusive-spaces)

Media for Trainings

- "To Treat Me, You Have To Know Who I Am" (2012), produced by the National LGBT Cancer Network, includes interviews with patients and providers and offers suggestions for change. (https://www.youtube.com/watch?v=XqH6GU6Trzl)

- "Simon's Story," produced by the University of Washington School of Medicine, features a transgender man talking about what he needed to comfortably access healthcare. (https://www.youtube.com/watch?v=fgyFWTpk_Wc)

Guidelines for Creating Good PowerPoint Presentations

Helpful websites for creating successful PowerPoint slides:

- http://cobaltcommunication.com/qualitiesofagoodslide/

- http://office.microsoft.com/en-us/powerpoint-help/tips-for-creating-and-delivering-an-effective-presentationtraining-HA010207864.aspx

- http://lifehacker.com/how-can-i-make-my-powerpoint-presentationtrainings-amazing-507552122

- http://www.igniteshow.com

Resources for Anti-Oppression Trainings

- http://www.westernstatescenter.org/tools-and-resources/Tools/shared-oppressions

- http://www.ykhong.com/wksps.pdf

Accessibility

- http://www.w3.org/WAI/training/accessible

- http://www.jisctechdis.ac.uk/techdis/resources/ae

- http://www.ada.gov/2010ADAstandards_index.htm

Evaluation

- Writing effective survey questions (http://www.qualtrics.com/blog/writing-survey-questions/)

- Evaluation consulting (http://www.strengthinnumbersconsulting.com)

Evaluation Appendix

Kirkpatrick's Model of Evaluation

Level 1—Reaction

The first level of evaluation focuses on gathering feedback from the participants about their reactions to the training, e.g., how interesting and useful they found the training. This level emphasizes getting information on how well the LGBTQ-focused material met participants' expectations and needs and the trainer's performance in presenting it. Assessing participants' experience of the training is critical. Even when the training material used is of high quality, if it is delivered in a disorganized or uninteresting manner, then participants may be less receptive to the information or not retain it. Similarly, even if the trainer is skilled in communicating the content but the content is not focused and organized, the impact of training can be diminished. Level 1 evaluation will help determine whether the training should be changed to better serve the needs of future participants.

Reaction Evaluation Method Option #1:

Post-training surveys are typically used to collect participants' opinions/feedback about the training. The survey should include various questionnaire types:

CLOSED-ENDED QUESTIONS are questions that limit respondents to a list of answer choices from which they must choose to answer the question. Closed-ended questions can be written as multiple-choice, true/false or using the Likert scale (see below).

> **Example 1**
>
> "Did the trainer establish a group agreement (ground rules) at the beginning of the training?"
> a) Yes   b) No

> **Example 2**
>
> *Likert Scale item (a type of a closed-ended question):* This question type captures the intensity of the respondents' feelings on a symmetric agree-disagree scale.
>
> "I felt safe discussing LGBTQ issues during the training without feeling judged by the trainer or my peers." (Please circle one).
>
> | Strongly Agree | Agree | Neither Agree or Disagree | Disagree | Strongly Disagree |
> | --- | --- | --- | --- | --- |

OPEN-ENDED QUESTIONS are questions that require more thought and more than a one-word answer. Opened-ended questions are commonly known as "short answer questions."

> **Example**
>
> "What would you have added/changed if you were a trainer?"

Reaction Evaluation Method Option #2:

Group feedback or focus group is another way to evaluate Level 1. The only drawback to this method is that, since people's responses are verbally collected, the issue of confidentiality and trust may be a factor in gathering people's honest feedback. This would be ideal in a group setting where there is a great level of trust within the group.

> **Example**
>
> Ask the group at the end of the training session a list of positive things about the training and then a list of things that they would like to change for future trainings. This can be done in a "shout-out" style.

Level 2—Learning

An evaluator cannot make an assumption based on participants' positive feedback of the training (i.e., Level 1 - they liked the training) that they learned (retained knowledge) about LGBTQ cultural competency. Therefore, all training programs should include Level 2 evaluation (Learning) to document that participants had increased knowledge after the training. This level of evaluation measures changes occurring from beginning of the training (pre) to after the training (post) in knowledge, attitudes, self-efficacy, intentions or perceived skills. By conducting this pre- and post-evaluation within such a short time period, it can be safely assumed that any significant changes that are observed are a result of the LGBTQ cultural competency training itself.

Learning can entail the following:

• Increase in LGBTQ knowledge

• More positive attitudes toward LGBTQ people and their concerns

• Greater self-efficacy (self-confidence) in providing culturally competent care

• Greater intention to put into practice the knowledge and skills learned

• Stronger perceptions that the trainee has the skills to provide culturally competent care

Learning Evaluation Method Option #1:

The most common and feasible Level 2 evaluation method is to administer a PRE-test and a POST-test questionnaire (not just post-test) to quantify any changes in the target characteristics of trainees. Without measuring the participants' baseline knowledge or attitudes (through a pre-test), it is not accurate to claim that there was a change in either category.

KNOWLEDGE QUESTIONS must be written in way that has a correct answer. They should not be opinion questions. These questions can be formatted as multiple-choice, matching, open-ended (e.g., short answers) or closed-ended (e.g., true-false) questions.

ATTITUDE QUESTIONS do not have a right or wrong answer. They are phrased in a way to solicit feelings or beliefs about an issue. Questions can be written as closed-ended, open-ended or using the Likert scale.

SELF-EFFICACY QUESTION is a type of an attitude question.

Learning Evaluation Method Option #2:

Another method of evaluating knowledge and/or attitude of the participants is by using the pre- and post-test scores of a control group (a group that did not receive your LGBTQ cultural competency training) and comparing the pre- and post-test scores of the participants who completed the training. However, this method may not be feasible for many agencies because of limited resources, time and lack of knowledge on this method.

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[3]Lambda Legal. Facts: Gay and Lesbian youth in schools. Retrieved from http://data.lambdalegal.org/pdf/158.pdf

Level 3—Behavior

Suppose that you were able to successfully measure an increase in knowledge among the people you trained. How do you know that they can successfully implement what they have learned? Will such learning transfer to their real-world work setting?

> In other words, just because participants were satisfied with the training (Level 1) and they acquired new knowledge about LGBTQ issues (Level 2), it does not mean that participants can and will apply what they learned (Level 3).

Therefore, it is important to evaluate whether participants are actively incorporating the LGBTQ knowledge and skills they learned from the training to effectively serve their LGBTQ clients/patients.

Level 4—Results

> Lastly, even if participants were satisfied with the training (Level 1), showed increased knowledge on LGBTQ issues (Level 2), and they were able to apply what they learned during training or at their job settings (Level 3), it does not necessarily mean that all of these will lead to improvement in the psychosocial well-being or health of the participants' LGBTQ patients/clients (Level 4).

For example, prior to the delivery of LGBTQ cultural competency trainings, there may have been a number of external factors (e.g., passing of a state level non-discrimination law, greater access to health care coverage, etc.) that may have contributed to the improvement in the health of LGBTQ people (e.g., increase in LGBTQ patients accessing healthcare services). It is important to methodically measure the LGBTQ cultural competency training's impact because it cannot be assumed that it was the training itself that caused improvement in LGBTQ health outcome.

Behavior evaluations tend to be time-consuming, require agency support and may need long-term evaluation since behaviors do not change immediately. Although it is much more difficult to evaluate participants' behavioral change compared to their knowledge, behavior evaluation can provide evidence on whether the participants went back to their "old habits" or were able to make a deeper and lingering change at work place when working with LGBTQ clients/patients.

This level of evaluation is the most difficult and expensive because it looks at the deeper changes that have resulted from the training(s). It may entail using an independent evaluator, using experimental design and quantitative statistics and measuring changes over extended periods. Depending on the nature of the training program, it can take months or even years to complete; however, such evaluation provides the strongest evidence that training has made a significant difference in the lives of LGBTQ clients or patients. It is the "gold standard" of evaluating training impact.

Tips on Evaluation

BEFORE Distributing Pre- or Post-test Evaluation Surveys:

- Because many people (even those who often attend trainings) do not see evaluation as a part of the training process, it is important to explain *at the beginning of the training* why evaluation is necessary. Here are some points you can make:

  —"You are here today to make sure that your LGBTQ clients or patients are treated with respect and felt to be welcome at your home organization. Evaluation of the impact of training on your knowledge, attitudes, intentions and confidence in your skills is vital for us to know that we are meeting your needs."

  —"We've kept the evaluation as brief and to the point as possible, so thanks in advance for taking the time to let us know the impact of this training for you."

  —"Please give thought to your answers, as we depend on your input for improving the quality of our training. Thank you."

- Allocate enough time (at least 10 minutes) for participants to thoroughly and thoughtfully complete the evaluation

Writing Pre-test or Post-test Training Evaluation:

- First, decide what you would like to evaluate: knowledge, attitude, self-efficacy, behavioral intentions or all? Then make sure that the knowledge-based questions are written in a way that it extracts information about their actual knowledge as opposed to their perceived knowledge. (Please refer to *"Learning Evaluation Method option #1"*)

- Include "Don't Know" as an answer choice option in ALL KNOWLDEDGE questions. (If they chose "Don't Know" in a knowledge question, then it is marked as incorrect when you analyze the data)

- Balance positive and negative questions. For instance, ask participants to list BOTH the most AND least useful part of the training to avoid biased feedback

- The post-training survey/feedback should always include *demographic questions and, ideally, it would be asked at the end of the survey.* The suggested demographic information is listed below (however, you can tailor the list for your audience):

  —Name of organization and/or job department

  —Highest education completed

  —Age

  —Ethnic/racial identity

  —Gender identity

  —Sexual orientation

AFTER Collecting and Analyzing the Surveys:

- It is important to recognize the distinction between knowledge and behavior (i.e., just because you know something, it does not mean that you can do it). In other words, be cautious of how you articulate your claim about Level 2 evaluation (Learning). It is not accurate to extrapolate and state that your participants are now "competent" in LGBTQ issues even if the evaluation showed an increase in LGBTQ knowledge. All you can accurately claim is that after the completion of your training, participants' knowledge on LGBTQ issues increased.

Sample Training Fidelity List Items

	Did Not Do This	Did This	Not Applicable
1. I was able to complete the full training in the time that was allotted.			
2. I discussed ways to create a welcoming environment for LGBTQ clients or patients.			
3. I presented information on LGBTQ health disparities in access to care and health outcomes, as well as protective factors.			
4. At minimum, I conducted Level 1 (reaction) and Level 2 (learning) pre- and post-training surveys.			
5. Was there any other content or process of your training that you delivered but was not in the items above? If so, please specify below:			

Sample Survey Items

Level 1—Evaluation of Reaction (Post-test)

NOTE To be completed AFTER the training. You would NOT write "Evaluation of Reaction…" title in the survey that you hand out

We value your views of this training and they will help improve our future trainings. Thank you!

1. Please indicate by placing a checkmark (✔), whether you agree with the following statements:

	1 Strongly disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly agree
The _trainer_ was knowledgeable on this topic.					
The _trainer_ created opportunities for participants to actively engage in the training.					
The training content (information) was clearly presented.					
Overall, I am satisfied with the training I attended today.					

2. Please indicate by placing a checkmark (✓), how USEFUL you found the following items from the training (check all that apply):

	1 Not at all useful	2 A little useful	3 Somewhat useful	4 Very useful	5 Not covered
Terminology (LGBTQ basics)					
Intersectionality of identities					
LGBTQ health disparities					
Creating welcoming space					
Personal stories of LGBTQ people					
Diagrams and visual aids					
Group discussions/exercises					
Handouts and resources					
Other (please specify): _____					

3. What would you have changed about this training, if any?

_____

_____

4. Additional Comments?

_____

_____

Level 2—Evaluation of Learning (Pre-test)

NOTE To be completed BEFORE the training. You would NOT write "Level 2—Evaluation of…" title in the survey that you handout

Knowledge Questions

NOTE You would NOT write "knowledge" in the survey that you hand out

1. Please indicate (using "X" mark) whether the following statements are true, false or you don't know.

Statements	True	False	Don't Know
LGBTQ youth are twice as likely as their heterosexual peers to say they have been physically assaulted at school.			
Lesbian/gay youth attempt suicide at a higher rate than transgender youth.			
LGBTQ students are nearly three times more likely to drop out of high school.			
LGBTQ youth are overly represented in the homeless youth population.			

2. Compared to the general population, I think LGBTQ people smoke:

   a) 10-50% less than the general population

   b) Somewhere near the same rate as the general population

   c) 10-50% more than the general population

   d) Over 50% more than the general population

   e) Don't know

3) Please list at least 2 different ways that we can show we are trans-affirming at our workplace.

_____

_____

Attitude Questions

You would NOT write "Attitude" in the survey that you hand out

1. I am aware that LGBTQ people exist but I do not see how it might affect my role at work.

Strongly Agree	Agree	Disagree	Strongly Disagree

2. I would be comfortable if I became known among my professional peers as a provider/staff who cares for LGBTQ patients.

Feel very comfortable	Feel somewhat comfortable	Not care either way	Feel somewhat uncomfortable	Feel very uncomfortable

3. It is more challenging to discuss sexual behavior with LGBTQ patients than with straight (and non-transgender) patients.

   a) More

   b) Equally

   c) Less

Self-Efficacy Question

You would NOT write "Self-Efficacy" in the survey that you hand out

1. How confident are you that you will be able to recognize what transphobia looks like at work?

Very confident	Mostly confident	Moderately confident	Not very confident	Not at all confident

Behavioral Intention Questions

You would NOT write "Behavior Intention" in the survey that you hand out

1. How likely would you use the word "partner/spouse" instead of "boyfriend(husband)/girlfriend(wife)" when asking all your clients/patients about their significant other? Please circle one answer.

Very likely	Most likely	Somewhat likely	Not very likely

2. How likely are you to intervene in a homophobic or transphobic interaction at your work place? Please circle one answer.

Very likely	Most likely	Somewhat likely	Not very likely

Level 2—Evaluation of Learning (Post-test)

To be completed AFTER the training. You would NOT write "Evaluation of Learning…" title in the survey that you handout

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Knowledge Questions

You would NOT write "knowledge" in the survey that you hand out

1. Please indicate (using "X" mark) whether the following statements are true, false or you don't know.

Statements	True	False	Don't Know
LGBTQ youth are twice as likely as their heterosexual peers to say they have been physically assaulted at school.			
Lesbian/gay youth attempt suicide at a higher rate than transgender youth.			
LGBTQ students are nearly three times more likely to drop out of high school.			
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   c) 10-50% more than the general population

   d) Over 50% more than the general population

   e) Don't know

3) Please list at least 2 different ways that we can show we are trans-affirming at our workplace.

   _____

   _____

Attitude Questions

1. I am aware that LGBTQ people exist but I do not see how it might affect my role at work.

Strongly Agree	Agree	Disagree	Strongly Disagree

2. I would be comfortable if I became known among my professional peers as a provider/staff who cares for LGBTQ patients.

Feel very comfortable	Feel somewhat comfortable	Not care either way	Feel somewhat uncomfortable	Feel very uncomfortable

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Very likely	Most likely	Somewhat likely	Not very likely

2. How likely are you to intervene in a homophobic or transphobic interaction at your work place? Please circle one answer.

Very likely	Most likely	Somewhat likely	Not very likely

3. An example of an open-ended format:

Now that I know _____,

I will (think/reflect on) _____.

I will (learn more) _____.

I will (share) _____.

I will (do) _____.

Demographics

1) What is your job position at the organization/agency (check all that apply)

☐ Administrative
☐ Clinical services
☐ Educator/trainer
☐ Health care delivery
☐ Manager/executive director
☐ Other (Specify: _____)

2) What is the highest degree you have completed?

☐ High School Diploma or GED
☐ Technical Certificate
☐ Associates (AA)/2-yr college
☐ Bachelors (BA/BS)/4-yr college
☐ Masters Degree
☐ Doctoral Degree
☐ None of the above (Specify: _____)

3) What is your age?

☐ 17 and under
☐ 18-30
☐ 31-50
☐ 51-64
☐ 65 and over

4) What is your racial/ethnic identity? (Check all that apply)

☐ African/Black/African American
☐ Asian/Asian American
☐ Bi-racial/Multi-racial
☐ Caucasian/White
☐ Latino/Hispanic
☐ Middle Eastern
☐ Native American/American Indian
☐ Pacific Islander
☐ None of the above (Specify: _____)

5) What is your gender identity? (Check all that apply)

☐ Cisgender (Non-transgender) man
☐ Cisgender (Non-transgender) woman
☐ Genderqueer
☐ Nongender
☐ Questioning
☐ Transgender man
☐ Transgender woman
☐ Two-Spirit
☐ None of the above (Specify: _____)

6) What is your sexual orientation? (Check all that apply)

☐ Asexual
☐ Bisexual
☐ Gay
☐ Heterosexual
☐ Lesbian
☐ Pansexual
☐ Queer
☐ Questioning
☐ Same-Gender-Loving (SGL)
☐ None of the above (Specify: _____)

C3

Cultural Competency
Coordination