Assessing Beliefs, Skills, Attitudes, and Practice Changes to Improve Healthcare Outcomes for Transgender/Non-Conforming (TGNC) Persons

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Abstract

The Center's design of a gender-affirming clinical educational initiative began with a local activity which was scaled to a regional pilot study, and ultimately, a national systems-based, multi-modal, HIV behavioral health CME-certified training and certificate program that has reached over 1,800 health care professionals and their clinical care teams.

The activity's novel outcomes initiatives were designed to expand our methodology beyond the pre- and post-test quantitative norm to a mixed-methods capability using both quantitative and qualitative data.

Our development of qualitative measures inspired the creation of a new evaluation methodology to measure the effect of attitudinal and behavior shifts on clinical skills and practice change. This innovative methodology combined with semi-structured interviews with health care practices provided additional insight on activity impact for evaluating systems-based improvement in care and behavior.

Educational Design

Reducing health disparities and improving patient experience by changing clinical behavior is a complex task influenced by the beliefs, skills and attitudes of the entire care team.

We started by carefully identifying the gaps between current and desired patient experience and linking them to educational needs, learning objectives and desired outcomes. The Center then constructed a logic model to develop a multi-modal activity that provided integrated learning experiences and toolkits for all care team members to facilitate practice-wide change.

Desired Outcomes

The initiative was designed to help clinicians provide better care for TGNC patients. Our primary intent was to train, educate and support healthcare providers and their staff on "what is" culturally competent and gender affirming care and "how to practice it" within the context of optimal HIV care in the TGNC community.

Secondary practice change and desired patient outcomes included educating patients and providers about: prevention; testing and access to care; sharing HIV status with partners and healthcare providers; early initiation of care; and retention in care. Our program specifically addressed key social determinants of stigma and discrimination including self-esteem or internalized stigma, emotional and physical abuse, as well as healthcare, workplace, socioeconomic and household insecurities.

Qualitative Outcomes Design

To measure impact on attitudes, skills and beliefs as well as clinical behavior change, the Annenberg Center designed a two-part qualitative outcomes methodology to complement and enhance our quantitative measurements.

First, a three-factor self-assessment measure was developed to evaluate change in learner attitudes, skills and beliefs on multiple clinical skills that are relevant to individual competence-based learning objectives (LO). By using 5-point Likert-scales, learners self-assess each LO as well as multiple clinical skills in matched pre- and post-activity across 3 domains: importance, proficiency and motivation (IPM). For example, the pre-activity assessment asks learners, *"think about the **past few months** in your practice with regard to identifying opportunities to implement TGNC-inclusive prevention strategies for HIV: (a) how **important** is this to you?; b) how **proficient** are you?; and c) how **motivated** are you to improve?"* The post-activity assessment asks learners, *"think about when you **return** to your practice, with regard to identifying opportunities to implement TGNC-inclusive prevention strategies for HIV): a) how **important** will this be to you?; b) how **proficient** will you be?; and c) how **motivated** will you be to improve?"*

Second, qualitative semi-structured interviews were designed to evaluate care delivery system behavior change and improvement with interested practices. Literature and content from the activity informed 25 open-ended questions in the following 4 primary domains: a) challenges to providing gender-affirming & culturally competent care; b) practices for creating a gender-affirming clinical environment; c) challenges in evaluating / managing TGNC patients in the context of HIV prevention and treatment; and d) perspectives on program impact. The questions were reviewed by expert faculty, TGNC specialists, a qualitative researcher, and Scientific Director.

Results & Discussion

Goal **Discuss culturally competent terminology and practices for creating a gender-affirming clinical environment**

Clinical Skill 1: Offer solutions that address stigma, discrimination, lack of insurance, and other barriers transgender patients face when considering or accessing health care

Clinical Skill 2: Implement gender-affirming, culturally competent communication practices such as inclusive intake forms, deferring unnecessary questions, and the use of preferred names and pronouns

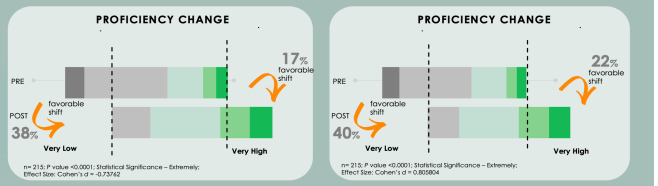

Figure 1. Pre- & post-proficiency changes for 2 clinical skills

Results & Discussion (cont.)

Figure 1 represents an example of pre- & post-proficiency changes for 2 clinical skills. The IPM methodology offers educators a more comprehensive approach to measuring impact. By enumerating a broader scope of clinical skills that support learning objective achievement and by assessing changes in beliefs, skills, and attitudes the IPM methodology provides greater insight on factors likely to impact clinical behavior change. IPM outcomes data also provides insight on differences between learner groups, enables more in-depth narrative on activity impact and highlights remaining gaps to support future activity development and continuous improvement.

The Center is in the process of importing transcript codes into qualitative analysis software that will identify potential practice change themes from a highly engaged Federally Qualified Health Center that participated in all the educational components of the activity. Semi-structured interviews should provide additional qualitative data on participant perspectives regarding the activity, clinical behavior change, remaining barriers to improvement and future education. This validated methodology does not require large sample size to provide reliable, comparable data while allowing participants the freedom to express views in their own terms.

Additional examples of institutional systems-based impact from this activity include: a) participants creating a Transgender Advisory Committee (TAC) for a nonprofit provider with more than 30 years of delivering quality patient-centered HIV care and community-based wellness services; and b) TAC Co-Chairs and the Chief Medical Officer collaborating with statewide STI Sexual Health and Wellness Centers to include the Center's culturally competent gender affirming care program, as part of their mandatory training.

Conclusions

Most importantly, this activity demonstrated impact on achieving desired clinical behavior change. This accomplishment reflects innovative and replicable systems-based approaches to fostering change in clinical behavior.

The novel outcomes design of this activity successfully expanded our methodology beyond the industry pre- and post-test norm to a mixed-methods capability using both quantitative and qualitative data. Traditional case-based quantitative knowledge and competence-based multiple-choice questions support important statistical interpretation and useful generalizations. Additionally, the innovative qualitative self-assessments on importance, proficiency and motivation combined with semi-structured interviews complemented quantitative outcome measures and provided us with greater insight on factors likely to impact clinical behavior change.