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QUEERING HEALTHCARE EQUITY: EXPLORING HOW TWO COMMUNITY
HEALTH CENTERS THAT SPECIALIZE IN LGBTQ HEALTHCARE
FRAME CULTURAL COMPETENCE

by

Tommy A. Royston

A dissertation submitted in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

May 2023

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TITLE OF DISSERTATION: QUEERING HEALTHCARE EQUITY: EXPLORING
HOW TWO COMMUNITY HEALTH CENTERS THAT SPECIALIZE IN LGBTQ
HEALTHCARE FRAME CULTURAL COMPETENCE

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ABSTRACT

Despite increased advocacy and funding, significant inequities in healthcare access, quality of care, and health outcomes have continued to persist for lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) communities. Intersecting marginalized identities such as race, gender, and disability compound health inequities faced by LGBTQ folx. These inequities are not random; rather, they result from deeply embedded homophobia, transphobia, ableism, and racism that pervade the U.S. healthcare system. An exploratory comparative case study was completed using qualitative data collection methods (i.e., key informant interviews, focus groups, and document analysis) to investigate how two California-based Federally Qualified Health Centers (FQHCs) that specialize in serving LGBTQ populations assess the needs and provide culturally competent care to the queer community. Health provider cultural competence is often cited as a promising practice in health disparities literature; however, there is a lack of agreement as to what the construct means and how it should be enacted. Critical race theory and queer theory served as the theoretical paradigm supporting the design and analysis of this study. In total there were 41 study participants consisting of 10 key health center leaders, 21 health center staff/providers, and 10 health center patients/clients. Using grounded theory analysis techniques, 14 themes were identified from the data. From those themes, five study findings emerged. Findings suggested both study sites primarily use patient advisory groups, existing patient data, and community outreach to identify LGBTQ healthcare needs. Despite differing patient demographics, these sites also use similar care strategies to meet the needs of LGBTQ individuals, including hiring staff who are reflective of the population; providing specialty care

services (e.g., sexual health and gender-affirming care); taking a holistic patient-centered care approach; creating a welcoming and affirming clinic environment; providing care in an open, nonjudgmental way; and partnering with other organizations. Workforce training was seen as important to providing culturally competent care for LGBTQ individuals, yet both study sites reported lacking the ongoing training opportunities they need. Findings suggested although there may be several common components as to what defines LGBTQ cultural competence specific to an FQHC setting, a nuanced critical approach is needed.

Keywords: Federally Qualified Health Centers, community health centers, cultural competence, culturally competent healthcare, LGBTQ health disparities, intersectionality, health equity

DEDICATION

I would like to dedicate this dissertation to my husband Joe and my ‘momma’ Patricia. To my husband and best friend Joe, thank you for supporting me throughout this journey. You continue to believe in me even when I do not believe in myself. You teach me every day how to be a better human. To my mother, Patricia, thanks for showing me what unconditional love looks and feels like. You have often said that I expanded your understanding of the world and its people, but in fact, you are the one that taught me to be curious about the world and to fight for justice.

I love you both.

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The process of choosing a dissertation committee is not easy. It starts out like an awkward prom proposal – “*Will you be on my committee?*” Assuming the answer is yes, from there it can be a match made in heaven... or not so much. Dr. Stolz and Dr. Tullis, thank you both for your encouragement, patience, persistence, wicked intellect, humility, and humor. I am lucky to consider you both as colleagues and now friends. It’s been a match made in heaven!

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Lastly, I owe deep gratitude to the health center patients, leaders, and employees that participated in this study. Thank you for sharing your insights, personal stories, and commitment to health equity. The world is a better place because of who you are and what you do.

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LIST OF ABBREVIATIONS

ACA: Affordable Care Act

ASO: AIDS Services Organization

BIPOC: Black, Indigenous, People Of Color

CME: Continuing Medical Education

CRT: Critical Race Theory

CVCC: Central Valley Community Care (study site pseudonym)

FQHC: Federally Qualified Health Center

LGBTQ: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning

MSM: Men Who Sleep With Men

PTH: Palm Tree Health (study site pseudonym)

SDOH: Social Determinants of Health

WPATH: World Professional Association for Transgender Health

CHAPTER ONE

INTRODUCTION

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

—Martin Luther King, Jr., *Convention of the Medical Committee
for Human Rights, 1966*

Background

It could be argued that the prior quote from Martin Luther King, Jr. is as relevant in 2023 as it was when he initially said it in 1966. In fact, in 2003, the Institute of Medicine (IOM) released a groundbreaking report that documented over 175 studies showing health disparities for racial, ethnic, and other marginalized populations in the United States. Prior to and since 2003, countless interventions aimed at addressing these disparities have been proposed, debated, implemented, researched, and evaluated. Despite these efforts, significant inequities in access, quality of care, and health outcomes continue to exist for many historically marginalized communities. For example, infant mortality rates among African Americans are more than double that of white Americans (Centers for Disease Control and Prevention [CDC], 2020a); tuberculosis rates for Native Americans were seven times higher than those of whites in 2019 (CDC, 2020b); and certain subpopulations of the undocumented Latino/Latina/Latinx populations underutilize health care services out of fear regarding their or a family members' immigration status (Ortega et al., 2015). These inequities are not random; they exist and are perpetuated through systemic inequities and the structurally unequal distribution of power and resources.

Significant health inequities also exist for other marginalized populations including those that identify as gay, lesbian, bisexual, transgender, queer/questioning (LGBTQ)¹. LGBTQ individuals experience higher rates of mental health conditions, substance abuse, and suicide. Sadly, LGBTQ youth also have higher rates of depression and suicidal ideation than their heterosexual peers (Hafeez et al., 2017). Data suggest that the COVID-19 global pandemic has negatively impacted the mental health of LGBTQ individuals more severely than it has heterosexual populations (Dawson et al., 2021).

Health disparities for the LGBTQ community are not limited to mental health. Inequities in physical health outcomes also exist. For instance, despite significant advances in HIV research and treatment, gay and bisexual men still account for approximately 83% of new HIV diagnoses among men, with Black and non-white men and male-to-female transgender individuals being disproportionately represented in these numbers (Hafeez et al., 2017). A study conducted by the American Heart Association found significantly higher levels of heart disease among transgender individuals, linking these higher rates of heart disease to the stress and transphobia that transgender individuals often face (Streed et al., 2021). Research has also indicated that other intersecting marginalized identities increase negative health outcomes for LGBTQ populations; for instance, one study found Black women who identify as lesbian or bisexual are three times more likely to have a stroke than white heterosexual women (Trinh et al., 2017). This same study found that lesbian and bisexual Latinas were less likely to have had a mammogram in the last 12 months as compared to heterosexual

¹ Although a range of terms, initials, and acronyms exist to describe minoritized sexual orientations and gender identities, the initials “LGBTQ” as well as the terms “queer” and “gender and sexual minorities” are used synonymously throughout this text as umbrella terms.

Latinas, even despite there being no differences in health insurance status across these two groups (Trinh et al., 2017). Again, these disparities do not just happen. They are the result of deeply embedded systemic racism, homophobia, and transphobia that pervades the U.S. healthcare system.

Problem Statement

Federally Qualified Health Centers (FQHCs), also known as *community health centers* or simply *health centers*, are important safety net providers and have been shown to narrow health inequities (Geiger, 2005; Laiteerapong et al., 2014; National Association of Community Health Centers [NACHC], 2021; Proser, 2005) while serving those with the greatest health needs (Shi & Stevens, 2007). In 2020, this national network of community health centers collectively provided care to almost 30,000,000 patients (Health Resources and Services Administration [HRSA], 2021a). The majority of health center patients (63%) identify as non-white and 1 in 4 (25%) patients receive care in a language other than English (HRSA, 2021a). Given their geographic locations within medically underserved communities, many health centers specialize in serving specific populations such as the Latino/Latina/Latinx community, migrant and seasonal farmworkers, the unhoused/homeless, and refugee populations. Additionally, starting in 2002, after years of advocacy, the U.S. Department of Health and Human Services began funding community health centers focused on serving LGBTQ populations (Martos et al., 2017). To date, approximately a dozen LGBTQ-focused health centers are in operation. Also, other FQHCs that do not have a specialized focus on serving LGBTQ populations have been working to ensure they are able to meet the needs of their patients that identify as LGBTQ.

Whereas FQHCs serve racially, culturally, and linguistically diverse patients, most health centers are clinically and administratively run by white people (Bond et al., 2013). This problem is not unique to community health centers, but is pervasive throughout the U.S. healthcare system (HRSA, 2017). Given the changing population demographics in the United States, this trend is expected to continue; therefore, there is a need to diversify the healthcare and community health center workforce (HRSA, 2019; Institute for Healthcare Improvement, 2021; Jetty et al., 2021; NACHC, 2022; Street et al., 2008). Moreover, there is a concomitant, perhaps more pressing need to provide existing healthcare staff and providers at all levels with workplace cultural competence training and education aimed at increasing their ability to provide care in ways that meet the unique needs of their patient population. Although literature exists within the larger health sector (Betancourt et al., 2003; Campinha-Bacote, 2002; Margolies & Brown, 2019; Souleymanov et al., 2022), there is limited empirical evidence on how FQHCs specifically understand, implement, and educate their employees on this construct (Bruner et al., 2011; Felsenstein et al., 2018; Hooper et al., 2018; Shaw, 2010). Drilling down further, community health centers, including those that provide specialized care (e.g., LGBTQ-focused community health centers), have grown significantly as a result of the Affordable Care Act (ACA), and this growth is expected to continue (HRSA, 2021b; Markus et al., 2018; Martos et al., 2017; NACHC, 2020). This is an additional reason for research exploring how these specialized health centers go about understanding the needs of the LGBTQ community and then put that understanding into practice to provide culturally competent healthcare specific to context and population.

Purpose

Historically, LGBTQ advocacy has been deeply divided by both class and race (Cohen, 2001). Unfortunately, the AIDS epidemic not only amplified existing imbalances in privilege and access to health care, it further racialized health care so economically advantaged LGBTQ individuals were able to distance themselves from the most damaging anti-gay hate rhetoric. This study sought to examine how healthcare access and care have been shaped across the intersections of LGBTQ status and other marginalized identities to fill existing gaps in the research literature related to how cultural competence is understood and enacted within an FQHC setting. Culturally competent health care has been cited as a best and promising practice in health disparities literature (Betancourt et al., 2003; Bond et al., 2013; Schafer et al., 2019); however, there does not appear to be agreement as to what the construct of cultural competence means and how it can be measured (Beach et al., 2005; Cain et al., 2017; Tehee et al., 2020). Specifically, qualitative research designed and analyzed with a critical theoretical lens—specifically critical race theory and queer theory—has the potential to shed additional light and help to elucidate understandings about what providing culturally competent healthcare to LGBTQ populations actually means by centering the voices, experiences, and counternarratives of queer individuals. This understanding could inform policy, practice, and workforce education for FQHC employees aimed at increasing individual-level and organizational-level cultural competence.

Research Questions

The research questions (RQs) used to guide this investigation were as follows:

RQ1: How do community health center staff, providers, and leaders go about understanding the healthcare needs of their LGBTQ patients/clients and the larger LGBTQ community?

RQ2: What are the specific ways in which community health centers go about providing care that is tailored to the needs of LGBTQ individuals? In what ways do these understandings align with practices and procedures that LGBTQ patients/clients report as affirming?

RQ3: What training/education opportunities are provided to health center staff and providers on how to meet the healthcare needs of LGBTQ individuals?

Rationale

In the United States, health inequities have continued to persist for BIPOC and LGBTQ communities as a result of deeply embedded systemic racism, homophobia, and transphobia built and maintained through institutions, policies, processes, and public opinion. As preliminarily discussed in Chapter 1 and detailed further in Chapter 2, a variety of interventions have been implemented in the past and are currently being implemented that attempt to address these inequities. One promising intervention is training healthcare providers on cultural competence. Given the varying definitions and models of culturally competent healthcare that exist in the scholarship, more research is needed to understand how FQHCs understand and provide culturally competent care and how they prioritize queer communities in this work. In particular, research that centers

patients' needs and perceptions is warranted, as these patients are the ones that should benefit from an improved understanding and implementation of culturally competent care. And lastly, more scholarship is needed on existing and/or promising models and best practices to provide ongoing and transformational training and education to FQHC employees aimed at increasing both individual staff/provider and organizational cultural competence.

As Cohen et al. (2002) stated, "Health care professionals cannot become culturally competent solely by reading textbooks and listening to lectures. They must be educated in environments that are emblematic of the diverse society they will be called upon to serve" (p. 92). This investigation attempted to shed additional light on this phenomenon to provide a deeper understanding to guide future policy and practice. Well-constructed research has the potential to uncover new knowledge and insights, providing a better understanding of how LGBTQ-focused FQHCs understand and enact care that meets the needs of their community.

Potential Significance

As FQHCs have continued to grow and serve more patients, additional providers and staff are needed to meet the demand. Still, increasing staffing numbers at community health centers alone is not enough. Given the increasing diversity of patients seen by community health centers, it is important that new providers and staff—in addition to existing employees—are able to meet the varying healthcare needs of these individuals. Those of us who work in healthcare, and specifically community health, must ensure FQHC staff and providers have adequate and growing knowledge and skills to be able to serve patients in ways that affirm their dignity and humanity. This education likely

requires tailoring care and services to better meet the unique needs of patients and communities and may also include the creation of more population-focused community health centers such as FQHCs that specialize in LGBTQ healthcare.

Although this research was specific to two community health centers in California, the findings could have wider implications for FQHCs and perhaps even the larger healthcare sector. It is safe to assume that most FQHCs and other health entities serve at least some LGBTQ patients. Therefore, a nuanced understanding of care that is attentive to sexual and gender minorities could provide additional awareness to these entities. Additionally, findings from this study can influence how health centers and other health sector providers develop and implement workforce cultural competency training programs as well as other policies and practices. Moreover, as FQHCs continue to seek ways to improve the quality of care provided, this research study has the potential to provide additional insights and add to the existing research literature—specifically within an FQHC context. This study’s critical theoretical orientation centered unheard voices and engaged in activist-oriented research. This approach may be able to minimize and eventually eliminate health inequities that currently exist.

Nature of the Study

Given the exploratory nature of this study, qualitative case study research methods were used in hopes of providing a more holistic understanding of the phenomena. As Mertler (2018) postulated, qualitative inquiry is interested in “providing descriptions in thick, rich detail” (p. 77). Bogdan and Biklen (2007) further suggested that qualitative research helps to make sense and meaning of the topic of interest. Comparative case studies allow researchers to explore how different contextual factors

affect the outcome of a phenomenon, and by comparing cases, researchers can identify patterns and trends that can be used to develop new theories or refine existing ones (Creswell & Creswell, 2018).

Two FQHCs in California participated in this study. Besides having a specialty focus on serving LGBTQ populations, several other factors were considered when choosing these sites, including geographic diversity across the state, population density (i.e., urban, suburban, rural), racial and cultural diversity among patients served, as well as the organization's interest in participation. At both selected organizations, staff/providers, senior leaders, and patients/clients volunteered to be study participants.

Data collection methods included key informant interviews, focus groups, and document content analysis. Focus groups are group interviews that provide in-depth understanding of a particular phenomenon by bringing together small groups of people to share their insights (Krueger & Casey, 2014). Calderón et al. (2000) posited focus groups can work particularly well when conducting research with minority and other vulnerable populations because the design focuses on collectivity and in-group membership. In total, six focus groups were conducted: three at Central Valley Community Care and three at Palm Tree Health (both pseudonyms). Separate focus groups were conducted for health center staff and patients at each site using a semistructured protocol, with the hypothesis that these separated focus groups might reveal similarities and key differences in how these populations identify attitudes and behaviors needed to provide culturally competent care to LGBTQ individuals. Participants were recruited using purposive sampling techniques. Four focus groups were conducted virtually and two were conducted in person. All focus groups were recorded.

One-on-one key informant interviews were also completed using a semistructured interview protocol to guide these conversations. Using purposive sampling techniques, 10 interviews were conducted: six at Central Valley Community Care and four at Palm Tree Health. The goal of the key informant interviews was to further explore the study topic through a guided conversation with identified FQHC leaders. Key informant interviews are designed to collect information from individuals who have firsthand knowledge of the phenomenon being studied (Merriam & Tisdell, 2016). Each of the key informant interviews was conducted virtually via Zoom and lasted approximately 1 hour. Each interview was audio-recorded.

Lastly, content analysis was conducted on each study site's website. Bowen (2009) suggested analyzing existing documents relevant to a study population or research question (including organizational websites) can be advantageous because these documents are "unaffected by the research process" (p. 31). Given many organizations' documents are considered to be cultural representations that share their values, attitudes, beliefs, and perspectives (Saldaña, 2021), critically analyzing organizational documents can be an important research approach. The website review served to triangulate the data obtained from the interviews and focus groups.

Data from the focus groups, key informant interviews, and website review were analyzed using a grounded theory approach. Grounded theory, first introduced by Glaser and Strauss (1967), is used as both a methodological tool to conduct qualitative research and to develop a theory grounded and informed by the collected data (Bachman & Kyngäs, 1999; Creswell & Creswell, 2018). Given the exploratory nature of this

investigation, using this analysis approach allowed for the discovery of new insights and hidden meanings (Charmaz et al., 2018).

Researcher Positionality

Stating a researcher's positionality is a task that requires the researcher to acknowledge and disclose how their worldview, consisting of ontological, epistemological, and axiological assumptions, may influence the research they conduct. Positionality requires researchers to think "about the ways in which our social positions influence not only our interactions in the field but also what we see and hear" (Reyes, 2018, p. 212). This process typically consists of the researcher locating themselves in relation to the topic of inquiry, study participants, and the study context (Holmes, 2020; Rowe, 2014, Savin-Baden & Major, 2013). In considering researcher positionality, Bhattacharya (2017) posited that researchers need to be critically self-reflexive throughout all aspects of the study process. The creation and revision of this positionality statement is one of the ways that I attempted to be self-reflexive throughout this dissertation process. Additionally, attending to my positionality in this work involved a significant amount of reflexive memoing. This process and other activities and resources that I used are discussed further in Chapter 3.

Careful consideration and critical self-reflection help researchers to better position themselves within their research topic (Milner, 2007) and can lead to a reduction in researcher bias (Rowe, 2014). Specifically, my interest in healthcare cultural competence emerged in my early adulthood as I, a cisgender gay male, struggled to find an LGBTQ-identified and/or affirming primary care doctor to meet my healthcare needs. In the mid-1990s, I was living in Nashville, Tennessee, and was searching for a doctor to whom I

would feel comfortable coming out, and a doctor with whom I felt comfortable discussing all aspects of my health, including sexual practices and sexual health. As I became increasingly more frustrated with heteronormative providers who either assumed I was straight or seemingly felt uncomfortable when I disclosed my sexual orientation, I began to imagine that other marginalized groups likely experienced similar, and perhaps more profound, frustration, apprehension, and mistrust of the healthcare system. This frustration and the resulting curiosity led to a career focused on healthcare workforce training and education, including working for the national association that represents FQHCs in Washington, DC, and subsequently serving on the board of directors for an FQHC in central California. Based upon these experiences, I came to this research with a deep appreciation for the role that community health centers play in the healthcare safety net in this country. I have seen the passion and commitment that FQHC employees and board members have in addressing the needs of the communities they serve.

There are additional aspects of my identity that inform my positionality as a researcher within this investigation. As Bhattacharya (2017) contended, instead of me trying to lock those in a box and not acknowledge that they exist, it was important for me to acknowledge these up front and to contend with them throughout all aspects of the investigation. First, related to healthcare and healthcare access, I currently have access to high-quality and affordable healthcare, have never been without health insurance, and have generally been in good health my entire life. I recognize that these realities do not hold true for all. For example, in 2019, 10.3% of the U.S. population (33.2 million people) lacked health insurance (Cohen et al., 2020). Additionally, given the majority of health center patients across the United States are part of racially, ethnically, or otherwise

minoritized communities, my racial identity as a white male—and the known and unseen privilege that comes with identifying as and being seen as “white”—undoubtedly informed my ontological stance and epistemological beliefs. Additionally, my race and gender impacted how I viewed this research topic. Continued awareness and reflection on how my own identity and experiences impacted the assumptions, decisions, and interpretations I made as a researcher was important. Milner (2007) posited that researchers “should be actively engaged, thoughtful, and forthright regarding tensions that can surface when conducting research where issues of race and culture are concerned” (p. 388). Given that I identify (and am seen by others) as white, Milner’s (2007) comment was poignant, especially given my research interests and social justice aims. It was, and is, important for me to position and acknowledge my whiteness in relation to this work; without doing so negates the profound and detrimental impacts of a color-evasive/race-evasive “objective” approach to this work.

Milner’s (2007) framework for conducting research around race and culture informed my approach. This four-step reflection-to-practice framework invites researchers to critically engage in: (a) racial and cultural introspection around self, (b) reflection of self in relation to others, (c) engagement with participants that places race and culture at the center through narrative and counternarrative, and (d) considerations of how “history and politics shape their racialized and cultural systems of knowing” (Milner, 2007, p. 397).

In relation to this specific inquiry, I positioned myself as both an insider and an outsider. This notion challenged the more traditional dichotomy and operated in what Dwyer and Buckle (2009) called “the space between.” I am an insider in that I identify as

gay, and therefore consider myself to be part of the larger queer community. Having experienced homophobia throughout my life, including within the healthcare system, I believe I possess an awareness that may have helped me navigate the research topic and better relate to and build rapport with research participants. Additionally, having worked within the community health center field, I have insights and knowledge that likely benefited me as a critical researcher in this study. For example, my professional and board experiences within the community health center arena have undoubtedly allowed me greater access and credibility with the thought leaders and decision-makers whose support I needed to be able to move forward with this study. This insiderness also opened doors to the two FQHCs that signed on as research partners in this work.

Despite my insiderness, I also came to this inquiry as an outsider in many respects. I am an outsider in that my lived experience and current reality are different than that of the “typical”² health center patient. For example, although I grew up in a low-income, working-class family, today I am solidly part of the middle class. Unlike many health center patients, I have always had private health insurance, and except for struggling to find gay-affirming doctors at various points in my life, access to high-quality and affordable health care has never been a concern. Also, despite experiencing homophobia as a gay man, my cisgender white male identity has provided me countless unearned privileges from which others in the queer community do not benefit.

In addition to these insider/outsider aspects of my identity, I recognize that I am an activist researcher. Therefore, I was not a dispassionate removed observer, which

² Although FQHCs serve everyone, the model of care is designed to meet the needs of low-income populations. Nationally, the majority of health center patients identify as BIPOC. Health center patients on average have more adverse health conditions and comorbidities than non-health center patients.

researchers have been historically called to be. Instead, like Kuntz (2015), I argue all research is—and should be—a political act. My goal with this study was not only to further explore the topic, but to also use my privilege (e.g., white, male, cisgendered, postsecondary educated, insiderness) to push for praxis and change. I strive to move beyond being an ally toward health equity aims, but to, as Love (2021) said, “be a co-conspirator” in this liberation work. I know this activist researcher orientation is not universally celebrated within the academy; in fact, by claiming (and celebrating) this identity, some may question this study’s purpose and findings. I accept such critiques while also reaffirming my belief that no research or researcher is completely objective. The social change needed to actualize equity has no room for bystanders.

Definitions of Key Terms

AIDS Services Organization is an organization whose primary mission is to provide healthcare and/or support services to individuals affected by HIV/AIDS.

BIPOC is an acronym that stands for Black, Indigenous, and people of color. The acronym/term grew out of people of color (POC) and the addition of Black and Indigenous began to show up more frequently in social media in the aftermath of George Floyd’s murder as a way to remind and call out often silenced Black and Indigenous voices (Garcia, 2020).

Black/African American is a racialized descriptor used in the United States to refer to individuals of African descent, often associated with darker skin tones. In this manuscript, both terms are used interchangeably with respect and sensitivity to different preferences that people have for the terms that are used to describe them.

Cisgender is an adjective that describes a person whose gender identity and expression match that of their biological sex assigned at birth (American Psychological Association, 2015). Throughout this dissertation, cisgender is also identified as “CIS” or “cis,” which are commonly used shortened versions.

Culturally Competent Health Care looks at tailoring health care delivery to meet the unique cultural and/or linguistic needs of the patient(s) being served. Culturally competent health care is related to the term cultural competence which has many definitions in the literature (further discussed in Chapter 2).

Culture is “the distinctive customs, values, beliefs, knowledge, art, and language of a society or a community” that are “passed on from generation to generation, and they are the basis for everyday behaviors and practices” (American Psychological Association, n.d., para. 1).

Ethnicity, often measured alongside race, usually refers to shared group identity based upon culture, tradition, religion, etc.

Federally Qualified Health Center (FQHCs) are nonprofit health clinics that provide primary care to medically underserved and/or medically vulnerable populations across the United States and U.S. territories (HRSA, 2018). These organizations receive a federal designation and partial funding from the U.S. Department of Health and Human Services, Health Resources and Services Administration. FQHCs are also known as “community health centers” or simply “health centers” and unless otherwise noted are used interchangeably throughout this manuscript. More specifics about FQHCs are provided in Chapter 2.

Genderqueer/GenderQueer references a gender identity that falls outside the man–woman binary. Usually considered to be synonymous with terms such as nonbinary and gender fluid.

Health Care versus Healthcare are terms often used interchangeably, although there is debate, the two-word “health care” is usually considered a noun (e.g., “your health care is vital”) whereas the one-word healthcare is considered an adjective (e.g., “ensuring healthcare providers are culturally competent”).

Health Center Leaders, most commonly refers to senior-level leaders within an FQHC, including board members with elevated leadership or authority, although this term does not have a precise definition. This is not to suggest that other staff, providers, and board members are not leaders.

Health Center Providers traditionally refers only to FQHC employees that are authorized to treat patients such as medical doctors, dentists, nurse practitioners, physician assistants, clinical psychologists and psychiatrists, licensed clinical social workers, or other trained health workers with defined scopes of practice.

Health Center Staff, within the context of this dissertation and unless otherwise indicated, health center staff is an inclusive term that denotes anyone employed at a community health center (including full-time and part-time staff, contracted employees, and clinical providers).

Health Equity was defined by Braveman et al. (2017) as:

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of

access to good jobs with fair pay, quality education and housing, safe environments, and health care. (p. 2)

HRSA is an acronym that stands for the Health Resources and Services Administration, the division of the U.S. Department of Health and Human Services that oversees the community health center program.

Latinx is a gender-neutral descriptor reference for someone with Latin American heritage³.

LGBTQ is an acronym used to denote individuals who identify as lesbian, gay, bisexual, transgender, or queer/questioning. *LGBT* is also often used.

Queer is often used as an umbrella term for sexual orientations as well as gender identities and expressions that do not conform to the dominant societal norms (American Psychological Association & National Association of School Psychologists, 2015). Although the term originally was used in a derogatory manner, many *LGBTQ* individuals and activists have reclaimed the term and use it as a term of collective power and unity.

Race is defined by the Census Bureau (n.d.) as “a person’s self-identification with one or more social groups” based upon . . . Often used in data collection alongside ethnicity.⁴

Sexual Minorities most commonly refers to individuals that are gay, lesbian, and bisexual.

³ There is debate about the use of the *Latinx* descriptor, including within Latino/Latina communities.

⁴ Race is a problematic social construct, and the Census Bureau (n.d.) race/ethnicity categories conflate racial subgroups into broad categories making disaggregation of data difficult. Accepting the U.S. Census Bureau definition of race is not an endorsement but is practical for this study given that FQHC patient data uses this racial classification system.

Sexual and Gender Minorities is an inclusive descriptive identifier that includes LGBTQ individuals as well as those who are intersex, asexual, Two-Spirit, gender non-binary and gender non-conforming.

Transgender refers to individuals whose current gender identity differs from the sex to which they were assigned at birth.

White is a racialized descriptor used to refer to light-skinned individuals of European descent.⁵

Whiteness is defined as “the overt and subliminal socialization processes and practices, power structures, laws, privileges, and life experiences that favor the White racial group over all others” (Helms, 2017, p. 718).

White Privilege, as defined by McIntosh (1988), white privilege is:

Unearned assets which I can count on cashing in each day, but about which I was ‘meant’ to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools and blank checks. (p. 30)

Summary and Organization

This chapter provided an overview of the dissertation study by providing a background on health inequities that continue to persist for BIPOC and LGBTQ communities and the need for culturally and linguistically tailored health care for these populations. Chapter 2 identifies and summarizes the literature that was reviewed. The

⁵ Note throughout this manuscript, the racial descriptors of white and/or whiteness are lowercase intentionally, unless these words are capitalized as part of direct quote or they begin a sentence (in keeping with standard grammar and punctuation practices). This was done as an act of defiance, a way to visually call out and disrupt the power that words have—and to challenge traditional structures (including academia and the world of “scholarly” publication) that too often benefit white people through white supremacist roots.

literature review provided the context from which the research questions and methodological approach for this qualitative research study were derived. Chapter 3 describes the methods used to gather data for this inquiry and details the analysis procedures that were undertaken to interpret the study findings. Chapter 4 presents these findings by highlighting the themes and patterns that emerged from the data. The final chapter, Chapter 5, discusses the research findings, shares an emerging grounded theory of LGBTQ cultural competence specific to FQHC settings, identifies practice recommendations and research implications, and shares the limitations of the study.

CHAPTER TWO

LITERATURE REVIEW

Creativity requires input, and that's what research is. You're gathering material with which to build.

—Gene Luen Yang

Introduction

Chapter 2 provides a review of the relevant literature that supports this investigation. The literature is synthesized and organized into four sections relating to themes that emerged in the literature. The first section details research and data highlighting inequities that exist within the U.S. healthcare system, and in particular the health disparities/inequities present within lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ), Black, Indigenous, people of color (BIPOC), and other marginalized communities. The next section provides examples of current interventions that are occurring within the health sector attempting to address these inequities. The third section looks specifically at the intervention of healthcare cultural competence. This healthcare cultural competence section details the history of the term and its understanding and use within health care generally, as well as specific to LGBTQ healthcare. The healthcare cultural competence section ends by synthesizing research on training and educating healthcare staff and specifically Federally Qualified Health Center (FQHC) staff on providing culturally competent care. The last literature section of Chapter 2 shares the history of the FQHC movement and provides data on community health centers today as a way to provide additional context to why FQHCs were chosen as sites for this study. Finally, Chapter 2 concludes by further describing the critical

theoretical frameworks of critical race theory and queer theory that support this dissertation investigation.

Health Disparities and Inequities

There is a vast amount of literature showing that health inequities exist and persist for minoritized and marginalized populations. Whether connected to race and racism (Benamins et al., 2021; Bleich et al., 2021; Kung et al., 2008; Ortega et al., 2015; Williams et al., 2016; Williams & Mohammed, 2009), disability and ableism (CDC, 2021b; James et al., 2016; VanPuymbrouck et al., 2020), or immigration status (Chávez et al., 2021; Rhodes et al., 2015), the impact of discrimination is profound and real, adversely affecting the health and well-being of minoritized populations. One need only look at the COVID-19 global pandemic to see how these inequities translated into decreased access and quality of care (Johnson-Mann et al., 2020). The Centers for Disease Control and Prevention (CDC, 2021a) reported that American Indian/Alaskan Natives, Black/African Americans, and Latino/Hispanic communities in the United States suffered higher rates of hospitalizations and death from COVID-19 as compared to white people.

Among the leading causes of death in the United States in 2005, including cancer, heart disease, stroke, kidney disease, diabetes, hypertension, and homicide, Black individuals had higher rates of death than white individuals (Kung et al., 2008). Unfortunately, this pattern continues. Between 2009 and 2018, mortality rates for the Black community were 24% higher than among whites (Benamins et al., 2021). Black individuals are more likely to die of cancer than any other racial group besides American Indians/Native Americans; and Black women record more breast cancer deaths than their

white counterparts, despite having similar diagnosis rates (Williams et al., 2016). A survey conducted in 2020 found more than one third of Black and Latinx patients who had sought healthcare within the past year experienced at least one form of discrimination during their encounter(s) with the healthcare system (Bleich et al., 2021). Forms of discrimination reported included not being offered the best treatment, being denied access to services, and not receiving referrals for specialty care because of race, ethnicity, and/or language.

The Indigenous population in the United States has the highest cancer rate of any racialized group (Williams et al., 2016). The historical trauma of colonization has continued to impact the lives and well-being of Indigenous communities across the United States to this day. Research has shown how the historical trauma from genocidal policies, forced relocation, Indian boarding schools, and restrictions against practicing spiritual rituals and speaking native languages has been handed down through generations of Native Americans and is linked to health inequities such as high rates of obesity, diabetes, and substance abuse (Carron, 2020). According to the Indian Health Service (2019):

The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality-of-life issues rooted in economic adversity and poor social conditions. (para. 2)

These inequities exist even though the United States is legally obligated to provide healthcare to over 560 recognized Native tribes (Smith, 2018). Congress has historically underfunded the Indian Health Service.

Though evidence exists showing that many immigrants have better health outcomes and lower mortality rates than their U.S.-born counterparts (Bustamante et al., 2021; Jasso et al., 2004), inequities in health access and health outcomes linked to immigration status exist (Chávez et al., 2021; Derose et al., 2007; Rhodes et al., 2015). A mixed-methods study in North Carolina (Rhodes et al., 2015) exploring the impact of local immigration enforcement policy on Latino/Hispanic healthcare utilization concluded that Latina mothers delayed prenatal care and received inadequate care when compared with non-Latina mothers. In a qualitative study using community-based participatory research methods, Chávez et al. (2021) brought voice to Latinx unauthorized (also pejoratively called “undocumented”) youth who are unable to get insurance because of their immigration status, connecting this lack of access to emotional and financial stress and fear of engaging with the healthcare system. Participants talked about being “exposed” and possibly deported if they were to try and seek care and discussed the ways in which this fear impacted their health (Chávez et al., 2021). One participant talked about delaying care for a broken nose, whereas another shared, “We went to a hospital first but they didn’t want to treat [my mom for H1N1] and then we went to another one and she got admitted that day and actually went into a coma” (Chávez et al., 2021, p. 574). This study is notable as it is one of the few studies cited in this literature review where the researcher specifically mentioned using a critical theoretical perspective in their work.

Health inequities exist for other marginalized populations as well. According to the CDC (2021b), approximately 1 in 6 people in the United States with disabilities have diabetes (16.6%), whereas only 1 in 14 people without disabilities (7.4%) has diabetes. Figures specific to California show similar results. Again, these inequities are not random; they result from historic subjugation, oppressive systems and institutions, and unfair access to the resources needed for health and well-being. Reichard et al. (2011) attributed increased chronic disease inequities that many in the disabled community face to factors such as lower referrals for preventive care. Adding additional credibility to this, a secondary data analysis study conducted by VanPuymbrouck et al. (2020) showed many healthcare providers were not aware of their own implicit bias related to disability. VanPuymbrouck et al. reviewed implicit bias test results of 25,006 healthcare providers from a larger sample ($n = 352,722$) finding although only 32.1% of providers explicitly reported preferring nondisabled people, implicitly 83.6% of providers preferred nondisabled people. Undoubtedly the implicit biases providers hold against people with disabilities and other marginalized groups complicate optimal health.

LGBTQ Health Inequities

According to 2020 estimates from the Williams Institute, a leading research center on sexual orientation and gender identity out of the UCLA School of Law, there were approximately 13,042,000 LGBT people (ages 13+) residing in the United States (Conron & Goldberg, 2020). LGBTQ individuals are racially and culturally diverse, yet as a community, they collectively suffer various forms of health disparities ranging from less access to care to disparate health outcomes as compared to non-LGBTQ individuals. LGBTQ people are two times more likely than heterosexuals to experience a mental

illness in their lifetime (Lee et al., 2017). Lesbians and bisexual women have a higher chance of being obese (Ahmad et al., 2021). Gay and bisexual men are three times more likely than heterosexual men to have an eating disorder in their lifetime (15% for gay and bisexual men; 4.6% for heterosexual men; Feldman & Meyer, 2007). Gonzales and Zinone (2018) analyzed 4 years of data from the National Health Interview Survey and found that gay men were more likely to have been diagnosed with cancer than straight men and that bisexual women were more likely to have had a cancer diagnosis than heterosexual women. Also, men who sleep with men (MSM) and the transgender male-to-female community still make up the majority of new HIV diagnoses in the United States, despite significant advances in research, prevention, and treatment (Hafeez et al., 2017).

A quantitative study conducted by the American Heart Association (Alzahrani et al., 2019) analyzed data collected as part of the national Behavioral Risk Factor Surveillance System (BRFSS) survey between 2014–2017 and found that transgender men were twice as likely to have had a myocardial infarction (heart attack) than were cisgender men (95% CI, 1.14–5.63; $p = 0.02$) even after adjusting for other risk factors, and they were four times more likely to have a heart attack than cisgender women (95% CI, 2.21–10.90; $p < 0.01$). The study, which used multivariate analysis techniques on a combined dataset of 1.8 million survey responses ($n = 1,842,439$) also found transgender women were twice as likely to have suffered a heart attack than were cisgender women (95% CI, 1.78–3.68; $p < 0.01$) but were no more likely to have had a heart attack than cisgender men. Alzahrani et al. (2019) hypothesized the significant increase in myocardial infarctions among the transgender community was likely due to a multitude

of factors including social stress and other health inequities faced by the trans community. The role that hormone replacement therapy may have played was unclear.

The UCLA Center for Health Policy Research analyzed responses to the California Health Interview Survey between 2017–2020 ($n = 79,965$) and found transgender adults in California experienced more barriers to care than cisgender Californians, despite both groups having similar health insurance coverage rates (Babey et al., 2022). As compared to cisgender Californians, gender minority adults were less likely to have had a preventive care visit within the last 12 months (39% versus 28%) and more than twice as likely to experience delays in care (33% versus 14%). They were also far more likely to report difficulty in finding a healthcare specialist (29% versus 11%). These findings reinforced other research highlighting lower rates of healthcare access (Herman et al., 2017; Hoy-Ellis et al., 2022; Lee & Kanji, 2017) and lack of preventative care (Hoy-Ellis et al., 2022; McRee et al., 2018) for transgender and gender nonbinary individuals. Undoubtedly, lack of access and preventative care combined with other risk factors such as higher rates of poverty contribute to adverse health outcomes within the transgender community.

Health inequities are exasperated by the societal stigma, violence, and victimization that the LGBTQ community face (Mulé, 2015). This stigma manifests in LGBTQ individuals not seeking medical care for fear that they will be discriminated against by their healthcare provider or the larger healthcare system (Mulé, 2015). The Institute of Medicine (2011) suggested inequities in the care LGBTQ individuals receive are likely due in part to healthcare providers lacking the awareness and sensitivity of their unique healthcare needs. National studies have shown that LGBTQ individuals are less

likely to have health insurance and a primary care provider as opposed to heterosexuals (Rhoades et al., 2018). This phenomenon of LGBTQ individuals not seeking care out of fear likely results in underreporting of health disparities the LGBTQ community faces.

Lee and Kanji (2017) conducted a literature review to explore the healthcare experiences of LGBT people in North America “in an attempt to identify barriers to care and to help develop strategies to improve their experiences in the healthcare system” (p. 81). In total, 33 sources were included in the review (28 empirical studies, one systematic review, one literature review, one report, and two books). Based upon the review, Lee and Kanji found one of the most common barriers cited in the existing literature was LGBT individuals coming out to their healthcare provider and then experiencing anti-LGBT discrimination by that provider. Regarding discrimination from providers, Lee and Kanji (2017) also noted, “In some cases LGBT individuals may have been at risk for compounded discrimination due to their affiliation with multiple marginalized groups” (p. 84), a finding consistent with growing evidence regarding how intersectional identities further health inequity. Other barriers identified across the review included LGBT patients not feeling seen or valued during the healthcare experience, providers using heteronormative language and/or assuming patients are heterosexual/straight, and lack of general LGBT knowledge and cultural competence among health care professionals. The existing literature suggested that these barriers impact the health of LGBT individuals because they are less likely than their straight counterparts to seek care and will often not disclose their sexual orientation and gender identity to providers when they do seek care. Lee and Kanji (2017) concluded by highlighting existing literature on efforts to improve individual and organizational level LGBT cultural competence for

health care providers stating that this work is “critical in forming a trusting client-provider relationship” (p. 86) that may result in decreasing health disparities that LGBT individuals face.

Health Inequities Impacting Other Minoritized and Marginalized LGBTQ Populations

Data on the health inequities for LGBTQ individuals who also identify as BIPOC show the compounding impacts of oppression in our society. BIPOC LGBTQ individuals face disproportionate health challenges such as increased rates of specific types of cancer and increased mental health conditions such as depression and suicidal ideation. Gay men in general experience more suicidal thoughts and depression as compared to heterosexual men, with BIPOC gay men having even higher risks for depression (Lee et al., 2017). A study by Ryan et al. (2009) found Latinx/Latino gay men report more negative mental health outcomes than white gay men. Guareno (2007) posited these increases may be due to family rejection, pressure to adopt conventional gender norms, and other cultural norms that exist within Latinx/Latino communities. A study by Díaz et al. (2001) explored how discrimination impacted the psychological health of 912 self-identified gay and bisexual Latinx/Latino men across three major U.S. cities had similar findings. Study participants who had experienced social discrimination reported high rates of depression (80%), anxiety (44%), and thoughts of suicide (17%; Díaz, 2001). De Santis et al. (2008) found gay Latino men who experienced depression were more likely to engage in high-risk behaviors that increased their HIV exposure risks. Gay, bisexual, and transgender male-to-female individuals who are non-white are disproportionately affected by HIV (Hafeez et al., 2017).

Members of the LGBTQ community who are Black experience greater violence and death than others that identify as LGBTQ. This is particularly true for Black transgender women (Waters et al., 2018). According to a report from the National Coalition of Anti-Violence Programs, there were 52 LGBTQ hate-crime homicides in 2017. Among these victims, 22 were transgender women of color (Waters et al., 2018). This figure represents almost half (42%) of the total LGBTQ hate crime homicides in 2017. Between 2017 and 2021, there was a 92% increase in the number of transgender and gender nonconforming people that were murdered in the U.S. and Puerto Rico (Mandler, 2022). Nearly three fourths (67%) of these victims were Black transgender women. These numbers alone, though powerful and saddening, fail to convey the personal stories of the lives lost to hate and ignorance, such as Mesha Caldwell from Canton, Mississippi. Mesha was a 41-year-old Black transgender woman, a beloved hairstylist, whose body was found along a rural road in early January 2017 (Waters et al., 2018). She had been shot multiple times. Media reports both misgendered Mesha and used her deadname in articles. Based on publicly available information, no arrest has been made in connection to her killing.

Health inequities at the intersection of LGBTQ status and other often oppressed identities are not limited to queer identity and race. For example, research has shown a high prevalence of disability within the transgender community. A study by James et al. (2016) surveyed almost 28,000 people in the United States that identified as transgender and found that 39% had one or more disabilities, as compared to 15% for the general population. This study, considered to be the largest transgender identity study to date, was groundbreaking because it is believed to be among the first studies looking at the

intersections of transgender and disability identity that characterized disability as a demographic characteristic instead of as a “health outcome” (Myers, 2018).

Lack of Data on the LGBTQ Community

There is still much to be learned regarding the queer community. Data collection—or more precisely, the lack thereof—limits current understanding of this group. It is estimated there are approximately 13 million people who live in the United States that identify as a sexual or gender minority, but more systematic data collection is needed (Conron & Goldberg, 2020). Getting a clear picture of health inequities faced by queer individuals and communities is difficult to assess given the lack of systematic data collection. National surveys and local provider intake forms have historically not asked individuals to disclose their sexual orientation and gender identity (SOGI) status, making it difficult to ascertain accurate health access and outcomes data. In 2016, the U.S. Department of Health and Human Services, Health Resources and Services Administration (HHS/HRSA) started requiring federally supported healthcare entities to collect self-reported SOGI data from all patients (Grasso et al., 2019). FQHCs are required to report these data yearly to the federal government. LGBTQ and public health activists had long advocated for the required collection of SOGI data given the lack of demographic data that have been collected. Having these data not only allow healthcare providers to better understand who their patients are but can also be used to provide culturally appropriate and patient-centered care. These data also provide researchers and policymakers with invaluable information—information that can be used to better understand and intervene on issues of health access and health outcomes across sexual orientation and gender identity.

What is Being Done: Different Approaches Toward a Solution

Given the vastness and pervasiveness of the problem, no one solution holds the magic cure. The following section includes examples of programs, policies, and initiatives that are either currently underway or being advocated for, each with the goal of addressing health inequities faced by BIPOC, LGBTQ, and other marginalized communities. This section does not detail the full gamut of approaches but instead is intended to highlight the range of options—most emphasizing organizational and system-level change.

Increasing the Diversity of the Healthcare Workforce

Only 5% of physicians identify as Black or Latinx/Hispanic, yet Black/African Americans and Latinx/Hispanic individuals make up 13% and 19% of the U.S. population, respectively (Bleich et al., 2021). In 2008, 83.2% of registered nurses in the United States identified as white (HRSA, 2010). The same dataset 10 years later in 2018 showed improvement with 10% of the nursing workforce identifying as Latinx/Hispanic, 8% Black/African American, 5% Asian, and approximately less than 2% identifying as multiracial (HRSA, 2019). However, this still means that three fourths of U.S. nurses are white, whereas non-Latinx/Hispanic white people make up 59% of the U.S. population (Census Bureau, n.d.). Increasing the diversity of the medical workforce has been a crucial component of the country's effort to enhance health and healthcare for more than a decade (Institute for Healthcare Improvement, 2021; Shimasaki & Walker, 2013); however, progress has been slow. In comparison to the overall population of the United States, Black and Latinx individuals continue to be disproportionately underrepresented in medicine, nursing, and dentistry. Furthermore, no reliable data exist on the number of

LGBTQ healthcare providers in the United States. Sexual orientation and gender identity are not typically collected as part of healthcare provider data, and many providers may not disclose their identity for fear of discrimination or stigma.

The Affordable Care Act tasks the HRSA to expand initiatives to increase the diversity of healthcare professionals within the healthcare industry. These include programs such as the National Health Service Corps (HRSA, n.d.-a) and the J1 Visa Waiver Program (Rural Health Information Hub, 2020)—both designed to improve workforce diversity within the health care sector, including the community health center sector. Since its creation in 1972, the National Health Service Corps has provided scholarships in the form of loan repayments for over 20,000 physicians in return for committing to provide care in FQHCs (HRSA, n.d.-a.). The Indian Health Service (IHS), the federal agency that provides treaty-bound healthcare to Indigenous tribes, also has a similar loan repayment program that has been providing scholarships to American Indian and Alaska Native students pursuing careers in health care since 1978 (Smith, 2018). After completing their education, these new providers are placed in IHS facilities throughout the country. Since its inception, the IHS program has provided loan repayment scholarships of up to \$40,000 to approximately 7,000 Indigenous students. Smith (2018) argued these efforts are not enough, noting, “With shortages of clinicians that number in the thousands across American Indian and Alaska Native communities, markedly expanding these programs is essential to ensuring communities have needed providers” (para. 4).

In addition to these federal initiatives, there are other efforts underway to diversify the healthcare workforce. Among other things, these efforts include:

- targeted recruitment programs to attract diverse candidates. These programs may include partnerships with universities, outreach to underrepresented communities, and targeted advertising campaigns (Rittenhouse et al., 2021).
- the creation of pipeline programs to increase the number of underrepresented minorities in the healthcare workforce by providing educational and career development opportunities. These programs may include scholarships, internships, and mentorship opportunities (Rittenhouse et al., 2021; Snyder et al., 2018)).
- a growing number of healthcare organizations retooling human resources policies and practices to promote diversity, equity, and inclusion. These may include requirements for diverse candidate slates for job openings, diversity training for hiring managers, and the establishment of diversity and inclusion committees (Institute for Healthcare Improvement, 2021).

All of these efforts, and many more, are likely needed to recruit and retain a representative healthcare workforce. The literature suggests that healthcare leaders must be intentional and cannot take a passive approach to make the situation better or assume that any one strategy or initiative alone will solve the lack of workforce diversity issue (Betancourt et al., 2003; Shimasaki & Walker, 2013). Leaders must recognize the time and resources needed and commit fully to recruiting diverse staff while also growing the knowledge and skills of existing staff as it relates to embracing diversity in the workplace (Betancourt et al., 2003).

Patient–Provider Concordance and the Search for Queer and Queer-Friendly Providers

Research suggests that racial and cultural concordance between healthcare providers and patients is related to improved healthcare utilization, less dependency on emergency room care, and lower cost of care. According to Street et al. (2008):

Concordance has emerged as an important dimension of the patient–physician relationship that may be linked to healthcare disparities. As a concept, concordance is most often defined as a similarity, or shared identity, between physician and patient based on a demographic attribute, such as race, sex, or age. (pp. 1–2)

In a national quantitative study ($n = 50,626$) using existing multiyear Medicaid expenditure data, Jetty et al. (2021) found Black, Asian, and Latinx/Latina patients who had concordant providers had lower overall healthcare expenditures (14%, 34%, and 20% respectively, $p < 0.001$). Some studies have claimed racial/ethnic concordance is important and that it may result in better care for racial and ethnic minorities (Jetty et al., 2021; Street et al., 2008). However, findings from a qualitative ethnographic study by Shaw (2010) that explored the value of racial/ethnic concordance in a New England community health center suggested racial/ethnic concordance may not be an important factor in providing high-quality health care and may, in fact, further segregate the provision of health care. Shaw (2010) stated:

The assumption that minority physicians bring a special expertise to caring for their minority patients, understood to be intrinsic to their identities as minority, perpetuates an essentialized view of authentic ethnic and racialized identities. . . .

Further, an emphasis on semblance as a means to address health care access and quality locates the problem and the solution to health disparities in minority communities. (p. 528)

Specific to LGBTQ individuals, a study by Klitzman and Greenberg (2002) found gay men were more likely to talk openly about sexual health, substance use, and HIV if they had a gay or gay-friendly doctor. Similarly, a qualitative focus-group study undertaken by Barbara et al. (2001) examined 32 lesbians' experiences within the healthcare environment in North Carolina and Massachusetts finding that the majority of participants desired having an "out" gay or lesbian doctor. Barbara et al. (2001) noted:

Participants wanted to be able to present themselves truthfully and completely.

However, they preferred to do this with a physician who could really understand their needs, which usually meant having a physician who shared their sexual orientation. (p. 53)

Despite increased social acceptance for LGBTQ individuals in the United States, many queer individuals still fear rejection or discrimination in healthcare settings and specifically seek out medical providers that have a shared queer identity or experience and desire to serve the LGBTQ population (Hudak & Bates, 2019; Ogden et al., 2020; Rose et al., 2017).

Hudak and Bates (2019) undertook an exploratory qualitative study designed to better understand how queer individuals made decisions related to choosing a healthcare provider and whether to continue seeing that provider. Using criterion sampling techniques, 20 participants from across the United States who identified as either gay ($n = 9$), lesbian ($n = 6$), bisexual ($n = 2$), queer ($n = 2$), or pansexual ($n = 1$) took part in either

in-person or online semistructured interviews. Interviews were analyzed using a constant comparative method and three themes emerged. The first theme centered on participants feeling that it was important they have a “queer-friendly” health care provider which could be a provider that identifies as queer themselves or has experience, interest, and openness in providing care to LGBTQ individuals. Although participants felt it was important for queer-friendly providers to actively note this in marketing and outreach materials, most participants sought out recommendations from other queer friends or social networks to find a queer-friendly provider. The second theme to emerge from the data was that participants felt even if they were able to find a queer-friendly doctor, other elements of the healthcare system might still make them fail to disclose their sexual orientation to the provider. Examples of this ranged from participants fearing that their medical records wouldn’t be kept confidential, to participants fearing that insurers would see them as engaging in “risky behaviors” and might, therefore, raise insurance rates or drop them if they disclosed their sexual orientation.

The final theme Hudak and Bates (2019) discussed was that even if study participants did find a queer-friendly provider and did disclose their sexual orientation to them, other barriers such as the geographic location of where the provider was located and insurance policies (e.g., in-network versus out-of-network providers) could still exist that would limit or preclude access to that provider. For this study, the authors purposely chose not to include transgender individuals because of existing research literature that suggests trans individuals experience health care differently than sexually diverse individuals do. Furthermore, regarding study limitations, Hudak and Bates noted although the sample was intended to be geographically representative, most participants

lived in the Mid-Atlantic region of the United States and only one participant identified as non-white (African American).

Community Health Workers

In attempts to provide care that meets the cultural and linguistic needs of racialized and minoritized communities, Community health workers (CHWs) are a growing trend within certain aspects of the U.S. healthcare sector (American Public Health Association, n.d.; Landers & Levinson, 2016; Rodriguez, 2022). According to Landers and Levinson (2016):

CHWs, also referred to as health workers, health navigators, promotores, and various other titles, play a variety of roles within both research and patient-centered care teams including fostering linkages with local communities, data collection, outreach and case management, counseling and education, and health system navigation. . . . CHWs are increasingly involved in public health interventions that identify and address barriers to prevention, care, and treatment. As members of their local communities, CHWs can help programs create culturally responsive public health interventions. (p. 591)

Research has suggested the trust and relationships built between CHWs and minoritized communities may help reduce health disparities because CHWs are better able to communicate health information in culturally and linguistically appropriate ways (Cosgrove et al., 2014; Scott et al., 2018) and by connecting community members with resources and care (Cosgrove et al., 2014; Rodriguez, 2022).

Provisions within the Affordable Care Act (ACA) called for more CHWs to be integrated into primary care (Rodriguez, 2022). Since the bill's passage, CHWs have

been particularly effective in enrolling hard-to-reach populations in healthcare coverage because of their credibility within the community (Malcarney et al., 2015). There is growing evidence that CHWs were an essential resource in the U.S. response to the COVID-19 global pandemic. Across several studies, these trusted community members were shown to be instrumental in dealing with vaccine hesitancy and misinformation (Rahman et al., 2021) as well as encouraging communities that historically mistrust the healthcare system to follow public health guidelines, get tested, and get vaccinated (Moir et al., 2021; Ponce-Gonzalez, 2021). Existing literature on using CHWs as a strategy to connect with and intervene to improve LGBTQ health is scarce. A 2019 scoping report conducted for the European Union attempted to identify and assess research literature on CHWs and LGBT healthcare in Europe and concluded that “very little scientific literature” (Folch et al., 2019, p. 81) existed. The lack of empirical research regarding using the CHWs model within LGBTQ healthcare settings also holds true for this literature review.

Although Landers and Levinson (2016) suggested CHWs can be an effective strategy within HIV and LGBT healthcare by serving in critical and needed roles such as case managers and peer navigators, only two empirical studies were identified that talked specifically about LGBTQ CHWs. One was a 2005 study by Sperber et al. (2005) where transgender individuals in Boston were recruited to be short-term CHWs helping to cofacilitate focus groups for the local transgender community to identify healthcare needs and barriers to care for this population. The success of these individuals being able to outreach and connect with the transgender community led Sperber et al. to recommend additional use and study of transgender CHWs within healthcare entities looking to serve

this vulnerable community. Rhodes et al. (2013) tested the development of an intervention where local immigrant Latino men who sleep with men (MSM) were trained to provide sexual health and HIV prevention outreach and health messaging to other immigrant Latino MSM. This study took place in North Carolina, and Rhodes et al. (2013) concluded:

An LHA [CHW] approach had the potential to effectively and efficiently reach large numbers of Latino MSM, particularly given that Latino MSM may be hard to reach by “outsiders” (e.g., non-Latinos) because of the stigma around immigration and same-sex orientation and behavior. (pp. 610–611)

Health Professions Education Response

Health professions education (HPE) is an umbrella term that is used broadly to define the education of healthcare providers. Typically, the term incorporates formal preservice education such as medical or dental school, pharmacy training programs, and nursing programs. Bush (2021) posited that racism is a “pillar of the American experience” (p. S6) impacting all systems and structures including the field of health professions education (HPE). In detailing the ways in which racism impacts minoritized populations in HPE, Bush (2021) stated, “It is felt through admissions committees devaluing their experiences; microaggressions from their peers and professors; and flowery mission statements touting equity, diversity, and inclusion as a priority only to be followed by empty promises” (p. S6). Bush situated their article within the current sociopolitical context that has given rise to increased conversations regarding racial injustice and contends that academic and health professions training institutions must do more than performative actions (e.g., emails condemning racism, equity statements) to

disrupt the status quo. Bush advocated for embedding critical race theory within HPE to connect words to actions, actions to accountability, and accountability to change.

Halman et al. (2017) also believed that critical theory in health professional education (HPE) is important and understudied. They conducted a literature review exploring how the use of critical pedagogy, specifically Freire's concept of critical consciousness, was defined and discussed within health professions education (HPE).

Halman et al. (2017) proposed:

A critical stance allows one to notice the social and political nature of education and healthcare, the influences of power and privilege in the delivery of care, and the ways in which all learners as individuals and as members of a healthcare culture can contend with unexamined assumptions that foster oppression. (p. 13)

After analyzing 30 articles using thematic analysis, Halman et al. found five overlapping key themes arose in the literature: (a) appreciating context in education and practice; (b) illuminating power structures; (c) moving beyond procedural; (d) enacting reflection; and (e) promoting equity and social justice. Halman et al. also scanned the literature for practical ways that HPE educators can infuse critical consciousness into their pedagogical practices. In doing so, six common practices were identified ranging from ways to promote authentic dialogue, sharing and inviting stories from healthcare consumers (personal and counternarratives), and ways to challenge the status quo that dominates the healthcare system. They concluded by cautioning against HPE using competence-based approaches without also including critical consciousness.

Several provisions of the ACA aim to address educational inequities within the HPE field while also enhancing the recruitment and retention of providers from

underrepresented communities (as cited in the previous section). However, there appears to be a need for greater policy intervention in the form of legislation and regulatory mandates to drive greater action, accountability, and system-level change.

Queering Health Professions Education

Additionally, HPE programs have historically lacked training and education content specific to meeting the healthcare needs of LGBTQ patients. Although the American Medical Association (Hollenbach et al., 2014) and the American Association of Medical Colleges (2007) have both advocated for the inclusion of curricular content focused on LGBT health care as part of medical school education, Obedin-Maliver et al. (2011) found on average, only 5 hours of content is provided in U.S. medical schools. Clearly more preservice education is needed.

Some HPE programs are starting to respond. For example, in an effort to equip preservice healthcare professionals with the necessary knowledge and skills to adequately serve lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) patients, researchers at Georgetown University School of Medicine (DeVita et al., 2018) conducted a systematic curriculum audit of their school's preclinical education by examining the amount of content related to LGBTQI competency. Using video lecture capture software that is commonly used in medical school education, all individual class lectures taught as part of the program were able to be analyzed. This analysis process included quantitatively identifying all existing LGBTQI health content presented in the curriculum and then comparing those against nationally established competencies developed by the American Association of Medical Colleges (AAMC) and Vanderbilt University Medical School. Results from the curriculum audit showed that of the 30

nationally recognized competencies, Georgetown's preclinical education completely addressed seven of the competencies and partially addressed an additional eight competencies. Given that half of the identified competencies were unmet, DeVita et al. (2018) concluded there were significant gaps in the curriculum and "solid evidence that GUSOM [Georgetown University School of Medicine] did not adequately prepare its students to meet the health needs of their future LGBTQI patients" (p. 4). The school used the study results to identify curriculum reforms to address unmet competencies specifically in the areas of mental health, pediatric and geriatric health, and gender-affirming care for transgender patients. Additionally, DeVita et al. encouraged other medical schools to conduct a similar curriculum audit to improve the chances that future medical providers will be able to provide culturally competent care to LGBTQI patients.

Social Determinants of Health

Although approximately 95% of healthcare expenditures in the United States go toward medical care, most experts agree that medical services alone have a limited impact on well-being and health (McGinnis et al., 2002; Woolf, 2019). A promising intervention to address health inequity is focusing attention on addressing the underlying social determinants of health (SDOH). SDOH refers to the conditions or circumstances in the social environment in which individuals are born, live, grow, learn, work, and age, and often affects individual and population health, quality of life, and health outcomes (Hahn, 2021). Research related to the SDOH has posited that these nonmedical social factors—including but not limited to unsafe neighborhoods, chronic unemployment and lack of good paying jobs, pollution and environmental racism, food insecurity, and failing schools—are the root cause of many of the health inequities and negative health

outcomes people across the globe (as well as in local communities) face as of 2023. SDOH advocates have contended to achieve health, effort must be made to identify, minimize, and ultimately eliminate these adverse social factors. The SDOH model, whose development has been attributed to the World Health Organization (Wilkinson & Marmot, 2003) recognizes that the reasons these health inequities exist are complex and, to improve population health, we have to focus on more than just clinical outcomes. The SDOH model also works to push against prevailing interventions that focus on individual-level behavior change all while ignoring community and societal level determinants such as access to healthy food, policies and laws that impact health, and the health care system more generally (Baum & Fisher, 2014).

SDOH are usually shaped by social, political, and economic forces (Hahn, 2021; Islam, 2019; Singh et al., 2017). Ideally, the socioeconomic–political circumstances in a particular society or community should be that its members have access to social resources that are equitably distributed based on need. The quantity, distribution, and quality of these resources help predict citizens’ well-being and health. Take for example the Flint water crisis in Michigan. In 2014, the city of Flint faced a budget crisis and decided to switch to using a different water source and process to save money. Unfortunately, this political and economic change resulted in water-based lead contamination that impacted nearly 100,000 residents, 54% of whom were African American (Hanna-Attisha et al., 2016). Several concerning and deadly health impacts followed, including a 58% increase in fetal deaths and a 12% decrease in fertility rates (Grossman & Slusky, 2019). Given the known long-term effects of lead toxicity, the full

extent of the health impacts of this public policy change and the resulting crisis will not be known for some time.

Various studies have shown that focusing on the SDOH may improve population health and aid in minimizing health disparities of marginalized and racialized populations (Daniels, 2012; Nutbeam & Lloyd, 2021; Olds, 2002). For example, a 25-year-long longitudinal randomized control trial study conducted by Olds (2002) paired home-visiting nurses with low-income new mothers. In addition to helping these new mothers learn how to care for their new baby, the nurses also helped the mothers identify and access educational and employment opportunities to increase their economic self-sufficiency. Mothers placed in the intervention group showed greater workforce participation and less use of public assistance programs than mothers in the control group. Additionally, the intervention led to improvements in health-related behaviors and better prenatal health outcomes for future pregnancies. Improved health outcomes were also seen in the children of these mothers, including fewer reported accidental illnesses and injuries (Olds, 2002).

Improving access to quality education is one crucial SDOH that has shown promise in improving health. Research literature has suggested that people who participated in quality education were at a lesser risk for obesity, blood pressure, and elevated blood sugar. Individuals who acquired quality education experienced better health than those who do not (Nutbeam & Lloyd, 2021). Studies have highlighted that people with higher education levels live longer and healthier lives than those with low education levels (Brunello et al., 2015; Ross & Wu, 1995). The groundbreaking Perry Preschool Project study (Weikart, 1970) provided an illustration of education as a SDOH.

The project aimed to test the hypothesis that early childhood education could have a long-lasting positive impact on the lives of low-income Black children and their families. Over 100 children were randomly assigned to either a high-quality preschool program or a control group that did not receive any preschool education. Additionally, the students enrolled in the preschool received additional supportive services. The project followed the children throughout their lives, collecting data on their educational attainment, employment, criminal behavior, health, and other outcomes. The findings of the project were groundbreaking and showed that the children who received preschool education had better educational and economic outcomes than those who did not. A follow-up study conducted 37 years later by Muennig et al. (2009) showed that participants in the Perry Preschool Project had higher rates of health insurance coverage and lower rates of behavioral risk factors that impact health such as smoking and illicit drug use than did participants in the control group.

Queering the Social Determinants of Health

Within the LGBTQ community, several social determinants of health can have a significant impact on health access and health outcomes. One of the most significant SDOH for queer individuals is discrimination and stigma. Whether historically or currently, many LGBTQ individuals face discrimination and stigma, which can lead to stress, anxiety, and depression (Austin et al., 2016; Downing & Rosenthal, 2020; Singh & Durso, 2017). Stigma can negatively impact both physical and mental health outcomes. Another SDOH for LGBTQ individuals is access to healthcare. As discussed previously, LGBTQ individuals often may face barriers to accessing healthcare, such as discrimination from healthcare providers, lack of insurance coverage, and lack of access

to LGBTQ-competent healthcare providers. For some within the queer community, especially transgender individuals, obtaining adequate housing and employment is often a barrier. Collectively, the poverty rate for LGBT people in the United States is 21.6%, higher than the 15.7% rate for cisgender straight people. Transgender adults in the United States are twice as likely to live in poverty than non-transgender adults (Badgett et al., 2019; Downing & Rosenthal, 2020). Discrimination in housing and employment can lead to food insecurity, poverty, and homelessness (Badgett et al, 2019). Rejection and lack of support from family members may also be a contributor to poorer health within the queer community (Austin et al., 2016). A study by Downing and Rosenthal (2020) analyzed survey data from the 2017 behavioral risk factor surveillance system survey, an annual survey conducted by the CDC. Results from regression analyses found that lesbian, gay, and bisexual men and women had a higher prevalence of food and housing insecurity than heterosexuals. Downing and Rosenthal (2020) postulated that discrimination in the mortgage and rental industries was a likely contributor to the higher rates of housing insecurity within this population. Additionally, they cited previous research that sexual minorities are more likely to experience food insecurity because of poor mental health, drug use, and adverse events in their childhood.

Sexual orientation and gender identity cross with other identity markers such as race/racialization, disability, immigration status, etc. Although these multiple identities in and of themselves should have little to no bearing on a person's health and well-being, the intersections of homophobia, transphobia, racism, ableism, xenophobia, etc. often present these individuals with additional challenges and barriers. This can lead to increased rates of discrimination, harassment, and violence, which can negatively impact

mental and physical health (De Santis et al., 2008; Díaz et al., 2001; Guareno, 2007; Hafeez et al., 2017; James et al., 2016; Mandler, 2022; Waters et al., 2018). In discussing how healthcare providers should attend to multiple marginalization specifically within the Black queer community, the National LGBTQIA+ Health Education Center (2019) stated:

To commit to adequately and fully providing health services for Black/African American people who are lesbian, gay, bisexual, transgender, and queer (Black LGBTQ people), is to recognize and help address the social determinants affecting their health. Further, it is to confront our own personal views and institutional approaches day in and out. Finally, it is to celebrate the resilience of Black LGBTQ people and to examine how, as health care providers of all races and ethnicities, we can contribute to and build on resilience narratives despite the inaccurate yet widely distributed narratives of risks and deficits. (p. 1)

Policy Matters

Health inequities are, in many respects, direct results of laws and statutes that have resulted in worse health outcomes for Black and brown communities, those that are LGBTQ, individuals with disabilities, those who are undocumented, and those who have been characterized and subjugated as the “other.” For policy to lead to greater equity, we need to acknowledge that the healthcare system as we know it was never really designed to be equal, much less equitable. Of course, this also holds true for many other U.S. systems and institutions including education, housing, and banking and finance, just to name a few. For healthcare policy to actualize equity, massive disruptive changes in both the policies with a big “P” (e.g., state and federal laws, regulations, structures) and the

policies with a little “p” (e.g., organizational policies and procedures) must occur. Both policy with a big “P” and policy with a little “p” involves power and privilege, historically and socially constructed concepts that are seemingly antithetical to equity.

The Hope of the ACA

The ACA, a big “P” policy passed in 2010, was the most substantial disruption in U.S. healthcare policy since the establishment of Medicare in 1965 (Mahal et al., 2020). Initially, the ACA aimed to achieve three key goals: increase the number of people covered, lower the costs of healthcare, and raise the standard or quality of care (Buchmueller & Levy, 2020). Additionally, the ACA promised to reduce health and medical disparities by promoting more equitable and efficient healthcare access (Lipton et al., 2017). The following subsections delve deeper into this signature piece of healthcare legislation.

Success of the ACA. Since its enactment in March 2010, the ACA has achieved much of the objectives set during the drafting period. Most significantly, there has been a substantial increase in the number of people with health insurance coverage. According to Reisman (2015), more than 20 million people obtained access to health coverage due to the ACA. Mahal et al. (2020) reported different figures with the reduction of uninsured Americans going from 41 million down to 27 million. The expansion of Medicaid eligibility, which resulted in a 13-million-person increase in the 1st year of the ACA (Kaye, 2019), accounts for more than half of the gains in coverage. Furthermore, the ACA’s dependent-coverage ruling reduced the proportion of young adults without health insurance. Among these people, the majority of the newly insured were youth, who make up the most significant part of the U.S. population. The ACA has also been reported to

have reduced overall healthcare costs, its second goal, although the evidence to support this is far more anecdotal and speculative (Colla & Skinner, 2020) and it is assumed that prices would have risen even further if the legislation had not been passed.

The Difference Between Coverage, Access, and Affordability. Although connected, healthcare coverage is not necessarily the same as healthcare access. Health coverage is a fiscal mechanism used to pay for healthcare, whereas access relates to obtaining those medical services. This distinction has been frequently overlooked in debates regarding the ACA and, despite progress in expanding coverage, access to healthcare remains a significant concern, especially for marginalized and historically oppressed populations. Numerous surveys have previously examined the association between health coverage and access. Gaffney & McCormick (2017) found people who have health coverage, whether through Medicaid or private insurance, had more efficient access to medical care than those who do not. Several studies have been conducted since the ACA's passage to examine how the population's access to healthcare has improved. By the culmination of the second registration period in 2015, Americans without a personal physician had decreased by 3.5% and the percentage reporting difficulty in affording healthcare had reduced by 5.5% (Mahal et al., 2020). These gains were distinct in states that expanded Medicaid. According to a Commonwealth Fund survey, at least 72% of people with health insurance through the marketplace or Medicaid used it to see a physician, hospital, or other healthcare provider (Manchikanti et al., 2017). More than

half of those polled said they could not access or afford medical care if the ACA had not been in place.

Amendments to the ACA. On the other hand, the ACA was not universally regarded as a success. Since its passage in 2010, critics such as conservative-leaning think tanks, health insurance companies, and some labor unions have raised concerns about the legislation's impact on healthcare spending, labor supply, and providers' ability to care for the population (McMorrow et al., 2020). Among the notable changes made to the ACA since its enactment were those concerned with the Medicaid expansion. Before the passage of the ACA, most states did not provide Medicaid to low-income people without children and many of the programs for low-income parents limited eligibility to those earning less than the federal poverty level (FPL; Reisman, 2015). When the ACA was passed, states were obligated to extend Medicaid eligibility to individuals earning up to 138% of the FPL. If a state refused to comply with the law, the federal government had the authority to withhold all Medicaid funding from that state. Following enactment of the ACA, 26 states filed a complaint against the U.S. government to overturn the mandate to expand state Medicaid coverage. On June 28, 2012, the Supreme Court upheld the ACA but ruled that state Medicaid expansion provision was unconstitutionally coercive, and the requirement was dismissed (*National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services et al.*, 2012). The decision effectively allowed states to opt out of Medicaid expansion. By failing to expand Medicaid, many

low-income individuals, particularly those in marginalized communities, may not have access to essential medical care, including preventive care.

Another significant amendment to the original ACA legislation was the repeal of the individual mandate for coverage. The individual mandate was a provision that required most individuals to have health insurance or pay a penalty. The intent of the individual mandate was to ensure that more people obtained coverage, including healthier individuals, to help spread the costs of healthcare across a broader population. In the original legislation, there were some exemptions to the individual mandate, such as for individuals who could not afford coverage, as well as members of certain religious groups. The individual mandate was repealed in 2017 as part of the Tax Cuts and Jobs Act which took effect in 2019. An analysis conducted by Soni (2022) found the repeal of the individual mandate led to a 20% increase in the number of uninsured individuals across the country. In 2020, California became one of five states (and the District of Columbia) to institute a statewide individual mandate requiring coverage (Covered California, 2023).

The ACA's Impact Toward Health Equity. Despite modifications and attempts to overturn the law, the ACA retains several components critical to its success, notably the decline in the number of uninsured individuals, specifically those from low- and middle-income backgrounds and people of color. According to a national health interview survey, the rate of uninsured Black and Hispanic people dropped substantially between 2013 and 2014, by 8% and 4%, respectively (Lipton et al., 2017). Evidence suggests the ACA Medicaid expansion improved the healthcare outcomes of people of color by narrowing long-standing disparities in health coverage and accessibility of

services. According to the Kaiser Family Foundation (2023), which tracks Medicaid expansion, 40 states, including the District of Columbia, have expanded Medicaid coverage. Discrepancies in uninsured rates between African American and Latinx adults in these states have narrowed significantly, more so than in states that have not expanded Medicaid health coverage.

The ACA also offered an unprecedented change to improve the health and financial security of LGBTQ people by making health coverage more affordable and comprehensive (Jennings et al., 2019). Many LGBTQ people have benefited from the antidiscrimination provisions of the ACA and obtained health insurance because of the law. Precise numbers are hard to identify given the already discussed challenges of sexual and gender minority data collection. In 2013, the year prior to the ACA fully taking effect, the Center for American Progress reported 34% of LGBTQ individuals making less than \$45,000 a year did not have insurance (Medina & Mahowald, 2020). However, in 2020 they found that only 16% of LGBTQ individuals making less than \$45,000 were uninsured. Furthermore, when the ACA was passed, Section 1557 which addressed nondiscrimination in healthcare, was seen as a major victory for queer rights (Musumeci et al., 2020). Section 1557 of the ACA specifically prohibited discrimination based on sex, sexual orientation, and gender identity. In June 2020, the Department of Health and Human Services (under the Trump administration) issued a final rule striking some nondiscrimination protections from Section 1557, including the nondiscrimination protections based on gender identity (Musumeci et al., 2020). Just before the Section 1557 revisions were set to take effect in August 2020, the Supreme Court ruled in an unconnected case that discrimination based on sex does include sexual orientation and

gender identity. This Supreme Court ruling immediately resulted in two federal court injunctions blocking the proposed Section 1557 revisions from taking effect (Musumeci et al., 2020). When the Biden Administration came into the White House, the Department of Health and Human Services removed the proposed revisions allowing Section 1557 of the ACA to continue to protect against homophobia and transphobia.

Despite the success of the ACA in significantly reducing the number of uninsured individuals, the act excludes unauthorized immigrants from obtaining healthcare coverage either through Medicaid or via the health exchange marketplace. This includes most Deferred Action for Childhood Arrivals (DACA) recipients. Estimates suggest there are over 7 million unauthorized noncitizens who are in the United States who do not have health insurance (Budiman et al., 2020). According to the Kaiser Family Foundation (2022), which tracks healthcare issues at the national, state, and local levels, states can opt in to provide prenatal care regardless of immigration status and, as of January 2022, 18 states have adopted prenatal care. This coverage only covers the birthing parent and does not extend coverage to the child. California is one of those states. Additionally, California covers unauthorized individuals through the state's Medicaid program, Medi-Cal, if they are under 26 years of age or if they are a DACA recipient (Covered California, n.d.).

State and Local Policy Approaches

Federal policy plays an important role in achieving health equity, but federal legislative invention alone is not sufficient. States and local municipalities must also engage in policy interventions designed to correct past wrongs and engender greater equity—health equity and otherwise. These interventions may take many forms, ranging

from data collection and reporting requirements, increased funding for health disparities research and public health programming, statutes requiring healthcare workers to receive cultural competence training, and executive orders declaring racism a public health crisis. To this end, several state and local governments have made legislative progress. States expanding Medicaid under the ACA, as previously discussed, is just one policy action occurring outside of the federal government.

A detailed discussion of state and local policy approaches extended outside the scope of this review; however, it is worth highlighting a few of these legislative efforts across the United States to illustrate what state policy interventions might be able to achieve. For example, 10 states now require cultural competency training for healthcare workers (Office of Minority Health [OMH], n.d.-a). As vaccines to protect people against COVID-19 began rolling out in early 2021, several states prioritized racially minoritized communities and other vulnerable populations in the distribution efforts (National Academy for State Health Policy, 2021). Over 200 city and county governments have declared racism a public health crisis (American Association of Public Health, n.d.). Though anti-racism policy position statements alone are insufficient, the American Association of Public Health believes these declarations “are an important first step to advancing racial equity and justice” and “can drive meaningful change” if “followed by allocation of resources and strategic action” (American Public Health Association, n.d., paras. 1–2). Also, increased public attention and demands for change from social injustices such as the murders of George Floyd and Breonna Taylor have forced legislative bodies to act. According to data collected from the National Conference of State Legislatures (2022), states enacted 143 pieces of legislation in the 2021–2022

legislative cycle alone that specifically state the action of addressing health disparities within the text of the bill.

State Policy Interventions Specific to California. Given that this dissertation study occurs within the state of California, let me briefly touch on legislative policy initiatives within The Golden State relevant to healthcare cultural competency. In 2006 California passed Assembly Bill 1195 mandating cultural competence training for medical doctors. Assembly Bill 1195 required that all continuing medical education (CME) courses for physicians in California contain curriculum that includes cultural and linguistic competency (Cultural and Linguistic Competency, 2006). The premise behind the legislation is that cultural competency training will result in doctors providing culturally competent care, thereby alleviating health inequities at the delivery site. However, the bill's language as to what training should focus on is limited to a few bullet points. such as "applying linguistic skills to communicate effectively with the target population" and "utilizing cultural information to establish therapeutic relationships" (Cultural and Linguistic Competency, 2006, Sect. 2190.1.c1B) without further elaboration. One possible interpretation of the second point is to collect aggregate data and information on a particular group (e.g., Latinx, LGBTQ) and use it to tailor healthcare to that population. This collection of data is not in itself problematic, but could limit understanding if it fails to recognize that culture evolves and members of a particular racialized or minoritized group are not monolithic or homogenous. Furthermore, this conceptualization lacks an intersectional approach to identity. Garces

and Gordan de Cruz (2017) posited an intersectionality-based understanding of culture and identity is required for policy to move in the direction of equity.

Since the passage of A.B. 1195, there is no record of any state appropriation to help fund the implementation or tracking of this legislation. As Like (2011) pointed out, unfunded legislative mandates complicate and slow down the implementation of policy interventions. Although groundbreaking at the time, A.B. 1195 is mostly focused on change at the individual provider level, missing important opportunities to position and address health equity advancement at the system level. Given most doctors work within highly structured systems with deep white supremacist roots (Wyatt et al., 2016), focusing on improving individual knowledge and skills without addressing the larger healthcare system may be inadequate to foster real sustained change. A.B. 1195 does not include any mention of CME course content including issues of power and privilege, implicit bias, institutionalized racism, or critical self-reflection.

California Assembly Bill 241, enacted in 2019, added to A.B. 1195 by requiring that doctors, nurses, and physician assistants complete CME on implicit bias (Implicit Bias: Continuing Education, 2019). This bill made California the first state in the United States to require that physicians and other key medical providers receive training on implicit bias. According to the bill's language (A.B. 241), implicit bias CME offerings should address at least one of the following:

- (1) how implicit bias affects perceptions and treatment decisions of licensees, leading to disparities in health outcomes or, (2) Strategies to address how unintended biases in decision making may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of

race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics. (Section 3)

Instead of offering standalone CME courses on cultural and linguistic competence and implicit bias, a CME offering that includes a patient care component must be adapted to include both elements within the course. This law took effect on January 1, 2022. All CME providers must attest that they have complied with the requirement during CME accreditation, reaccreditation, as well as during annual CME reporting (California Medical Association, 2021). The California Medical Association was tasked with developing the accreditation standards and maintains a webpage that provides additional information and resources to assist CME providers in complying with A.B. 241. No additional information as to the status of compliance or evaluative feedback on A.B. 241 was available online as of March 2023.

In another first, the California Legislature passed Assembly Bill 1407 (Nurses: Implicit Bias Courses, 2021) requires implicit bias training for preservice and new nurses as of 2021. This law mandates that nursing students receive instructional content on implicit bias as part of their preservice nursing education. Additionally, new nurses are required to take additional implicit bias CME training within 2 years of passing their nursing license exam. A.B. 1407, which went into effect on January 1, 2023, was the first such law passed in the country (Gaines, 2021). Michigan passed a similar piece of legislation soon after (Gaines, 2021). Despite the passage of A.B. 1407, it remains to be seen if this legislation will have any impact on health inequities in the state, especially because that the law only requires 1 hour of instruction in an entire nursing education program to be dedicated to implicit bias. Given how ingrained bias and discrimination are

within all aspects of our society, it is questionable if a one-time 1-hour lesson will make any lasting change. One of the foremost thinkers and researchers on implicit bias, Banaji, believed that unlearning bias is possible but contend that it is not easy and takes sustained effort (Lai & Banaji, 2020). Furthermore, the text of the bill (A.B. 1407) requires that the 1-hour implicit bias training cover 10 different areas, such as identifying the following:

Personal, interpersonal, institutional, structural, and cultural barriers to inclusion. . . . information on the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of minority communities; [and] . . . information about communicating more effectively across identities, including racial, ethnic, religious, and gender identities. (Section 1)

The other seven implicit bias topic areas that must be addressed are as substantial and important as the three mentioned here. A 1-hour instructional period attempting to cover any one of these topics seems inadequate. Notwithstanding this critique, A.B. 1407 includes language specifically in the bill that requires the California Board of Nursing Registration to evaluate the success of the implicit bias education requirement at least every 5 years and make recommendations for improvement based upon that review. This formal inclusion of an evaluative mechanism within the bill text makes room for improvement. This is an important component of any piece of legislation because, without analysis and data collection on how a piece of legislation is actually being implemented, it is very difficult for policymakers to know if it is working or not. Neither A.B. 1195 nor A.B. 241 have evaluation requirements expressly written within the statute.

Other recent California state legislative efforts not directly related to cultural competence but still relevant to this study's topical areas of achieving health equity within the LGBTQ community include:

- Assembly Bill 929. This bill requires health insurance plans participating in Covered California (California's health insurance marketplace) to provide enrollee information to Covered California annually, including patient cost, quality and disparity data (California Health Benefit Exchange: Data Collection, 2019).
- Assembly Bill 959. This bill requires four California State Departments (Department of Health Care Services, Department of Public Health, Department of Social Services, and Department of Aging) to collect and report sexual orientation and gender identity (SOGI) data as part of their routine client/customer intake processes (Lesbian, Gay, Bisexual, And Transgender Disparities Reduction Act, 2015).
- Assembly Bill 1184. This bill further protects patient confidentiality by expanding the definition of sensitive services to include both gender-affirming and behavioral healthcare (Medical Information: Confidentiality, 2021).
- Assembly Bill 1204. This law requires California hospitals to share race-disaggregated healthcare quality and workforce data with the state (Hospital Equity Reporting, 2021).
- Senate Bill 932. This law requires that public health officials collect data needed to quantify the impact of the COVID-19 global pandemic on LGBTQ communities (Communicable Diseases: Data Collection, 2020).

- Senate Bill 107. This law is designed to protect transgender and gender-diverse children and their parents who come from out of state to receive gender-affirming care services. S.B. 107 makes it illegal for health providers or insurers to release medical records to a state that prohibits gender-affirming care and it prohibits law enforcement in California from assisting any individual or out-of-state entity seeking to arrest or extradite an individual for violating another state's law against receiving gender-affirming care services (Gender-Affirming Health Care, 2022).

Trans Lives and Trans Health Under Attack. In addition to the state and local policy interventions designed to address health inequities, recently there have been legislative efforts in many states and municipalities across the country to restrict the rights of LGBTQ individuals. Many of these have targeted the transgender community. Although this dissertation study takes place in California, which as referenced above has implemented several laws to support and care for sexual and gender minorities, the actions occurring in other states add additional fear and anxiety to a community already under stress. According to the American Civil Liberties Union (2023), in 2022 there were 278 bills targeting LGBTQ individuals introduced in state legislatures across the country. Twenty of these bills became law, and of those, 17 were laws targeting transgender youth and adults. As of the beginning of March 2023, there were over 395 proposed bills sitting in state legislatures targeting LGBTQ communities, with 334 of those receiving the support needed to advance to a vote (American Civil Liberties Union, 2023). Of those 334 bills that are advancing, 88 of them focus on limiting healthcare access and/or services. Four states have already passed laws making it illegal to provide gender-

affirming care services to transgender youth and as of late February 2023, five states were debating bills that would restrict gender-affirming care for adults (Javaid, 2023).

Federally Qualified Health Centers

FQHCs have a long history of providing high-quality primary care to low-income individuals. The health center model began in the 1960s and grew out of both the civil rights movement and the War on Poverty (Lefkowitz, 2005). The FQHC designation was established in 1975 with the passage of the Public Health Service Act (HRSA, 2019). According to the HRSA, the division of the U.S. Department of Health and Human Services that oversees and funds FQHCs, “Federally Qualified Health Centers are community-based and patient-directed organizations that deliver comprehensive, culturally competent⁶, high-quality primary health care services” (HRSA, 2019, para. 1). The term “Federally Qualified Health Center” is often shortened to “FQHC,” “FQ,” “community health center,” or simply “health center” and these terms are often used interchangeably.

There are several unique social-justice oriented features of the community health center model of care. For example, FQHCs—which operate as individual nonprofit organizations—are required to serve everyone within a geographically defined and medically underserved service area, regardless of ability to pay or immigration status. Additionally, they are required to have a majority consumer/patient board of directors. In other words, most of the people making strategic and financial decisions on behalf of the organization are also those receiving care. This governing structure is unique within

⁶ Note although cultural competence is one of the distinguishing characteristics of an FQHC, neither HRSA nor the U.S. Department of Health and Human Services provides health centers with a definition of cultural competence means.

healthcare, whether it be nonprofit or for-profit healthcare. FQHCs receive a portion of their funding from the U.S. federal government, and in doing so are required to identify and minimize barriers to care (NACHC, 2020). The unique patient-majority governance structure of FQHCs contributes to this by putting important community health center decisions into the hands of those most impacted by those decisions. Additionally, community health centers conduct detailed community needs assessments every 3 years to ensure that the services they are providing meet the needs of the larger community they are designed to serve. Furthermore, based on the identified barriers to care, FQHCs are required to provide “enabling services.” (HRSA, n.d.-a). The Health Resources and Services Administration (HRSA, n.d.-a) defined enabling services as, “non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes” (p. 2). Examples of enabling services include case management services, translation/interpretation, transportation, childcare, and health education. Another requirement to be an FQHC includes having a sliding scale fee to allow anyone regardless of ability to pay to access services. Additionally, though FQHCs can specialize in serving a particular underserved population (e.g., farm workers, the homeless, LGBTQ individuals, indigenous communities), they must serve anyone who needs care within their geographic service area.

The health center model of care has been shown to increase health outcomes among low-income patients while also decreasing the utilization and costs associated with emergency room visits (Geiger, 2005; Laiteerapong et al., 2014; Markus et al., 2018; Proser, 2005). Health center patients are more likely than other primary care patients to receive preventive services such as immunizations, pap smears, and tobacco cessation

education; and hypertension and diabetes control rates are higher than the national average among health center patients (HRSA, 2017). Community health centers save U.S. taxpayers \$24 billion annually by diverting millions of patients away from receiving their primary care services through expensive emergency room care (NACHC, 2021).

Community Health Centers in 2023

The community health center model continues to grow both in numbers of people served as well as services offered. In 2010, there were 1,124 FQHCs nationally collectively serving approximately 19,500,000 patients. Fast forward just 10 years to 2020 when FQHCs served more than 29,000,000 patients at over 1,400 health centers which operated out of 13,500 sites across the United States (HRSA, 2021a). Drilling down to California, there were 175 community health centers operating out of over 2,000 service sites serving 5,162,835 patients across the state in 2021. California has the most community health centers of any state in the nation, having more than double the number of the next state, Texas, which had 72 FQHCs in 2021 (HRSA, 2021a). Nationally, 63% of health center patients were from racially and ethnically minoritized groups (HRSA, 2021a). According to the National Association of Community Health Centers, 1 in 7 people from a racial/ethnic minority group received their primary health care from FQHCs (NACHC, 2020). These percentages were significantly higher in California. Figure 1 shows the race and ethnicity breakdown for patients seen at California FQHCs in 2021. The majority of patients served by California FQHCs are Latino/Latina/Latinx.

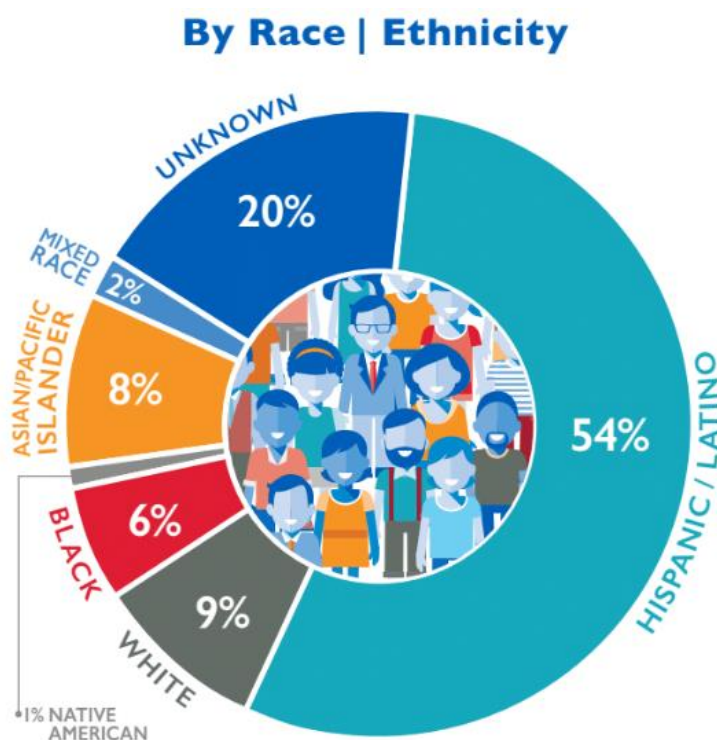


Figure 1. Race and Ethnicity Breakdown for Patients Seen by California FQHCs in 2021

Note. Infographic showing race/ethnicity breakdown for FQHC patients in California in 2021. From “CHC Data and Reports” by California Primary Care Association, n.d. (https://www.cPCA.org/CPCA/About/Publications%20and%20Reports/CHC_Data/CPCA/About/CHC_Data.aspx?hkey=aa0afb8e-493a-450c-b039-13087ad22e44). Copyright 2021 by California Primary Care Association. Reprinted with permission.

The total number of staff employed by community health centers nationally in 2020 was 255,011 full-time equivalents (HRSA, 2021a). This figure included clinical staff and providers (e.g., physicians, nurses, behavioral health specialists, case managers) as well as other administrative and support personnel (e.g., fiscal, IT, facilities, nonclinical executive leadership). In California specifically, there were 47,484 full-time equivalent employees during the same year—more than one sixth of the entire health center workforce (HRSA, 2021a). Given the massive growth of the community health center model of care and expansion in the range of services provided beyond primary

care (e.g., behavioral health, dental, vision) staffing challenges are an issue at most FQHCs. A national survey assessing workforce staffing issues at FQHCs conducted in February of 2022 found that 68% of health centers had lost between 5%–25% of their workforce in the 6-month period immediately before the survey. Fifteen percent of health centers reported losing 25%–50% of their workforce in that period (NACHC, 2022). Like the entire health sector, these staffing shortages have been exasperated by the ongoing COVID-19 global pandemic.

Though health centers are required to collect and report detailed data on patients—including but not limited to demographic information such as race, gender, sexual orientation, age, income, and health status—this granular level information is not required for employees. This lack of information is problematic. Despite the lack of demographic data on FQHC employees at both the state and national levels, the racial, ethnic, and cultural composition of the health center workforce does not appear to reflect the communities they serve. According to Bond et al. (2013), even though the majority of health center patients are people of color, most health center leaders—executives, managers, and clinical professionals—are white. Bond et al. (2013) also noted men are disproportionately represented in senior-level positions despite FQHCs generally employing more women than men. However, Xierali and Nivet (2018) posited that it is safe to assume the community health center workforce is generally more diverse than other primary care providers given that FQHCs are located in medically underserved communities and BIPOC and other minoritized clinicians practice in underserved communities at higher rates than do their white counterparts. Because one promising intervention to help address health inequity is to have a workforce that is reflective of the

community, the lack of health center workforce data broken down by demographics of race, gender, and sexual orientation is likely worth being addressed.

FQHCs That Specialize in LGBTQ Healthcare

Given their locations within medically underserved communities, many health centers specialize in serving specific populations such as the Latinx community, migrant and seasonal farmworkers, and refugee populations. Additionally, starting in 2002, after years of advocacy, the U.S. Department of Health and Human Services HRSA began funding community health centers that focused on serving LGBTQ populations (Martos et al., 2017). Though LGBT-focused health entities have been in existence since the 1970s, as of 2017, there were only 14 federally funded community health centers (approximately .01% of the total number of FQHCs) that specifically focused on the health needs of LGBTQ populations (Martos et al., 2017). More recent data on the number of FQHCs that now specialize in serving the LGBTQ community is not readily available.

Regarding existing research literature specific to these specialized FQHCs organizations, this literature review produced only a few results (Adams et al., 2018; Hudson, 2018; Martos et al., 2017; Shaw, 2010). Hudson (2018) sought to better understand the patient demographics and services provided by the few LGBTQ-focused health centers that exist. This mixed methods study analyzed data from eight of these FQHCs, including patient data submitted to the HRSA and other publicly available information (e.g., health center annual reports). Hudson found each of these health centers served a higher percentage of people with HIV, offered more behavioral health and enabling services, and were more likely to serve homeless individuals as compared to

the national average. Additionally, these eight FQHCs offered services and programs “with particular attention to the intersections of age, race, and socioeconomic status and illness experiences” (Hudson, 2018, p. 293).

Findings from Hudson (2018) suggested LGBTQ-focused FQHCs operate through a critical lens that is sensitive to the compounding discrimination often brought on by intersecting identities. However, Martos et al. (2017) suggested research exploring intersectionality within the LGBTQ-focused health center context is significantly lacking. According to Martos et al. (2017):

Although LGBT community health centers may be more aware of and sensitive to the needs of clients with diverse gender and sexual identities than general healthcare providers, this capacity for greater cultural competence does not necessarily extend across racial/ethnic groups, socioeconomic diversity, and immigration status. (p. 12)

Additionally, research conducted by Adams et al. (2018) looking at facilitators and barriers to accessing HIV and sexual health services for young Black men and transsexual women of color found that multidimensional stigma (e.g., racism, homophobia, transphobia) was the biggest single barrier to accessing care. Due to the lack of an intersectional approach, sexual and gender minority patients may be less understood and less comfortable with the overall healthcare experience. Given the growing body of research and general awareness of how intersectional identities often lead to multiple forms of discrimination, it seems necessary to increase the number of LGBTQ-focused health centers while also ensuring that these organizations are aware of

and sensitive to how intersectional discrimination impacts patients and can impact their overall health.

Cultural Competence

As highlighted in legislative efforts in California, focusing on improving the cultural competence of health providers and the overall healthcare system is another intervention being used. There is evidence that when healthcare providers receive cultural competence training, it improves their knowledge and skills in connecting with patients who may not look, believe, or behave like them (see the Cultural Competency Training for Healthcare Providers and Staff section within this chapter for more information). As this dissertation further explored how community health centers that specialize in serving the LGBTQ community go about understanding and providing culturally competent care, this section of the literature review delves deeper into what is known, and remains to be understood, about this concept.

The term cultural competence in relation to health care has many definitions in the literature and its direct origin is debated. Betancourt et al. (2003) defined *cultural competence* as the ability of an individual to interact with other people from another culture and respect and appreciate their beliefs. Cross (1988, 2012) was one of the first researchers to contextualize cultural competence specifically within the healthcare sector. He describes cultural competence as the ability of healthcare professionals to interact with patients with different beliefs, feelings, and values, in a respectful manner. DeAngelis (2015), through the lens of psychology, defined cultural competence “as the ability to understand, appreciate and interact with people from cultures or belief systems different from one’s own” (p. 64). DeAngelis suggested cultural competence has been an

integral component of psychological practice for over 50 years. However, Danso (2016) posited the term, although in use since 1989, did not gain popularity within the healthcare sector until 2002. Greene-Moton and Minkler (2019) studied the history of the term and suggested the idea of providing culturally competent healthcare started appearing in health and medical literature in the late 1980s. Based upon their analysis, they contended that in addition to racially minoritized populations, it was the LGBTQ and disability communities that originally brought attention to healthcare disparities and the need for culturally competent providers to serve their unique healthcare needs (Greene-Moton & Minkler, 2019). Regardless of the term's origin, Kumagai and Lypson (2009) offered a compelling idea of what culturally competent healthcare should and should not be:

Cultural competence is not an abdominal exam. It is not a static requirement to be checked off some list but is something beyond the rigid categories of knowledge, skills, and attitudes; the continuous critical refinement and fostering of a type of thinking and knowing . . . of self, others and the world. (p. 783)

As previously mentioned, FQHCs are mandated to identify and address barriers to accessing and receiving care and create plans and actions (also known as enabling services) to minimize those barriers at the individual and community levels (Proser, 2005). These enabling services might include translation, transportation to and from appointments, childcare, extended evening and weekend office hours, etc. Although it is unclear how FQHCs specifically define, implement, and measure culturally competent care, identifying and providing enabling services to patients is likely part of how they go about understanding and enacting culturally competent care. Further study is needed in this area.

But What Exactly Is Cultural Competence?

As already acknowledged, cultural competence in healthcare has been studied since at least the mid-1970s (Kumar et al., 2019), and although recognized as important to the goal of eliminating health disparities, there appears to be wide disagreement in the literature about how to define and, therefore, assess what culturally competent healthcare is (Beach et al., 2005; Betancourt et al., 2003; Cain et al., 2017; Gilmer et al., 2017; Lucas et al., 2008; Shepherd et al., 2019; Tehee et al., 2020; Truong et al., 2017). According to a 2019 mixed-methods study conducted by Shepherd et al. (2019), although most healthcare professionals involved in the study ($n = 56$) believed that cultural competence training should be required and ongoing for healthcare staff, almost none of the study participants were able to articulate principles that should be part of a cultural competence framework including acknowledging power imbalances, dominant narratives, differing worldviews, and institutionalized inequities. Similarly, Dogra et al. (2009) interviewed representatives from 12 different U.S. healthcare institutions, including commercial and noncommercial health plans, public and private hospitals, and a veterans' hospital, and found that although cultural competence training was perceived as important for each of these organizations, there was a general lack of clarity about what such training should include as well as who within their agencies should receive the training. In a literature review analysis, Shen (2015) identified 12 different definitions of cultural competence that existed within published nursing literature alone. Dogra et al. (2009) further suggested a need for the various accreditation and policy-making entities involved in health care regulation and compliance "to reach a consensus on the meaning

of cultural competence and to provide consistent and clear directives that can be effectively implemented” (p. 132).

When identifying what specific services or behaviors constitute culturally competent healthcare, providing linguistic access and racial/ethnic concordance were most often cited in the literature (Aggarwal et al., 2016; Handtke et al., 2019; Jetty et al., 2021). Research by Cain et al. (2017) suggested the key ingredient to providing culturally competent healthcare may simply lie in providers taking the time to ask questions about a patient’s culture and listening with an open mind. Studying the development and validation of a patient report assessment for measuring provider cultural competency, Lucas et al. (2008) supported a similar view.

Even though “cultural competence” is most commonly used within the healthcare sector, the way this term is understood and conceptualized is problematic, both within and outside of health disciplines (Gorski, 2016; Tehee et al., 2020; Tervalon & Murray-Garcia, 1998). For some, the word “competence” suggests that one can reach a level of mastery or proficiency, although most cultural competence theories and theorists do not suggest that one can achieve true competence or mastery (Shepherd et al., 2019; Tervalon & Murray-Garcia, 1998). Additionally, there are arguments that cultural competence-based training and education programs within healthcare often fail to include key components such as power and privilege, implicit bias, institutionalized racism, or critical self-reflection (Shepherd et al., 2019; Whaley & Longoria, 2008). Gorski (2016) postulated that cultural competence models were “empty” (p. 222) in that they do not actually address inequity. Aggarwal et al. (2013) postulated that cultural competence was not a race-centered approach and given that racism is the primary factor for health

inequities, race and racism must be central to gaining cultural competence skills. Despite these tensions and points of convergence and divergence in the literature about the conceptualizations/definitional understandings of what providing care that is culturally competent actually means, the idea is still widely discussed, studied, and trained on in healthcare.

Cultural Competence Models

There are many existing conceptual and theoretical models of cultural competence. Some of these models situate themselves squarely in healthcare such as the national cultural and linguistically appropriate services (CLAS) model (OMH, 2013) and Tervalon and Murray-Garcia's (1998) cultural humility model. Others come from other academic disciplines such as the multidimensional model for developing cultural competence (Sue, 2001) within the field of psychology. Still, others are considered to be transdisciplinary such as Cross's (1989) model of cultural competence, which has applications in a variety of fields including health care, the social sciences, and education. Betancourt et al. (2003), Handtke et al. (2019), and Shen (2015) provided reviews of existing cultural competence models that exist within health care. These reviews suggested most conceptualizations of cultural competence within the healthcare space tend to focus on one or more of the following: individual-level knowledge and behaviors, organizational-level knowledge and actions, specific strategies for individual providers to use, and/or specific strategies for healthcare systems to employ.

A couple of frequently cited models are detailed in this section. These include Cross's (1989) cultural competence model, the multidimensional model for developing cultural competence, the national CLAS standards model, and the cultural humility

model. Given competing conceptualizations of cultural competence within both the literature as well as in practice, this study was not designed to test the fidelity of any of these, or other, existing models.

In my experience of working in and around healthcare for close to 2 decades, I have rarely, if ever, heard a nurse, social worker, healthcare administrator, doctor, etc., refer to a particular theorist or model when they discuss cultural competence. Instead, existing models and literature were used as a foundation to inform my understanding as a researcher attempting to build a theory grounded in the data collected from participants.

Cross Model of Cultural Competence. Cross's (1989) definition and model of cultural competence is one of the most cited (Handtke et al., 2019). Within Cross' (1989) model, there are six stages for the developmental process of acquisition of cultural competence. These stages are cultural destructiveness, cultural incapacity, cultural blindness, cultural precompetence, cultural competence, and cultural proficiency. The stages are characterized on a continuum with a negative and a positive end. Cross intended this model to apply at both the individual and organizational levels. The first stage on the negative side of the continuum is cultural destructiveness. Cultural destructiveness is characterized by negative beliefs, attitudes, and policies toward certain cultures that are destructive. For example, the Tuskegee Study had over 400 Black men go untreated with syphilis for years to gather medical information. This tragic and unethical study was allowed to happen because of the negative beliefs that existed about Black men at the time (Cross, 1989). The second stage, known as cultural incapacity, looks at how systems and organizations lack the capacity to adequately respond to the needs of culturally and/or linguistically diverse individuals (Cross, 1989). Cultural

incapacity is an often subversive process where individuals and organizations seek to make nondominant cultures feel inferior or less significant than the dominant culture (Lindsey et al., 2018).

The third stage is cultural blindness⁷, which is characterized by the inability of an individual to understand how matters can be understood differently by other cultures due to the rigidity of one's culture and belief system. An example is people's ideology of "not seeing" color and that everyone is the same. Although everyone should be treated fairly, visual aspects of their identity such as race should not be overlooked. Color-evasive ideology ignores the shared experiences, traditions, and norms that often guide behavior and interaction among racial and cultural groups. The fourth stage in Cross's (1989) model is cultural precompetence. This stage is characterized by levels of awareness within individuals and organizations and one's strength and ability to respond to matters concerning diversity. Within this stage, there is value for diversity. People in this stage tend to educate themselves about cultural differences and organizations start offering training and promoting diversity in hiring. In the cultural precompetence stage, however, there is a tendency to have no clear plan for how individuals or organizations will achieve cultural competence.

The fifth stage is the cultural competence stage. Individuals and organizations show that there is respect for cultural diversity. Inclusion is fostered and brought about in various ways including creating mission statements that spell out the principles, goals, and values for cultural competence. Individuals attempt to accommodate cultural differences and examine themselves as cross-cultural collaborators. Organizationally at

⁷ There is a recognition that terms such as "color blind" have ableist roots, however, given that this is wording that is used in Cross's cultural competence model, the wording was not changed.

this stage, cultural competence is supported in other ways including incentives, professional development, research, and cultural competency organizational assessments. The sixth, and last, stage is cultural proficiency. This is where the organizations and systems hold culture in high esteem and use the foundation of culture to direct their plans and goals. The organization keeps adding knowledge through research, direct intervention, and approaches that cater to mental health, education, and general delivery of care for diverse cultures. A culturally proficient organization also employs experts to help maintain their cultural proficiency (e.g., research, training). Individually at this stage, people move beyond appreciating and accommodating cultural differences to actively educating others. They become allies and feel comfortable interacting in multicultural environments (Cross et al., 1989).

Multidimensional Model for Developing Cultural Competence. The multidimensional model for developing cultural competence by Sue (2001) has epistemological roots in the field of psychology. Federal agencies such as the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services, promote the use of this model in behavioral health settings (SAMHSA, 2014). Sue's (2001) model incorporates three primary dimensions: (a) racial and culture-specific attributes of competence, (b) components of cultural competence, and (c) foci of cultural competence. The first dimension encourages providers to wrestle with tensions surrounding race in relation to

other identities and how it is common in discussions of cultural competence to focus on culture at the expense of calling out and addressing racism. Sue (2001) stated:

As a result, race becomes less salient and allows us to avoid addressing problems of racial prejudice, racial discrimination, and systemic racial oppression. This concern appears to have great legitimacy. I have noted, for example, that when issues of race are discussed in the classroom, a mental health agency, or some other public forum, it is not uncommon for participants to refocus the dialogue on differences related to gender, socioeconomic status, or religious orientation. (p. 792)

Furthermore, Sue (2001) posited that culturally competent care must include the development of cultural awareness, knowledge, and skills (Dimension 2) and must occur across the organization, not just at the individual provider level (Dimension 3).

National Cultural and Linguistically Appropriate Services (CLAS)

Standards Model. The federal Office of Minority Health (OMH), a division of the U.S. Department of Health and Human Services, has created the CLAS standards to assist healthcare providers to identify and track the provision of effective, respectful, and equitable care to diverse populations (OMH, 2013). All healthcare entities (e.g., hospitals, inpatient and outpatient treatment facilities, ambulatory care centers, FQHCs) are encouraged to adopt and use these 15 standards. The CLAS standards provide guidance in the areas of: (a) governance, leadership, and workforce; (b) communication and language assistance; and (c) engagement, continuous improvement, and accountability (OMH, n.d.-b). Unlike other cultural competence models that explore the cultural competence construct theoretically, the CLAS standards are designed to provide

concrete steps and actions that healthcare entities can take to provide culturally competent care (Diamond et al., 2010). It is unclear how many healthcare facilities, including FQHCs, use the national CLAS standards in designing and/or evaluating the provision of culturally competent care. A 2010 quantitative study conducted by Diamond and colleagues found that only 13% of U.S. hospitals were following the four CLAS standards related to language access and translation. In 2014, The Joint Commission, the nation's oldest and largest healthcare accrediting body, recommended but did not require accredited healthcare entities to use the CLAS standards (The Joint Commission, 2022). In 2022, The Joint Commission accredited 250 FQHCs (Darling, 2022).

Cultural Humility Model. Tervalon and Murray-Garcia (1998), in their work as physician and clinic administrator respectively, felt that common understandings of cultural competence were limiting. Pushing back against the word “competence,” which they felt suggested one can become fully competent in learning all they need to know about the communities and cultures they work with, instead proposed a new theory/construct called cultural humility. There are three tenets of cultural humility, including seeing the learning process as a lifelong commitment rather than a finite destination, working to mitigate power imbalances, and holding the institution accountable (Tervalon & Murray-Garcia, 1998). Tervalon and Murray-Garcia contended that obtaining knowledge about a group of people that a provider or system may be serving is wise, but that at both the individual and organizational levels, cultural humility focuses on being humble and curious instead of attempting to be all-knowing. The cultural humility model also emphasizes the importance of constant interrogation of assumptions and attitudes. Although Tervalon and Murray-Garcia's original 1998 article

has been cited in over 1,500 peer-reviewed publications, the concept of cultural competence continues to be much more popular in publication and in practice (Greene-Moton & Minkler, 2019). Furthermore, Greene-Moton and Minkler (2019) suggested the debate between cultural competence versus cultural humility was not helpful, stating:

Particularly in the troubling contexts of our time characterized by increasingly virulent racism and a weakening of civil and human rights both nationally and globally, we believe it imperative to find a road around the false choice between cultural humility and cultural competence . . . [as] . . . both concepts grew out of increasing recognition of the need for public health, medical, social work, and other professionals to reflect on and address our own biases and actively seek to understand and address the cultural and social realities of the diverse individuals, groups, and communities with whom we and our groups and organizations interact. (p. 144)

In later writings, Tervalon and Murray-Garcia suggested that cultural humility and cultural competence could be thought of as complementary rather than necessarily contradictory (Danso, 2016).

LGBTQ Cultural Competency

Across the various definitions and models of cultural competence, there appears to be agreement that cultural competence refers to a set of skills, knowledge, and attitudes that individuals and organizations can develop to effectively work with and support marginalized populations (Betancourt et al., 2003; Campinha-Bacote, 2002). Similar to the Cross model of cultural competence (Cross, 1989) and the multidimensional model for developing cultural competence (Sue, 2001) cultural competence in the LGBTQ

context involves understanding the unique experiences, challenges, and needs of this population, as well as developing skills to communicate sensitively and respectfully with LGBTQ individuals, families, and communities. Also, like the cultural humility model (Tervalon & Murray-Garcia, 1998), LGBTQ cultural competence involves recognizing and addressing one's own biases and assumptions about queer people, and actively working to create safe and inclusive environments. The National LGBTQIA+ Health Education Center (2021) posited that LGBTQ cultural competency is an enacted process that involves developing strategies and interventions that are responsive to the needs of the queer community, such as creating safe and welcoming clinical spaces that encourage disclosure and offering specialized services such as sexual health and gender-affirming care. Margolies and Brown (2019) purported that LGBTQ cultural competence may be a key factor in reducing health disparities and improving health outcomes for LGBTQ individuals, particularly in areas such as mental health, HIV/AIDS, and cancer.

Cultural Competency Training for Health Care Providers and Staff

Cohen et al. (2002) contended, "Health care professionals cannot become culturally competent solely by reading textbooks and listening to lectures. They must be educated in environments that are emblematic of the diverse society they will be called upon to serve" (p. 92). Despite the need for healthcare professionals to receive training and education about how they can provide culturally competent care in hopes of overcoming health inequities, most providers lack these development opportunities in their preservice clinical education (Dupras et al., 2020; Landry et al., 2021). Research has shown that the lack of culturally competent healthcare providers further increased health disparities and inequities faced by minoritized populations (Beach et al., 2005; LaVeist &

Issac, 2012). In their 2012 book titled *Race, Ethnicity, and Health: A Public Health Reader*, LaVeist and Issac highlighted the importance of healthcare providers developing their cultural competence through ongoing training and education. They recommended that this training provide opportunities for individual healthcare providers, especially those from dominant cultural groups, to explore their own privilege and the resulting impacts on the care they provide. LaVeist and Issac also contended cultural competence training should address power dynamics and systemic racism that exists within the U.S. healthcare system. Bleich et al. (2021) argued cultural competence training must go “beyond brief diversity trainings” and “the goal should be to confront health care professionals with evidence of their own discriminatory behavior and provide concrete actions for addressing it” (p. 2). A review of the literature on LGBTQ cultural competence in social work found that social workers who had received training on LGBTQ issues were more likely to provide appropriate care to LGBTQ clients, and that LGBTQ clients who received such care reported higher levels of satisfaction and better mental health outcomes (Fredriksen-Goldsen et al., 2014).

A recent quantitative study conducted by Souleymanov et al. (2022) examined whether or not sociodemographic (e.g., age, race, sexual orientation, level of education) and socioecological factors (e.g., discrimination in healthcare, healthcare providers’ knowledge and competence regarding queer male issues) were associated with healthcare access for queer men in Manitoba, Canada. Using a community based participatory research (CBPR) model, 368 two-spirit, gay, bisexual, queer, or MSM were recruited across the Manitoba, Canada area to complete an anonymous online survey. In addition to collecting demographic data, this survey asked questions about access to healthcare,

sociostructural determinants of health, perceptions of health providers' knowledge and competence in serving the healthcare needs of queer men, as well as experiences of discrimination within the healthcare system. Findings from bivariate and multivariable analyses found that 65.3% of the respondents reported experiencing discrimination in healthcare settings. Furthermore, a statistically significant relationship between provider competence and having a regular health care provider was indicated ($\chi^2 = 18.95$, $df = 4$, $p = 0.001$), suggesting queer men who felt their health care provider was competent in serving their unique health needs were more likely to report having a regular provider. Additionally, study participants were more likely to report having been to their provider in the last 12 months if they perceived them as having *very good* or *good* competence/knowledge of queer men's health issues ($\chi^2 = 24.89$, $df = 4$, $p = 0.001$). In the context of this study, healthcare access was defined as having a regular healthcare provider and having had a healthcare visit within the last 12 months.

Cultural Competency Training for FQHC Providers and Staff. In addition to pipeline education and recruitment strategies designed to ensure that health center staff and providers are more racially, ethnically, and culturally reflective of the communities they serve, there is also a need for existing staff and providers to receive training and education related to cultural competency. Simply hiring staff that mirrors the diversity of patients is not enough (Castillo & Guo, 2011). A qualitative focus group study by Bruner et al. (2011) found patients reported higher positive feedback regarding the quality of care after FQHC staff were provided cultural competency training and education. Additionally, in a 2-year ethnographic study conducted by Shaw (2010), patients from one community health center suggested well-designed and implemented cultural

competency training may “play an equally if not more important role in health care quality” than “relying solely on ethnic resemblance to provide culturally appropriate care” (p. 535). Furthermore, a quantitative study conducted by Hooper et al. (2018) found that FQHC patients receiving behavioral health treatment ($n = 88$) were 33% more likely to adhere to treatment if they perceived their provider as having high cultural competence, suggesting cultural competence training might create a more trusting relationship between patient and provider.

Waite et al (2013) suggested ongoing training and workplace education related to cultural competency helps create a learning organization and assists in establishing a workplace culture that promotes and values diversity and equity. In a national mixed-methods pilot and feasibility study evaluating a multisession training program focusing on community health workers (CHW) mostly employed by FQHCs, Damian et al. (2020) found program participants’ self-efficacy to address health issues for vulnerable populations increased, with those who attended more training sessions showing a larger increase in self-efficacy. Additionally, 63% of study participants expressed an intent to work differently with patients because of the program.

Felsenstein (2018) detailed an empirical action/intervention study developed to address known LGBT cultural competence deficiencies among healthcare providers in a small urban Minnesota care community health center setting. The mixed-methods investigation consisted of 11 staff participants and was conducted as part of the organization’s ongoing quality improvement work. The study looked at how clinic staff created a welcoming environment for LGBT patients, provided opportunities for LGBT patients to disclose their LGBT status, and addressed LGBT health issues with their

LGBT patients. Data collection methods included preliminary assessments to assess baseline knowledge and learning needs followed by one-on-one meetings to learn about each individual staff member's experience and comfort in serving LGBT patients. Following that, the training intervention component incorporated a 1-hour self-paced online module followed by a 90-minute in-person panel discussion. A 12-item pre-post questionnaire was used to determine if a change in knowledge had occurred because of the training intervention. Findings suggested that interventions such as adding an affirmative LGBT symbol and nondiscrimination policy in the waiting room combined with adapting patient intake forms to include questions about sexual orientation and gender identity helped to create a more welcoming environment and facilitate LGBT patients' self-disclosing their status. Regarding the cultural competence training portion of the study, a statistically significant increase ($p = .033$) was found between pre and posttest and 72% of participants indicated that they were more prepared to provide appropriate care to LGBT patients postintervention.

Like Felsenstein (2018), Furness et al. (2020) described a mixed-methods action/intervention study that was part of a quality improvement initiative to improve how FQHCs provide culturally competent and affirming care to LGBT populations. Using a pre-post intervention design, Furness et al. (2020) chose 10 FQHCs across nine states to participate in the 1-year study. Research participants (staff teams at FQHCs) were recruited through purposive sampling and participated in monthly coaching calls, train-the-trainer sessions, in-person as well as online meetings, and monthly written reports to help support change efforts. Additionally, participating FQHC teams received twice-monthly short presentations that were followed by participant-led discussions on

how to apply knowledge from the presentation to their FQHC setting. To evaluate the effectiveness of the intervention, quantitative data were collected via surveys and through participating FQHCs sharing monthly aggregated clinical data. Qualitative data were collected via participant interviews and used to support the quantitative data outcomes. As a result of the intervention, all FQHCs reported increases in culturally affirming practices. There was a 42.9% increase in the collection of SOGI data. Risk-based sexual health screening of LGBT patients also increased significantly (22.3% to 34.6% for syphilis, 25.3% to 44.1% for chlamydia and gonorrhea, and 14.8% to 30.5% for HIV). Additionally, findings showed there were modest increases in the number of participating FQHCs that provided LGBT cultural competence training to staff postintervention. In the implications and limitations section, Furness et al. (2020) noted that the 1-year intervention took place in 2016, the same year that the federal agency that oversees the health center program started requiring FQHCs to collect and report SOGI data for all adult patients on an annual basis. They postulate that this mediating factor likely influenced the increased collection of SOGI data across study sites.

Theoretical Framework

The community health center model of care began in the 1960s growing out of the civil rights movement and the War on Poverty (Lefkowitz, 2005). As of 2023, FQHCs continue to work for equity by attempting to improve access to high-quality primary care targeted at either medically underserved populations and/or in medically underserved geographic locations. Given the social justice roots of the community health center movement and the growing racial, ethnic, and cultural diversity of health center patients, a critical theoretical lens—specifically critical race theory and queer theory—was used in

hopes of providing additional insight into how the two LGBTQ-focused community health centers involved in this study understand the needs of the queer community and then went about providing culturally competent care to address those needs. Critical theory challenges dominant ideologies and power structures that shape society and offers alternative ways to understand social phenomena. This paradigm is particularly useful when studying issues related to power and oppression (Anyon, 2009).

Critical Race Theory

Critical race theory as originated by legal scholars in the 1970s (Bell, 1980) and emerged as its own theory beginning in the 1980s (Martinez, 2014). Critical race theory emerged because a few legal scholars, mostly people of color, were frustrated by the lack of direct attention and focus on race and racism in the legal field (Martinez, 2014). From this frustration, Martinez (2014) stated a theory emerged that rejected:

The liberal notion of color blindness and argues that ignoring racial difference maintains and perpetuates the “status quo with all of its deeply institutionalized injustices to racial minorities” and insists that “dismissing the importance of race is a way to guarantee that institutionalized and systematic racism continues and even prospers.” (p. 17)

Critical race theorists believe racism is endemic, pervasive, and has been normalized in our society (Delgado & Stefancic, 2001). Other key tenets and principles of CRT include a rejection of the idea of color evasiveness in favor of a more race-conscious perspective, the importance of voice and counter-narrative by people of color, the concept of the intersectionality between race and other aspects of self (e.g., gender, sexual orientation) as described by Crenshaw et al. (1995), the belief that race is a social construct, and the

idea of interest convergence where the dominant group (i.e., white people) will only work toward racial justice when there is something in it for them (Ladson-Billings, 2013). Solórzano and Bernal (2001) explained, “CRT challenges claims of neutrality . . . and meritocracy in policies and practices shaped around the dominant ideology” (p. 336). Considering the founding principles upon which the community health center model is built, combined with the desire and expectation for FQHCs to serve more people while continuing to improve individual and community health, research conducted in and about FQHCs can aptly use a critical theoretical lens with the goal of centering marginalized voices through counternarratives, calling attention to systemic racism deeply ingrained within healthcare, understanding how overlapping oppressed identities complicate optimal health, and continuing to challenge and fight for health and social equity.

Of particular interest in this investigation was to look at if, and how, the critical race theory tenet of intersectionality played into how the two health centers involved in this study understand the construct of cultural competence especially given their specialization in serving the needs of the LGBTQ community. For example, are these health centers’ conceptualization of LGBTQ cultural competence mindful of the idea that multiple identities can intersect to create multiple marginalization? If so, how does this understanding inform how they go about providing care that desires to meet the needs of *all* queer members of their community? Do tenets of critical race theory show up in organizational practices such as hiring and training staff and providers? And if so, how? Likewise, because the majority of the general healthcare workforce is white, I contend using the lens of critical race theory to critically interrogate organizational beliefs and

practices such as workforce cultural competence training and education may yield new insights that challenge the dominant ideology that exists within this space.

Queer Theory

Given this study's focus on LGBTQ-focused community health centers, I felt that queer theory was also an important theoretical lens to adopt alongside critical race theory. Like critical race theory, queer theory grew out of the critical tradition, though the origins of queer theory are harder to pinpoint (Jagose, 1996). Critical scholars representing feminist thinking, postcolonialism, gay/lesbian studies, poststructuralism, and others have all contributed to the development of queer theory. Additionally, the AIDS crisis beginning in the 1980s greatly influenced the current understanding of queer theory (Jagose, 1996). Though the origins of, and contributors to, queer theory are varied, the term is believed to have been coined by professor and researcher De Lauretis (1991) in 1990 (Halperin, 2003). According to Halperin (2003):

[De Lauretis] had heard the word "queer" being tossed about in a gay-affirmative sense by activists, street kids, and members of the art world in New York during the late 1980s. She had the courage, and the conviction, to pair that scurrilous term with the academic holy word, "theory." (pp. 339–340)

Queer theory, which focuses on the discourse regarding sexuality, posits that we should expand our understanding beyond dichotomous views of gender and sexuality, reject the idea of heteronormativity, and further explore the role of race as it relates to sexuality and sexual expression. Like critical race theory, queer theory believes the ideas and beliefs we hold are socially constructed and based on power and privilege. The writings of philosopher and activist Foucault have also contributed to the current

understanding of queer theory. Foucault's work detailed how the binaries of sexuality have been historically/herstorically contested. According to Spargo (1999), "A vital feature of Foucault's argument is that sexuality is not a natural feature or fact of human life but a constructed category of experience which has historical, social and cultural, rather than biological, origins" (p. 12). Queer theory is not concerned with nature versus nurture debates surrounding sexuality and gender. Instead, queer theory is concerned with how understandings and conceptualizations of sexuality function in society. Apropos for a dissertation study contextualized within the health/medical field, Foucault (1978) argued that the modern understanding of sexual desire in Western culture is controlled by the medicalization of sex and pleasure. Case in point, it was not until 1973 that the American Psychological Association (APA), after years of protest, reluctantly voted to remove homosexuality as a disorder (Drescher, 2015). What is often not reported with the APA's 1973 decision is that the "homosexual" diagnosis was replaced with another diagnosis, sexual orientation disturbance (SOD), which would continue the pathologization of sexual orientation for many more years (Drescher, 2015). Being transgender was considered a disorder in the APA's *Diagnostic and Statistical Manual of Mental Disorders* until 2012 and up until 2019, the World Health Organization listed being transgender as a mental disorder (Haynes, 2019).

Many of the reasons noted for using critical race theory in this study also hold true for adding queer theory as part of the theoretical lens from which this research was positioned. More research calling attention to modern-day manifestations of systemic homophobia and transphobia within the healthcare space is needed to challenge the status quo. Through the lens of queer theory, I was curious to know if health center leaders and

provider participants would talk about the systemic or institutionalized homophobia or transphobia within the healthcare system, and, if so, how that impacted the way they provided care to those that have, and are, victims of that homophobia and transphobia. How might this critical awareness change how providers went about building rapport and trust with their patients/clients? Furthermore, this study sought to center marginalized voices and counternarratives, a central tenet of both queer theory and critical race theory. And of particular interest in this investigation was to explore if, and how, the tenet of intersectionality—central to both critical race theory and queer theory—played into study participants’ understanding of what culturally competent care for LGBTQ populations might involve. Queer intersectionality recognizes that “most queers face multiple aspects of discrimination, as women, as people of color, as poor people, as cross-gendered people, and as sexual subversives” (Rosenblum, 1994, p. 89). My belief going into this research was that using the lens of CRT *and* queer theory to critically assess how these two health centers understood, provided, and trained their employees on culturally competent care specific to the LGBTQ community had the potential to unearth new knowledge and promising practices. I still hold that belief.

It Is Not About Disparity, It Is About Inequity

Hoy-Ellis et al. (2022) stated, “Health disparities are a measure of where we are and where we need to go to achieve health equity” (p. 845). Much of the existing research and policy discourse in the United States surrounding discussions of healthcare workforce diversity, cultural competence, and how to improve health outcomes for historically oppressed populations uses a passive and hegemonic “disparity” framing which masks root cause issues of inequities based upon power and distribution of

resources (Lynch & Perera, 2017). The word disparity is synonymous with difference; however, the reasons why health outcomes for BIPOC and LGBTQ populations are not on par with their white, heterosexual, cisgendered counterparts is not about difference—it is about inequity. The National Institute on Minority Health and Health Disparities (NIMHD), in their own definition of health disparity, furthers the problematic difference narrative, stating “NIMHD defines a health disparity as a health *difference* [emphasis added], on the basis of one or more health outcomes, that adversely affect disadvantaged populations” (Alvidrez et al., 2019, p. S16). The negative health outcomes and discriminatory practices faced by BIPOC, LGBTQ, and other marginalized populations are not about difference, they are about inequity.

Perpetuating false yet dominant healthcare “disparity” narratives are problematic because they serve to maintain the status quo and remove the need for urgent action. Therefore, conducting research through a critical race theory and queer theory lens could provide a much-needed perspective on how to effect positive change. Using a critical theoretical approach aligns with Sharma et al.’s (2018) critique that healthcare cultural competency training is often missing key elements regarding oppression. Sharma et al. (2018) pointed to the ways “we can talk about poverty but not oppression, race but not racism, sex but not sexism, and homosexuality but not homophobia” (p. 27).

Summary

Chapter 2 identified and summarized the canon of literature relevant to this proposed inquiry. Health disparities literature was shared to further define the problem and need. From there several current areas of intervention attempting to address health inequities were described. The purpose of this review was to build a case for the study.

There appears to be a lack of literature specifically focused on how community health centers that specialize in serving the LGBTQ community understand and provide culturally competent care that meets the needs of the diverse spectrum of individuals that identify as sexual and gender minorities. As these health centers continue to expand because of increased federal investment and Medicaid expansion from the ACA, now is an ideal time to learn more. Research conducted through a critical theoretical paradigm may generate new knowledge and understanding that decenters existing dominant narratives. This new knowledge and understanding is needed to inform practice and policy.

CHAPTER THREE

METHODOLOGY

Research is formalized curiosity. It is poking and prying with a purpose.

—Zora Neale Hurston, *Dust Tracks on a Road*

Introduction

Given the lack of empirical evidence on how community health centers that specialize in serving the gay, lesbian, bisexual, transgender, queer/questioning (LGBTQ) community go about understanding the needs of the queer community and then translate those understandings into services and care, an exploratory comparative case study using qualitative data collection methods was completed at two health centers in California. In this chapter, the methodological aspects of the study are further explicated. This chapter includes details and a justification for the study's qualitative research design, a discussion of the collection methods and instruments that were used, and a detailed description of the two Federally Qualified Health Centers (FQHCs) and 41 study participants. Data analysis procedures are outlined and I elaborate on methods to ensure greater data validity, including researcher reflexivity protocols.

Research Methodology: An Exploratory Qualitative Approach

Research questions inform research design (Bhattacharya, 2017; Mertler, 2018; Roberts & Hyatt, 2019). The three research questions (RQs) that framed this investigation were:

RQ1: How do community health center staff, providers, and leaders go about understanding the healthcare needs of their LGBTQ patients/clients and the larger LGBTQ community?

RQ2: What are the specific ways in which community health centers go about providing care that is tailored to the needs of LGBTQ individuals? In what ways do these understandings align with practices and procedures that LGBTQ patients/clients report as affirming?

RQ3: What training/education opportunities are provided to health center staff and providers on how to meet the healthcare needs of LGBTQ individuals?

Qualitative Inquiry

Qualitative researchers are primarily interested in people's experiences and perspectives and how they make sense of their daily lives (Bogdan & Biklen, 2007). Qualitative research provides rich and thick detail about a topic or issue by focusing on "the *quality* of a particular activity rather than on how often it occurs" (Mertler, 2018, p. 77, emphasis in original). Unlike quantitative methods that often provide a "snapshot" of the topic, qualitative research collects nonnumerical data and places "greater emphasis on *holistic description*" (Mertler, 2018, p. 77). Because this investigation sought to center the perspectives and experiences of health center leaders, staff/providers at all levels, and health center patients/clients, it was appropriate to use a qualitative research approach because doing so allowed "individual voices, including the voices of those from marginalized groups, to be heard" (Thomas & Campbell, 2021, p. 361). According to Denzin and Lincoln (2017), qualitative research has its roots in the disciplines of anthropology, sociology, and philosophy. Qualitative research can be either exploratory or explanatory and there are many approaches used to conduct qualitative research (e.g., ethnography, narrative research, phenomenological research, case study).

Exploratory Research

Exploratory studies generate new knowledge and understanding helping to answer “how” research questions (Merriam, 2009). Exploratory research does not seek to offer definitive solutions, and findings from these studies are often used to help inform future research and inquiry. Although the exact origin of exploratory research is unknown (Swedberg, 2020), one of the first cited studies to specifically propose this type of research was Dollard (1937), whose study on race relations in the southern United States helped inform decades of future research and is still considered a foundational piece of literature regarding racial discrimination and racial justice (Adams & Gorton, 2004; Anderson et al., 2012; Ferris & Dollard, 2004). Dollard (1937) stated, “The task of an exploratory study is to pick out the crude outline of the object later to be more exactly defined” (p. 32). As of 2023, exploratory research designs are a common form of qualitative inquiry. The lack of understanding about how FQHCs that specialize in LGBTQ healthcare go about understanding and meeting the needs of the queer community strongly suggested the need for this inquiry to be exploratory rather than explanatory.

Comparative Case Study Design

Creswell (2007) stated, “Case study research is a qualitative approach in which the investigator explores a bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information” (p. 73). Yin (2009) added to this definition, stating, “A case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are

not clearly evident” (p. 18). Case study design has partial origins in the medical field’s case reports (Creswell & Creswell, 2018) and the term appears to be generally palatable in the healthcare sector. This familiarity within healthcare was one reason why I chose a case study design for this investigation.

Comparative case study research, also known as multiple or collective case studies, describes and compares two or more cases and often provides better insight into an issue or phenomenon than a single case study (Creswell, 2013; Stake, 2005). The cases that make up a comparative or multiple case study should be similar in some way to compare data findings effectively (Stake, 2005). Both of the cases, or organizations, involved in this study were similar in several ways. The sites were both FQHCs located in California and with similar organizational history/herstory that included organizational beginnings as AIDS Services Organizations (ASOs). By comparing different cases, researchers are able to explore how different contextual factors impact the phenomenon. Furthermore, comparative case study research design is often used in the development and refinement of theory (Miles et al., 2019). Given the lack of understanding surrounding the concept and provision of culturally competent care for queer individuals and communities, a comparative case study design was considered to be the most appropriate approach to provide answers to the study’s research questions.

Research Sites and Study Participants

Central Valley Community Care (CVCC) and Palm Tree Health (PTH)⁸ were the two FQHCs that agreed to participate as research sites, or cases, for this study. Both organizations specialize in providing healthcare to the queer community and were

⁸ Both Central Valley Community Care and Palm Tree Health are pseudonyms.

identified using purposive sampling techniques. Purposive sampling is a nonprobability sampling technique commonly used in qualitative research to select participants who are thought to be particularly relevant or useful to the study (Merriam & Tisdell, 2016). The main goal of purposive sampling is to select participants who can provide rich and detailed information about the topic of interest. The legacies and expertise that CVCC and PTH have in LGBTQ healthcare, combined with their convenient locations, made both organizations ideal study sites.

Central Valley Community Care

CVCC is a nonprofit FQHC located in a large city in northern California. The organization began in the late 1980s in direct response to the then-emerging AIDS epidemic in the region. As HIV became a manageable chronic disease in the late 1990s and early part of the new millennium, CVCC adapted its service model to focus more on whole-person care. According to CVCC documents, the board and leadership of CVCC made the decision to become an FQHC in 2014, thereby converting from being an ASO to a primary care clinic serving the health care needs of all within their service area. As of 2023, CVCC operates out of two clinic sites, serving more than 16,000 patients annually. According to data submitted to the U.S. Department of Health and Human Services, Health Resources and Services Administration (HHS/HRSA), approximately 65% of CVCC's patients identify as BIPOC, with many of these individuals identifying as Latino/Latina/Latinx (30%), followed by Black (25%) and Asian (10%). In 2020, almost 1 in 5 of their patients (19%) were best served in a language other than English (HRSA, n.d.-b) and this number has continued to increase due to emigration patterns and refugee resettlement programs in their community. CVCC has long specialized in serving the

LGBTQ community with approximately 18% of their patients identifying as LGBTQ in 2020.

Palm Tree Health

PTH is a nonprofit FQHC located in a resort community in southern California. The organization was founded in the mid-1980s to address the unique healthcare needs of the community's gay population. Shortly after its beginning, the mission of PTH morphed to exclusively focus on HIV and AIDS, and the organization grew to be a nationally recognized ASO. According to the PTH website, amid advancements in AIDS/HIV research and treatment, PTH made the decision in 2012 to transition to an FQHC, thereby expanding its mission to provide comprehensive primary care services to anyone within their service area regardless of ability to pay. As of 2023, PTH serves over 8,000 patients with a specialized focus on serving the healthcare needs of LGBTQ individuals. According to data submitted to the U.S. HHS/HRSA, approximately 29% of PTH's patients identify as BIPOC, with most of these individuals identifying as Latino/Latina/Latinx (22%), followed by Black (4%) and Asian (2%). In 2020, 4% of their patients were best served in a language other than English (HRSA, n.d.-b). Approximately 62% of PTH's patients identified as LGBTQ in 2020. Although PTH collects gender identity data on patients, exact figures were unavailable from the site. In conversation with the organization's chief executive officer (CEO), it was estimated that approximately 80 patients identify as transgender or gender nonbinary. Figure 2 provides additional organizational and patient information for both CVCC and PTH.

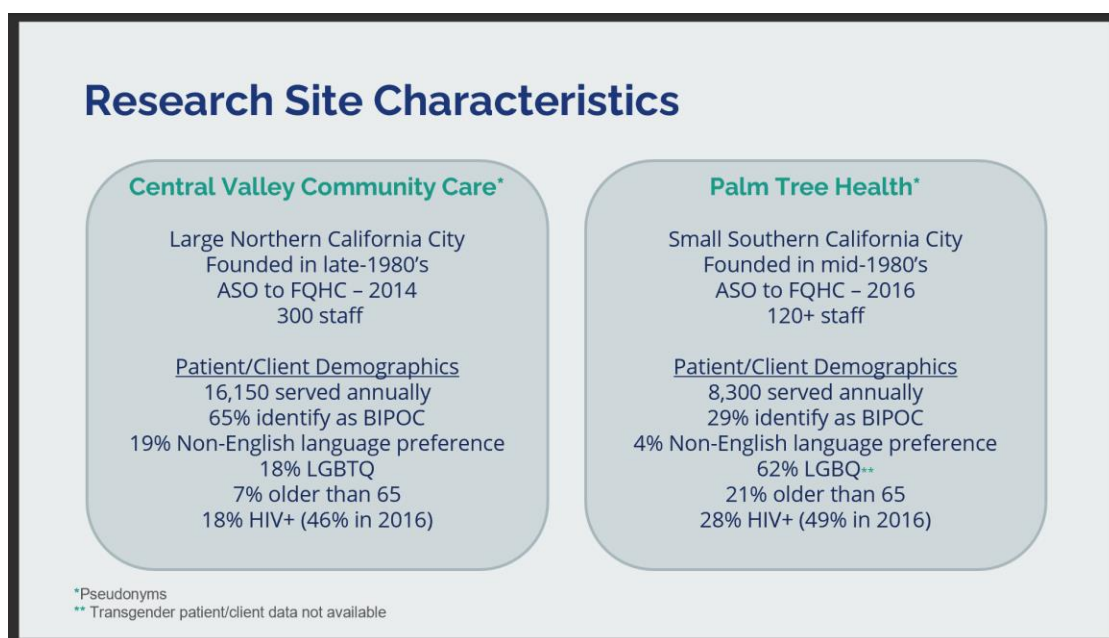


Figure 2. *Study Site Organizational and Patient Characteristics*

Individual Participant Selection

There were three categories of participants at each of the two study sites. These individual participants included: (a) health center senior leadership (e.g., C-suite, board of directors), (b) health center staff/providers at all levels (except C-suite/senior), and (c) health center patients/clients⁹. The following inclusion and exclusion criteria were identified to solicit appropriate study participants:

- participants had to be 18 years of age or older;
- participants had to be willing to participate in either a one-on-one interview (for key informant interviews with health center leaders) or focus group (for health center staff/providers and patients/clients); and

⁹ Many health care entities, including FQHCs, use different words to describe the people they serve. Given that “patient” and “client” are the two most commonly used within the community health center space, both are used with the forward slash “/” throughout this manuscript as a way to acknowledge and pay respect to differences in the terminology used.

- patient/client participants needed to be current patients/clients of the health center (defined as having received some type of service within the last 12-month period).

Because of the study's focus on LGBTQ healthcare, it was recommended that participants have knowledge of the healthcare services provided to the queer community (e.g., be a patient/client who identifies as LGBTQ or a staff/provider who provides services to LGBTQ patients). Racial, cultural, and other forms of diversity were also encouraged.

Study participants, based on aforementioned categories, were recruited using purposive sampling techniques. The CEOs at both study sites designated a staff member to serve as a staff liaison¹⁰ for this study. I worked with these two designated organizational representatives to determine the best ways to recruit individual participants at their FQHCs. These efforts included targeted emails and announcements at organizational meetings (e.g., senior leadership meetings, departmental staff meetings, board meetings, and patient advisory group meetings). Because of concerns about patient privacy, I did not conduct any initial recruitment outreach to potential patient/client participants. That recruitment was facilitated through the organizational staff liaisons.

Following Institutional Review Board (IRB) guidelines, all potential participants received information about the study's purpose, were informed of any possible risks of participating in the study, and were provided my contact information in case they had any questions (see Appendix A). Potential participants were also made aware that participating in the study was voluntary, and they could withdraw from the study at any

¹⁰ The organizational representatives that I have coordinated with at CVCC and PTH are referenced as "staff liaisons" throughout the rest of the dissertation.

time. Potential participants were screened via a short online participant eligibility survey (see Appendix B) which was designed to ensure participants met the eligibility requirements previously mentioned. In addition to confirming eligibility, additional questions asked for demographic information relevant to the study topic, such as sexual orientation and gender identity (SOGI), race, or disability status. Responding to these questions was optional. Participants were provided with a consent form (see Appendix C) either via email or in-person to review. The approved IRB guidelines for this study allowed for consent to be obtained either verbally or via written or electronic signature. The informed consent included permission to audio record. Participants were also reminded of informed consent at the beginning of each data collection session.

Participant Demographics

Table 1 illustrates the demographic information for 36¹¹ of the 41 participants in this study. Regarding age distribution, 28% ($n = 10$) of the respondents were between the ages of 35–44, 25% ($n = 9$) between the ages of 45–54, 19% ($n = 7$) between the ages of 55–64, 14% ($n = 5$) between the ages of 65–74, 11% ($n = 4$) between the ages of 25–34, and 3% ($n = 1$) between the ages of 75–84. Thirty-one percent ($n = 11$) of the respondents said they had a disability, and an additional 8% ($n = 3$) preferred not to state. When asked to identify what gender(s) with which they identified, 19 respondents (48%) identified as male, 14 (35%) identified as female, four ($n = 4$, 10%) identified as genderqueer/gender nonconforming/gender nonbinary, and two ($n = 2$, 5%) identified as transgender¹². Of the participants that completed the online eligibility and demographics survey, 50% ($n = 18$) were staff/providers, 28% ($n = 10$) were patients/clients, and 22% ($n = 8$) were leaders

¹¹ The participant eligibility/demographic survey was encouraged but optional.

¹² Participants were given to choose more than one option for the racial category and gender questions.

who participated in key informant interviews. In total, there were 21 staff/provider participants, 10 patient/client participants, and 10 health center leadership participants. Racially, the majority of study participants identified as white (60%, $n = 23$), followed by Hispanic/Latino/Latina/Latinx ($n = 8$, 21%), Black or African American ($n = 4$, 11%), Native American/American Indigenous or Alaska Native ($n = 2$, 5%), and Asian ($n = 1$, 3%). Regarding current sexual orientation, 42% ($n = 15$) identified as lesbian, gay, or homosexual; 33% ($n = 12$) identified as straight or heterosexual; 17% ($n = 6$) identified as queer, pansexual, and/or questioning; and 6% ($n = 2$) identified as bisexual. One participant (3%) preferred not to state their current sexual orientation.

Table 1 further breaks down participant demographic information by study site for comparison. PTH had more participants who were staff/provider participants than did CVCC. Also, PTH had a significantly higher percentage of participants who identified as lesbian, gay, or homosexual than did CVCC (63% versus 18%). In regard to gender identity, there were no participants from PTH who identified as genderqueer/gender nonconforming/gender nonbinary or transgender, whereas CVCC had four respondents who identified as genderqueer/gender nonconforming/gender nonbinary and two participants who identified as transgender.

Table 1

Participant Demographics Based on Eligibility Survey Responses

| Participant characteristic | Total | | Central Valley Community Care | | Palm Tree Health | |
|----------------------------|----------|----|-------------------------------------|----|---------------------|----|
| | <i>n</i> | % | <i>n</i> | % | <i>n</i> | % |
| Age range | | | | | | |
| 24–34 | 4 | 11 | 1 | 17 | 3 | 16 |
| 35–44 | 10 | 28 | 6 | 35 | 4 | 21 |

| Participant characteristic | Total | | Central Valley Community Care | | Palm Tree Health | |
|---|----------|----|-------------------------------------|----|---------------------|----|
| | <i>n</i> | % | <i>n</i> | % | <i>n</i> | % |
| 45–54 | 9 | 25 | 5 | 29 | 4 | 21 |
| 55–64 | 7 | 19 | 3 | 18 | 4 | 21 |
| 65–74 | 5 | 14 | 2 | 12 | 3 | 16 |
| 75–84 | 1 | 3 | 0 | 0 | 1 | 5 |
| Disability | | | | | | |
| Yes | 11 | 31 | 8 | 47 | 3 | 16 |
| No | 22 | 61 | 8 | 47 | 14 | 74 |
| Prefer not to state | 3 | 8 | 1 | 6 | 2 | 11 |
| Gender ^a | | | | | | |
| Female | 14 | 35 | 6 | 32 | 8 | 42 |
| Genderqueer/gender nonconforming/ gender nonbinary | 4 | 10 | 4 | 24 | 0 | 0 |
| Male | 19 | 48 | 8 | 42 | 11 | 58 |
| Transgender | 2 | 5 | 2 | 10 | 0 | 0 |
| Health center role | | | | | | |
| Key informant/leader | 8 | 22 | 4 | 24 | 4 | 21 |
| Patient/client | 10 | 28 | 6 | 35 | 4 | 21 |
| Staff/provider | 18 | 50 | 7 | 41 | 11 | 58 |
| Race ^b | | | | | | |
| Asian | 1 | 3 | 1 | 5 | 0 | 0 |
| Black or African American | 4 | 11 | 2 | 11 | 2 | 11 |
| Hispanic/Latino/ Latina/Latinx | 8 | 21 | 3 | 16 | 5 | 26 |
| Native American/ American Indigenous, or Alaska Native | 2 | 5 | 2 | 11 | 0 | 0 |
| White/Caucasian | 23 | 60 | 11 | 58 | 12 | 63 |
| Sexual orientation | | | | | | |
| Bisexual | 2 | 6 | 2 | 17 | 0 | 0 |
| Lesbian, gay, or homosexual | 15 | 42 | 3 | 18 | 12 | 63 |
| Straight or heterosexual | 12 | 33 | 6 | 35 | 6 | 32 |
| Queer, pansexual, and/or questioning | 6 | 17 | 5 | 29 | 1 | 5 |
| Prefer not to answer | 1 | 3 | 1 | 6 | 0 | 0 |

Note. *N* = 36 (*n* = 36 of 41 participants that completed the survey). Percentages may not equal 100% because of rounding.

^a Participants were able to choose more than one racial category. ^b Participants were able to choose more than one gender.

Data Collection Methods

Data were collected via key informant interviews, focus groups, and document analysis, with each tactic seeking to elicit the ways in which the two FQHCs went about understanding the needs of their LGBTQ patients and community and then translated those understandings into providing culturally competent care (see Table 2). I used these various methods with the identified participant categories to provide a more holistic understanding of the phenomena being investigated (Creswell & Creswell, 2018). All data collection sessions were conducted in English, although participants were asked if they preferred the interview or focus group to be conducted in another language as part of the prescreening eligibility survey. Based on the patient demographics and threshold languages at each of the two participating FQHCs, the prescreening eligibility survey was made available in English and Spanish. The staff liaisons at each site informed potential participants that documents and translation services could be provided in other languages beyond English and Spanish, if needed. No translation was requested. Data collection began in October 2022 and was completed in early February 2023. Each data session was audio recorded for the purposes of data analysis.

Table 2*Description of Dissertation Study Data and Sources*

| Data source | Scope/reach of data source |
|-----------------------------|--|
| Key informant interviews | Semistructured one-on-one interviews with key organizational leaders (e.g., C-suite, board members); each interview approximately 60-minutes in length |
| Staff/provider focus groups | Semistructured focus groups for health center staff/providers; separated by site; each focus group approximately 60-minutes in length |
| Patient/client focus groups | Semistructured focus groups for health center patients/clients; separated by site; each focus group approximately 60-minutes in length |
| Organizational website | Review of organizational websites to confirm/triangulate data themes and findings |

Key Informant Interviews

In total, 10 key informant interviews were completed for this study, six at CVCC and four at PTH. These one-on-one interviews occurred with health center senior leadership (e.g., CEO, chief medical officer, board chair). Given these individuals are ultimately responsible for the strategic direction and services provided by the health center, their perspectives regarding the study topic were important to beginning to answer the stated research questions. Key informant leadership participants included a range of senior-level positions at each health center (e.g., CEO, chief medical officer, head of personnel, director of operations). One board member also participated as a key informant. Eight of the 10 key informant leader participants provided demographic information¹³. Of those, four identified as straight/heterosexual, and four identified as lesbian, gay, or homosexual. Five of these key informant leaders identified as male, and

¹³ Completion of demographic characteristics in the participant eligibility survey was optional.

four identified as female. The majority were white, two were Black, and one was Asian. Only one reported having a disability.

One-on-one interviews are common in qualitative social science research (DiCicco-Bloom & Crabtree, 2006; Jamshed, 2014). DiCicco-Bloom and Crabtree (2006) contended that qualitative interviews “contribute to a body of knowledge that is conceptual and theoretical and is based on the meanings that life experiences hold for the interviewees” (p. 314). Interview research allows for retrospective sensemaking premised on the experiences, perspectives, and “been there” (Lindlof & Taylor, 2002, p. 173) knowledge of those being interviewed. Key informant interviews use this one-on-one approach to engage with individuals who have specialized knowledge, history, status, or power (Lokot, 2021; Patton, 2002). As Lokot (2021) noted, “Engaging with key informants is particularly important for gaining ‘insider’ knowledge” (p. 3) and this method, combined with other data collection methods that also seek “ordinary” voices, prove invaluable in further understanding a particular phenomenon. These key informants were selected because of their expertise, position, or involvement in the research topic, and because they could provide valuable information that may not be accessible through other sources (Creswell, 2014).

Additionally, Solarino and Aguinis (2020) contended a semistructured interview format is the most ideal interview method to use when conducting one-time interviews with busy organizational leaders because it allows for opportunities to cover relevant topics without overly restricting the conversation. Given the iterative nature of qualitative and grounded theory research, information gleaned from the key informant interviews

helped to further inform focus group questions for both the staff/provider focus groups and the patient/client focus groups.

A semistructured interview protocol was used to guide the interview conversation (see Appendix D). Semistructured interviews generally have a loose interview protocol, or set of questions, that allow the researcher to probe further with additional questions that emerge from the dialogue. In other words, semistructured interviews allow the researcher to prepare some topical questions in advance while also remaining flexible to ask additional follow-up questions as needed based on where the conversation heads (Creswell & Creswell, 2018; Merriam & Tisdell, 2016). Furthermore, the semistructured interview format is the most used interview format for qualitative research and they are frequently used in medical and health professions education research (Jamshed, 2014; McGrath et al., 2019).

Following this semistructured design, the interview protocol began with questions designed to help the interviewees feel more comfortable and build rapport between the interviewees and me as the researcher (DiCicco-Bloom & Crabtree, 2006). For example, I would ask the participant to share how long they have worked at the health center and what brought them to this line of work. From there, interview questions became more specific and targeted to gather data relevant to the research questions for this inquiry, such as how FQHCs understand the needs of the LGBTQ community, how they operationalize this understanding, and the role that workforce training/education plays. Examples included questions such as:

- Can you share with me some specific examples of how your community health center provides care tailored to the needs of the LGBTQ community?

- Given that LGBTQ folx are not a monolith, I am curious to hear about some of the ways in which your health center thinks about and approaches other intersectional identities that may further marginalize the LGBTQ community you are trying to serve.

Charmaz (2014) and Jacob and Furgerson (2012) posited building from general to specific is a wise practice when developing semistructured interview protocols.

Generally, the interview questions were open-ended to allow participants the opportunity to share as much as they felt comfortable.

Each interview lasted between 45 minutes to 1 hour and were conducted in a single session. Although interviewees were offered for the interview to be conducted either in-person or virtually, all interviewees opted for a virtual interview. As previously mentioned, interviews were audio-recorded. Additionally, I took notes throughout each interview. These hand-written notes included jotting down keywords or statements made by the interviewee, along with noting my own in-the-moment observations or reflections.

Focus Groups

In addition to one-on-one interviews, a total of six focus groups were conducted as part of this investigation. At CVCC, there were three focus groups, two for staff/providers and one for patients/clients. At PTH, there were also three focus groups, two for staff/providers and one for patients/clients. Focus groups serve as small group interviews and can provide in-depth understanding of a particular phenomenon by bringing together groups of people to share their insights (Krueger & Casey, 2014) as well as individual meanings and interpretations (Liamputtong, 2011). Thomas and Campbell (2021) posited focus groups are structured conversations and the method's

“major strength is that people can build on the ideas of others in the group” (p. 355).

Unlike one-on-one interviews, where the researcher acts as an investigator by asking questions of the interviewee, focus groups require the researcher to act as a facilitator, thereby moderating group discussion among research participants (Smithson, 2000).

Although focus groups became popularized in market research conducted in the 1950s, focus group methodology has a long history in social science research dating back to at least the 1920s (Liamputtong, 2011).

Calderón et al. (2000) posited focus groups can work particularly well when conducting research with minority and other vulnerable populations because the design focuses on collectivity and in-group membership and does not seek to achieve group consensus. Madriz (2003) furthered this assertion by postulating that focus group methodology can help reduce power imbalances between researcher and participants. Liamputtong (2011) also believed focus groups can be a useful approach when seeking feedback from historically marginalized populations, stating:

Focus groups put control of the interaction into the hands of the participants rather than the researcher. The interaction between participants themselves substitutes for their exchange with the researcher, and this gives more prominence to the points of view of the respondents. . . . In this way, the focus group method allows researchers to pay attention to the needs of those who have little or no societal voice. (p. 4)

Focus groups are commonly used in health-related research (Kitzinger, 1993, 1994; Wilkinson, 1998a) and allow researchers to explore “the gap between what people say and what they do” (Conradson, 2005, p. 131) while also empowering marginalized

communities via collective voice (Liamputtong, 2011). This method seemed appropriate to use to gather data from health center employees and patients/clients because of the context and research questions pertaining to the present inquiry.

Semistructured focus group protocols were developed to help guide the focus group conversation (see Appendices E and F). Most of the questions were open-ended to allow participants opportunities to share. At the beginning of each focus group, I followed a brief script to remind participants of the study's purpose and how the information collected would be used and protected. This script also included norms designed to help the focus group run smoothly and ensure that everyone was able to share. These norms were adapted from guidelines created by the Agency for Healthcare Research and Quality (2018) and included tactics such as making sure to talk in a loud conversational tone to a reminder that all points of view are welcomed. This script and the guidelines are also included in Appendices E and F. As with the key informant interviews, all focus groups were audio-recorded.

Staff and Provider Focus Groups

Because health center staff/providers are the ones providing and supporting the delivery of care to patients, understanding how they go about understanding and attempting to address the healthcare needs of the queer community in their day-to-day routines was important. Four staff/provider focus groups were conducted as part of this investigation, two at each location. Using purposive sampling techniques to recruit staff, a total of 21 individuals participated in the staff/provider focus groups (12 at PTH, nine at CVCC). Eighteen of the 21 staff/provider participants provided demographic information. Among those, seven identified as lesbian, gay, or homosexual; seven

identified as straight or heterosexual; three identified as queer, pansexual, and/or questioning; and one identified as bisexual. There were 12 women, six men, and one transgender individual. The majority were white, followed by seven Hispanic/Latino/Latina/Latinx, and one person who racially identified as Black or African American. Three participants reported having a disability, and an additional two preferred not to answer that question.

Staff/provider participants were asked to participate in a 1-hour long focus group. Each focus group was purposefully small, ranging from three to seven participants. Robinson (2020) suggested keeping focus groups to no more than six participants, especially if the focus group topic is sensitive or of particular importance. The staff/provider focus groups were designed to collect data from a cross-section of health center employees, including frontline workers (e.g., receptionists), clinicians (e.g., nurses and doctors), and nonclinical staff (e.g., case managers and human resources staff). I worked with the study staff liaisons at CVCC and PTH to help determine dates, times, and format (i.e., virtual or in-person) for the staff/provider focus groups.

A semistructured focus group protocol was developed and used for the staff/provider focus groups (see Appendix E). Similar to the semistructured protocol for the key informant interviews, questions flowed from more general questions, such as (a) *Tell me about your position and the reason why you work here at [name of health center]* to more targeted questions related to the study topic like (b) *Tell me about training and educational opportunities your health center provides employees to learn and improve the way you serve the LGBTQ community*. All staff/provider focus groups occurred during the organization's workday.

CVCC Staff/Provider Focus Groups

At CVCC, one of the staff focus groups was held virtually via Zoom and the other was held in person at the health center's main clinic. Staff at CVCC were given the choice to participate in either the virtual or in-person focus group. I discussed the power dynamics that often exist within the healthcare workforce (e.g., hierarchical dynamics with doctors at the top) with the staff liaison from CVCC and offered that we could work to arrange the focus groups so that those power dynamics might be minimized. For example, I suggested one of the focus groups could be for higher classification clinicians such as doctors, nurse practitioners, and psychiatrists, whereas the other focus group could include lower-classification participants such as case managers or nurses. The staff liaison felt this further separation was not necessary and the organization had worked to create a culture of open dialogue and psychological safety. Additionally, the participants wanted to provide employees with a couple of date options to maximize participation. I followed their recommendation. The in-person focus group was conducted over the lunchtime period. During that time each day, the clinic stops seeing patients. Food was provided for the in-person focus group. The virtual focus group had three participants, and the in-person focus group had six participants.

PTH Staff and Provider Focus Groups

Both of the staff/provider focus groups at PTH were conducted virtually via Zoom. In conversations with the staff liaison and chief of clinical operations, it was decided to have one focus group for clinical staff (e.g., nurses, medical assistants, medical social workers) and one focus group for nonclinical staff such as case managers, outreach workers, and human resources staff. The first of these focus groups was for

clinical staff and had seven participants. The second focus group consisted of five staff participants. These individuals represented several different roles and functions including human resources, case management, and outreach workers.

Patient and Client Focus Groups

Given each of the FQHCs involved in this study seek to meet the needs of their unique patient population, including those of whom identify as LGBTQ, gaining perspectives and insights from patients/clients at both research sites was important for this investigation. Because FQHCs exist to meet the healthcare needs of their community, insights about care practices, outreach, and viewpoints on how the health center was, or was not, meeting the healthcare needs of the queer community provided a more comprehensive understanding of the research topic. Two patient/client focus groups were conducted, one at each location. Ten health center patients/clients participated in these focus groups (four at PTH; six at CVCC) and were recruited using purposive sampling techniques. All 10 of the patient/client participants provided demographic information. Regarding sexual orientation, four identified as lesbian, gay, or homosexual; three identified as queer, pansexual, and/or questioning; and then one each for bisexual, straight or heterosexual, and prefer not to state.

Among the patient/client participants, the majority identified as male ($n = 8$); two identified as genderqueer, gender nonconforming or gender nonbinary; two identified as transgender; and only one patient/client identified as female. Regarding racial characterization, eight identified as white, followed by two Native American, American Indigenous, or Alaska Native; one patient/client who identified as Black or African

American; and one participant who identified as Hispanic/Latino/Latina/Latinx. Six participants shared they had a disability and one preferred not to answer that question.

Due to concerns regarding patient privacy, the staff liaisons at both study sites outreached to potential patients/clients using purposive sampling techniques. At CVCC, the staff liaison identified existing patient support groups and social groups pertaining to the LGBTQ community and sent targeted emails to those groups regarding possible participation. At PTH, the staff liaison sent targeted emails to patients/clients who participated in wellness programs for LGBTQ patients that the health center offered. At both locations, once patients/clients responded that they were interested in participating, the staff liaison confirmed it was okay for their name and email to be shared with me. Once that permission was given, the staff liaison forwarded their contact information to me to follow up with more information about the study. Dates, times, and format (i.e., virtual or in-person) for the patient/client focus groups were determined in collaboration with the staff liaisons. These discussions centered on ways to minimize the barriers that might keep a patient/client who was otherwise interested in participating from being able to participate.

A semistructured focus group protocol was developed and used for the patient/client focus groups (see Appendix F). The approach and questions were similar in nature to the protocol developed and used in the staff/provider focus groups; however, the questions were tailored to capture patient/client perspectives. Question examples included:

- On a scale from 1 to 10 with 1 being “not at all” and 10 being “couldn’t be better,” how good of a job does [name of health center] do in meeting the

unique healthcare needs of the LGBTQ community in your area? Briefly explain why you chose that number.

- When seeking a healthcare provider, what do you look for? In other words, what do you need or want from them that would help you feel safe, respected, and cared for?

CVCC Patient and Client Focus Group

The one patient/client focus group that was conducted at CVCC was held in person at the health center's main clinic location. As the staff liaison at CVCC reached out to recruit, they surveyed potential participants regarding whether or not to conduct the focus group online or via Zoom. It was determined an in-person focus group was preferred by most. The focus group was held in the early afternoon and food was provided. There were six patients/clients who participated in the focus group at CVCC.

PTH Patient and Client Focus Group

The one patient/client focus group conducted at PTH was held virtually via Zoom. The staff liaison suggested this format because PTH already offers several of their wellness and social support activities for patients/clients online and they have found many prefer the online options over traveling to the clinic location for in-person events. The focus group was held in the evening. Four patients/clients participated in the focus group from PTH.

Document Analysis

Lastly, portions of each organization's website were reviewed using document analysis to triangulate the data obtained from focus groups and interviews. Although document analysis is a data collection method in and of itself, this analysis strategy is

often used to corroborate findings from other data collection procedures (Creswell & Creswell, 2018; Spickard, 2017). Qualitative document analysis has emerged within the past 2 decades and is now a widely used qualitative data collection method across many disciplines (Bowen, 2009; Kuckartz, 2014). Bowen (2009) suggested analyzing preexisting documents relevant to a study population or research question can be advantageous because these documents are “unaffected by the research process” (p. 31). Many organizations’ documents, including websites, are considered to be cultural representations that illustrate their values, attitudes, beliefs, and perspectives (Saldaña, 2021).

Glaser and Strauss (1967) contended that reviewing existing documents is useful in theory development for grounded theory studies. According to O’Leary (2014), there are three primary types of documents that can be analyzed: (a) public records, which include official organizational documents such as mission and vision statements, annual reports, strategic plans, and organizational websites; (b) personal documents, including items such as emails, social media posts, and duty logs; and (c) physical evidence (also known as artifacts), such as photocopied flyers, posters, and printed training curriculum. Even though websites are a collection of multimedia content and are not considered by most to be a document per se, within O’Leary’s (2014) topography, organizational websites are most commonly considered public and official organizational documents.

This review included searching the organizational webpages for both CVCC and PTH looking for information related to data themes and findings from the interview and focus group analyses. Bowen (2009) posited coding this type of preexisting data follows

a similar process to that of reviewing and coding other data, such as interview and focus group transcripts.

Data Collection Instruments

The various data collection instruments that were used in this study, including the semistructured key informant interview protocol (see Appendix D), the semistructured staff/provider focus group protocol (see Appendix E), and the semistructured patient/client focus group protocol (see Appendix F), have been previously described.

Testing Data Collection Instruments

Each of these instruments were reviewed and pilot tested before official data collection began. Pilot testing data collection instruments is considered a qualitative research best practice (Mertler, 2018; Thomas & Campbell, 2021). Using instruments that are clear and help to build a connection between researcher and participant tends to improve the quality of the data (Thomas & Campbell, 2021). McGrath et al. (2019) purported that pilot testing study instruments is vital for novice researchers, as the practice helps ensure that framing and questions are clear, and that instruments are structured in a way to build rapport and open dialogue between researcher and study participants. This process involved four distinct phases. First, my two dissertation committee members reviewed the protocols and then we met to discuss and make revisions. Both of my committee members have extensive qualitative research experience.

Next, I shared the revised semistructured protocols via email with a colleague and with my husband, asking them to review and provide feedback. The colleague works in an FQHC and has over a decade of experience in the healthcare field. My husband, on the

other hand, has limited knowledge of FQHCs or the healthcare sector. I felt both an expert and unprofessional perspective could help fine-tune and clarify the questions I was considering asking during data collection. After making slight revisions based on their feedback, I then selected several questions across all three semistructured protocols and held a “mini” focus group with two fellow PhD students. In the post discussion, my peers felt the questions were clear and related well to the study’s focus. Lastly, I shared the draft instruments with the CEOs and staff liaisons at CVCC and PTH and asked them to review prior to commencing data collection. The staff liaisons thought the sample questions on each of the protocols were clear and relevant. The CEO at one of the health centers confirmed they also believed the questions were clear and relevant for the different study participant groups. This person also asked me to consider adding a question about the concept of belonging, as the organization had recently been using that language as part of their organizational diversity, equity, and inclusion (DEI) efforts.

Data Analysis Procedures

The collected data were analyzed using principles of grounded theory. Grounded theory analysis is a systematic approach used to analyze and generate theories from empirical data, primarily in the social sciences (Bachman & Kyngäs, 1999; Creswell & Creswell, 2018; Glaser & Strauss, 1967). The key objective of grounded theory is to build theory inductively from the data collected, rather than starting with a preconceived hypothesis or existing theoretical framework. Strauss (1987) recommended pairing case study design with grounded theory when seeking to develop theory regarding phenomena that are not well understood. Likewise, Stake (2005) postulated, “A case study is both a process of inquiry about the case *and* the product of that inquiry” (p. 8, emphasis added).

Grounded theory analysis ensures the product of this inquiry is grounded in the perspectives and experiences of the participants.

Grounded theory draws upon inductive reasoning where the collected data are used to create patterns, themes, and theory. According to Glaser and Strauss (1967), constant comparative analysis is what separates grounded theory from other qualitative analytical approaches, such as discourse analysis and phenomenology. Constant comparative analysis, as the name suggests, is an iterative and ongoing process where collected data are compared against each other, and where emerging themes and codes are also evaluated and reevaluated against new data that are collected. Typically, with grounded theory, researchers do not wait until all data are collected to begin analysis (Strauss & Corbin, 1990). Instead, data are generally analyzed as they are collected and this early analysis can help guide further data collection. This technique allows for flexibility in working with the study data and its iterative cyclical design helps to ensure data saturation, or the point at which no new coding categories or themes emerge (Denzin & Lincoln, 2017). Given the exploratory nature of this study's research questions, using this approach allowed for the discovery of new insights and hidden meanings (Charmaz et al., 2018).

Coding Process

Following the completion of a data collection session (i.e., interview or focus group), Zoom would alert me when the recording was ready for me to access (usually within 1–2 hours after the session was complete). The recorded files were downloaded and saved in a password-protected Google document folder. The recording file was then uploaded to Otter.ai to assist with data cleanup and creating transcripts. Otter.ai is an

artificial intelligence enabled transcription service that converts speech to text. The software also assists speaker identification and has an easy-to-use interface that automatically syncs the audio file with the produced transcript. This functionality allowed for easy review and transcript cleanup.

Once that process was complete, I then downloaded the transcript into a Microsoft Word document to use in the coding process. According to Saldaña (2021), “A code in qualitative analysis is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data” (p. 5). Data transcripts from the interviews and focus groups were read twice prior to beginning the coding process, which allowed me an opportunity to refamiliarize myself with the data. Following the grounded theory tradition, inductive open coding was the first stage of analysis that was used. Strauss and Corbin (1990) called this stage *open coding* because “to uncover, name, and develop concepts, we must open up the text and expose the thoughts, ideas, and meanings contained therein” (p. 102).

As I reviewed each data transcript, both descriptive and in vivo codes were applied. Descriptive coding, also known as “topic coding,” uses a word or short phrase to tag salient pieces of data (Saldaña, 2021). In vivo coding uses a word or short phrase taken directly from the participant. I primarily read and coded short transcript statements to pull out distinct ideas from each participant. In instances where individual responses were longer than a few sentences or when several distinct ideas were presented within the same brief participant statement, I coded line-by-line to capture varying ideas. The coding process was completed manually using the generated Microsoft Word transcript.

To code data, I used the comments feature in Word to select and highlight the data to be coded and then wrote in the comment the relevant code(s) for each piece of data. As each new data source was analyzed, additional codes were added as needed.

Codes were clustered under categories, and these categories were compared across key informant interview transcripts, staff/provider focus group transcripts, and patient/client focus group transcripts for both cases using a constant comparative process. This iterative process involved comparing data against data, along with data against codes and emergent categories (Charmaz, 2014; Saldaña, 2021). This process occurred both within each individual case, as well as across both cases. Through constant comparison, in addition to analytic and reflexive memoing, I parsed out similarities, differences, and general patterns across the data (Bowen, 2009). What resulted was 14 data themes. These themes and the study's findings are reported in Chapter 4.

Data Reliability and Validity

All qualitative research requires a process to be undertaken to ensure the trustworthiness of the data and the rigor of the analysis and interpretations (Creswell, 2013; Merriam & Tisdell, 2016). I, like others (Denzin & Lincoln, 2017; Kuntz, 2015; Rowe, 2014, Savin-Baden & Major, 2013), believe researchers and research are never completely objective; however, it is important that researchers contend with their own positionality and use validation strategies so that findings can be as close to accurate and reliable as possible. In this study, data triangulation, researcher reflexivity practices, and peer review were all used to further validate the data themes and resulting findings.

Data Triangulation

Data triangulation refers to the practice of comparing several sources of data against one another to enhance data credibility (Bowen, 2009). According to Yin (2018), “Comparative case study designs enable the researcher to triangulate data from multiple sources and ensure that the results are not idiosyncratic to any one case” (p. 53). For this study, four processes were conducted to triangulate data themes and findings. First, key informant interview data, provider/staff focus group data, and patient/client focus group data were compared against each other. Given each of these participant groups offered differing roles and perspectives from which to explore the phenomenon of interest in this study, analyzing the data in this way seemed crucial to ensuring the themes and resulting findings were consistent across groups.

Moreover, the comparative case study design allowed for data collected from PTH to be compared against the data collected from CVCC. Creswell (2013) and Stake (2005) contended comparative case studies often provide deeper insight into the phenomena of interest than does a single-case study design. Additionally, content from both organizations’ websites was reviewed to triangulate the themes identified across the three primary data collection methods. Finally, the constant comparative method used in this study’s analysis helped further ensure the findings were robust and not limited to a single data source, thereby supporting claims made by seminal grounded theorists about the constant comparative method being a useful tool for triangulating data (Charmaz, 2014; Glaser & Strauss, 1967; Strauss & Corbin, 1998). I hold each of these four processes helped to improve the accuracy and reliability of the findings.

Researcher Reflexivity

Researcher reflexivity is the process of intentionally and consistently reflecting on how the researcher's personal biases, and assumptions, as well as epistemological, ontological, and axiological stances, may influence the research process and the interpretation of research findings (Wilkinson, 1998b). Reflexivity involves acknowledging the subjective nature of research and taking steps to minimize how this subjectivity impacts the research process. Researcher reflexivity activities continued throughout each element of the dissertation. This process began with creating a positionality statement where I "positioned" myself in the context of this study. Throughout the 3+ years that I have worked on this dissertation, I regularly revisited and reread versions of the positionality statement, making revisions to capture new insights about "self as researcher" (Denzin & Lincoln, 2017; Savin-Baden & Major, 2013) as I have progressed through this program and investigation.

Notetaking and Memoing

Note taking occurred during and immediately following each data collection session, combined with analytical and reflexive memoing to provide needed space to reflect on the data collected; to consider the personal stories and experiences shared by many of the study participants; and to process how I was thinking about the data, that data's connection to the research topic and specific research questions, and the data's connection on my own beliefs and values. During the course of the study, I amassed approximately 103 pages of handwritten notes collected across three bound journals. Many of these notes became part of analytic and reflexive memos.

According to Pidgeon and Henwood (1995), “Memos are unconstrained musings on what is happening. Unlike categories, they are not limited to thinking about one thing or another, but are textual representations of the questions researchers begin to ask themselves as they analyze the data” (p. 3). Memoing helps researchers keep track of their thought processes and to clarify their thinking about the data (Saldaña, 2021). This process can help the researcher to identify patterns, themes, and relationships in the data, and make connections between different pieces of data.

As someone who finds academic writing difficult, I found memoing to be quite freeing because I was able to write without worrying about constraints or rules, or creating a polished convincing piece of writing that would be critiqued by others. Memoing also allowed me to reflect on the internal dialogue I had during data collection. During data analysis, memoing became a way to explore and question connections between codes and categories. Perhaps more importantly, reflexive memoing pushed me to question my experiences and how those experiences might be impacting the assumptions and interpretations I was making (Creswell & Creswell, 2018). My belief is the notetaking and memoing done as part of this study helped me to get closer to the concept of *parrhesia*, or the truth-telling status for which Foucault (2011) advocated.

Peer Review

Peer review, also known as peer debriefing, was another strategy used to improve the reliability of the study findings (Merriam & Tisdell, 2016). According to Creswell and Creswell (2018), peer review “involves locating a person (a peer debriefer) who reviews and asks questions about the qualitative study so that the account will resonate with people other than the researcher” (p. 201). As part of the coursework for this

doctoral program, students were assigned to small groups, called critical friends forums, in the 2nd year of the 4-year program. These groups were designed to be used as advisors and peer reviewers as we moved through the coursework and dissertation processes. The two other members of my critical friends forum group—cleverly named Get Sh*t Done—were “encouraged to function as rigorous examiners and auditors of my analyses” (Saldaña, 2021, p. 53). We met approximately twice per month via Zoom and during those sessions, shared parts of transcripts and assigned codes for review and discussion. Additionally, I would occasionally share portions of the data analysis with them electronically for review, advice, and critique. These two peer reviewers also used similar qualitative research methods for their dissertations and, as such, provided several opportunities to discuss different analysis strategies and learn from one another.

Data Ethics, Storage, and Security

This study was approved by the University of San Diego’s IRB. As part of the IRB process, all study participants received a study consent form (see Appendix C) prior to participation. This form was shared with potential study participants either via a physical copy or via email depending on whether they participated in a virtual or in-person data collection event. Participants were required to review the consent form and agree to participate either via a signature (both wet or electronic signatures were accepted) or verbal consent. Additionally, at the beginning of each data collection event, participants were reminded their participation was voluntary and they could withdraw from the study at any time.

All study data (e.g., recorded focus groups and key informant interviews, transcripts, analytic and reflexive memos) were stored in password-protected cloud

software applications. I, as the sole researcher on this study, was the only one with access to personally or organizationally identifying participant data. As is a standard practice in research, personally and organizationally identifying information was either redacted or replaced with pseudonyms (Spickard, 2017).

Chapter Summary

This qualitative investigation sought to add new understanding to how FQHCs that provide care to LGBTQ communities go about understanding this population's needs and then go about providing care to meet them. The exploratory comparative case study design used for this study was discussed in this chapter. Qualitative data collection methods, including interviews, focus groups, and document analysis, were detailed. The semistructured interview and focus group data collection instruments developed for this inquiry were described along with the grounded theory data analysis process. Additionally, several strategies that were used to improve data reliability and validity, including data triangulation, researcher reflexivity practices, and peer review, were highlighted.

CHAPTER FOUR

FINDINGS

What we find changes who we become.

—Peter Morville. *Ambient Findability*

Introduction

This study sought to better understand how nonprofit community-based Federally Qualified Health Centers (FQHCs) that specialize in serving lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations go about understanding the unique healthcare needs of this marginalized community and meet these needs through policy, program, and practice. Although there is a vast canon of research literature specific to (a) LGBTQ healthcare (especially research conducted within the last decade), (b) LGBTQ health disparities, and (c) interventions designed to better address the health needs of LGBTQ individuals, there remains a gap in the literature that specifically looks at how FQHCs “queer” the services they provide to serve the needs of this vulnerable population. The research questions (RQs) that guided this study were:

RQ1: How do community health center staff, providers, and leaders go about understanding the healthcare needs of their LGBTQ patients/clients?

RQ2: What are the specific ways in which LGBTQ-focused health centers go about providing care that is tailored to the needs of LGBTQ individuals?

In what ways, do these understandings align with practices and procedures that LGBTQ patients/clients report as affirming?

RQ3: What training/education opportunities are provided to health center staff and providers on how to meet the healthcare needs of LGBTQ individuals?

To begin to answer these questions, an exploratory comparative case study design using qualitative data collection methods was employed. Qualitative case studies allow researchers to study complex phenomena within the contexts from which they occur (Creswell, 2013). Two California FQHCs with a long legacy of serving the healthcare needs of LGBTQ individuals participated in the study. Palm Tree Health (PTH) was a community health center located in southern California and Central Valley Community Care (CVCC)¹⁴ was a community health center located in northern California. Methods of data collection involved 10 one-on-one key informant interviews with health center leaders, four focus groups with health center staff/providers, and two focus groups with health center patients/clients. Document analysis conducted on both organizations' websites also helped to inform and triangulate the findings. There were a total of 41 study participants.

Grounded theory was used as the overarching approach for identifying data themes and study findings. Grounded theory, which can be both a research design and method for data analysis, is an iterative process of constantly going back and forth between data and analysis to interpret, make meaning, and develop theory (Charmaz, 2014). Initial codes were developed through an open coding process that involved reading and rereading data transcripts. Through constant comparison (Creswell, 2007), segments of data were compared against other segments of data to identify similarities

¹⁴ The organization names "Palm Tree Health" and "Central Valley Community Care" are pseudonyms.

and differences. Data were then grouped according to similar categories as patterns in the data began to become clear. Similarly, constant comparison was used to further analyze these categories to identify relationships. These relationships became the overarching themes used to support the findings and to form the grounded theory (Merriam, 2009).

The remainder of this chapter details 14 identified data themes and five study findings. Data themes represent broad categories of data that helped to organize and ground research findings, whereas the study findings reflect specific conclusions drawn from the data that sought to answer the research questions. These themes and findings are organized by research question. I rely heavily on excerpts from data transcripts to support and further contextualize these themes and the resulting findings. These excerpts are the words that participants shared; their words grounded this investigation, as I sought to represent their stories, personal experiences, beliefs, hopes, and attitudes. Through the use of these excerpts, I, as the researcher, sought to center participants' narratives as the source of the findings. Further discussion and implications of these findings are presented in Chapter 5.

Data Themes and Findings Related to Research Question 1

RQ1 asked: How do community health center staff, providers, and leaders go about understanding the healthcare needs of their LGBTQ patients/clients? The crux of RQ1 centered on how the health centers involved in this study went about understanding the healthcare needs of their existing LGBTQ client base as well as the larger queer community in their service delivery area.

Study Finding 1

Study sites primarily use patient/client data, community outreach efforts, and formalized patient advisory groups as mechanisms to understand the healthcare needs of the queer community in their service area. Three main data themes supporting this finding were derived from participants' responses to interview and focus group questions, along with content analysis of each organization's website. These themes include patient advisory groups, collecting and analyzing patient data, and outreach efforts to the larger LGBTQ community.

Theme 1: Patient Advisory Groups

Across the collected data, participants consistently mentioned how they used formalized patient advisory groups to encourage and center patient voices as they sought to understand the healthcare needs of their existing LGBTQ patients and the larger queer community. Both PTH and CVCC have patient advisory groups that meet regularly to provide feedback and advice. These groups have dedicated health center staff who support their efforts.

Despite patient advisory groups lacking any formal authority over the health center's operations (unlike the health center's board of directors), study participants viewed these groups as an important avenue to understanding the needs of LGBTQ patients. The patient advisory group at PTH is called the client advisory board (or the CAB for short), and is comprised of up to 15 members who meet monthly. One of the leadership participants from PTH suggested this group "provide[s] feedback on services and input or suggestions for what [leadership] can do to add to services that would be valuable to them." The organization has a subpage under the "About [PTH]" section of

their website that lists current members of the CAB and provides a group photo that includes most of these individuals. Additionally, this subpage includes a brief description of the CAB's role "to improve the experience for clients and staff of [Palm Tree Health]" as well as basic information on how clients can apply to become a CAB member. Similarly, CVCC has a patient advisory council that, as one leadership participant explained, is a "direct tie into the community, meeting on a monthly basis to give us feedback."

Study participants at both study sites talked about how these patient advisory groups "elevate client voices." One patient/client participant shared about how serving on the organization's patient advisory group for 6 years was a way to give back and deepen their association with the organization, noting, "I'm not just a taker, I'm a giver." This individual continued to talk about how this volunteer role was a significant commitment and one they took very seriously, saying, "I took my work home with me far too often." Another patient/client shared serving in this capacity gave them an opportunity to understand, as they put it, "What goes on behind the curtain. I'm all about trying to help improve [health center name] in any way. . . . It does its best job, but I think there's always room for improvement." Another patient/client participant commented:

I'm on what's called the patient advisory council and I'm also transgender/nonbinary. People often have a fear of speaking up for themselves, but it's important to me to be a visibly trans person to [help others] understand them and to advocate for them.

A few participants who were either current or former members of these patient advisory groups, or who were staff that supported these groups, shared examples of how

patient advisory groups assisted the health centers to improve care and services. One example involved the patient advisory group thinking through how to better communicate with patients about the various services and opportunities available to them through the health center. Additionally, several health center employee participants seemed to recognize the role and value of these formalized patient advisory groups.

Furthermore, the use of patient advisory groups to improve care is supported by existing research. Such groups can provide unique insights and perspectives on the patient experience that healthcare providers may not have considered (Domecq et al., 2014) and may help to address disparities in healthcare by giving a voice to underserved and marginalized populations (Waterman et al., 2020). Cahill et al. (2014) suggested formalized patient advisory groups consisting of diverse LGBT individuals can help community health centers identify and address the unique needs and experiences of LGBT patients and provide feedback on ways to improve communication and build trust between LGBT patients and providers.

Theme 2: “It’s All About the Data”

Another prevalent theme across both case study sites had to do with the importance of collecting and analyzing data to better understand the needs of LGBTQ patients as well as the larger queer community they attempt to serve. Health center employees and leaders clearly expressed the value of data and shared examples of how they use these data to inform patient care. Sentiments such as “so I guess from my point of view, to really make an impact on patient experience, you have to have good data” were common. Another staff/provider participant stated, “In our department, we are very big on tracking data, like crazy! We have Excel sheets, we work in Epic [their electronic

health records system], we have various forms.” Another participant in this same focus group shared identifying and collecting data is important because, as they noted, “We’re constantly trying to seek out what we’re missing and how we can improve.” Specifically, leadership and staff/provider participants discussed collecting and analyzing data via patient surveys, ensuring that sexual orientation and gender identity (SOGI) data are recorded for all patients, and maximizing the data analytics capabilities via electronic health records (EHR) systems as specific ways in which both health centers seek to understand the need.

Patient Surveys. As study participants shared examples of the types of data CVCC and PTH collect, patient satisfaction, patient engagement, and patient feedback surveys were frequently mentioned. One senior leader talked about the importance of patient surveys, saying:

Every single time that a patient leaves here, whether it’s the first time or the fifth time, they’re going to be asked a different series of questions . . . and I know that input goes into a dashboard that is routinely looked at. So if we identify a clinician, a nurse, or just an entire clinic, whenever it may be, where we’re not [providing] excellent customer service and a good patient experience, then we’re able to look at that and begin to [understand] the root cause and make adjustments.

Participants talked about closely analyzing patient experience feedback, with one participant explaining, “So that we can understand more directly what that population needs from a patient satisfaction perspective.” One of the leadership participants, a health

center board member, spoke about how they believed the decisions the board made were grounded in patient surveys and other community feedback:

It's telling that all of the new programming comes from . . . like surveys. So, they always canvas the community and check to see what where everyone's at. . . . I don't think I've ever seen any new program, new initiative, or anything start, or really get off the ground without having a survey . . . it's always like in response to the community.

Patient/client participants also talked about regularly being asked to perform a number of tasks; one participant cited they "complete surveys after an appointment," whereas another participant mentioned that they "respond to annual surveys that the health center sends out to patients so they can get feedback on what they are doing right and where they need to improve."

Collecting SOGI Data. In addition to various types of patient surveys, staff/provider and leadership participants also stressed the importance of collecting SOGI data on all patients and using that data to inform and improve care. One provider participant said:

So when I do my intake process with folks, I go through what's called setting up their SOGI, which is sexual orientation and gender identity. There's a section in there [the health center's EHR] and we have so many different ways people can identify as far as their gender, their sexuality, and their pronouns as well. So like even in their patient chart, we get signals of how people would like to be identified and referred to.

Another leadership participant commented, “We do a good job of collecting that type of SOGI information. And so, we’re able to stratify our patient experience data based on that.” This participant went on to share how the organization has worked to further finetune the reporting of patient experience data to better compare against the SOGI data they collect “to understand our population’s needs, specifically LGBT and transgender populations. We want to know what their feedback is. This is [important] to us.” Collecting SOGI data was confirmed as an important practice by many of the patient/client participants; one participant noted, “Asking that information helps normalize it” and another noted this practice “helps my provider know who I am from Day 1.”

As further detailed in Chapter 2, collecting SOGI data is crucial to better understanding the health risks and needs of LGBTQ community (Grasso et al., 2019). The systematic collection of these data can help healthcare providers identify and address disparities, while also signaling to LGBTQ patients that they are in a welcoming and inclusive environment (National LGBTQIA+ Health Education Center, 2021).

EHR Data. Leadership and staff/provider participants also discussed how their organization’s EHR system assists in data collection and analysis to better understand the needs of their gender and sexual minority patients. Participants mentioned monitoring EHR data dashboards on key health indicators (e.g., substance use and behavioral health) as specific examples. Additionally, a couple of participants shared about how the EHR helps to better serve LGBTQ patients. One nursing assistant talked about how their EHR is “set up to provide a patient’s preferred name and pronouns” which helps staff not accidentally misgender or misidentify a patient. Other staff and provider participants also

shared about how their health centers have upgraded the EHR systems to display the preferred name and pronouns of patients which, as one participant said, “is great as a method to, you know, connect with the patient a little bit faster, because you’re using their preferred names and pronouns.”

Other staff and leadership participants shared how their health center has invested time, money, and human resource capital into using data generated from the EHR to improve the care they provide to all patients, including their queer patients. Specifically, one participant mentioned the data analytics capabilities that EHRs provide; they noted EHRs allow clinical teams and health center leadership to “compare data on LGBT patients against data of patients that are straight [which can] be used for targeted interventions or different approaches to improve care and outcomes towards LGBT patients.”

Theme 3: Outreach to the Queer Community

Study participants felt that intentional outreach to the queer community was another way that CVCC and PTH went about identifying the healthcare needs of the LGBTQ community. Participants noted much of this outreach has allowed the health centers to talk with and engage individuals who may not be currently connected with their organizations, thereby augmenting data collected by existing patients to provide a more expansive view of community needs and desires. This theme is broken down into four categories or subthemes further detailed in the following sections, including the importance of Pride, community events, social media and paid advertising, and community health workers (CHWs).

The Importance of Pride. Patients, employees, and leaders shared how they saw participating in community Pride events as important opportunities to connect with the LGBTQ community. One leadership participant said, “[Health center name] has an active presence at the Pride Festival. We’ve done that for a long time and people get really excited about that event.” Another staff/provider participant expanded on the importance of being part of Pride and other LGBTQ community events by stating, “It’s just about being, you know, being in those spaces and showing a continued effort of where our roots are from.”

One leadership participant shared more insight on why their health center believes being a part of Pride is important. They noted they are able to reach community members who are not current patients and hear from them about what the needs are. This participant also discussed how they are able to provide health screenings (e.g., HIV and STI testing) and provide wellness services like yoga. Patient/client participants also referenced their health center’s participation in Pride as an important way to outreach to the queer community and understand their needs. One participant stated, “They [health center name] are active in the community, things going on, like the Pride Festival and the Korean Festival.” The National LGBTQIA+ Health Education Center (2021) recommends health centers be involved in local Pride events as a way to engage with and build alliances with the queer community.

Social Media and Paid Advertising. Staff/provider and leadership participants referenced social media and paid advertising as other ways in which PTH and CVCC outreached to the queer community. Both organizations have a social media presence. As of February 2023, CVCC had 14,000 followers on Facebook and 650 followers on

Instagram. Also, as of February 2023, PTH had 7,300 Facebook followers and 2,570 Instagram followers. Frequently, the social media posts for both health centers promote the services they provide to the queer community. Figure 3 shows three social media postings from CVCC that include both messaging and imagery meant to appeal to LGBTQ viewers. Similarly, Figure 4 shows three social media postings from PTH that also include messaging and imagery meant to appeal to queer audiences.

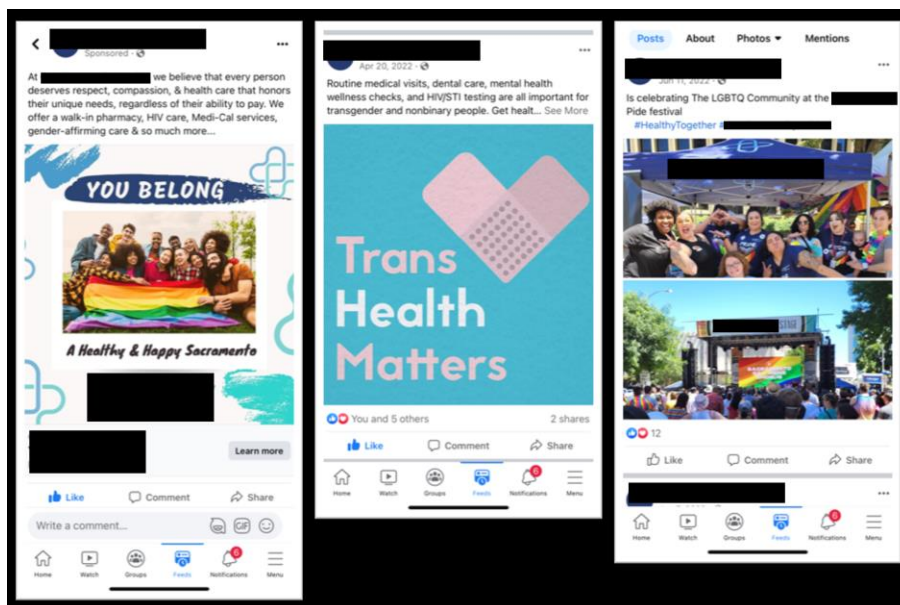


Figure 3. *Sample Social Media Posts from Central Valley Community Care*

Note. Figures are screenshots from CVCC social media sites. In the public domain.

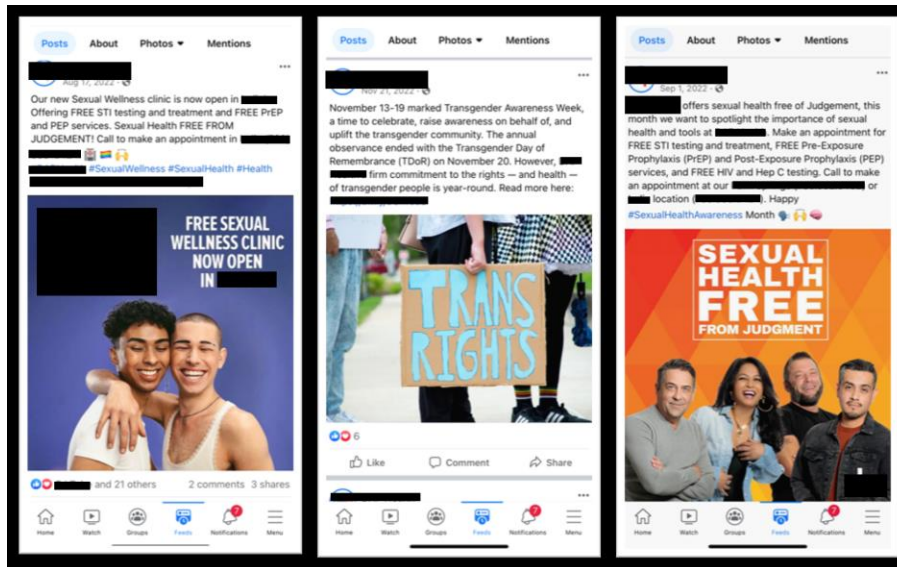


Figure 4. Sample Social Media Posts from Palm Tree Health

Note. Figures are screenshots from PTH social media sites. In the public domain.

Additionally, CVCC and PTH engage with the queer community in their service area through paid advertising in queer-focused mediums such as local LGBTQ print publications and online via popular location-based social networking and dating applications (aka “apps”) such as Grindr and Scruff. As one participant said:

[We have] alternative ways of reaching out to the LGBTQ community that maybe are not aware of the services [we] offer. . . . [we] seek them out knowing the different ways they’re communicating, you know . . . Grindr, Scruff, Facebook. So, yeah, we do things not necessarily to the norm.

Grindr and Scruff are two of the largest and best-known dating/“hookup” apps for gay m (Zane, 2022). PTH also advertises on Jack’d, which is an app that targets diverse gay, bi, trans, and queer individuals. Jack’d is considered to be the most inclusive dating/hookup app for queer people of color (Zane, 2022). Researchers have suggested

that gender and sexual minorities are avid users of social media, specifically for social support and dating (Anderson et al., 2020; Miles, 2019).

Community Health Workers. Although less frequently cited, using community health workers (CHWs) to connect to segments of the queer community was another strategy that came up in conversations with study participants. Centers for Disease Control and Prevention (CDC, 2021a) defined CHWs as frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. Participants discussed how CHWs create bridges and connections to communities—particularly hard-to-reach populations and subpopulations. One leadership participant shared:

We launched our community health worker program, and quite literally their responsibilities are to go out into the community and . . . speak with the gatekeepers of various communities and find out what it is that they need, what is it that they are looking for, what are their barriers, and then they bring back that information to us and we start figuring out ways to help reach them and help, you know, eliminate those barriers.

In addition to using CHWs to connect to particular communities (e.g., Latino/Latina/Latinx community, Black community) to better understand their healthcare needs, a couple staff/provider participants shared they see CHWs as one way in which their health center goes about providing culturally competent care. When invited to share further, these participants referenced hiring a CHW who had experienced homelessness to work on homeless outreach and engagement, as well as hiring bilingual (Spanish/English) Latino/Latina/Latinx patient navigators specifically for sexual health

services. These efforts are supported by literature regarding the role and effectiveness of CHWs. In the United States, CHWs have been recognized as an effective strategy for improving health equity and reducing health disparities (Landers & Levinson, 2016; Malcarney et al., 2015).

Barriers and Challenges. Although participants felt outreach to the queer community was important to better understand the health needs of a diverse LGBTQ population, several participants noted there were challenges in being able to connect with specific segments of the community. One provider participant said:

I think a common thread with all of these populations is a history of mistrust with the healthcare system. And I think, I mean, we're trying to rebuild that. But I think in general, it can be quite difficult. . . . In terms of outreach, I've been finding difficulty finding where those communities are, like where their safe spaces are and how we can introduce ourselves so it makes it hard to pinpoint how to reach out to them.

This fear and mistrust that LGBTQ individuals have with the healthcare system has been reinforced in the literature (Lee & Kanji, 2017; Mulé, 2015). Furthermore, despite efforts to build relationships with Latino/Latina/Latinx communities in their area, a number of participants referenced mistrust of institutions, including healthcare providers and FQHCs, as a continued barrier in accessing and understanding the healthcare needs of this broad population and its many subpopulations. The concern and fear that many individuals in the queer community feel when interacting with the healthcare sector is another reason why CHWs may play a critical role in helping the LGBTQ community access and achieve health.

Data Themes and Findings Related to Research Question 2

RQ2 asked: What are the specific ways in which LGBTQ-focused health center staff report providing care that is tailored to the needs of LGBTQ individuals? In what ways, do these align with practices and procedures that LGBTQ patients/clients report as affirming?

RQ2 sought to move beyond how PTH and CVCC go about *understanding* the needs and instead focuses on what they actually *do* to provide healthcare designed to meet the needs of LGBTQ folx. This research question was about implementation and all the ways in which these FQHCs carry out policy, practice, and programs to hopefully meet the healthcare needs of those to whom they deliver care. The subquestion (i.e., in what ways, do these align with practices and procedures that LGBTQ patients/clients report as affirming?) sought to compare the data collected from health center leadership and employees with data collected from health center patients and clients. Given that FQHCs are patient-directed and community-based organizations with the stated goal of “deliver[ing] comprehensive, culturally competent, high-quality primary health care services to the nation’s most vulnerable individuals and families” (HRSA, 2021b, para. 1), perspectives gleaned from patients/clients about what they desire and whether or not they see these practices and behaviors as affirming seemed important to discover.

Seven data themes were identified in the analysis. These themes included: staffing that is reflective of the patients/community being served, specialty care and tailored services, holistic care, clinic design and symbols, care without judgment, partnerships, and training staff. These themes provided insight into the mindsets and actions study participants felt are important to provide ideal healthcare to the LGBTQ community.

Study Finding 2

CVCC and PTH use a variety of approaches to meet the healthcare needs of the LGBTQ community. Despite vastly different patient demographics, both health centers use similar approaches and these approaches generally align with practices and procedures that patients/clients view as affirming. All of the seven identified data themes, as further detailed in the following sections, support this finding.

Study Finding 3

To meet the healthcare needs of the LGBTQ community, both health centers involved in this study place a high value on human resources. This value was exhibited in two ways: (a) attempting to hire a workforce that is representative of the queer community and (b) providing training and educational efforts to their employees to equip them with the knowledge and skills they need to effectively provide care to LGBTQ individuals. Three of the seven data themes supported this finding. These themes included: staffing that is reflective of the patients/community being served, care without judgment, and training staff.

Theme 4: Staffing That is Reflective of the Patients/Community Being Served

When discussing the ways in which CVCC and PTH move from understanding the healthcare needs of their queer patients and the larger queer community to actualizing those, hiring diverse staff/providers who mirror patient and community demographics was most noted across all data collection methods. Within this theme, participants primarily talked about the importance of hiring queer staff and providers with specific emphasis placed on hiring transgender/nonbinary as well as BIPOC staff and providers.

Hiring LGBTQ Staff and Providers. Participants in all categories (i.e., leadership, staff/provider, and patient/client) felt strongly that because CVCC and PTH specialize in serving the queer community, there need to be LGBTQ staff/providers at all levels. One leadership participant said, “I think part of that starts with hiring people. . . . that look like our patients. . . . it could be women, it could be by race, it could be trans, it could be any number of different factors.” Another leadership participant expressed, “We should be striving to have people who are caring for the community also look like the community.” In regard to this idea of staff and providers matching the diversity of the community (commonly referred to patient/provider concordance), one staff/provider participant felt the employees’ demographics at their health center accomplished the following:

Sort of reflect who our clients are, you know, we *are* the LGBTQ community. We are [the] people who come to work for [health center name]. . . . So it’s all about, as far as understanding what the needs are, recognizing that we’re part of the community. You know, that’s super important.

Another leadership participant talked about “having a strong intent on who [the organization is] hiring” and recommended other health centers “match [their] patient population as much as [they] can at all levels.” These sentiments generally aligned with literature cited in Chapter 2 on racial and cultural concordance in healthcare settings (Hudak & Bates, 2019; Jetty et al., 2021; Street et al., 2008). Interestingly, unlike existing literature, which has primarily looked myopically at physician providers and their racial or cultural concordance with the patient, many participants in this study made sure to expand traditional notions of “provider” beyond medical doctors or physician assistants

to also include behavioral health clinicians, nurses, case managers, and others. Figure 5 provides a screenshot from the “Careers” page of PTH’s website. The six images include imagery and symbols that are LGBTQ affirming (i.e., the pride flag) and also appear to show racial and gender diversity, which may be appealing to potential job candidates who are sexual and gender minorities, BIPOC, and/or are part of other marginalized populations. It is unclear if these images are actual photos from the health center or stock images.

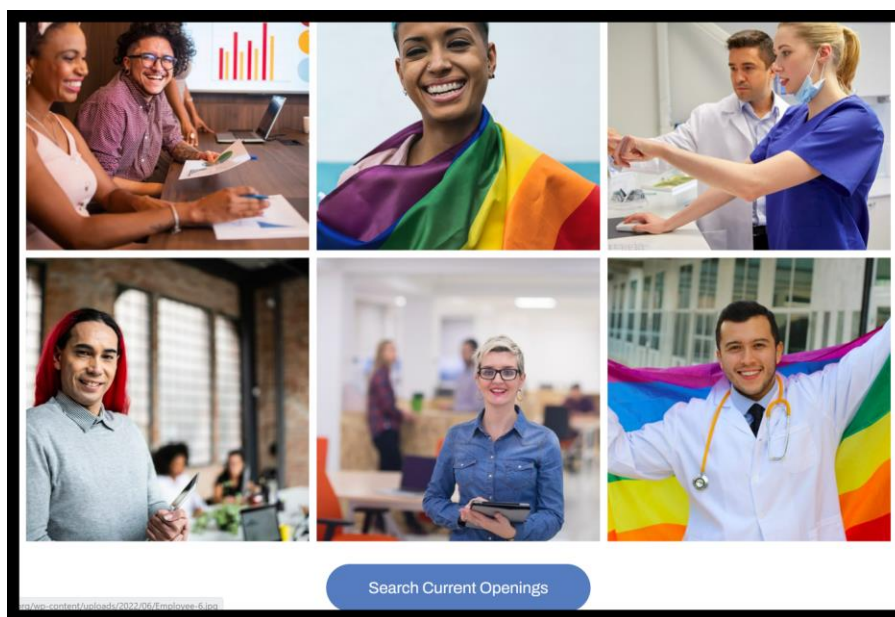


Figure 5. Screenshot of Palm Tree Health’s Website Highlighting LGBTQ Diversity in Hiring

Note. Images from the public domain.

A Special Focus on Trans/Nonbinary Staff and Providers. Within this category of hiring more LGBTQ staff and providers, there was a particular focus on hiring transgender and nonbinary employees. This finding is likely even more important given both health centers have prioritized and expanded gender-affirming care services.

One of the leadership participants rejoiced that they had been able to hire transgender and nonbinary providers, noting, “Some of our providers identify with that community [transgender and nonbinary], and, therefore, you know, it’s like there is a different safe space that’s created.” Their joy was immediately tempered with, “But you know, with provider turnover and provider burnout, there is always a risk. Like, what if we can’t provide providers in that space?” Patient/client participants also appreciated that there were finally a few medical providers at both CVCC and PTH who were part of the transgender/nonbinary community; however, at least one of them expressed concern about a transgender provider’s workload, stating, “Like he’s one person, so that means that other people are waiting on long waiting lists.” According to Dimant et al. (2019), less than 1% of medical students and practicing physicians in the United States identify as transgender or gender nonbinary despite growing numbers of youth and adults identifying as transgender or gender nonbinary (GLAAD, 2017; Herman et al., 2022).

LGBTQ Providers and Staff of Color. In one of the staff/provider focus groups that talked about the need for more LGBTQ-identified staff, it was noted that LGBTQ status alone may not be the only demographic indicator on which health centers should focus when working to ensure that health center employees are reflective of the patients and communities they serve. One participant said:

I also think that having more representation in our providers would be awesome, like having more LGBT-identified folks and providers of color. I don’t know if we have a provider who identifies as Black or African American, like a medical provider. So I think that in that way, we’re not serving our African American

patients as well as we could. Because representation is really important—having a provider that shares some life experiences and can provide care in that way. Another participant talked about how he believed his life experiences and racialized identity has helped him in his job, noting:

You know, I think that being a Latino gay [man] with HIV myself allows me to connect with the people who are enrolling into PrEP because . . . I don't see that nervousness of them being able to talk about having receptive sex, or any stigma about, you know, high risk activities, because they're talking to a peer.

Further reflection and thinking about staffing that represents the full diversity of queer patients caused another staff/provider participant to rhetorically ponder this question: “How can we be providing adequate care without having representation from people who are taking care of them?” Although not in response to this question, one health center leader rejoiced as they commented, “Just in the last few months we hired our first trans Latina nurse practitioner . . . which is fantastic.”

Another leadership participant agreed they need to be intentional about recruiting BIPOC providers and added, “Especially since our patient demographics are quickly changing.” Yet, this participant expressed some dismay at the prospect, saying, “There is such a provider shortage already and unfortunately there aren't as many Black and brown docs and NP's [nurse practitioners] as we need.” Participant sentiments reflected much of the previously cited literature regarding the lack of, and need for, more racial diversity in the healthcare workforce (Betancourt et al., 2003; Bleich et al., 2021; HRSA, 2019; Lipton et al., 2017; Shimasaki & Walker, 2013).

Theme 5: Specialty Care and Tailored Services

Staff, providers, leaders, and patients at both FQHCs proudly shared the various ways in which they go about providing specialty care and other services specifically designed to meet the needs of LGBTQ community. When further analyzed, subthemes including gender-affirming care, sexual health, and specialized equipment and diagnostic services emerged.

Gender-Affirming Care. Although both organizations have long identified as LGBTQ health providers specifically focusing on HIV/AIDS, in reality, most of their patients historically have been gay, bisexual, and men who sleep with men (MSM). As CVCC and PTH have grown, both organizations have sought to provide gender-affirming care for those who identify as transgender and/or gender nonbinary. This focus came up in many different ways during data collection at both sites.

Over the past 5 years, PTH has worked to expand services to the transgender and gender nonbinary community in their service area. One of the organization's leaders stated, "We've got three clinicians who specialize in transgender care, and I think it's something like 70 [or] 80 patients currently." PTH has also created a transgender navigator position, a dedicated person to help their transgender and nonbinary patients access the care and support they need.

CVCC, in an effort to better serve the transgender and nonbinary community, created a dedicated specialty practice focusing on gender-affirming care. This practice includes staff and providers who self-identify as transgender and/or nonbinary. One leadership participant shared CVCC started with "about 400 or 500 people, I think," who were part of the gender-affirming care program, but noted, "now it's up to 7[00] or 800, which is incredible growth, or we're collecting better data, or maybe both?" Patients

participating in this program undergo a different patient intake process and have additional case management and care coordination support. According to one staff/provider participant:

We have a gender-affirming services coordinator who is basically like a care coordinator except specifically focused on the gender-affirming population. They do a really good job of following up on these cases to make sure that the patients are getting their referrals, getting what they need, [and] know what they have to bring to their appointments and stuff like that.

One patient who identified as gender nonconforming/gender fluid passionately shared about the value of having gender-affirming care:

I realized that I don't have to teach my doctors how to take care of me. They listen. And they asked me, "What do I want to do for my gender identity?" rather than telling me what I'm supposed to do. . . . so I'm really thankful to have that.

It's definitely a weight off my shoulders. I'm really proud to be here.

Later in the focus group, this patient participant expressed additional appreciation for the care coordination/case management services that are specific for the gender-affirming care patients, noting, "I think . . . personally, if we didn't have our patient coordinator, I probably wouldn't get half the things done or directed by my doctor at all, because they are like the middle person to take the weight off."

Another transgender patient/client talked about the evolution of gender-affirming care they had received at their health center and how they had seen positive changes, including the addition of transgender/nonbinary providers and additional case management services. However, they also shared there is still more room for

improvement, noting, “For example, I’ve had staff members tell me ‘this transgender stuff is new.’ I’ve been transgender since I was 16 when I came out. I’m 53 now. I’ve been out a really long time. It’s not new.” This patient went on to discuss the need for additional awareness and training of health center employees, in addition to increasing the number of transgender staff at the health center. All three patients/clients who identified as transgender or gender nonbinary mentioned the need for further training for health center providers and staff. Existing literature supports this as well. Studies have shown that healthcare providers lack basic knowledge and skills to effectively interact with transgender and gender diverse patients (Alzahrani et al., 2019; Cahill et al., 2014; Furness et al., 2020; James et al., 2016; Ogden et al., 2020).

In these discussions about the need and value of providing gender-affirming care, the difficulty in accessing specialty care and managing referrals for transgender and gender-conforming patients came through as one of the reasons this specialized care and support was needed. One patient/client participant said:

My doctor referred me for gender-affirming care. It took him a year to get that appointment. I had to get new letters [medical and psychiatric approval for gender-affirming surgery]. Other patients I know have gone through the same process of trying to get it done and have decided not to have the surgeries because of that wait.

Study participants across all participant categories from both organizations shared about the complexity of getting referrals for gender-affirming care services approved, including payers who do not understand transgender and gender-affirming healthcare and, therefore, want to reject payment for services. Previous research has also supported

claims that transgender and gender nonbinary individuals have more difficulty accessing specialty care services both because of referral issues and insurance acceptance or payment issues (Babey et al., 2022, National Coalition for LGBTQ Health, 2022).

Pronouns. Participants frequently cited the understanding and use of preferred pronouns when talking about efforts to create environments that are more inclusive to transgender/nonbinary patients. According to one patient/client participant:

This was actually the first place where I ran into the pronoun assignment and preference, and so initially, there was somewhat of a shock value, but that was quickly overtaken by the fact that I was addressed specifically, what do I want to be identified as. . . . It means a lot. Even that simple little pronoun assignment is huge!

Other participants spoke about how employees at their health center wear pronoun pins on their name badges. One staff/provider participant said, “It normalizes that we may have pronouns that may, or may not, align with how we present.” Another staff participant agreed that promoting the use of pronouns was important but said, “I’m still trying to get used to they/them pronouns . . . it’s not grammatically correct.”

Sexual Health. Besides offering gender-affirming care services, services related to sexual health was the next most common theme across the data collected from study participants. Participants shared about their organization’s efforts to reduce stigma related to sexual activity. They highlighted the organization’s work to provide HIV and STI testing and treatment as well as promote and provide PrEP and PEP. PrEP stands for preexposure prophylaxis, whereas PEP is short for postexposure prophylaxis. Both are medicines taken by HIV-negative individuals that have been shown to significantly

decrease the likelihood of contracting HIV (National Institute of Health Office of AIDS Research, 2021).

HIV/STI Testing and Treatment. Both PTH and CVCC were started in response to the AIDS epidemic and are proud of the work they have done and continue to do related to HIV/STI testing and treatment. One leadership participant said:

We also offer 100%, free HIV testing for syphilis, gonorrhea, chlamydia, HIV, and Hep-C and most of our team members are cross trained. So it's great, you can walk into the clinic, be seen by one of our outreach team members who's also a certified phlebotomist, and is also certified in HIV counseling.

This participant went on to explain:

So let's say you test positive with the person that you're tested with, that person is your point of contact through your treatment—you test with them, you get counseled by them, you get assigned to a case manager by them, and link to care with them. So I think we have a great warm handoff system.

A leadership participant from the other health center site proudly highlighted their HIV testing and treatment services, noting:

Despite our small size in comparison to other big health systems in [the area], we serve 60% of the HIV patients in [the area]. All of the other big health systems share that remaining 40[%]. But we have at little [name of health center] 60% of that population! That's because they know we are the experts in it.

HIV and STI testing and treatment services are prominently featured on PTH's homepage, which includes colorful and centrally located information and links to “Free Self-HIV Tests” and “Free Sexual Health Services” (see Figure 6). Information regarding

HIV/STI testing and treatment does not appear on CVCC’s homepage, but is easily accessible via the “services” dropdown button located at the top of the homepage (see Figure 7).

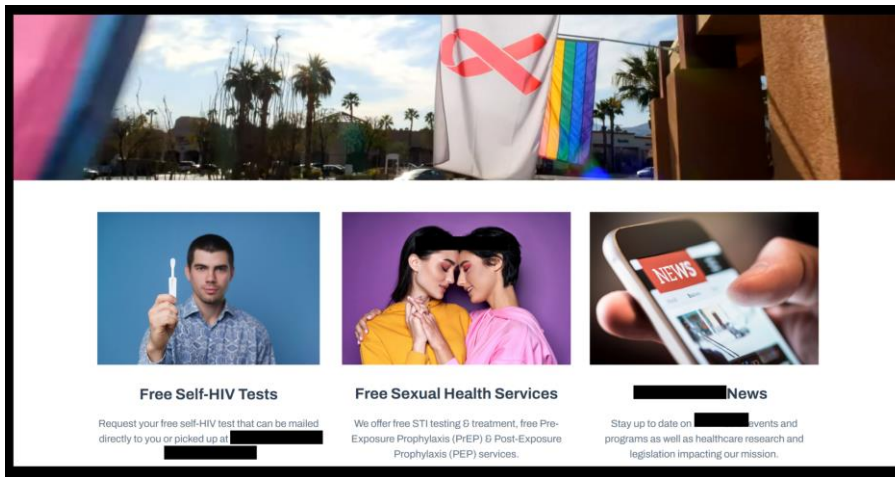


Figure 6. Screenshot of Palm Tree Health Homepage Showing HIV/STI and Sexual Health Services

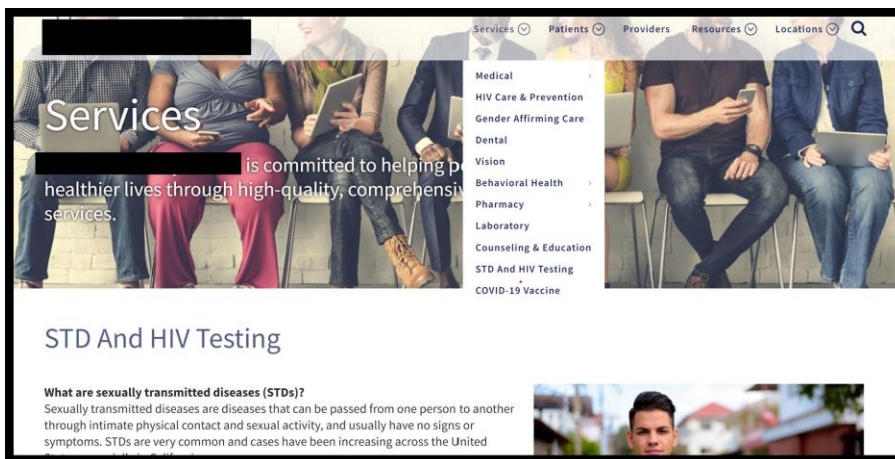


Figure 7. Screenshot of Central Valley Community Care Webpage Showing STD and HIV Testing

One staff/provider participant shared the belief that these HIV and STI testing and treatment efforts not only help these individuals seeking those services, but also help with public health aims:

So one of the things that we have to be aware of and track is our patients that do come in and they are testing positive for STIs for an example, whether it's syphilis, gonorrhea, chlamydia . . . or whether we have a case where a patient hasn't been in, maybe they're a sex worker, [and] we haven't seen them in a year . . . but they're out there practicing perhaps unsafe sex. All those things pose a risk to the community. So it's our obligation to make sure that they're receiving treatment . . . not only for them, but for the community as a whole.

Many of the patient/client participants confirmed the importance of HIV and STI testing and treatment as both important services and key differentiators between the health centers and other more "mainstream health providers." One patient/client stated, "Given that HIV rates continue to be higher amongst gay and bisexual men, oh and definitely for transgender women, having HIV and sexual health is so important."

PrEP and PEP. Access to PrEP and PEP was highlighted as another way these two FQHCs about tailoring their care to meet the needs of the LGBTQ community. According to the CDC (2022), correct usage of PrEP reduces the risk of getting HIV from sex by about 99% and by about 74% among those who inject drugs. PEP treatment, which should only be used in emergency situations, is also highly effective at reducing the risk of contracting HIV if started within 72 hours of the potential exposure (CDC, 2022). Both organizations promote and offer PrEP and PEP for free to individuals within their communities. Also, PTH and CVCC have dedicated staff members who coordinate

PrEP and PEP services, assisting with case management and coordination for follow-up appointments. One health center leader spoke about how their health center recently expanded to open up a sexual wellness clinic in a remote part of their geographic service area, noting:

It was our responsibility to open up a free STI and PrEP and PEP clinic there because we could, because we can afford to do it, and to help our brothers and sisters who are living in [the area] who are driving, you know, 45 to 60 minutes to get to our [main clinic].

This new sexual wellness clinic primarily serves the Latino/Latina/Latinx community, including migrant and seasonal farmworkers. Additionally, similar to how both organizations highlight HIV and STI testing and treatment on their webpages, they also promote PrEP and PEP services via their webpages and social media accounts.

Among the collected data, many health center patients/clients confirmed PrEP and PEP services were needed and valued. During one of the patient/client focus groups, a participant shared excitement and appreciation for the health center helping him access “the new injectable PrEP . . . I can’t think of the name of it.” The National LGBTQIA+ Health Education Network (2021) includes access to PrEP and PEP as one of the top strategies they recommend for creating inclusive healthcare environments.

“It’s Not Just the G.” According to one staff/provider participant:

When you think about the LGBTQ community, it’s not just the G [gay]. So, we excel at providing care to gay men, in particular, but you know, I rarely see very many women being given care, that includes lesbian women. I don’t think that the first thing they think of when they think of health care [is] that they would come

here . . . I don't think that it is marketed to women or lesbian women, as part of the LGBTQ community. . . . I think we could do better with the other letters.

As this participant shared this comment in one of the focus groups, at least three heads nodded up and down, presumably in agreement with the statement. Another staff/provider participant immediately chimed in, "Definitely, I think that there are more people than gay men that identify in the LGBTQ plus community." A similar sentiment was expressed during one of the patient/client focus groups when a participant noted:

I'm fairly new, like I said, I could be totally wrong, I'm not educated enough, but I don't know if they're reaching out to the entire LGBTQ community. Are they reaching out to lesbians, for example? I'm seeing gay males everywhere. I'm not seeing lesbians or [those] questioning, or bisexuals necessarily. I don't know that they're not reaching these people, but if they're not they need to be.

Participants at both FQHCs involved in this study acknowledged the need to further expand their reach to serve people across the queer spectrum. As mentioned previously, one of the ways this is accomplished is by investing in transgender and gender-affirming care services. In addition to that investment, one of the health center leader participants commented on how their health center had created a women's health department to serve more women in their community. They went on to share how this specialty department was designed to "better meet the healthcare needs of cisgender identified women, including straight, lesbian, and bisexual women." The participant contextualized this need by referencing a significant increase in the number of female identified patients they serve. Moreover, a couple of leadership and staff/provider participants at the other FQHC shared the organization was in the process of exploring a

women's health initiative. One of them stated, "In retrospect, [name of health center] has not had much or a lot of focus on women's health care, and it's just time that we matured into that."

Specialized Medical Equipment and Diagnostic Devices. Specialized medical equipment was also referenced as a way in which the unique healthcare needs of the queer community are being met. One staff/provider participant stated:

We have some care that other facilities that are larger, maybe even larger, don't have like we have the fiber scanner to scan for liver, hepatitis and other liver infections that were one of only three organization facilities in all of [the area] that has a fibro scanner. . . . We also have endoscopic high-resolution endoscopy, which allows us to check for signs of rectal cancer, which, again, we're one of only a few facilities in all [the area] that have that available for that service.

A leadership participant went on to share how these specialized medical diagnostic devices are important for medical practices that see a high number of LGBTQ individuals. MSM have an increased risk of contracting sexually transmitted infections that can cause serious damage to the liver, including hepatitis (CDC, 2020c). Anyone who has receptive anal sex (also known as bottoming) is more susceptible to rectal cancer (Wheldon et al., 2021). PTH's website highlights the Fibroscan technology where they are able to "painlessly scan the liver" without having to refer patients out for that service.

Theme 6: Holistic Care—Serving the Entire Person

Consistently across the data, leadership, provider/staff, and patient/client participants talked about how both health centers went beyond just focusing on the biomedical needs of their patients by attempting to also address many of the underlying

issues affecting health for the LGBTQ community. Words and terms such as “holistic care,” “whole-person care,” “case management,” “social services,” “wellness programs,” “social determinants of health,” and “patient-centered care” were commonly used to conceptually describe this important work. One of the health center leaders shared:

We have our Social Services Program, which has been traditionally mostly for the HIV-positive population. We’re starting to expand that to other populations, and do . . . medical case management for other populations and so forth. . . . But because of the lessons that we learned being stigma, you know, having that population stigmatized, we understand what the needs are.

As staff/provider participants shared, they provided concrete examples of how this holistic care approach is translated into action:

Another big thing that kind of differentiates [name of health center] from other medical organizations is that we take the whole person approach when it comes to treating [patients]. It’s not only they’re coming here for their medical services, but they can also come . . . we have chair massages and we have social groups and whatnot. So we can see that even if they are coming here for a medical service, that is not all that they are here for or all that they need. We have behavioral health, we have dental, but we also have pizza and a movie, we have haircuts, we have different groups where they can meet and talk about various topics. So it’s definitely a whole-person approach.

Providing holistic care to meet the needs of LGBTQ individuals also came up in conversations with health center patients/clients. One participant shared how they transitioned their care from another provider so they “could take advantage of the holistic

approach that [name of health center] takes to health and wellness.” Most patient/client participants referenced specific ways in which CVCC and PTH treated them, as one participant noted, “As a whole person, not just a medical diagnosis or condition.”

Supporting Community Connection. Health center patients/clients who participated in the study also highlighted the theme of holistic care to help them and other LGBTQ folx stay healthier and thrive. They discussed participating in support groups, such as those for long-term survivors of HIV and those dedicated to providing safe spaces for transgender and nonbinary individuals. One patient recounted the value of being able to regularly participate in an HIV support group for men, noting, “I was fortunate to be eligible for the senior men’s group. At one time, that was very important to me and that was the safe place to talk about things.” Another participant shared, “[I] cofacilitate four different Zoom support groups, one being a yoga chair yoga class . . . [a] strength in numbers group . . . a men’s group . . . and then a golden girls group . . . I’m really happy to be a part of that.” One former peer support patient volunteer who is now on staff explained being in a peer role, noting:

Really supported me in finding value in myself. . . . After having gone through all the things that I’ve gone through . . . HIV positive . . . addicted to drugs . . . getting out of jail, being able to volunteer and do something that was beyond me . . . really helped me get, you know, to be stronger to where I am today.

Three patients/clients who identified as transgender or gender nonbinary shared about their participation in support groups specifically targeted to them. One stated the support group has accomplished the following:

Been really helpful because trying to find resources is very, very difficult for me. . . there's not a lot of resources that, you know, are for nonbinary [individuals] and so it makes it very difficult to find places for gender nonconforming people to go and relate to others. So that's something that is a really important resource.

Several patients/clients particularly appreciated how these support networks continued in some form when COVID-19 restrictions made meeting in person impossible. One participant said, "Right at the beginning of the pandemic, they started all these Zoom classes, which are wonderful, every single one of them." Other patients/clients further praised these efforts, with one noting:

I should say the [health center] did a wonderful job putting that together during COVID. Because there are a lot of people who were isolated and weren't being socialized with their own friends or their neighborhood because they can't go out. . . . And in my opinion, that department is what kept people alive and sane for 2 years during COVID.

The Social Determinants of Health. Additionally, the concept of social determinants of health (SDOH) came up by study participants when sharing ways in which the two FQHCs involved in this study provide holistic care. SDOH refer to the various economic, social, and environmental conditions in which people are born, grow, live, work, and age that influence their health outcomes and opportunities for wellness (World Health Organization, 2021). Among other factors, these conditions can include access to healthcare, education, housing, food security, employment, and social support.

Food. One of the organizational leader participants spoke about how their health center began to ask about food, noting:

Every patient who comes in what their food situation is like . . . and if we determine that there's a food insecurity issue, that by the time they come out of their appointment they have 48 hours' worth of food waiting for them. Without any sort of discrimination [staff] ask every single person, and it's surprising how many people need it.

Relatedly, a patient/client participant shared:

I appreciate how [name of health center] treat[s] every aspect of the person, not just their physical health, but also their mental health. I went in to have my teeth cleaned and I was asked "do you have enough food [at home]?" . . . Obviously, if there's food scarcity, you're gonna have problems with your physical health and your mental health. You're gonna be stressed that you're not eating, you're physically going to be ill because you're not eating. You know?

Another patient/client participant said, "I've heard from friends of mine who were receiving care over the last couple of years that they were receiving bags of food being brought to them and stuff, which I thought was excellent."

A couple of patient/client participants shared about a food truck that comes to the health center to provide free food to patients and community members; however, in discussion, one participant shared frustration that this opportunity was being underutilized:

There's a food truck that comes over on the first Saturday of the month, and there's less than five people that go and get food out of the 80 people that live in

that apartment. There's a certain malaise about what's being offered, and "Oh, I can't get out of bed for that." You know, there's so many opportunities that they could just walk into the building and participate with, and even living in that proximity doesn't encourage people into the building. I have no idea why.

This participant was referencing a health center-owned and operated low-income apartment complex that is part of their main clinic complex.

Housing. In addition to food insecurity, both CVCC and PTH staff seemed to understand that for their patients and community to be able to achieve health, they must also help address social determinants of health affecting LGBTQ individuals, such as housing and homelessness. One of the health center leadership participants summed it up by saying:

It's all about affordable housing. Housing is the first step to healthcare. You can go to as many therapy sessions as you want, but if you're sleeping in the backseat of your car, you're still going to be depressed. You can go to the doctor as much as you want, but if you're not, if you're skipping meals because you're hungry at night, the medications will not be effective.

In addition to making housing referrals and offering housing assistance to patients, this health center had put significant resources into addressing the housing crisis in their community. They established an 80-unit low-income housing complex and were in the process of constructing an additional 60 units at the time of this study. Future plans included building an aging-in-place senior living complex for low-income senior LGBTQ members of their community. A staff/provider participant at the other study site mentioned they have two case managers who focus on housing, noting:

They [the two case managers] discuss housing, make referrals and provide assistance as they can. I'm sure you're aware that there is a housing shortage so we'd love to get more people housing if the facilities were available. We work with and refer to organizations that [run] shelters or have housing such as.

One of the staff participants for the study shared a personal and inspirational story about how they became connected to the health center after receiving an HIV diagnosis. This story added additional credence to the value of focusing on housing and other social determinants of health. This participant noted, "They help[ed] me get on my feet. . . . They provided me, you know, housing, [and] all sorts of assistance . . . so I volunteered for the clinic for a few years prior to getting hired." At least four patient/client participants mentioned how their health center helped them access affordable housing.

Homelessness. During several of the staff/provider focus groups and leadership interviews, I asked health center employees and leaders to share more about subgroups or specific populations within the LGBTQ spectrum that they were having a hard time serving. Seemingly before I was even finished asking the question, most respondents had an answer, and their answer was the same—the desire to better serve unhoused/homeless individuals within their community, including those who are part of the queer community. One staff/provider participant responded:

Supporting folks who are unhoused [is] one of the most challenging things that I deal with because there's just so few resources to offer in [city]. These patients have tried, have pursued every avenue and often remain unhoused and continue to ask for help. And there's like, literally nothing I can do. It is really hard to help someone pursue their health goals when they are not housed. I mean, we

obviously do our best, but that's sort of like one of the most, I think, heart-wrenching.

In the same focus group, another staff/provider participant said:

I just want to like triple down on the challenge of folks who are unhoused or housing unstable. It's so difficult for someone to engage with their healthcare when they don't know where their head is laying at night, or where their next meal is coming from.

Health center leaders and employees consistently spoke about how difficult it was to reach and serve the homeless population. One participant who was part of a nursing team talked about the treatment approach they used with homeless patients once they were able to get them into the health center, noting:

Our goal is . . . when they're here we do as much for them as we possibly can, because we don't know when we're going to see them again. So are they caught up on vaccines? Or [are] they caught up on, you know, medication refills? Do they need.

In another focus group, a participant shared a very similar concern, stating, "Like you try to, you know, get them into all the services that they need at that time . . . because once they walk out that door, you don't know if they'll show up for their follow up." One staff/provider participant even shared about how their health center has caseworkers who will go into homeless camps to try to "track patients down and bring other unhoused individuals into care."

The fact that one of the main data themes coming out of this study concerned SDOH reinforced literature suggesting that interventions targeting SDOH may hold

promise in addressing LGBTQ health inequities (Austin et al., 2016; Badgett et al., 2019; Downing & Rosenthal, 2020). Additionally, studies have consistently shown that LGBTQ individuals in the United States are disproportionately represented in those that are homeless/unhoused (DeChants et al., 2021; Durso & Gates, 2012; Ecker et al., 2019; Robinson, 2021). A national survey study conducted by Durso and Gates in 2012 reported 40% of homeless youth identified as LGBTQ. A national survey study conducted by DeChants et al. (2021) found 28% of LGBTQ youth had experienced homelessness at some point in their lives. These rates were significantly higher for transgender and nonbinary youth (38%) and Native/Indigenous youth (44%). Lesbian, gay, and bisexual adults are twice as likely to have experienced homelessness or housing insecurity in their lifetime than the general population (Wilson et al., 2020).

Theme 7: Clinic Design and Affirming Symbols

Another main theme for how CVCC and PTH translated the needs of the LGBTQ community into action had to do with the clinic spaces themselves. Whether talking with health center leaders, employees, or patients, all participants discussed the importance of intentionally creating a welcoming and affirming environment. Participants commented on the historic mistrust and fear many within the queer community feel in relation to healthcare; one participant noted focusing on design elements “[is] an essential first step and ongoing priority” to ensure all patients receive appropriate care without fear of discrimination or bias. Two subthemes arose from further analysis: (a) physical design, and (b) affirming signage and symbols. The National LGBTQIA+ Health Education Center (2021) listed both of these subthemes on their list of top 10 strategies for creating inclusive healthcare environments for LGBTQIA+ people.

Affirming Signage and Symbols. Signage and symbols are a way to signal a welcoming and safe environment for LGBTQ individuals. Participants shared many ways in which their health center uses signs, symbols, and imagery to denote that they are affirming to gender and sexual minorities. These strategies ranged from seemingly easy and simple actions such as including LGBTQ publications in lobbies and waiting areas (see Figure 8), to more complex actions such as including the rainbow Pride colors into a new logo and branding design. One staff/provider participant stated:

We try to create a space where people feel safe. Downstairs in the basement, there are the flags—the Pride flags—and providers are encouraged to wear pronoun buttons. . . . So just having those, seeing those small little messages are like, “Oh, I’m in a space where people are going to the effort to make me feel safe”. . . . I think that type of stuff goes a long way.



Figure 8. *LGBTQ and HIV Related Publications in CVCC Lobby*

Other staff/provider participants talked about “making efforts to post [signs] on the multi-stall bathrooms saying, ‘Please use whatever bathroom you personally identify with’ just to kind of reaffirm those who don’t identify just male or female.” This effort was in addition to having dedicated single-stall gender-neutral bathrooms. Other examples of affirming signage and symbols repeatedly mentioned in data collection sessions included:

- ensuring that images and marketing materials include diverse queer representation;
- staff wearing pronoun pins or having other commonly understood LGBTQ symbols on their staff name badges (e.g., trans flag or pride flag stickers, rainbow lanyards); and
- displaying inclusive signage both inside and outside the clinic that indicates support for the queer community (e.g., having the Pride flag flying in front of the clinic, having Black lives matters and trans lives matter signs).

Several participants shared a reminder that the queer community is not a monolith. One noted, “It’s important that images, marketing materials, and other visual cues not just be white gay men.” In designing a new clinic, one of the leadership participants shared about how their health center went about including imagery decor that signaled their commitment to the LGBTQ community while also attempting to connect to the largely Latino/Hispanic population within this particular community. This participant shared about commissioning a local well-known Latina muralist to design a mural for their new clinic waiting room, noting:

It has a massive tree, and there's a whole bunch of different meaning behind each color, and the images related to the Latino culture, and it ended up working very well for our interior designer, because he put a different accent wall color in each exam room, which is pulled from the [health center name] logo.

During focus groups with patients/clients, one of the questions asked participants to share what they looked for when seeking out a healthcare provider. In addition to talking about looking for providers who identify as LGBTQ, one participant mentioned the importance of “visual cues and symbols that suggest the practice is queer affirming,” a sentiment shared by many others as well. This finding also aligned with existing research showing LGBTQ patients often look for a visual cue that the medical practice is LGBTQ affirming when they initially enter the space (Hudson & Bruce-Miller, 2022; Wilkerson et al., 2011). Additionally, both organizations' websites and social media postings use imagery and graphics designed to be welcoming and inclusive to the LGBTQ community (see Figure 5 Figure 6, Figure 7, & Figure 8).

Physical Design. In addition to affirming signage and symbols, several participants shared ideas and examples of other physical design elements they believed were crucial to providing an inclusive and welcoming environment. Having accessible facilities for queer patients with mobility, visual, or other disabilities was mentioned. Also, one staff/provider participant mentioned privacy concerns should be considered when designing exam rooms and consultation spaces “because of the discrimination and trauma that many queer folx have faced.”

Gender-Neutral Bathrooms. The importance of having gender-neutral and single-stall bathrooms was the most mentioned aspect of physical design. Gender-neutral bathrooms are important because they provide a safe and inclusive space for people of all genders to use the restroom without fear of discrimination or harassment. This safety is particularly salient for transgender and gender nonbinary/nonconforming individuals. One patient/client participant also noted gender-neutral restrooms “can be a good idea for disabled patients too, especially if they have a caregiver with them that’s not the same gender.” There is a wealth of literature confirming access to gender-neutral restroom facilities helps create welcoming spaces for transgender individuals (Hudson & Bruce-Miller, 2022; Mathews, 2016; Ricca et al., 2018; Roberts & Fantz, 2014; Wilkerson et al., 2011).

The “Bathroom Incident.” At one of the two study sites, several leadership, staff/provider, and patient/client participants talked about “the bathroom incident,” a story that seemed to serve as a pivotal learning moment in how the health center went about meeting the needs of their transgender and nonbinary patients. This story illustrated the importance of health centers critically assessing the needs of patients and potential patients as they think through clinic design. One participant from this health center explained:

The very short version of this drama is a bathroom, shocking, a bathroom issue, right? Basically, we had transgender patients that did not have easy access to gender-neutral bathrooms, and in trying to get that, they were met with things they shouldn’t have had to experience by existing staff, contractors, and volunteers.

This participant, who identified as cisgendered, continued:

And it was shocking to me . . . I didn't even notice, it never occurred to me to look. It wasn't even on my radar. But then, like the things that they had to put up with from staff, security guards, and volunteers was just ridiculous.

In further explanation, it was revealed that at the time, the health center did technically have a gender-neutral bathroom, but it was located out of sight and behind a locked door, whereas multistall female and male restrooms were easily accessible for patients. Anyone who wanted access to the single-stall gender-neutral bathroom had to request a key from either the front desk staff or a security guard. One of the leadership participants declared:

We have now fixed all of that right, [but] given our history, it was shocking to me that we had to literally bring in, you know, construction people to reconfigure one of the bathrooms in the main clinic. So it was done. It wasn't even that hard of a retrofit and didn't even cost that much, and it solved the problem. But the process of getting there was kind of ridiculous.

In another staff/provider data collection session, a participant shared a similar recounting of the story and noted how some patients “felt awkward about . . . [having to get] permission to get behind those doors to go to the bathroom. They wanted more discretion.” The “bathroom incident” came up in other data collection sessions as well. One of the patient/client focus group participants who identified as transgender shared they were one of the patients who initially raised this issue. This participant talked about feeling “looked down on by the front desk or security people” when they would request the key to access the gender-neutral restroom. They noted that they decided to speak up because, as they shared, “An organization that is about serving the needs of the queer

community, the trans community, I felt they needed to do better.” Another leadership participant further reflected on the incident and resolution, discussing their belief “that [the creation of an easily accessible gender-neutral restroom] wouldn’t have happened without the advocacy of our patients.”

Theme 8: Care Without Judgement: “Things You Can’t Talk About With Your Family Practice Doctor”

When asked how their health center provides care that meets the unique healthcare needs of the diverse spectrum of LGBTQ individuals, responses frequently included statements about providing care in a nonjudgmental manner. One staff/provider participant stated:

Whether it’s bottoming or PrEP and PEP, you know that the doctors here are going to know exactly what U equals U means, and are comfortable discussing things like fisting, you know . . . things you can’t talk about with your regular family practice doctor.

“Bottoming” usually refers to the sex position of being on the receiving end during anal sex, and “fisting” is a sexual practice that involves inserting part or all of the hand into the anus or vagina. The reference to “U equals U” in this participant quote referred to undetectable = untransmittable, an HIV messaging campaign implying that HIV-positive individuals cannot transmit HIV to others through sex if their viral load is undetectable. A similar comment was shared in another staff/provider focus group, when a participant noted, “We talk about things here that I’ve never seen discussed in other healthcare settings I’ve worked in . . . nowhere else would it be okay to talk about sex dungeons at work.”

This participant continued:

You know, we are a very sex positive organization. So again, we don't have a normal conversation sometimes . . . and there are some things that, you know, that are said to us, they can take you back a little bit. But, it's all in our mannerisms, and you have to be respectful.

During another data collection session, a provider said:

So for me, an individual provider, when I'm talking to somebody about sex, I'm asking them what kind of sex they like to have, and what kinds of people they like to have sex [with]. So making sure that I'm meeting people where they're at, and nothing is taboo. My hope is that they feel comfortable and safe to open up a conversation. Lots of people do.

Another staff/provider participant shared their health center is not afraid of "using the lexicon of the culture. Instead of using words like, anally insertive or anally receptive sex, [we] use language like 'are you a top or are you a bottom?'"

Patient/client participants shared comments that confirmed the importance of comfortably sharing and disclosing information and behaviors. When asked what they looked for in a healthcare provider, one patient/client participant said:

I want someone knowledgeable [that] knows their stuff. I don't want to have to educate them. If I want to talk to my doctor, male or female, about anal sex, I don't want them to be squeamish. I just want direct answers and take care of business.

Other patient/client participants shared similar comments. Previous studies have demonstrated the importance of LGBTQ patients feeling that their healthcare providers

offer nonjudgmental care (Klitzman & Greenberg, 2002; Ogden et al., 2020). Patients have reported having a queer or queer-friendly health provider is a facilitator to open and frank conversations about sexual health as well as increased use of healthcare services (Barbara et al., 2001; Rose et al., 2017).

Theme 9: Partnerships

The importance of developing partnerships with other organizations in the community came up during discussions with participants at both CVCC and PTH. These partnerships take many forms, including formal partnerships such as (a) co-locating clinic site operations within existing nonprofit organizations, and (b) informal arrangements such as collaborations with local food banks to provide patients/clients improved access to food. One staff/provider focus group participant shared about an important partnership their health center developed with a local legal services organization that provides pro bono legal assistance to transgender and nonbinary patients. They shared how this partnership has assisted patients in processes such as legally changing their name and gender markers to helping patients fight delays and appeal denials from insurance companies or payers for gender-affirming care services. Delays in accessing specialty affirming care because of referral and insurance authorization issues are common struggles gender minority individuals face within a healthcare system that largely still operates from a binary fixed mindset regarding biological sex and gender (Babey et al., 2022; Bakko & Kattari, 2020; National Coalition for LGBTQ Health, 2022). One of the leadership participants said:

They've been also a great partnership for us, because there's a lot of like policy that create these barriers. And so they've helped us push back on that for surgery

denials, or just laser hair electrolysis referrals [that] have been really challenging, because that's considered a cosmetic procedure historically. So we've had a lot of pushback on that, and that's [the partnership has] been really helpful. I can't imagine how people can have gotten carried through insurance without having that team to support them. The fact that we can offer that here is huge.

One of the FQHCs created a formal partnership with a local youth homeless shelter that serves a large number of queer youth in their community. This partnership model co-locates clinic services directly within the organization, which helps minimize barriers to care for these vulnerable youth by providing care directly onsite. One staff/provider participant shared more about this partnership, noting:

They're a really awesome organization. . . . It's pretty cool to have our clinic located there and learn about all the services they provide. They do a lot of housing for transient youth and runaways, and they provide clothes and food. . . . And so our clinic is there. We're serving them, and we're trying to prioritize them for our dental services as well as our behavioral health services.

Another leadership participant shared about how this partnership "helps expand the scope and reach of the health center to the community."

Theme 10: Training Staff

Training and workforce education efforts were also frequently mentioned as a way in which both CVCC and PTH provide care that is tailored to meet the needs of queer individuals. Unlike more tangible and noticeable ways noted in the previous themes (e.g., physical design and symbols, gender-affirming care services), these training efforts appear to be instrumental efforts aimed at creating the conditions where LGBTQ

individuals feel safe and respected within the clinic space and also feel the healthcare services they receive are appropriate and sensitive to their needs or situation. Given this theme directly connected to RQ3, additional description and findings are detailed in the following section that focused on data themes and findings related to RQ3.

Barriers and Challenges

For RQ2, staffing challenges and lack of funding were identified as the primary barriers the FQHCs faced when attempting to provide care that is responsive to the needs of LGBTQ individuals. Participants at both study sites talked about high staff turnover and difficulties attracting well-qualified staff and providers. One staff/provider participant shared their frustration with not enough staffing, noting, “We don’t have enough providers to serve the community. . . . We need to have more providers and other support staff that can help [with] any barriers that the patients come across.” The majority of other participants, regardless of role (i.e., leadership, staff, provider, patient) confirmed staffing as a major concern. Although patients/clients agreed it was important that staff and providers be representative of the LGBTQ community, at least two of them felt that staff and provider retention is as important, if not more important. One patient/client participant said:

I think the biggest question about staffing really has to be the excessive turnover gap. . . . It is, you know, it’s a problem that’s been going on, as I understand for probably 15 years. . . . So my perception [is that] it’s not like these staff would not or could not accept your—situation—your sexuality or your identity. My perception is that when somebody starts with a doctor, and then the doctor quits after 4 months, that continuity is the problem.

Immediately following this comment, another patient/client participant chimed in to confirm, stating:

That's one of the two reasons I'm not at [name of health center] currently. It was the turnover and the emotional investment you make in your own care. Because I'm looking down the road, I'm one hell of an advocate for myself right now, but as things change in my health, I want to be somewhere that will take care of me, you know.

This person went on to share a personal story about how they believed frequent provider turnover had impacted their health directly because a new provider to whom they were assigned was not well-versed on their health situation and did not take a health complaint seriously, resulting in a life-threatening health emergency. Additionally, a couple of other patients/clients across both health center sites shared personal accounts where they also believed that high employee turnover had directly impacted the quality of care they received.

Participants noted the lack of demographic data that are available on employees further complicates the desire to have a workforce that reflects the diversity of the patients and community being served. Although FQHCs are required to collect SOGI data on patients, no such requirement exists for staff and providers. During one of the leadership interviews, a participant stated:

So when I started, I was shocked to find out that for an organization that is steeped in the LGBTQ community, we didn't even have a way of identifying who on our own staff identified as LGBTQ, which was bizarre to me.

This participant went on to talk about how in previous jobs, this information was gathered from employees and it was advertised “so that people knew it was safe to work there.” The participant further shared that attempts are currently underway to capture SOGI data on employees at their health center “so they have baseline data they can use to compare and work from.”

Lack of funding was also frequently cited as a challenge. Leadership and staff/provider participants shared how difficult it was to provide holistic care services (e.g., case management and housing support) more broadly because those services are often not reimbursable expenses. In discussing adding additional gender-affirming care services, such as more legal assistance and laser hair removal, one of the leadership participants said their challenge was as follows:

Pretty simple. What we don’t have is funding specific to that program. . . . We can, for the most part, provide the kind of, you know, basic necessity of services like medical care and bill insurance [for those services]. But some of those support services will require more funding.

They elaborated more about trying to weave some of the gender-affirming care services into other areas of care that have more financial resources available, as well as pursuing grants to cover some of these costs.

Findings Related to Research Question 3

RQ3 asked, What training/education opportunities are provided to health center staff and providers on how to meet the healthcare needs of LGBTQ individuals? During each of the key informant interviews and the staff/provider focus groups, I asked questions about what training and educational opportunities exist for staff to learn about

and refine how they go about meeting the healthcare needs of the queer community.

Participants shared a variety of examples, such as gender sensitivity training, “training on best practices when it comes to people who are gender nonconforming,” training on the “differences between gender and sexual orientation,” and “general training on LGBTQ cultural competence.”

Three data themes were identified in the analysis. These themes are titled: “The Basics are Covered,” “Other Training is Happening but ‘It’s Accidental and Not Cohesive,’” and “Need for Additional Ongoing Education.” The first theme centered participants’ beliefs that CVCC and PTH are providing the necessary basic training to all employees on how to effectively serve the LGBTQ community. The second theme captured the idea that although other educational opportunities are happening related to increasing employee knowledge on LGBTQ healthcare, participants felt these trainings are not part of a thought out and coordinated training plan. Relatedly, the third theme focused on the notion that more ongoing training and education needs to be provided to health center employees. These themes inform the study findings related to Research Question 3.

Study Finding 4

Participants at both PTH and CVCC recognized the need for more continuous learning opportunities to educate their workforce on providing care that is sensitive to the needs of the LGBTQ community. Three data themes supported this finding. As previously stated, these themes are: ““The Basics are Covered,” “Other Training is Happening but ‘It’s Accidental and Not Cohesive,’” and “Need for Additional Ongoing Education.” These themes are detailed in the section that follows.

Theme 11: “The Basics are Covered”

Participants from both CVCC and PTH reported providing basic LGBTQ cultural competence training to all staff. One staff/provider participant noted:

I would just say that, like, as a whole, I think because of how we started, and kind of like what we represent, and who we want to represent and take care of, we have a high focus on cultural competency surrounding the LGBTQIA group. So you know, we have trainings for staff to make sure that they’re on the newest lingo and terminology and, you know, like, pronouns, a lot of people don’t understand that. So we do our best to make sure that our all of our staff, especially the frontline staff, are competent in those various areas.

Other leadership participants shared about the importance of these trainings in “creating a welcoming and affirming environment for everyone.” One staff/provider participant discussed how they observed employees taking pronoun training seriously, noting, “I could see some of my colleagues who are a bit older, you know, not understand that conversation quite as much as someone from my generation, but putting in just as much effort as everybody else to understand.” Although patient/client participants were not aware of what trainings were offered to health center employees, many appeared to concur with the notion that their health center did a good job covering basic cultural competence components in their workforce training efforts. One patient/client shared, “[Name of health center] does a pretty good job on training staff on things like terminology, pronouns, how to ask questions respectfully, things like that.”

Most Training Occurs When New Employees are Onboarded. Training that is conducted as part of new employee orientation/onboarding was referenced frequently

when participants were asked to share more about the learning opportunities that are provided to health center employees. Training topics such as LGBTQ terminology, cultural competence, trauma-informed care, and gender-affirming healthcare were commonly cited. Since 2020, CVCC has required that all new staff go through a live Gender 101 training. This 30-minute training explores terminology, shares differences between gender identity and sexual orientation, and provides some common best practices on engaging with gender diverse patients such as using inclusive language. The training was created by a provider in the gender-affirming care department and is facilitated by the gender-affirming care coordinator. Similarly, all new staff employed at PTH must go through a basic gender-affirming care training as part of their orientation. One staff person described this training, stating:

We go through lots of these kinds of issues that are subjects that people may or may not have even thought about before. I mean, that's where I learned the term sex worker, and the respectful way to speak. . . . [The training] then went through the pitfalls of what do you do, and what to do when you make a mistake. If you make a mistake . . . you just apologize, move on, and know better and do better. And if you see a transgender person, or intersex person, and you're unsure of what their pronouns are, and you haven't look[ed] before you get in the room, you can easily identify yourself, "Hi, my name is [insert name] and my pronouns are she/her/hers. What are your pronouns?" and then move on from there. So it's cultural competence.

Compliance-Related Training. Much of the current workforce training offered at CVCC and PTH is related to healthcare practice compliance. Given the nature of the

work that occurs at these health centers, ensuring that staff are regularly trained and up-to-date on compliance is crucial. Being out of compliance could lead to loss of funding, sanctions, lawsuits, and disruptions in care. These trainings typically address medical care standards as well as legal, fiscal, and regulatory requirements applicable to a medical practice.

Although some leadership and staff/provider participants referenced compliance trainings may address LGBTQ healthcare issues (e.g., Ryan White funding training, training on collecting SOGI data), the majority of these trainings appeared to be general in nature (e.g., dealing with bloodborne pathogens, Health Insurance Portability and Accountability Act [HIPAA] compliance). The human resources department at both health centers oversee this employee training process and track completion. Some of these compliance training topics are mandatory for all health center staff regardless of role (e.g., health center risk management training), whereas others are only required for specific employee groups/classifications (e.g., basic life-support training for clinical staffing). One staff/provider participant noted, “I think we also have an online mandatory training for cultural competence. I know that a lot of our providers do that because the health plans also require that. So, we do it from a compliance perspective.”

Theme 12: Other Training is Happening but “It’s Accidental and Not Cohesive”

In talking with health center employees and leaders, they referenced other training and educational opportunities that are provided to increase the knowledge and skill set of their employees as it relates to providing care that is responsive to the needs of the queer community. One provider participant shared about the creation of a new “more in-depth

training” on transgender and gender-affirming healthcare that is a passion project for them, noting:

The Gender 2.0 [training] was something I initiated and created, because I felt that there was a lot more that we could talk about. It’s more nuanced. There’s the re-up on terminology, the importance of pronouns, lived name, being respectful, [and] taking words out of your vocabulary like sir and ma’am. But then it goes into an in-depth explanation about the lived experience, why trans and nonbinary people are at such a high disproportionate rate of on being unhoused, unemployed, discrimination, violence, etc., with a lot of visual representation of that too, because I think people think, “Oh, we’re doing so much better.” I mean, yeah, but the stats haven’t changed much. And then [the Gender 2.0 training covers] some basics on like, intersectionality and trauma-informed care.

Another staff participant shared their health center had recently developed a care communications training “to help staff think about how they’re communicating.”

Because the focus group time was almost up, the participant was not able to get into the specifics of the training (e.g., When it is offered? How long? Is it for all staff, or just staff that interact with patients?), but did briefly state some of the communication questions underlying the training’s focus: “Are they opening those doors [by] asking more open-ended questions? Are they eliciting the information from patients that they need to tell, actually helping them [share] what their needs are.”

Similar to the compliance trainings previously referenced, some of these “other” trainings are available to all staff, whereas some are just for provider level staff. At both PTH and CVCC, several participants mentioned having access to asynchronous

computer-based learning modules that cover many topics including “LGBTQ health,” “cultural competence,” “implicit bias” and “LGBTQ cultural competence.” One staff/provider participant shared:

We all have what’s called Relias. There’s assigned courses that we have to take every year, but there’s also like 20,000 other courses that you can choose from. So if there’s something that you’re not sure about, or you want more education on, it’s all free and available to any staff member that needs it.

Additionally, leadership participants at both sites mentioned their health center encourages physicians, nurse practitioners, and physician assistants to take part in specialized training and education opportunities that exist outside what is provided directly by the health center. Specifically, participants cited training offered by the World Professional Association of Transgender Health (WPATH, 2023). WPATH (2023) is a membership and professional development association that has created ethical guidelines and professional standards of care for providing care to individuals with gender dysphoria. A couple of health center leaders referenced having medical providers who were “WPATH certified.” Figure 9 is a screenshot from one of the health center’s webpage. The screenshot image highlights that health center providers treating “transgender, intersex, and gender diverse clients” receive WPATH training and continuing education.



Figure 9. Screenshot Image From Study Site Highlighting WPATH Certification

Although these additional workforce training and education efforts occur at both PTH and CVCC, participants made no mention of a larger vision or plan for these efforts. One leadership participant talked about trainings, noting they:

lack connections and cohesion. There's none of that cohesiveness . . . it [training] might be accidental, but it's not cohesive where people know "Oh, I'm doing this as I'm interacting with the patient based on the care training that we did, and that's why we do it this way. Those connections are not there.

Similar sentiments were mentioned by other staff, provider, and health center leadership participants; however, one staff participant at each site talked about current efforts that are underway to assess existing staff training activities and to further develop and better coordinate training delivery.

"So That's Not a Class, it's Just Everyday Experience." A handful of participants explained that not all the training and education health center employees

receive on how best to meet the needs of the LGBTQ community is formal. According to one staff/provider participant:

We are all being trained and educated by our patients [and] by our fellow staff members. We have gay, straight, everything in between, transgender, we have a little bit of everything here. So if you listen, you ask questions, a lot of our patients aren't shy about telling you. You just learned cultural competence by coming to work and paying attention. So that's not a class, it's just everyday experience. I've learned so much, like if you make a few mistakes, just apologize and explain, "You know, I didn't mean to call you that. I apologize. Can you please educate me on what I should be saying? What do you want to be addressed as?" Our patients are not usually shy about letting us know. So a lot, a lot of cultural competence comes from just working here.

Other staff/provider participants concurred with that sentiment. One stated:

I'm surrounded by [an] abundance of expertise and peers that I admire. They are always offering suggestions [and] ideas. When you surround yourself with those, that is . . . something that I that did not have it my other places of employment.

Another shared:

We have staff that come on board and, you know, we've watched them, what they experience when we start talking about certain things. They say like, "you can't talk about things like that." But this is the norm for us. It's *how* we're talking about it, right, in a professional manner. It's related to a patient and affects the patient. So, we may be talking about alternative sex dungeons, or we may be talking about like other alternative lifestyles that are not the norm. And that is on-

the-job training, you know. You have to learn and listen. You may not agree with that, but you have to understand this is that patient's preference, and you have to make that patient feel comfortable.

Theme 13: Need for Additional Ongoing Education

Most of the leadership interviews and staff/provider focus groups ended by asking participants what they would do, if they had a magic wand, to improve the health of the LGBTQ population in their community. Many responses seemed to concentrate on the workforce education and training theme, specifically the need for more training opportunities to ensure staff are capable of serving this vulnerable population. One leadership participant shared they want to “have a staff who has the cultural competencies they need to be able to navigate all of those conversations effectively.”

During conversations regarding training, a couple of provider-level staff shared their belief that the need for more training and education exists because of the inadequate education provided during their preservice health professions education program (e.g., medical school, nursing school). This participant noted, “Gender-affirming care has not been included in the training for most medical professionals. So there's such a huge learning curve. Because of this, [it] seems like a responsibility on the organizations [the health center that employs them].”

The participant went on to share that their health center tries to “minimize that with having trainings in house, [but given that] people come from so many different backgrounds, so many different life experience levels . . . [they] don't think that people have the training that the patients deserve, to some extent.” These comments validated

the literature cited in the “Health Professions Education (HPE) Response” section of Chapter 2 (DeVita et al, 2018; Hollenbach et al., 2014; Obedin-Maliver et al., 2011).

A leadership participant reflected, “Any kind of cultural humility and continuous learning of the trans and nonbinary population is just, kind of, something that’s not currently happening.” Another participant stated:

I think something I’ve found to be important is multiple layers of training, right? Like you can tell somebody everything they need to know in one training and it’s not going to sink in, right. So it takes time . . . it needs to be ongoing. I think that is really important.

In addition to the need for continuous and ongoing training opportunities, two participants thought about how such training could be systematized and measured. One leadership participant pondered, “How do we build it into performance objectives and metrics, so that, you know people are actually doing that stuff in their job?”

Challenges and Barriers

In addition to the need for more and continuous learning opportunities for health center employees, time constraints were mentioned by many participants as a barrier. When staff and providers are in a training session, whether online or in person, this time away impacts the FQHC’s ability to provide care. One leadership participant commented:

I wish we could close the health center down for a couple of days, you know, every so often, to be able to conduct training for all employees. That’s a dream, but not a reality. We only make money if we are seeing patients.

Similar comments were made by other health center leadership and employee participants. A couple of participants, though acknowledging the need for more ongoing

training, worried more training conducted during the regular work day could adversely impact patient care, as one participant noted, by “mak[ing] wait times for appointments even longer.”

Other Data Themes and Findings

Although the data collection methods and instruments were designed to shed light on the study’s three research questions, a significant amount of collected data centered on the decisions that CVCC and PTH made to become FQHCs. These data included insights from key leaders in both organizations, as well as perspectives of employees and patients/clients. Originally, my plan was to not spend much time analyzing these data because the data did not seem directly related to the stated research goals; however, in keeping with constructivist grounded theory analysis that pushes the researcher to go where the data lead and to recognize the researcher’s role in interpreting the results (Charmaz et al., 2018), I decided to dig deeper into the data. In doing so, one additional data theme and finding emerged. Although this finding was not directly tied to any of the three research questions, it seemed to be an important contextual finding that was at least tangentially connected to the study’s focus. This finding and the data theme that supports the data, “Expanding to Serve the Entire Community While Still Maintaining a Focus on LGBTQ Healthcare,” is outlined as follows.

Study Finding 5

Paradoxically, leadership at CVCC and PTH saw becoming a FQHC as a way to secure the resources needed to continue meeting the healthcare needs of the LGBTQ community, despite the fact that becoming an FQHC meant they could no longer exclusively focus on HIV and LGBTQ healthcare.

Theme 14: Expanding to Serve the Entire Community While Still Maintaining a Focus on LGBTQ Healthcare

Both PTH and CVCC were started as grassroots organizations during the AIDS crisis and later became ASOs serving primarily gay and bisexual men, as well as MSM. As AIDS turned from a death sentence to a treatable chronic condition, leaders at both organizations simultaneously celebrated this accomplishment while also questioning what the role and vision for their agencies would be moving forward. CVCC and PTH were not alone. Advances in research and treatment, combined with changes in federal funding streams and the passage of the Affordable Care Act (ACA), forced many ASOs to consider their long-term survival (Ryan, 2011). Although exact numbers are not available, many ASOs decided to merge with existing FQHCs or to expand their services and apply for FQHC status. Senior leaders, including the boards of directors at both CVCC and PTH, opted to apply to become FQHCs. PTH was awarded FQHC status in 2012 and CVCC was awarded FQHC status in 2014.

As detailed in Chapter 2, FQHC designation provided needed financial benefits to PTH and CVCC, such as access to additional federal funding and the ability to bill Medicaid for many of their services; however, one stipulation of becoming an FQHC is that although they can provide focused or specialized care to specific communities that the federal government deems as “medically underserved” (such as the LGBTQ community), by federal statute they are required to provide services to anyone in their geographic service area (HRSA, 2021b). This stipulation has become a delicate political issue for many ASOs that have considered or have gone through the conversion process

from ASO to FQHC. When asked about the decision to become an FQHC, one study's leadership participant talked about the decision being a practical and financial decision:

Funding for providing HIV/AIDS services was becoming less and less and if we wanted to continue to exist, we needed to explore ways to bring in other sources of revenue. Becoming an FQHC allowed for that. More importantly, we wanted to pay it forward and use our knowledge and expertise in community responsive care to be able to serve other marginalized populations.

This individual went on to say, "We will always maintain a focus on LGBTQ healthcare—it's in our DNA." Another leadership participant stated that serving the LGBTQ community was "core" to the organization's mission, and continued:

You can always expand, but you can't forget your core base . . . I think [name of health center] knows that if they don't focus on LGBTQ health needs, who will? . . . As long as the LGBTQ community is a community that's in high need, it's always going to be a focus, because that's just kind of how we roll.

This participant further highlighted the idea of using the organization's existing knowledge and expertise, expertise rooted in serving the LGBTQ community, in other ways:

COVID created a unique opportunity for [name of health center] to position themselves as providers of health care for the entire community . . . we are experts in infectious disease and this thing that's happening [COVID] that's very marginalizing, and people are afraid and don't want to get it . . . we went right in on day three and created a COVID clinic. Because of the, you know, the diseases that we're used to working with, I just think that [name of health center] was

uniquely positioned. I don't think there was a single lesson that had to be learned.

It was just like, "Oh, let's take all these things that we've learned over all the years that we're really expert at and apply them to this thing that's affecting the whole population." This [COVID] fast-tracked us to where we were going . . . to broaden the scope of who [name of health center] was providing services for.

This same participant went on to talk about how the decision to open up a COVID-19 clinic so quickly at the beginning of the pandemic "was a moment of pride."

Several other participants discussed the delicate nature of choosing to transition from an ASO to an FQHC. Several shared stories of fear, including one participant who worried that the gay community "would feel that we were turning our backs on them." Another leader talked about how the board of directors felt "very passionately about ensuring that the LGBTQ community wasn't left behind" during the transition, and expanded:

We have several board members [that] have been there since towards the beginning. . . . So while they wanted to expand services, they also did not want the LGBTQ community to be left behind. So it's been very intentional from a strategic perspective. And then also, for me, from an operational perspective, that's who we are. That's our niche. . . . Our [niche] has been those vulnerable marginalized community members who are LGBTQ.

Other staff/provider participants talked about the transitions, which included name changes and rebranding, with one participant noting the transition "creat[ed] some noise and drama" in their local gay community. This "noise" unfortunately led to some within the queer community feeling disillusioned. One of the few distinctions between the data

collected from participants at CVCC and participants from PTH had to do with how long-term staff and the queer community reacted to the conversion from an ASO to a FQHC. Participants from CVCC referenced negative reactions from the queer community and long-term staff much more frequently in the data than did participants from PTH. One staff/provider participant from CVCC shared how the decision to transition was done “without prewarning or authentic engagement with the staff and community.” They compared the sudden change to a grenade going off, stating, “I was here when that grenade went off. It not only damaged our reputation with the LGBT community, it actually damaged relations with the staff. . . . Literally overnight, we went from a family to a factory.” Shortly after making this comment, the participant transitioned to talking about the ongoing repercussions of this change, noting, “I don’t know how many patients I no longer see who won’t step inside the clinic anymore because they don’t feel safe.” Sentiments such as these were common among staff, patients/clients, and some leadership participants from CVCC. One patient participant stated:

I know a lot of, well, quite a few people from the [name of support group for patients who are long-term HIV survivors], I really feel like they, and myself included to some extent, feel like that when the name changed, that the HIV community anyway, and the gay community, was sort of pushed aside.

Current organizational leaders have acknowledged that the transition at CVCC did not go as smoothly as planned, and several participants shared how the health center has worked to repair trust within the LGBTQ community, including one participant who cited:

Making a commitment to honor what brought us here. . . . You know, we need that to be foundational, and continue to build on that because so much of what we do is serving underserved marginalized communities. That's the whole LGBTQ community, right? So why would we give that up?

Another leadership participant contextualized this notion within the larger healthcare landscape, stating:

You know that dynamic between going from an HIV clinic to an FQHC, I know that a lot of HIV clinics have done that. It's kind of been like a theme or something to remain sustainable. I don't know if it's just us, but I'm pretty certain it's all of them [that] have gone through this. They've gone through this transformation. It's been a, you know, kind of a push pull kind of struggle to retain that identity.

Summary

This chapter chronicled the five findings of this study that were derived from 14 data themes. Participant quotes helped to illustrate the data themes that supported these findings. These findings included:

- **Study Finding 1:** Study sites primarily use patient/client data, community outreach efforts, and formalized patient advisory groups as mechanisms to understand the healthcare needs of the queer community in their service area.
- **Study Finding 2:** CVCC and PTH use a variety of approaches to meet the healthcare needs of the LGBTQ community. Despite vastly different patient demographics, both health centers use similar approaches and these

approaches generally align with practices and procedures that patients/clients view as affirming.

- **Study Finding 3:** To meet the healthcare needs of the LGBTQ community, both health centers involved in this study place a high value on human resources. This value was exhibited in two ways: (a) attempting to hire a workforce that is representative of the queer community and (b) providing training and educational efforts to health center employees to better equip them with the knowledge and skills they need to effectively interact with queer individuals.
- **Study Finding 4:** Participants at both PTH and CVCC recognized the need for more continuous learning opportunities to educate their workforce on providing care that is sensitive to the needs of the LGBTQ community.
- **Study Finding 5:** Paradoxically, leadership at CVCC and PTH saw becoming a FQHC as a way to secure the resources needed to continue meeting the healthcare needs of the LGBTQ community, despite the fact that becoming an FQHC meant they could no longer exclusively focus on HIV and LGBTQ healthcare.

CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

The outcome of any serious research can only be to make two questions grow where only one grew before.

—Thorstein Veblen, *The Evolution of the Scientific Point of View*

Introduction

In this dissertation, a two-case comparative case study examined how two Federally Qualified Health Centers (FQHCs) went about understanding the healthcare needs of the lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) population and then sought to put those understandings into action to provide high-quality, culturally competent care specifically tailored to this underserved community. There were 41 participants consisting of 10 health center leaders, 10 health center patients/clients, and 21 health center staff/providers. The data collected from key informant interviews, focus groups, and document analysis were analyzed using grounded theory methods. Grounded theory analysis allowed for an in-depth exploration of the research phenomenon and facilitated the identification of emergent themes from the data (Bhattacharya, 2017; Creswell & Creswell, 2018).

Five findings were identified, pulling from 14 data themes. In this chapter, I discuss the findings outlined in Chapter 4 and apply the theoretical lens of critical race theory and queer theory to further explore how these findings can be interpreted and understood. From there, a preliminary theory of what LGBTQ cultural competence within FQHCs might entail is shared, grounded in the data. Practice recommendations, implications for future research, and study limitations are also outlined.

Aim of the Study

Despite the growing awareness and attention to health disparities within the LGBTQ community, significant health inequities continue to persist. Providing culturally competent healthcare is one proposed strategy that may mitigate these inequities (Betancourt et al., 2003; Felsenstein et al., 2018; Schafer et al., 2019); however, a lack of consensus exists on what constitutes LGBTQ cultural competence, hindering the implementation and evaluation of its effectiveness as an intervention strategy. This study sought to better understand the LGBTQ cultural competence construct by studying how two nonprofit FQHCs that specialize in serving the queer community understood and operationalized care targeted to this population. Three related research questions (RQs) guided this investigation. They were:

RQ1: How do community health center staff, providers, and leaders go about understanding the healthcare needs of their LGBTQ patients/clients?

RQ2: What are the specific ways in which LGBTQ-focused health centers go about providing care that is tailored to the needs of LGBTQ individuals?

In what ways, do these understandings align with practices and procedures that LGBTQ patients/clients report as affirming?

RQ3: What training/education opportunities are provided to health center staff and providers on how to meet the healthcare needs of LGBTQ individuals?

By exploring these research questions, I aimed to contribute to the limited empirical knowledge base and generate new insights to inform future research in this area. More importantly, as an activist researcher who believes in the community health center model

of care, my desire was for these findings to inform critical reflection, evaluation, and action that result in improved healthcare for LGBTQ communities.

Discussion of Data Themes and Findings

RQ1: Understanding the Need

RQ1 sought to explore how Central Valley Community Care (CVCC) and Palm Tree Health (PTH) went about understanding the healthcare needs of their existing LGBTQ patients and the larger queer community within their service area. The analysis of data collected regarding this question produced three main themes and one finding.

- **Study Finding 1:** Study sites primarily used patient/client data, community outreach efforts, and formalized patient advisory groups as mechanisms to understand the healthcare needs of the queer community in their service area.

Generally, the three themes and their subcategories were not surprising and were confirmed by previous literature; however, the theme regarding patient advisory groups and their role in advising CVCC and PTH, along with representing the voice of the LGBTQ community was both motivating and peculiar. Study participants, including current and former members of their respective health center's patient advisory groups, spoke of the importance of patient advisory groups to elevate the voices and perspectives of the patients and community. Within these data, a former patient advisory committee member shared, "I took my work home with me far too often."

This participant's comment struck me when it was shared in the focus group and has continued to sit with me. To me, this comment, along with others that highlighted the value of these patient advisory groups, illustrated the dedication and commitment that members of these volunteer groups felt. Given that FQHCs and other healthcare entities

are charged with providing patient-centered care, engaging patients/clients in authentic and structured ways that do not tokenize their involvement seems liberatory. Those needing care are included as partners in the discovery process, offering input and recommendations on specific approaches or services that would benefit them and other patients. Assuming these patient advisory groups are representative of the health centers' patient population (with a keen eye on ensuring that intersectional identities are included and prioritized), they have the power to disrupt traditional mindsets by offering important patient counternarratives. Counternarratives are one of the central tenets of both queer theory and critical race theory (Crenshaw et al., 1995; Delgado & Stefancic, 2001; Halperin, 2003). Mishler (2005) called these counternarratives *narratives of resistance*, suggesting patients sharing their stories about the dehumanizing aspects of the biomedical model can be viewed as a form of resistance whereby patients assert their agency and fight to be seen as individuals instead of a medical diagnosis. Tullis et al. (2017) contended, "Narratives of resistance provide alternative forms of knowledge important for countering dominant narratives and incorporating already marginalized individuals into society" (p. 66). By listening to and attempting to understand these alternative narratives, healthcare providers can become more patient-centered and customize care based on the individual's needs.

Further reflection and memoing on the role of these patient advisory groups brought up additional questions and a couple of possible concerns. First, my understanding was these groups are indeed advisory and that members of the patient advisory groups at both CVCC and PTH have no formal authority nor voting power over health center priorities or operations. These group members are not part of the board of

directors for the organization. Viewed through the critical paradigm that supported this study, the lack of formal authority brings up issues of power, specifically power imbalances and assumptions about power structures within organizations that may be taken for granted. If patient advisory groups are one of the main ways that PTH and CVCC solicit feedback and go about understanding the needs of their existing LGBTQ patients/clients, then why do these groups not have more authority? By posing this question, I am not suggesting that these groups do not have influence, nor that influence is not a form of power. Both critical race theorists (Collins, 2009; Delgado & Stefancic, 2001) and queer theorists (Foucault, 2011; Warner, 2000) have argued that formal power is not the only power that operates in a society. These theorists have contended that informal power and influence can play a significant role in shaping social relationships and cultural norms—although these forms of influence often disadvantage certain groups and privilege others. However, researchers have also suggested that influence is strengthened when combined with formal authority (Bonawitz et al., 2020).

Surprisingly, when asked about how CVCC and PTH personnel sought to understand the needs of their community—specifically the needs of the queer community—patient advisory groups were a central theme in these discussions, but not the health center’s official boards of directors. FQHCs are required by federal statute to have a board of directors consisting of between nine and 25 voting members. Health center boards of directors must be comprised of at least 51% consumers (also known as patients/clients) who receive healthcare services at the health center (HRSA, 2021b). Contradictory to many laws and regulations, requiring FQHCs to have a majority patient board gives power back to historically marginalized populations (HRSA, 2021b; Wright,

2013). This requirement seems responsive to critical race theory and queer theory critiques on how structural mechanisms have perpetuated inequity against racialized and queer communities.

I was expecting participants to talk about the role of this unique board structure in helping CVCC and PTH connect with, understand, and be responsive to community needs; however, across the corpus of data, the board of directors was rarely mentioned. One participant did mention, “During board meetings, there is some focus on bringing in patient voice into those conversations to kind of personalize the decisions you’re making.” The part of the comment stating “there is *some* focus on bringing in patient voice into conversations” (emphasis added) suggested to me that this participant did not feel like the patient perspective is already included among members of the board and, therefore, they have sought it out in other ways (e.g., from the patient advisory group). Furthermore, because participants did not mention the board of directors, they may not believe the board acknowledges patients’ perspectives.

In seeking to interpret the study findings, I further wonder why the patient advisory groups at CVCC and PTH are distinct and separate from the health center’s board of directors. Perhaps there is some plausible reason and value to this approach, but if so, this reason did not explicitly appear in the study findings. In an effort to have “professional boards” with more expertise in healthcare, management, and fundraising, some FQHCs have bent, or “worked within,” board composition requirements to recruit a board that does not live up to the original intentions of the majority patient board requirement (Bracken, 2007). Without knowing the board recruitment strategies at PTH and CVCC, or the number of board members who are genuinely health center patients

(i.e., the health center is their primary healthcare provider), I cannot say if this is the case at CVCC or PTH. If it is, there are likely opportunities for these health centers to critically reflect on this decision and assess how the stated value for patient advisory groups can be reconciled within the organizational structure and power dynamics. Critical reflection and interrogation related to this dynamic is highlighted in the implications and recommendations section of this chapter.

Discussion of RQ2 Findings: Translating Needs Into Action

RQ2 moved from understanding the need to translating this understanding into action by exploring how CVCC and PTH go about providing care designed to meet the needs of the LGBTQ community. The analysis produced seven data themes, and from those were derived two study findings.

- **Study Finding 2:** CVCC and PTH use a variety of approaches to meet the healthcare needs of the LGBTQ community. Despite vastly different patient demographics, both health centers use similar approaches and these approaches generally align with practices and procedures that patients/clients view as affirming.
- **Study Finding 3:** To meet the healthcare needs of the LGBTQ community, both health centers place a high value on human resources. This value was exhibited in two ways: (a) attempting to hire a workforce that is representative of the queer community and (b) providing training and educational efforts to their employees to equip them with the knowledge and skills they need to effectively provide care to the LGBTQ community.

With RQ2, I attempted to tease out mindsets, practices, and policies that get at this idea of cultural competence without overlaying a particular construct or definition as to what culturally competent healthcare looks like or has to be. Given the debates and ambiguity in the existing literature that were discussed in Chapter 2, I was less interested in exploring whether or not these health centers adopt an existing conceptualization of cultural competence but was more interested in the *how*—how PTH and CVCC go about enacting care tailored to the unique needs of existing queer patients as well as the larger queer community. Participants provided many ways in which CVCC and PTH go about meeting the unique healthcare needs of their existing queer patients as well as the larger queer community.

Across the collected data, the role of organizational policy appeared to be absent in these discussions, at least explicitly. For example, in their efforts to provide gender-affirming care and create clinic spaces that are affirming for LGBTQ folx while also appealing to other community members seeking services, I would suspect that both CVCC and PTH have had to refine and create new organizational policies to support those endeavors. I further surmise that policy interventions may not have come up in the conversations because those are less tangible than interventions such as providing hormone replacement therapy or access to housing support. Queer theory and critical race theories argue that policy plays a significant role in perpetuating inequity by reinforcing existing power structures and institutionalizing discrimination and oppression (Muñoz, 2009; Solórzano & Bernal, 2001). As both organizations continue striving to meet the needs of marginalized communities, there will likely be opportunities to (re)evaluate existing organizational policies, both formal and informal, to identify where there may be

opportunities to further dismantle institutionalized inequity. For example, policies regarding operating hours may need to be altered to ensure the health center is open and available on days and hours that are more convenient for their patients and community. Additionally, given both FQHCs serve an increasing number of patients who speak languages others than English, enhanced policies and procedures for ensuring language access seem warranted.

Revisiting “The Bathroom Incident”

Providing specialty care and tailored services to the queer community was one of the data themes identified in response to RQ2. Under this theme, providing gender-affirming care was a subtheme that consistently came up. “The Bathroom Incident,” as elaborated on in Chapter 4, served as an example of the need to consistently and critically challenge formulaic or rote ways of achieving culturally competent care. In existing literature, there are existing models of cultural competence that could be construed as providing a checklist for how healthcare providers can go about addressing cultural competence. For example, the national cultural and linguistically appropriate services (CLAS) standards highlighted in the literature review share 15 standards, or action steps, that all healthcare entities should take (Office of Minority Health [OMH], n.d.-b). Four of these action steps relate to language accessibility (e.g., providing translation services during appointments, ensuring that forms are available in multiple languages). Although these models provide concrete examples of what culturally competent healthcare is, they run the risk of also reinforcing static and myopic views that can be problematic if they assume culture is nonevolving and that cultural competence can be fully achieved through completion of a checklist of activities.

Furthermore, these standards can provide a false illusion to healthcare entities that they have achieved cultural competence. For example, the National LGBTQIA+ Health Education Center (2021) promoted having gender-neutral bathrooms as one of the 10 essential strategies for creating inclusive healthcare environments for LGBTQ individuals. Again, these strategies can be helpful, but they lack nuance and critical reflection. The health center where “the bathroom incident” occurred might have assumed that they were meeting the needs of their transgender and gender nonbinary patients because they technically had a gender-neutral bathroom; however, as this incident highlighted, there is much more nuance involved in LGBTQ cultural competence. Sure, checklists and other assessment tools can be helpful starting points, but efforts should not stop there. There needs to be a deeper and more critical process that challenges hegemonic understandings and digs into contextual nuances.

Overlaying critical race and queer theories, “the bathroom incident” could be viewed as another display of systemic and institutionalized discrimination operating through multiple layers of oppression including racism, sexism, homophobia, and transphobia. Queer theorists would argue that the social construction of binary gender and how this social construction manifests in inequitable ways has been reinforced in the built environment (Foucault, 1978). Furthermore, queer theory might emphasize that the fight for easily accessible gender-neutral bathrooms is part of a larger movement toward transgender rights and liberation (Halperin, 2003; Spargo, 1999). Critical race theory would also contend that the lack of easily accessible gender-neutral bathrooms has to do with policies and practices that are shaped around the dominant ideology (Solórzano &

Bernal, 2001) and provides an example of how inequity is so normalized in society that it often goes unchecked.

Stolz (2010) stated, “In the process of coming to voice, one may hesitate in silence, enduring gripping fear, and risk embarrassment and safety before finally having her voice heard” (p. 21). These words are a reminder that it is not only scary, but often risky for oppressed people to speak out against the status quo. Despite this risk, history/herstory has shown for many marginalized groups, power comes with finding voice, and sometimes so does change. Ultimately the gender-neutral bathroom issue was resolved through the centering of marginalized voices. Whether or not this resolution stemmed from the health center that centered those voices or the transgender patients themselves who demanded their voices *be* centered is likely dependent on the varying perspectives of those involved. Either way, dominant ideologies (e.g., the gender binary) work hard to keep resistant voices at bay. Dominant ideologies, and those that benefit from them, often disavow, discredit, and shame these voices when they do speak.

Discussion of RQ3 Findings: Continuous Learning

RQ3 dug deeper into the workforce training and educational opportunities that CVCC and PTH provide their employees to meet the healthcare needs of their LGBTQ patients and the larger queer community in their service area. One finding related to this research question that was derived from three data themes.

- **Study Finding 4:** Participants at both PTH and CVCC recognized the need for more continuous learning opportunities to educate their workforce on providing care that is sensitive to the needs of the LGBTQ community.

Study participants at all levels overwhelmingly cited the need for training that is ongoing. Health center leaders, providers, and staff all mentioned that much of the existing employee training efforts on how to engage and partner with marginalized communities in achieving health occur either as part of new employee orientation or in response to meeting compliance standards. Patients/clients at both CVCC and PTH shared personal examples of how the lack of adequate training had impacted the care they received. They shared instances where they were made to feel unwelcomed or misunderstood. Additionally, participants recounted instances where they believed the lack of proper training and employee skill development led to poorer care than they otherwise would have received. Participants acknowledged that existing training and workforce development opportunities are insufficient to create a culturally competent healthcare environment.

Originally, there was a subquestion under RQ3: Do these opportunities take into account intersecting identities that often create further marginalization for LGBTQ individuals? To help answer this subquestion, the original methodological design included a much heavier focus on document analysis, including reviewing organizational strategic plans and workforce training curricula and materials through the lens of critical race theory and queer theory, the theoretical framework adopted for this study; however, I was unable to access most of these documents and resources, which I further discuss in the study limitations section at the end of this chapter.

As many qualitative researchers do to be responsive to unanticipated obstacles, I adapted my plan. In lieu of this information, I asked study participants more questions about what types of workforce education opportunities exist at their FQHCs. I probed

deeper to try to get an idea of what was covered during these trainings and if there were explicit or implicit tenets of critical race theory and/or queer theory woven into training content. In doing so, I heard a mixture of perspectives on whether these educational opportunities were critically informed. One leadership participant stated:

I would be surprised if even 10% of the people in this organization understood the concept of intersectionality. I don't think they do. I mean, I think some of the providers do [and] I'm gonna guess that some of the clinicians understand intersectionality in terms of how it impacts clinical outcomes and people's overall health. But, in terms of how it impacts social determinants of health, and why people are in that condition in the first place, I don't think we have talked enough about that.

Another staff participant who had developed a Gender 101 training that was delivered as part of new employee orientation recognized this training missed essential opportunities to look at intersectional identity and acknowledged how the healthcare system perpetuates inequity to those who identify as transgender and gender nonbinary. Partly because of this issue, they created a Gender 2.0 training as a follow-up training. In reflecting on this new training, the participant stated:

I think one of the most important bits is that there's a case [group activity] for everybody to go over to kind of address implicit bias and really get the conversation rolling. I think that's been maybe the best part of this training.

This participant went on to describe how each of the case scenarios is tailored to the health center department that is being trained, noting, "So if I'm talking to the call center, I tailor [the] case for their department."

Without being able to further investigate objectives, curriculum, handouts, and evaluation feedback, I am not able to state with certainty whether or not the training and educational opportunities offered to staff at CVCC and PTH took a critical theoretical approach, weaving in perspectives from critical race theory or queer theory. However, based on the data collected from participants' recollections, there was minimal mention of opportunities for staff to interrogate their own beliefs and opinions or to understand the history/legacy of the medical industry's role in creating and perpetuating false pathology mindsets regarding race, ability, sexual orientation, and gender identity. Additionally, there was no mention of how counternarratives help to inform these trainings or how these alternative viewpoints could be used during the trainings to resist or subvert the dominant narratives in healthcare that are resistant to change.

Herein lies an opportunity. More work could be done to critically evaluate and refine existing LGBTQ cultural competence training efforts and to develop new and ongoing training and education offerings that address the evolving needs of the community, foster inclusivity, and promote a deeper understanding of the diverse experiences and identities within the LGBTQ spectrum. By explicitly embedding tenets of critical race theory and queer theory into training design, the stories and experiences of those most marginalized within the LGBTQ community, along with those most marginalized in healthcare, could be centered and better understood. Furthermore, intersectional identity could be factored into workforce training efforts, and in doing so, could lead to a more encompassing and holistic understanding of how to go about enacting culturally competent care.

Discussion of Additional Data Theme and Finding

In addition to the themes and findings connected to the three research questions for this study, there was extensive discussion about how both health centers transitioned from being AIDS Services Organizations (ASOs) to FQHCs. After additional examination and assessment of these data, another finding was discerned.

- **Study Finding 5:** Paradoxically, leadership at CVCC and PTH saw becoming a FQHC as a way to secure the resources needed to continue meeting the healthcare needs of the LGBTQ community, despite the fact that becoming an FQHC meant they could no longer exclusively focus on HIV and LGBTQ healthcare.

Health center leadership participants consistently saw the conversion from ASO to FQHC as a practical and necessary business decision to sustain organizational operations.

Staff/provider and patient/client participants held a range of opinions. Some agreed that the transition, and resulting expansion to serve a larger population, was needed. Others either were not convinced of the need to transition to an FQHC, and/or felt the transition was poorly executed. Now that CVCC and PTH are FQHCs that are required to serve anyone within their geographic service area, some of the staff/providers and patients/clients held the belief that the needs of the LGBTQ community are no longer primary objectives for the health centers. Contrary to that opinion, some CVCC and PTH leaders believed the expansion allowed them to continue to prioritize care for the queer community.

Critical race theory would attend to this tension by considering the subjective experiences and perspectives of marginalized or oppressed groups. Critical race theory

emphasizes the importance of understanding intersecting forms of oppression (Crenshaw et al., 1995; Ladson-Billings, 2013). In the context of an ASO becoming an FQHC, critical race theory would encourage an analysis of how race, socioeconomic status, and other factors intersect with the experience of living with HIV/AIDS and accessing healthcare services. On one hand, queer theory might caution against this organizational transition because of traditional norms and binaries that exist within healthcare and the need to have dedicated and inclusive spaces that cater to the needs of LGBTQ individuals; however, queer theorists might also hypothesize that the transition from ASO to FQHC helps the queer community because it could destigmatize HIV/AIDS by integrating it within a broader healthcare framework, thus normalizing the condition and its treatment.

Emerging Grounded Theory

Grounded theory analysis allows for a theory to emerge that is informed by, or better yet, grounded in the collected data. This approach is often used when a topic or phenomenon is not well understood (Leavy, 2017). The lack of consensus within the existing literature about what culturally competent healthcare is, and specifically how FQHCs go about providing culturally competent healthcare to the LGBTQ community, is one such phenomenon that is complex and poorly understood.

In the first few key informant interviews conducted for this study, I asked health center leaders to talk about what cultural competence means to them or to share how their FQHC goes about providing culturally competent care. A few respondents did not hesitate to respond. One health center leader stated, “Cultural competence means that people feel welcomed and understood.” As they further explained this statement, they

began to reflect upon this definition in relation to their own health center's practices, and they shared how currently most of their organization's signage is only in English and that this may not make everyone feel welcomed and understood, especially given the increasing number of Spanish-speaking patients the center serves. Another participant was less confident that they knew what the term "cultural competence" meant. They noted, "I think, you know, everything falls under this umbrella of cultural competence. But then we don't actually think about what that means." This statement supported existing literature shared in the literature review regarding the ambiguity of what culturally competent healthcare actually means (Beach et al., 2005; Betancourt et al., 2003; Cain et al., 2017; Gilmer et al., 2017; Lucas et al., 2008; Shepherd et al., 2019; Tehee et al., 2020; Truong et al., 2017).

Another participant seemed delighted to share their thoughts about what culturally competent healthcare actually is, stating:

There's a lot more to being culturally competent than [understanding the healthcare needs of] older white gay guys including those with HIV and AIDS. . . . Yeah, it goes beyond that. We need to care about our trans brothers and sisters. . . . Culturally competent care goes way beyond gender, or LGBT, it goes way beyond. I mean, it includes things like, are you culturally competent with the Hispanic and Latino, Latinx and African American [communities]? Are you culturally competent with people that are illiterate? Or people that are, you know, service veterans. . . . Do you provide language services beyond Spanish and English?

In this response, the participant highlighted a few important points that connected to existing literature. First, they recognized that culturally competent healthcare needs to consider intersectional identity and center those who are multiply marginalized. The lack of an intersectional critical conceptualization of cultural competence has been highlighted as a critique in some of the literature (Gorski, 2016; Whaley & Longoria, 2008). The participant also used abstract words and language such as “*it goes beyond*” and “*it includes things like are you culturally competent with*” with very little explanation or concrete examples as to what “*it*” (e.g., cultural competence or culturally competent healthcare) actually is. This observation connected to a previous comment about the vagueness of the term. Lastly, toward the end of the comment, the participant did provide a concrete behavior or practice that, in their mind, constitutes culturally competent care: “providing language services beyond English and Spanish.” This statement, too, aligned with the previous literature sharing that language access and translation are among the most commonly mentioned ways of providing culturally competent care (Aggarwal et al., 2016; Handtke et al., 2019; Jetty et al., 2021). Indeed, language access and translation are important considerations to those who need them, but are insufficient in framing and fully understanding what constitutes culturally competent care. Thus, the complexity in describing the term and identifying specific behaviors and actions related to it.

Another participant used the term “cultural humility” when describing the approach they use when working with patients who may have different identities or experiences than they have had. As discussed in Chapter 2, cultural humility is one of the many theoretical constructs akin to cultural competence (Tervalon & Murray-Garcia, 1998). The participant stated:

Cultural humility to me just describes this continuous learning process where cultural competency makes it sound like, there's a, there's an end, and there's never an end. It's just this constant level of learning.

In sharing this statement, they emphasized the point that the process, whatever one calls it, should be continuous.

I understand the need for clarity as to what defines culturally competent healthcare. Definitions and frameworks can help make sense of otherwise complex ideas. This clarity could be beneficial in many ways for FQHCs; it could inform staffing, workforce development and training, the services that are provided, and the way in which quality is measured. However, as with Greene-Moton and Minkler (2019), I wonder if philosophical debates about terminology (e.g., should it be “cultural competence” or “cultural humility”) distract from the ultimate goal of working to meet the healthcare needs of minoritized and marginalized populations. Sure, words matter; however, I suggest in the grounded theory outlined in the following section, that the lack of clarity on the construct of cultural competence persists because the actualization of the construct is contextual and nuanced. Take in point, “the bathroom incident.” Again, if that health center used a checklist approach as to what constitutes LGBTQ cultural competence, no doubt it would include having gender-neutral bathrooms. Because the health center did have gender-neutral bathroom facilities, they could check that box and move on. However, they missed important context and nuance, such as examining whether their structure (i.e., gender-neutral bathroom behind a locked door) and procedure (i.e., having to get a key from a security guard or receptionist to access the gender-neutral bathroom) constituted an approach that was worthy of being called “culturally competent.”

The Study's Grounded Theory: LGBTQ Cultural Competence

Comparing the data collected for this study against the existing literature, a theory of LGBTQ cultural competence within an FQHC setting began to emerge. This theory suggests that LGBTQ cultural competence involves many factors. Cultural competence in this context begins by (a) centering and giving authority to diverse LGBTQ patient voices; (b) collecting and using patient data to improve care; (c) outreaching to the queer community to better understand needs; (d) having employees at all levels that reflect the community; (e) providing specialty care and tailored services that include sexual health and gender-affirming care; (f) creating partnerships with other entities to support and extend care; (e) ensuring the health center space is welcoming and affirming; (f) providing nonjudgmental, holistic care; and (g) providing ongoing training and education to all health center employees that allows them to interrogate their own identity, privilege, and biases.

Moreover, LGBTQ cultural competence within an FQHC context must acknowledge that healthcare is a system deeply embedded with legacies of institutionalized racism, ableism, homophobia, and transphobia. This grounded theory further proposes that LGBTQ cultural competence is not a checklist and undoubtedly includes other things not identified in this list. There is no exact formula to providing culturally competent healthcare to LGBTQ folx. Such a provision involves constant critical dialogue and reflection, and an understanding that cultural competence is not a destination, but a journey. This theory, like the construct itself, is multilayered and highly nuanced. What works in one setting may, or may not, work in another, and what works in 2023 may not work in the future.

Implications and Recommendations

Several implications and specific recommendations can be drawn from this study. These broader implications and specific recommendations are outlined in the following section, beginning with recommendations for practice and policy, followed by implications for research.

Recommendations for Practice

Based on the research findings, PTH and CVCC have demonstrated commendable efforts in addressing the needs of the queer community. A few recommendations that these and other FQHCs attempting to meet the healthcare needs of the LGBTQ community should consider are as follows:

- **Apply a critical lens to evaluate training efforts.** Evaluate current cultural competence training and educational programming using critical theories (e.g., critical race theory, queer theory) to examine the content, methods of delivery, and outcomes. Review the training materials for representation and inclusion of diverse LGBTQ perspectives. Ensure that the content acknowledges and addresses the impact of systemic racism, heteronormativity, and cisnormativity on marginalized groups. Consider whether or not power dynamics are discussed within these trainings and, if not, consider adding content that challenges traditional power structures and dominant ideologies. Assess the impact of training and education efforts at the individual and organizational level looking for changes in attitudes, behaviors, policies, practices, organizational culture, and outcomes.

- **Strengthen workforce education efforts.** CVCC, PTH, and other health centers attempting to better meet the healthcare needs of LGBTQ community should identify ways to strengthen and better coordinate their workforce education efforts. To the extent possible, this process should seek out and listen to counternarratives or narratives of resistance from patients and community members who belong to marginalized LGBTQ communities. One way to do this is to use storytelling as a pedagogical method (Solórzano & Yosso, 2002) to foster understanding and awareness by inviting patients to these trainings to offer their insights and lived experiences. Ensure that trainings acknowledge and address the intersections of race, disability, gender, sexuality, and other social identities, recognizing that individuals who are multiply marginalized often face unique and additional barriers. Create spaces before, during, and after trainings for health center employees to critically reflect on their own biases, beliefs, and assumptions about race, disability, gender, and sexuality, and explore how these beliefs may impact their interactions with patients. As part of the training design process, center staff should conduct accessibility checks so as not to unintentionally exclude or other staff and attendees with disabilities. Perhaps most importantly, FQHCs must provide ongoing training and educational opportunities to sustain commitment and learning.
- **Improve referral process for gender-affirming care.** Health center patients/clients at both sites shared about the need to improve referrals, specifically the referral process and timeline for gender-affirming care

services. As the number of transgender and gender nonbinary patients seen at CVCC, PTH, and other FQHCs likely increase, consider prioritizing improvement to this specialized referral process so that patients seeking gender-affirming care services feel welcomed and respected.

- **Provide more authority to patient advisory groups.** Participants cited that the formalized patient advisory groups both CVCC and PTH have are one of the main avenues for understanding the needs of patients/clients. These groups, along with the existence of patient majority board of directors, provide important counternarratives about who directs care, as most other healthcare organizations do not have patient advisory groups or patient majority boards. As the findings of this study suggested, the role of patient advisory groups in representing the voice of patients is important; therefore, it is recommended that both FQHCs investigate ways to increase the authority and influence of patient advisory groups in health center strategy development and decision-making. In doing so, they should specifically interrogate perceived and real power dynamics and potential inequity between the patient advisory groups and health center board of directors. CVCC and PTH should ask themselves if their board of directors are representative of the patients and community they serve and how could the board of directors and patient advisory groups better share power and authority.

Recommendations for Policy

In addition to recommendations for practice, a couple of recommendations related to policy include:

- **Provide policy clarity to FQHCs on cultural competence.** Given that FQHCs are required by federal statute to provide culturally competent care, the Health Resources and Services Administration (HRSA), which oversees the health center program, should provide policy clarity regarding what constitutes the provision of culturally competent care within an FQHC context. As of 2023, there is no policy clarity nor guidance provided to FQHCs. This policy clarity should be specific enough so that health center staff know what is expected of them regarding how they go about providing culturally competent care (e.g., how is cultural competence being measured or evaluated). At the same time, this policy clarity should be flexible enough so that health centers can contextualize interventions to their unique situations. In addition to policy clarity, HRSA should provide training, technical assistance, and other resources to health centers so they can continually assess their services and educate their employees towards this aim.
- **Implement federal policies to protect the ability of FQHCs to provide LGBTQ affirming healthcare.** As previously mentioned, LGBTQ rights, including access to healthcare, are under attack in many states and localities across the United States. Because FQHCs are federally sanctioned entities that receive at least some of their funding from the federal government, federal policy interventions to protect FQHCs ability to provide LGBTQ specific health care, including gender-affirming care, should be considered. Precedent for this type of policy activism has already been established with the

determination that FQHCs must provide healthcare to undocumented individuals in their service area regardless of state laws or mandates.

Implications for Future Research

There is limited empirical evidence as to how FQHCs understand and provide culturally competent healthcare. Specifically, research seeking to understand the cultural competence construct within the context of providing healthcare to those who identify as LGBTQ is needed. Future research in this area should consider the following:

- **Expand geographical scope outside California.** Because California is considered to have progressive policies and laws, including several laws in place to protect LGBTQ rights and access to healthcare, investigating similar research topics in other states could provide a more comprehensive understanding of how to provide culturally competent healthcare sensitive to the needs and experiences of LGBTQ populations across the United States. As the political landscape for LGBTQ equality has shifted dramatically in the later part of 2022 and early part of 2023, recent months, this research could be particularly enlightening in states where recent legislative attacks have been made or enacted regarding the provision of gender-affirming care.
- **Employ critical theoretical frameworks to research design.** There is a lack of existing research using critical theoretical frameworks to assess how FQHCs operate. Because health centers aim to provide culturally competent care to marginalized populations, future studies looking at how FQHCs address health inequity could benefit from using critical theoretical frameworks such as critical race theory, feminist theory, DisCrit, and queer

theory. Furthermore, the community health center program has its roots in the War on Poverty and Civil Rights Movement, both of which sought to challenge systemic barriers that perpetuated inequality and discrimination. Using critical paradigms to further explore how FQHCs promote social justice and transformative change would be a worthwhile endeavor.

- **Investigate the role of community health workers.** Given the research literature showing success of community health workers (CHWs) in improving healthcare access and outcomes for racial and ethnic minorities and rural populations, future research should investigate the feasibility and effectiveness of this approach in serving LGBTQ populations across various racial, cultural, and geographic contexts.

Assumptions, Delimitations, and Limitations

All research is conducted under various assumptions and delimitations. Also, there is no perfect research study; therefore, all research has limitations (Guba & Lincoln, 2005). To the extent possible, it is important for researchers to make these known. The assumptions surrounding this study, delimitations placed on the study, and the limitations of the investigation are shared in the following sections.

Assumptions

According to Leedy and Ormrod (2010), “Assumptions are so basic that, without them, the research problem itself could not exist” (p. 62). There were a few key assumptions underlying this investigation. First, I operated from the assumption that the two FQHCs that participated in this study, and the staff they employ, desire to provide high-quality healthcare that is culturally and linguistically appropriate for their LGBTQ

patients and the larger queer community. Furthermore, I assumed all study participant responses collected from focus groups and key informant interviews were honest and truthful. To support the actualization of this assumption, protocols were developed and communicated to all study participants in hopes of building trust and rapport. These protocols explained the nature of the study, how individual identities would be protected and de-identified in the study results, and that study participants could withdraw at any given time without fear of retribution or other ramifications. Lastly, this dissertation inquiry assumed study reviewers (and hopefully future readers of this published manuscript) believe no research endeavor is entirely objective and, furthermore, that “our times require engaged researchers who can openly articulate the link between the work they do, the methodologies to which they subscribe, and the type of social change they envision” (Kuntz, 2015, p. 14). In this spirit, I made no attempts to hide my personal interest in the topic and my desire for social change.

Delimitations

Delimitations are restrictions or parameters that researchers put around a study to limit its scope (Mertler, 2018). This inquiry was limited by design to only include FQHC settings and did not include other types of healthcare providers, such as for-profit physician groups, managed primary care practices, private and nonprofit hospitals, and integrated health systems (e.g., Kaiser Permanente). These parameters were further limited by choosing to focus on FQHCs that specialized in serving the LGBTQ community. Doing so narrowed the possible population of health centers from approximately 1,400 to 14. Findings from this study were also delimited by geographic location, as both participating health centers operate in California.

Limitations

The quote “If we knew what it was we were doing, it wouldn’t be called research, would it?,” often attributed to Albert Einstein, is a good reminder that part of the research endeavor is about embracing the unknown. Limitations are the constraints or weaknesses in a study based largely on things that are beyond the researcher’s control. Limitations for this study included data collection limitations, time and financial constraints, and novice researcher experience.

Data Collection Limitations

Not being able to access and evaluate workforce training curricula and other organizational documents was a significant unforeseen challenge encountered during this study. In the original study design, I expected that several documents and resources relevant to the study’s focus area would be collected and analyzed. These documents included organizational strategic plans, training materials, and content available on each organization’s website. In addition to helping triangulate data gleaned from the interviews and focus groups, these organizational artifacts were planned to be assessed through the lens of critical race theory and queer theory. For example, reviewing content from cultural competence trainings through this theoretical framework could shed light on whether or not health center employees have opportunities to learn about issues of power and privilege, to examine the ways that homophobia intersects with other forms of social inequality, to explore the lived experiences of marginalized populations, and/or to understand the need for structural and policy-level changes in addition to individual behavior change. Unfortunately, most of these documents were not obtained and reviewed. Organizational strategic plans were not publicly available. Likewise, workforce

training content was not accessible either because of limited staff capacity to collect and share those materials with me or because the content was proprietary. This reality significantly limited the data themes and findings for RQ3.

Furthermore, the 10 patient/client participants were not representative of the racial and gender diversity of health center patients generally, nor were they representative of the racial and gender patient demographics of CVCC or PTH. Among the sample, eight of the 10 patients/clients identified as white, two identified as Native American, American Indigenous, or Alaska Native, one identified as Black or African American, and one identified as Hispanic/Latino/Latina/Latinx. In 2021, only 9% of health center patients in California were white (California Primary Care Association, n.d.). In 2020, 65% of health center patients at CVCC were BIPOC, and 29% of patients at PTH were BIPOC. Regarding gender, eight of the patient/client participants in this study identified as male and only one identified as female. Nationally and in California, over 50% of health center patients were female as of 2021 (HRSA, 2021a). In 2021, approximately 48% of CVCC patients identified as female. Also in 2021, approximately 15% of patients at PTH identified as female.

The lack of racial and gender diversity among the patient/client study participants may have generated data themes and findings that do not accurately reflect the experiences and perspectives of all queer individuals served by that FQHC. Presumably, a more representative patient/client study population would have led to more examples of how health centers can provide services that meet the needs of the entire queer community. Additionally, the lack of racial and gender variation among patient/client participants in the study may have overlooked important intersectional experiences of

discrimination faced by many within the LGBTQ community, resulting in an incomplete understanding of how to go about providing culturally competent healthcare.

Time and Financial Constraints

Time and financial constraints are two of the most common limitations of research (Moura, 2017; Simon & Goes, 2013). Data collection was initially scheduled to begin in July 2022 and run through the end of December 2022; however, data collection did not begin until October 2022, in part because of IRB approval delays. Luckily, some flexibility was built into my IRB application, which allowed for data collection to extend through mid-February 2023. This data collection extension left just enough time to complete the analysis and write-up to be able to defend in the Spring 2023 semester. Although it was anticipated that the ongoing COVID-19 global pandemic could delay the completion of this research, the pandemic did not end up becoming a limitation.

Regarding financial constraints, I wish I had been able to provide fair compensation to study participants, especially the health center patients and clients who participated, as an acknowledgment and appreciation for their time. I was able to afford \$25 gift cards for the patient/client participants and \$10 gift cards for all other participants, which I think was appreciated and hopefully served as a gesture of thanks for their time and commitment. That said, I know one of the health centers involved in this study typically pays health center patients/clients \$50 or more per hour for focus group participation. The lower amount may have dissuaded some potential participants from participating.

Novice Researcher

My relative lack of research experience was likely a limitation in this study. In many respects, this study was as much about learning how to conduct research as it was about the research itself. As a novice researcher, I learned things along the way that in hindsight, I would have likely done differently had I had more experience. For example, I imagine the IRB approval process would have gone more quickly if I had more experience in completing the IRB process and responding to IRB comments and requests for clarification. Guidance and feedback provided by my dissertation committee, doctoral program professors, and fellow PhD student peers was a tremendous asset to bridge my beginner researcher status.

Conclusion

Providing culturally competent healthcare is recognized as one promising strategy to eliminate health inequities for marginalized communities, including the LGBTQ community. This study sought to fill a gap in existing literature by examining the construct of culturally competent healthcare specific to FQHCs that attempt to meet the needs of the LGBTQ community. Using qualitative research methods, perspectives of health center leaders, staff, and providers, along with voices of health center patients/clients from two FQHCs, were shared. Using grounded theory analysis, several themes and findings emerged in the data as to how these health centers went about identifying the needs of the queer community and then putting those needs into practice to provide culturally competent care. The observed patterns and relationships within and between the cases generated a theory of LGBTQ cultural competence that offers both

specific behaviors and actions to consider while also acknowledging that providing culturally competent healthcare to LGBTQ individuals is highly nuanced and contextual.

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APPENDIX A

Participant Recruitment Sample Email

Hello. My name is Tommy Royston (he/his/him), and I am currently a doctoral candidate in the School of Leadership and Education Sciences at The University of San Diego. I am conducting a study exploring how community health centers go about providing care that is responsive to the health care needs of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) individuals. New insights gleaned from this study have the potential of impacting the training and education provided to health center employees on how to better meet the health care needs of LGBTQ and other marginalized communities.

For this study, I am hoping to talk with and learn from a variety of individuals from your health center, including patients/clients, staff and providers at all levels, as well as health center senior leadership (e.g., CEO, CMO, Board Chair). Please consider participating in this study.

To be eligible to participate, individuals should meet the following criteria:

- Be at least 18 years of age or older
- Have one (or more) of the following connections to X (name of health center): 1) be a current patient/client of the health center; 2) be a current staff or provider directly employed by the health center; 3) be in a senior leadership role at the health center (includes board executive positions).

- Be willing to complete a brief online eligibility survey that will take approximately three to 5 minutes to complete.
- Be willing to participate in either a 1-hour interview or 1-hour focus group led by me. Health center patients/clients will participate in a small focus group with other health center patients (approximately 4 to 6 people). Health center staff/providers will also participate in a focus group with other staff/providers (approximately 4 to 6 people) at the health center. Senior leaders will participate in a one-on-one interview.

Specific dates and times for the focus groups and interviews referenced above will be determined based on participants' schedules/availability and it is anticipated that these will occur in person at the health center. Interviews and focus groups will be audio-recorded solely for the purposes of accurately capturing participant responses.

Recordings will not be shared with anyone and will be destroyed once transcribed. All data collected from you will be confidential and coded with a number or pseudonym (fake name) to protect your identity. Information from this study will only be reported as a group, and not individually. Although chosen study participants will not receive financial compensation for participation, participants may receive a \$10 gift card (health center staff and leaders) or a \$25 gift card (health center patients/clients as a token of appreciation if they desire. Additionally, light snacks may be provided for in-person focus groups. You will receive this compensation even if you decide not to complete the entire focus group or interview.

If you meet the criteria identified above and are interested in participating, please complete this short eligibility survey and informed consent survey:

https://docs.google.com/forms/d/e/1FAIpQLSdxVLgDzy2MsJG2xeLY9aT0pn7Plz3UZ4wIqxOpzQVnYcCCw/viewform?usp=sf_link

The form should take less than 5 minutes to complete, and after completing I will follow up with you regarding next steps.

If you have any questions about this study titled “Queering Healthcare Equity: Exploring how LGBTQ Focused Community Health Centers Frame Cultural Competence”, please feel free to contact me at xxxxx@sandiego.edu. Additionally, you may contact my faculty advisor/dissertation chair Dr. Suzanne Stolz at xxxxx@usc.edu. Thank you for considering participating in this study.

Tommy Royston, M.Ed. (he/his/him)

PhD Candidate / Graduate Assistant

School of Leadership and Education Sciences

University of San Diego

xxxxx@sandiego.edu¹⁵

¹⁵ Given the significant number of Spanish-speaking patients/clients at both study sites, this email, and the eligibility survey, was also translated and made available in Spanish.

APPENDIX B

Participant Eligibility Survey

Google Forms Survey Link:

https://docs.google.com/forms/d/e/1FAIpQLSdxVLgDzy2MsJG2xeLY9aT0pn7Plz3UZ4wIqxQpzQVnYcCCw/viewform?usp=sf_link

Thank you for your interest in this study titled “Queering Healthcare Equity: Exploring how LGBTQ Focused Community Health Centers Frame Cultural Competence.” This study explores how community health centers go about providing care that is responsive to the health care needs of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) individuals. New insights gleaned from this study have the potential of impacting the training and education provided to health center employees on how to better meet the health care needs of LGBTQ and other marginalized communities.

The questions below will determine if you are eligible to participate in this study. Your responses are confidential and will only be viewed by the primary investigator (Tommy Royston). This survey should take less than 5 minutes to complete. If you have any questions, please contact Tommy at xxxxx@sandiego.edu.

Study Eligibility Criteria:

- Research participants must be 18 years of age or older
- Research participants must currently identify with at least one of these role categories: 1) be a current patient/client of the health center; 2) be a current staff or provider directly employed by the health center; 3) be in a senior leadership role at the health center (includes board executive positions)
- In addition to completing this eligibility survey, participants must be able to participate in a 1-hour focus group (patient/client, staff/provider) or a 1-hour interview (health center senior executives, board members) with dates and times to be determined based upon participants availability. It is anticipated that interviews and focus groups will occur in person at the health center.

Question #1: What is your role within your health center (check all that apply):

- ☐ Health Center Staff/Provider
☐ Health Center Client/Patient
☐ Health Center Board Member
☐ Health Center Senior Leadership
☐ Other (please fill in): _____

Question #2: What is your age?

- ☐ Under 18
☐ 18 - 24
☐ 25 - 34

- ☐ 35 - 44
- ☐ 45 - 54
- ☐ 55 - 64
- ☐ 65 - 74
- ☐ 75 - 84
- ☐ 85 or older
- ☐ I prefer not to provide range but confirm that I am 18 or older

Question #3: How do you racially/ethnically identify? (check all that apply)

- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic/Latino/Latina
- ☐ Middle Eastern/North African
- ☐ Native American, American Indigenous, or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Additional category (please specify) _____
- ☐ Prefer not to answer

Question #4: Which of these best describes your current sexual orientation? (please choose one)

- ☐ Bisexual
- ☐ Lesbian, Gay, or Homosexual
- ☐ Straight or Heterosexual
- ☐ Queer, Pansexual, and/or Questioning
- ☐ Unsure
- ☐ Prefer not to answer
- ☐ Additional category (please specify) _____

Question #5: What gender(s) do you identify as? (check all that apply):

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ GenderQueer/Gender Conforming/Gender Nonbinary
- ☐ Questioning/Unsure
- ☐ Additional category (please specify) _____
- ☐ Prefer not to answer

Question #6: Do you consider yourself to have a disability?

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Question #7: What is your preferred language (please type in answer)?

Question #8: If your preferred language is not English, would you need a translator in order to participate in this study (please choose one)?

____ Yes

____ No

____ Unsure

Question #9: Based on the information you have received, are you interested in being a part of this research study?

____ YES (if answer is yes, survey advances to question #10)

____ NO (if answer is no, survey respondent receives a message that they are not eligible, and thanking them for their time)

____ UNSURE (please reach out to Tommy Royston at xxxxx@sandiego.edu to discuss further)

Question #10: If you answered YES to the previous question, please provide an email address or other information where you can be reached.

Survey End Language (what screen says after survey respondent submits survey):

Thank you again for completing this survey. Additional information regarding participating in this study will be sent to you via email. In the meantime, do not hesitate to reach out with any additional questions.

Tommy Royston
xxxxx@sandiego.edu

APPENDIX C

Study Participant Adult Consent Form

**University of San Diego
Institutional Review Board
Research Participant Adult Consent Form**

For the research study entitled:
Queering Healthcare Equity: Exploring How Two Community Health Centers that
Specialize in LGBTQ Healthcare Frame Cultural Competence

I. Purpose of the research study

Tommy Royston is a PhD student in the School of Leadership and Education Sciences at the University of San Diego. You are invited to participate in a research study he/they is conducting. The purpose of this research study is to explore how community health centers go about providing care that is responsive to the health care needs of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) individuals. New insights gleaned from this study have the potential of impacting the training and education provided to health center employees on how to better meet the health care needs of LGBTQ and other marginalized communities.

II. What you will be asked to do

If you decide to be in this study, you will be asked to:

- Complete an online questionnaire to determine eligibility for the study. This should take between three and five minutes to complete.
- Assuming you are eligible, you will be put into one of three categories based upon the most appropriate role you have in relation to the health center: 1) health center senior leadership (including board members), 2) health center staff/provider, or 3) health center patient/client
- Category 1 – health center senior leadership – will participate in a private hour-long interview where the researcher will ask you open-ended questions about the study topic

- Category 2 – health center staff/provider – will participate in an hour-long focus group with 3-5 other health center staff/providers where the researcher will ask the group open-ended questions about the study topic
- Category 3 – health center patient/client – will participate in an hour-long focus group with 3-5 other health center patients/clients where the researcher will ask the group open-ended questions about the study topic

Your participation in this study will take a total of approximately 65 minutes.

Foreseeable risks or discomforts

Sometimes when people are asked to think about their feelings, they feel sad or anxious. If you would like to talk to someone about your feelings at any time, you can call toll-free, 24 hours a day:

**Palm Springs Area: Riverside County Helpline - (951) 686-HELP (4357)
Sacramento Area: Sacramento Mental Health Line - (888) 881-4881**

III. Benefits

While there may be no direct benefit to you from participating in this study, the indirect benefit of participating will be knowing that you helped researchers better understand how health providers serving LGBTQ populations can improve health care services by tailoring care to the unique cultural and/or linguistic needs of the communities they are serving.

IV. Confidentiality

Interviews and focus groups will be audio recorded to assist with data transcription. These recordings will only be available to the researcher. Any information provided and/or identifying records will remain confidential and kept in a locked file and/or password-protected computer file in the researcher's office for a minimum of five years. All data collected from you will be coded with a number or pseudonym (fake name). Your real name will not be used. The results of this research project may be made public and information quoted in professional journals and meetings, but information from this study will only be reported as a group, and not individually.

The information or materials you provide will be cleansed of all identifiers (like your name) and may be used in future research.

V. Compensation

If you participate in the study, the researcher will offer you a \$10 Starbucks gift card via email or in person. Additionally, light snacks may be provided for in-person focus groups only. You will receive this compensation even if you decide not to complete the entire focus group or interview.

VI. Voluntary Nature of this Research

Participation in this study is entirely voluntary. You do not have to do this, and you can refuse to answer any question or quit at any time. Deciding not to participate or not answering any of the questions will have no effect on any benefits you're entitled to, like your health care, or your employment or grades. **You can withdraw from this study at any time without penalty.**

VII. Contact Information

If you have any questions about this research, you may contact either:

1. Tommy Royston

USD Email: xxxxx@sandiego.edu

2. Suzanne Stolz, EdD

USD Email:

xxxxx@sandiego.edu

APPENDIX D

Semistructured Interview Protocol for Health Center Leaders

Interviewer: Thank you again for taking the time to talk with me. As mentioned in my earlier email, this interview should take between 45 minutes to one-hour and will focus on your perspectives about how X goes about providing care to the LGBTQ community. Although I have a few predetermined questions to ask you, based upon your answers to some of the questions I will likely deviate from these to gain additional insights or understanding based upon what you share. It's important that you know that there are no right or wrong answers, I am simply inviting you to share your thoughts and perspectives related to each question.

You have already consented to being a part of this study, but I want to remind you of a couple of things before we get started. First, this interview is being audio recorded so that I can transcribe the information you provide. This recording and the resulting transcript will only be accessible by me. Any identifying information will be obscured to maintain your anonymity. Also, you are welcome to stop me at any time to ask questions or to end our discussion for any reason. Although I don't anticipate any of the questions will be uncomfortable to answer, know that if you do prefer not to answer the question just say so and we will move along to another question. Do you have any questions before we begin?

After answering questions, begin recording.

Sample Interview Questions

| Question |
|--|
| Share with me a little bit of your background and what led you to work here at X health center. |
| So can you tell me about your current role and what this position entails? |
| Briefly describe the population demographics of the patients and community you serve here at X health center. |
| X health center has a long history/herstory of serving the healthcare needs LGBTQ community. As the organization has grown and expanded to serve others, why have you all decided to still maintain a focus on serving the queer community? |
| Can you share with me some examples of how your community health center operationalizes or provides care tailored to the needs of the LGBTQ community? |
| Does anything else come to mind - big or small - as to how your X health center works to meet the needs of the LGBTQ patients you serve and the LGBTQ community in your service area? |
| For a health center that is new to intentionally focusing on serving the needs of LGBTQ folx, what are the two most important things they should do or be aware of? |
| As it relates to your agency's efforts to meet the needs of the LGBTQ community you serve, what are you most proud of? |
| Given that LGBTQ folx are not a monolith, I am curious to hear about some of the ways in which your health center thinks about and approaches other intersectional identities that may further marginalize the LGBTQ community you are trying to serve (e.g., BIPOC LGBTQ patients, LGBTQ patients who are disabled, etc.). |
| Are conversations about intersection identity and how to meet the needs of the full spectrum of LGBTQ individuals common here? Can you recall a recent conversation regarding this that occurred? |
| I'm curious to know what terminology – if any – you and your health centers use when you talk about providing tailored services and approaches to meeting |

| |
|---|
| the needs of LGBTQ and/or other marginalized populations you work with? (e.g., cultural competence, etc.). |
| If I were to ask your providers and staff here the same question about terms/terminology, do you think their answers would generally be the same as yours? If not, what do you think the differences would be? |
| In your opinion, how does focusing on (insert whatever term/terms they use) impact health care? Do you believe it improves healthcare specifically for the LGBTQ+ community? |
| Does X health center provide training and educational opportunities for staff and or board members to learn and improve the way they serve the LGBTQ community? If so, can you walk me through some of these? |
| Who creates and provides these trainings/educational offerings (i.e., the health center directly, partner agency, government, health plan, etc.) and what formats are they offered in (e.g., in-person, online, etc.)? |
| Are these opportunities open to staff at all levels? Or are they offered dependent on the staff member's role? What about board members? |
| In what ways do you think these training and education opportunities have helped your health center provide better care to your LGBTQ patients as well as the other patients you serve? |
| As a leader at this health center, is there anything you would like to do from a training/education perspective to improve your organization's ability to reach and best serve LGBTQ individuals? If so, what? (focus or topic areas, audiences, format, etc.). |
| If you were able to do X (whatever participant stated they would like to do from the previous question), how do you think that might impact the care you provide to your patients/community? |
| If you had a magic wand and could do anything to improve health and healthcare for the LGBTQ community in your area, what would it be? And why? |
| Is there anything else we haven't touched on that you would like to discuss? |

Unless you have any questions or additional comments for me, this wraps up the interview. I really appreciate the information and insights you shared today and thank you for making the time to meet with me.

INTERVIEWER'S NOTE: It is not expected that all of these questions will be asked during the interview. Additionally, in keeping with a semistructured design, other questions may emerge during the conversation. Bolded questions are the most salient in relation to the study's research questions.

APPENDIX E

Semistructured Health Center Staff/Provider Focus Group Protocol

Welcome everyone – introduce myself and briefly explain my interest in this topic.

Researcher/Focus Group Facilitator: Thank you again for your interest in participating in today's focus group. During our time together I will be asking a series of questions focusing on your perspectives regarding how X goes about meeting the healthcare needs of LGBTQ patients and the LGBTQ community. This focus group will last approximately 1 hour. Your participation in this study is completely voluntary and I will discuss more about that in just a moment.

A little bit about myself... My name is Tommy Royston, and I am a PhD Candidate at the University of San Diego. I believe in the community health center model of care. I previously worked for the National Association of Community Health Centers in DC and have served on the board of a California health center in the past. I also have consulted with FQHCs. I identify as a cisgender gay white male, and want to use my privilege and this research to push for a more equitable health care system for LGBTQ folx, including those who are multiply marginalized because of racism, ableism, transphobia, etc.

Okay, now a little bit more about the study. You have already consented to be a part of this study, but before we begin let me go over a few things.

First, this focus group will be recorded so that I can transcribe the information you provide. This recording and the resulting transcript will only be accessible by me and any identifying information will be obscured to maintain your anonymity. Again your participation in today's focus group is completely voluntary and, therefore, you are welcome to withdraw your participation at any time without fear of it jeopardizing your relationship with _____ health center. If you do not wish to participate in this study, now would be a good time to log-off or leave the room.

Lastly, before we get started, let me share a few brief norms/guidelines that I ask we use today:

- *Please talk one at a time and in a loud conversational voice like I am modeling right now.*
- *It's important to know that all points of view are welcome. There is no right or wrong answer.*
- *My hope is that you feel comfortable speaking openly and honestly. I ask that what others share today is not discussed outside of this space without their permission to do so.*
- *It is okay to build upon someone else's comment but please avoid side conversations and please make sure that the other person is finished talking before jumping in.*

- *I will try to make sure that everyone who is interested has a chance to talk. Also, individually, if for any reason you want to pass and not answer a question, that is completely ok.*
- *And lastly, I encourage you to mute your line when you are not speaking to avoid background noise.*

Does anyone have any questions about the process before we begin?

Note: After answering any process questions, begin recording.

For those of you sticking around, are you consenting to participate in the focus group?

Please respond with a YES.

Sample Staff/Provider Focus Group Questions

| Question |
|--|
| <p>As a way to begin, I'd like for us to go around the room and have you briefly introduce yourself by sharing the following: 1) your position here at X health center, and 2) and reason why you chose to come work for _____ . Please keep your response to around 1 minute.</p> |
| <p>X health center has a long legacy of serving the healthcare needs of the LGBTQ community. Can you share with me some specific examples of how X provides care tailored to the needs of the LGBTQ community?</p> <p>Possible Probes:</p> <p>How does the org go about understanding what the needs of your LGBTQ clients and the LGBTQ community is?</p> <p>What are some of the ways that you, and/or your team or department, assist the organization to be able to provide care tailored to the needs of the LGBTQ community?</p> |

What else comes to mind - big or small - as to how your X health center works to meet the needs of the LGBTQ patients you serve and the LGBTQ community in your service area?

I'm curious to know more about... probe with questions specific to org policies and practices, recruitment of staff/providers, outreach in community, employee development...

On a scale from 1 to 10 with 1 being “not at all” and 10 being “couldn’t be better”, how good of a job does X health center do in meeting the unique health care needs of its LGBTQ+ patients/clients?

Note: Give each person a piece of paper and pen/pencil to jot down their number before sharing. Invite participants to share number and why they chose it. Remind participants that there is no right or wrong answer.

Possible Probes:

Based upon the numbers and range provided follow-up questions on how the health center can improve (e.g., For anyone who responded lower than a 7, what is lacking or needed to better serve these patients?)

Within the spectrum of the LGBTQ community, whose needs have been most difficult to meet and why?

Given that LGBTQ folx are not a monolith, I am curious to hear about some of the ways in which your health center thinks about and approaches other intersectional identities that may further marginalize the LGBTQ community you are trying to serve (e.g., BIPOC LGBTQ patients, LGBTQ patients who are disabled, etc.).

Possible Probes:

I understand that your health center serves a large number of X clients (use patient demographic data from UDS for X – example: Latino/a/LatinX). As you work to meet the needs of LGBTQ individuals that also identify as X, what have you had to be aware of or do to outreach and serve that particular group?

Is there anything that your peers have shared that you would like to follow up on, or are there questions you would like to ask your peers about what they shared?

Does X health center provide training and educational opportunities for you as employees to learn and improve the way you serve the LGBTQ community? If so, can you share with me some examples?

Possible Probes:

How often are trainings/educational opportunities such as these offered? What formats are they offered in (e.g., in-person, online, etc.)?

Are these opportunities open to staff at all levels? Or are they offered dependent on the staff member's role? Do senior leadership, board members, and/or patients participate in any of these offerings?

For those of you that have participated in any of these training/educational opportunities, have they helped improve the way you provide services or care? If so, in what ways?

What additional training/education do you feel that you and/or other employees here need in order to better serve the LGBTQ community? What specific content/topic areas should be included in this?

I'm curious to know what terminology – if any – you and your health centers use when you talk about providing tailored services and approaches to meeting the needs of LGBTQ and/or other marginalized populations you work with? For example, do you use terms such as cultural competence, cultural humility, etc.?

Possible Probes:

Any specific reason why you all use that term?

When I say the words cultural competence, what images, ideas, or examples come to mind for you?

If I were to ask senior leaders here the same question about terms/terminology, do you think their answers would generally be the same as yours? If not, what do you think the differences would be?

In your opinion, how does focusing on (insert whatever term/terms they use) impact health care? Do you believe it improves health care specifically for the LGBTQ+ community?

If you had the power and resources to do one thing here at X that you think would improve the overall health of the LGBTQ community, what would it be? This can either be something new or can be to expand something you are already doing.

As it relates to this topic, is there anything else we should have talked about but did not?

Unless you have any questions or additional comments for me, this wraps up the focus group. I appreciate the information and insights you shared today and thank you for making the time to meet today.

NOTE: It is not expected that all of these questions will be asked during the focus group. Additionally, in keeping with a semistructured design, other questions may emerge during the conversation. Bolded questions are the most salient in relation to the study's research questions.

APPENDIX F

Semistructured Health Center Patient/Client Focus Group Protocol

Welcome everyone – introduce myself and briefly explain my interest in this topic.

Researcher/Focus Group Facilitator: Thank you again for taking the time to participate in today's focus group. As mentioned previously, this focus group should last approximately one-hour. Today I will ask you all some questions that allow you to provide your opinion and perspective regarding how this health center works to provide healthcare services that are tailored to the unique needs of the patients and community it serves. Given the context of this study, most of the questions will specifically look at how the health center goes about meeting the needs of the LGBTQ community. As patients or clients, even if you do not identify as part of the LGBTQ community, your perspectives are still important.

A little bit about myself... My name is Tommy Royston, and I am a PhD Candidate at the University of San Diego. I believe in the community health center model of care. I have family members who are health center patients and I previously served on the board of a California health center in the past. I also have consulted with FQHCs. I identify as a cisgender gay white male, and want to use my privilege to push for a more equitable healthcare system for LGBTQ folx, including those who are multiply marginalized because of racism, ableism, transphobia, etc.

You have already consented to being a part of this study, but I want to go over a couple of things before we get started. First, this focus group is being audio recorded so that I can transcribe the information you provide. This recording and the resulting transcript will only be accessible by me. Additionally, I may jot down notes during the focus group. Any identifying information will be obscured to maintain your anonymity. Also, your participation in this study, and specifically today's focus group, is completely voluntary and, therefore, you are welcome to withdraw your participation at any time without fear of it jeopardizing the care you receive here at _____ health center.

Lastly, before we get started, let me share a few brief norms/guidelines that I ask we use today:

- *Please talk one at a time and in a loud conversational voice like I am modeling right now.*
- *It's important to know that all points of view are welcome. There is no right or wrong answer.*
- *My hope is that you feel comfortable speaking openly and honestly. I ask that what others share today is not discussed outside of this space without their permission to do so.*
- *It is okay to build upon someone else's comment but please avoid side conversations and please make sure that the other person is finished talking before jumping in.*

- *I will try to make sure that everyone who is interested has a chance to talk. Also, individually, if for any reason you want to pass and not answer a question, just say so.*
- *FOR ZOOM SESSIONS ONLY: And lastly, I encourage you to mute your line when you are not speaking to avoid background noise.*

Does anyone have any questions about the process before we begin?

Note: After answering any process questions, begin recording.

Sample Patient/Client Focus Group Questions

| Question |
|--|
| As a way to begin, I'd like for us to go around the room and have you introduce yourself by sharing the following: 1) how long you have been a patient/client here at X health center, 2) reason why you decided to join today's focus group. |
| <p>In what ways do you see X health center providing care that meets the different needs of its LGBTQ patients/clients and the wider community?</p> <p>Possible Probes: Probe with questions specific to org policies and practices (welcoming signage, policies that are patient centered, etc.), services provided (LGBTQ specific services such as trans health services, etc.), diversity of staff/providers, outreach in community...</p> <p>Within the spectrum of the LGBTQ community, in your opinion whose needs are being met and whose are not being adequately met?</p> <p>Is there anything that your peers have shared that you would like to follow up on, or are there questions you would like to ask your peers about what they shared?</p> |
| On a scale from 1 to 10 with 1 being “not at all” and 10 being “couldn’t be better”, how good of a job does X health center do in meeting the unique healthcare needs of the LGBTQ community in your area? Briefly explain why you chose that number. |

Possible Probes:

Based upon the numbers and range provided follow-up questions on how the health center can improve...

For anyone who responded lower than a 7, what is lacking or needed to better serve LGBTQ folx?)

What would it take for you to rate X health center a 10?

When seeking a health care provider, what do you all look for? In other words, what do you need or want from them that would help you feel safe, respected, and cared for?

Possible Probes:

Call out and connect themes after each person shares.

Based upon what others have just shared, is there anything else that comes to mind?

Other LGBTQ folx have said it is important for them to receive health care services at a place that “gets them” or understands them well. Can you think back and tell us about a time when you truly felt seen and heard by your healthcare provider? (Doesn’t have to be here at X health center). What did they do to make you feel seen and heard?

If you had to guess, what do you think your LGBTQ friends and/or family members would say is important to them when seeking a health care provider?

Everyone should feel like they are welcome and that they belong when receiving healthcare. What does belonging mean to you and how do you think this health center is doing at being a place where everyone belongs?

I’m curious to know what terminology – if any – you have heard or seen the health center use when talking about providing tailored services and approaches to meeting the needs of LGBTQ and/or other marginalized populations you work with? (e.g., what wording or terms do they use on their website, in flyers and other outreach materials you may have received, etc.)

Possible Probes:

Do you personally resonate or connect to that term(s)? Why or why not?

What words, images, ideas, or understandings come up for you related to this term(s)? There are no right or wrong answers, just share whatever pops into your mind.

As it relates to this topic, is there anything else we should have talked about but did not?

Unless you have any questions or additional comments for me, this wraps up the focus group. I appreciate the information and insights you shared today and thank you for making the time to meet today.

NOTE: It is not expected that all of these questions will be asked during the focus group. Additionally, in keeping with a semistructured design, other questions may emerge during the conversation. Bolded questions are the most salient in relation to the study's research questions.

IRB-2022-495 - Initial: Initial - Expedited

do-not-reply@cayuse.com <do-not-reply@cayuse.com>
To: sstolz@sandiego.edu, troyston@sandiego.edu

Tue, Sep 20, 2022 at 11:08 AM



Sep 20, 2022 11:08:18 AM PDT

Tommy Royston
Sch of Leadership & Ed Science

Re: Expedited - Initial - IRB-2022-495, Queering Healthcare Equity: Exploring how LGBTQ Focused Community Health Centers Frame Cultural Competence

Dear Tommy Royston:

The Institutional Review Board has rendered the decision below for IRB-2022-495, Queering Healthcare Equity: Exploring how LGBTQ Focused Community Health Centers Frame Cultural Competence.

Decision: Approved

Selected Category: 7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Findings: Approved!

Research Notes:

Internal Notes:

*The USD IRB requires annual renewal of all active studies reviewed and approved by the IRB. Please submit an application for renewal prior to the annual anniversary date of initial study approval.
If an application for renewal is not received, the study will be administratively closed.*

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited or exempt review at any time.

Sincerely,

Truc Ngo, PhD
IRB Administrator

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