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CE II

Cultural Competence and the Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Patient

By Chikita Brown Mann, MSN, RN, CCM

An ethical challenge faced by case managers and others working in health care is to respect the rights and inherent dignity of all clients and to treat each patient with dignity, maintain objectivity in their relationships with clients, and advocate for health care for all.

Cultural competence has received a great deal of attention in the past 10 years. The Institute of Medicine published *Crossing the Quality Chasm and Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* which drew attention to the interrelationship between patient-centered care and cultural competency. The only true way to provide patient-centered care is to be cognizant of the patient's way of life, which entails their beliefs and values, and being able to provide this care without bias or prejudice (Ard & Makadon, 2012). Cultural competence has been noted as an effective tool in decreasing health disparities, a major cause of increasing health care costs in the US. Three central constituents of culturally competent care are knowledge, expertise, and attitudes (Fredrikson-Goldsen, Hoy Ellis, Goldsen, Emlet, and Hooyman, 2014).

Most of us are acutely aware of the health care disparities that involve race and ethnicity. However, health care disparities based on sexual orientation have become more prevalent, with statistics to prove it. Gay men and men who have sex with men (MSM), especially those of communities of color, are more likely to contract human immunodeficiency virus (HIV) and sexually transmitted disease. Lesbian women are more likely to avoid seeking or obtaining preventive gynecological testing (ie, mammograms and Pap smears). Lesbian and bisexual women have a high risk of being obese or overweight. Older LGBTQ adults have higher incidence of poor mental health and increased cardiovascular disease (Fredrikson-Goldsen, Hoy Ellis, Goldsen, Emlet, and Hooyman, 2014; Ard & Makadon, 2012). Higher rates of substance and alcohol abuse are known within this population. This population additionally endures mistreatment, refusal of care, and restricted access to quality, timely treatment. (Ard & Makadon, 2012). Depending on their ethnicity, they may also have to deal with racial discrimination. These statistics have caught the attention of Healthy People 2020 and the Joint Commission, who have created specific initiativeus to better understand and improve the lesbian, gay, bisexual, and transgender (LGBTQ) population's health.

As case managers, we would be remiss in not making cultural competence with this population a high priority. One guiding principle of the Case Management Society of America (CMSA) is to provide culturally competent care by embracing and respecting diversity (CMSA's Standards of Practice for Case Management, 2016). The Commission for Case Management Certification (CCMC) mandates that "Board Certified Case Managers will respect the right and dignity of a client" and will "maintain objectivity in their relationships with clients" (CCMC Code of Professional Conduct for Case Managers, 2015). The National Association of Social Workers (NASW) has dedicated standards for cultural competence for social workers to possess and pursue definitive knowledge related to sexual orientation and gender identity to effectively coordinate care (Standards and Indicators for Cultural Competence

Chikita Brown Mann, MSN, RN, CCM*, is a Disability RN Case Manager Supervisor. She serves as a Commissioner with the Commission for Case Management Certification (CCMC). She is also a member of The Honor Society of Nursing, Sigma Theta Tau International.*

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in Social Work Practice, 2015). The foundation of the Certification of Disability Management Specialist (CDMS) Code of Professional Conduct includes the ethical behaviors of beneficence, nonmaleficence, justice, and fidelity (The CDMS Code of Professional Conduct, 2015). Legally, the Consumer Bill of Rights states that a patient has a right to receive care regardless of their race uality, timely treatment. atment, JC). organizations has to embody the core principles of cultural competency. and sexual orientation. Ethically and legally, this population deserves quality cost-effective care coordination.

Cultural competence requires case managers to view patients as individuals and to set aside their own bias and prejudices. It is necessary for those who are in constant contact with patients. The goal of culturally competent care is to provide care that is fair, safe, adequate, efficient, opportune, and patient centered (Lehman, Fenza, and Hollinger-Smith, 2012) .

In this article, we will define *cultural competence* and explore the components of cultural competence relevant to this article. We will also expound on the acronym *LGBTQ* as this knowledge is integral to communicating with patients and coordinating care. Lastly, we will provide organizational and health care professional culturally competent recommendations to consider for care coordination.

Before we delve into what cultural competence is, let's look at the seven assumptions from the Purnell Model for Cultural Competence that will help to set the stage for this discussion. This model is unique in that it is applicable to all health care disciplines (Rose, 2013). The first is that one culture is not superior to another—only different. The second is that all cultures share similarities. One of those similarities is that everyone has a basic human need to be understood and respected. Third, culture has a profound effect on one's perception of health care and how the health care professional provides health care. Fourth, each individual has the inherent right to be respected for their own unique culture. Fifth, cultural-general and cultural-specific data are needed to provide culturally competent care. Sixth, health care professionals who can assess, plan, intervene, and analyze in a culturally competent style will likely be more effective in care coordination. Lastly, each meeting with the patient is a cultural encounter (Purnell, 2013). A full listing of Dr. Purnell's 20 assumptions can be found in T*ranscultural Health Care: A Culturally Competent Approach.*

What is Cultural Competence?

Dr. Josepha Campinha-Bacote created a conceptual model called the process of cultural competence in the delivery of health care services. According to this model, cultural competence is defined as the process in which the health care professional works proficiently within the cultural context of the patient. The primary focus of this model requires the health care professional to make a conscious effort to understand the traditions, values, and beliefs of a specific population. Utilizing this model requires the health care professional to see cultural competence as an ongoing process. Becoming culturally competent requires the incorporation of cultural desire, cultural awareness, cultural knowledge, cultural skills, and cultural encounter. These are considered as the five constructs of Dr. Campinha-Bacote's model. (Rose, 2013). For this article, we will expound on cultural awareness, cultural desire, cultural knowledge, and cultural encounter.

Cultural Awareness

The case manager does self-examination of their own feelings, biases, and stereotypes toward their own cultural background, beliefs, and values. This self-examination is necessary to prevent cultural imposition—imposing one's beliefs and values on someone of a different cultural background. The results of this self-examination are then compared to their biases and beliefs toward other cultures. It is usually in this process that the case manager realizes how their preconceived opinions of other cultures could be helping or hindering their ability to coordinate care effectively. The case manager admits and affirms the reality of sexism, racism, and other types of discrimination experienced by other cultures (Rose, 2013). Cultural awareness usually leads to cultural desire.

Cultural Desire

Cultural desire is fundamental to cultural competence as it encompasses caring. Knowledge is irrelevant until it is evident how much a person cares. Cultural desire involves the case manager recognizing their lack of knowledge about a particular culturally diverse population. The case manager

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aspires to be culturally competent. The case manager makes a concerted effort to learn about a different culture that is totally opposite from their own. Learning about another culture is not done because it is a requirement. The case manager is able to motivate themselves to learn more about other cultures. The case manager is committed to care for all patients, regardless of their cultural practices, beliefs, and values. The case manager sees the LGBTQ as an individual, not a stereotype (Rose, 2013).

Cultural Knowledge

The case manager intentionally seeks information about the other culture. He or she goes the extra mile to apply this knowledge in care coordination. The information obtained should be the culture's health-related beliefs practices and cultural values (Rose, 2013). Another point of consideration for cultural knowledge is the case manager knowledge of laws and policies that offer protection for this particular population.

Securing cultural knowledge concerning LGBTQ patients involves learning what the acronym LGBTQ stands for. Now let's define each to expand our knowledge. A lesbian is a woman who is attracted emotionally, sexually, or romantically to other women. Gay is defined as a person who is attracted primarily to the same gender. Transgender, also known as transsexual, describes a person whose gender identification and assigned birth sex do not correspond. Queer is defined as an individual who thinks of their gender identity or sexual orientation as outside of societal standards. (For a more expansive glossary of LGBTQ terms for health care professionals, visit LGBT Health Education.org. (Glossary of LGBT Terms for Health Care Teams, 2015).

Cultural Encounter

Cultural encounter consists of the case manager deliberately interacting with patients with culturally diverse backgrounds. The case manager seeks out opportunities to connect and collaborate to modify their existing beliefs and values. Cultural encounters enhance cultural awareness and acquisition of cultural knowledge (Campinha-Bacote, 2011). The case manager has to bear in mind that interaction with one or two members of a specific cultures does not make one an authority on that culture. There are always variations within a culture.

The cultural encounter also entails the case manager understanding that they are representing case management as a whole. Each encounter is an opportunity for the case manager to show empathy and understanding. Each opportunity should include the case manager being an advocate and actively caring for the patient.

Special Consideration for Transgender Individuals

A transgender person can be confounding to someone who is not familiar with the LGBTQ population. Two dominant transgender classifications are female-to-male (FTM) and male-to-female (MTF). FTM means a person whose assigned birth sex was female but who lives and identifies as a male. MTF means a person whose assigned birth sex was male but who lives and identifies as a female (Ard & Makadon, 2012). Care coordination for the transgender individual can be challenging, especially if the individual has undergone surgical or hormonal treatment to transition to their gender of choice.

Special Consideration for LGBTQ Adolescents and Older Adults

Adolescence can be a challenging time for any adolescent, but even more so for the LGBTQ adolescent. This is a time of understanding and exploration of gender identification and establishment of gender roles. Others may not be receptive to the LGBTQ youth's sexual orientation or gender expression. This youth may be estranged or rejected by their parents. He or she also have high risk of bullying and psychological abuse (The Joint Commission, 2011).

It is anticipated that by 2030, there will be at least 3 million lesbian, gay, or bisexual elders. LGBTQ older adults experience a great deal of isolation due to rejection from family. Their "adopted" family may be a small group of close LGBTQ friends. Senior centers are not generally accepting of LGBTQ elders. These elders are at a greater risk of living alone. LGBTQ elders are less likely to be financially secure (Portz et al, 2014; The Joint Commission, 2011).

Delivering Culturally Competent Care Coordination

Cultural competence has to start on an organizational level. Culturally competent organizations will produce

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culturally competent health care professionals. The policies and procedures and standards of care for health care organizations should embody the core principles of cultural competency (The Joint Commission, 2011). This helps to ensure that culturally competent practices are executed by all in the organization who will be in constant contact with patients.

Suggestions for organization include the following (The Joint Commision, 2011):

- Post in plain sight the organization's nondiscrimination policy or bill of rights.
- Designate unisex restrooms, if possible.
- Make sure that visitation policies are executed in a nondiscriminatory manner.
- Create forms that are inclusive and contain gender-neutral language that encourage authentic self-identification.
- Enforce among staff that disclosure of one's LGBTQ status is protected by HIPAA and is considered to be sensitive and confidential information.
- Provide LGBTQ training to all staff, especially those who have constant patient interaction.

Individual Case Manager Recommendations

Role of Communication

Communication has the power to unite or divide. Effective communication skills will be the foundation for the cultural encounter with the LGBTQ patient. Therefore, breaking down barriers to communication is pivotal for quality and patient-centered care coordination (Epner & Baile, 2012). The case manager must be willing to identify and utilize different communications skills. Why? The LGBTQ community has endured discrimination, rejection, abuse, and denial of access to basic health care services. They are also vulnerable, which can sometimes be disguised by a tough persona. They have built up a protective wall around themselves that will only be broken down by effective communication skills.

Another point of consideration regarding communication is that communication is both verbal and nonverbal. Verbal elements of communication include using the right vocabulary—hence, another reason to be familiar with commonly used LGBTQ terms (Epner & Baile, 2012). Using terms that offend will quickly shut down communication between the case manager and LGBTQ patient. Keep in mind—words have power. Additionally, style of communication is paramount. Because of the rejection and discrimination LGBTQ patients have endured, most tend to be very straightforward. The case manager must not be offended or intimidated by this but should be willing to adapt to it.

Motivational interviewing can be an effective tool to facilitate verbal communication. Four elements of the underlying essence of motivational interviewing are partnership, acceptance, compassion, and evocation. Acceptance of and compassion for the LGBT patient—two things that are very important to the LGBT individual—will assist in promoting effective communication (Miller & Rollnick, 2013).

Nonverbal communication has a profound impact on dialogue also. Keep in mind that because of what they have been through, LGBTQ individuals are very adept at reading people. They can sense fear, disdain, judgment, and disapproval. And how you truly feel and think will be written on your face—hence, the reason for cultivating cultural desire and cultural knowledge. The LGBTQ patient may also be hard to "read." Observation of facial expressions will, therefore, be beneficial for the case manager too. The case manager will need to be perceptive and adaptive to be ready for when the LGBTQ patient lets their guard down. Other considerations for nonverbal communication include eye contact, physical space, and body language (Epner & Baile, 2012)

Other Points of Consideration for Individual Case Managers

The following points can enhance your ability to establish rapport with patients (The Joint Commission, 2011):

- Commit to getting rid of individual ethnocentrism—thinking that one's way of thinking and acting is the only way to think and act.
- When caring for transgender individuals, acknowledge and address them according to their gender of choice. Being respectful of the gender of choice has a positive influential effect on strengthening communication.
- Encourage the LGBTQ individual to include their support system when making health care decisions.
- When doing patient interviews and

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talking to patients, use inclusive and neutral language.
- Pay attention to how the LGBTQ patient describes their sexual orientation and how they refer to their relationship with their partner.
- Have on hand current local and online resources for LGBTQ individuals.
- Appropriate questions for LGBTQ patients are
  - —"To be respectful, how would you like for me to address you?"
  - —"Are you in a relationship?"
- Before asking a personal question, ask yourself, "Is this question relevant to the patient's care or am I just curious?"
- Be willing to apologize for any mistakes you may have made when communicating. Humility goes a long way.

Conclusion

In this article, we have expounded on the concepts of cultural competence. We explored why it is necessary for effective care coordination with the LGBTQ patient. Special considerations that need to be taken into account for the transgender individual, LGBTQ adolescent, and older adult were examined. Lastly, we explored how to use the information presented to provide appropriate, efficacious care coordination for the LGBT patient. We as case managers have the ability and knowledge to help decrease health disparities for this population. Being culturally competent enables us to be the advocates and allies this population so desperately needs. CE II

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