STATE OPTIONS FOR IMPROVING THE CULTURAL COMPETENCY OF PHYSICIANS

IN CARING FOR LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE

A Thesis

Presented to the faculty of the Department of Public Policy and Administration

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MASTER OF PUBLIC POLICY AND ADMINISTRATION

by

Theodore Dennis Muhlhauser

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Abstract

of

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Statement of Problem

Deficits in Lesbian, Gay, Bisexual and Transgender cultural competency of physicians create substandard healthcare and health disparities. Despite widespread recognition of the problem and efforts to solve it through physician education, LGBT health disparities persist.

Sources of Data

Data consulted for this thesis include research and practitioner literature, experimental studies, and surveys of physicians, medical students, and health educators.

Conclusions Reached

Legislative mandates to improve physician LGBT cultural competency through continuing medical education or medical school education offer robust public policy solutions.

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Mary Kirlin, D.P.A.

_____
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Chapter 1

THE PROBLEM OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER CULTURAL

COMPETENCY DEFICITS IN HEALTHCARE

In 2011, the United States Department of Health and Human Services (HHS) declared

that lesbian, gay, bisexual and transgender (LGBT) people experience subpar healthcare access

and healthcare. HHS proposed extensive reforms in the report, "Recommended Actions to

Improve the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Communities"

(United States Department of Health and Human Services [HHS], 2012).

This thesis focuses on one specific HHS recommendation: ensuring that healthcare

providers deliver culturally competent healthcare services to LGBT individuals and groups. The

HHS report describes why it recommends cultural competency training for prospective and

practicing physicians: "The lack of culturally competent providers is a significant barrier to

quality healthcare for many LGBT people, particularly those who identify as transgender" (HHS,

2012, Future Recommended Actions 5).

The increasing focus on LGBT cultural competency has raised awareness of the myriad

health challenges that LGBT people face everywhere (Institute of Medicine [IOM], 2011). A

report on LGBT cultural competency (Gay & Lesbian Medical Association [GLMA], 2006) lists

prominent LGBT health disparities. GLMA notes that LGBT people tend to suffer from higher

rates of certain cancers, conditions, communicable diseases, mental health disorders, suicide

ideation and other health challenges, all of which I explore further in this chapter. Poor health

access and quality produce and exacerbate LGBT health disparities. Individuals, couples and

families in the LGBT community are less likely to possess health insurance coverage than are

non-LGBT people (Ponce, Cochran, Pizer & Mays, 2010). The insurance deficit leads to fewer

than average doctor visits for LGBT patients (IOM, 2011). Health insurance is only part of the

access problem. Insensitivity or bias against LGBT people by physicians creates mistrust and

dissatisfaction among LGBT patients (Jillson, 2002), which discourages LGBT patients from

seeking treatment (McNair and Hegarty, 2010). Physician discomfort or incompetence with

caring for LGBT populations diminishes the quality of care received by LGBT patients (Turner,

Wilson & Shirah, 2006; Schatz & O'Hanlan, 1994). The United States Office of Minority Health

(2011a) identifies the lack of cultural competency as a contributing factor toward negative LGBT

health outcomes and calls for improving government data collection regarding LGBT health.

Health practitioners have joined HHS in promoting cultural competency. The American

Medical Association (AMA) has stated on multiple occasions (Hill, 2005; Council on Scientific

Affairs, 1996) that physicians need a better understanding of how to address health needs of

LGBT patients and reduce disparities in healthcare for the LGBT population. In a presentation to

the Institute of Medicine of the National Academy of Sciences (IOM), representatives of AMA

advised the IOM that both medical students and practicing physicians need enhanced training in

the area of LGBT cultural competency (Levin & Mayer, 2010).

<u>Public Policy Rationale, Brief Definition of LGBT Cultural Competency and</u>

<u>Exploring the Source of the LGBT Healthcare Cultural Competency Deficit</u>

Why LGBT Cultural Competency Warrants the Involvement of Policymakers

Despite the focus placed on LGBT cultural competency by both practitioners and

policymakers, there is little evidence that physicians have improved their capacity to serve this

vulnerable population (IOM, 2011). There are strong indications that medical students have a

similar competency deficit (Makadon, 2006). Although the Association of American Medical

Colleges (AAMC) recommended in 2005, and reiterated in 2007 (Association of American

Medical Colleges [AAMC], 2007), that medical schools require comprehensive LGBT

competency training of their students, survey data show that a great divide remains between the AAMC policy position and the levels of LGBT-centered training for future doctors.

Studies have attempted to quantify in hours the amount of time spent studying LGBT issues at medical schools and behavioral medicine departments and results indicate an increase in hours devoted to LGBT content since 1990 (Obedin-Maliver et al., 2011; Tesar & Rovi, 1998; Wallick, Cambre and Thompson, 1992). Curry (2011) questions the analytical value of measuring time spent on LGBT curriculum and suggests that quantifying time spent on LGBT topics may not allow researchers to understand completely the quality of curriculum and learning. In a survey of allopathic and osteopathic medical school deans in the United States and Canada, 69.7% of respondents portray their institution as providing students with either "fair," "poor" or "very poor" coverage of LGBT related health topics; only 24.2% reported having "very good" or "good" coverage (Obedin-Maliver et al., 2011).

Summary Description and Theory of LGBT Cultural Competency

This thesis centers solely on LGBT cultural competency of physicians. Other cultural competency categories may support the information and analysis presented in this thesis. In defining LGBT cultural competency, I distinguish between two interdependent yet differing forms of cultural competency. Physicians need to employ both variations to provide competent LGBT care (GLMA, 2006). The two versions are general cultural competency, which addresses legitimate and critical health issues of various cultures, races, ethnicities, genders, age groups, and linguistic groups; and LGBT cultural competency, which aims to address all aspects of the general type while adding elements critical to responsible and effective care of LGBT patients. Because general cultural competency began to take root among medical providers several years before LGBT competency became a publicly recognized policy problem (IOM, 2011), this thesis evaluates solutions for improving LGBT competency.

LGBT cultural competency of physicians typically occurs through in-class curriculum modules and clinical training modalities that may involve direct patient contact (GLMA, 2006). It can occur during medical school or during continuing medical education of licensed physicians (Beach, Price & Gary et al., 2005). Training may occur alone, or in groups (Human Rights Campaign [HRC], 2012a) and seeks to make physicians sensitive, willing, able and effective at treating both straightforward and complex LGBT health challenges (GLMA, 2006).

LGBT competency holds value as a policy goal because it shows promise for improving LGBT healthcare (GLMA and LGBT Health Experts, 2001). Cultural competency training helps providers mitigate the effects of bias, gain familiarity with how to incorporate sexual orientation or gender identity and expression into doctor-patient communications, and provide better care to their LGBT clientele (Sanchez, Rabatin, Sanchez, Hubbard & Kalet et al., 2006). IOM (2011) found that both LGBT patients and health provider organizations experience high cost impacts through incompetent care of major medical problems, such as inadequate preventive medicine and screening for fatal diseases like cervical (Matthews, Brandenburg, Johnson & Hughes, 2004), anal (Park & Palevsky, 2010) or hormone related cancers (Peterkin & Risdon, 2003; Futterweit, 1998). Training minimizes the negative cost effects from health disparities, access barriers and deficiencies in care quality experienced by the LGBT population (IOM, 2011).

The literature review portion of this thesis will consider the definitions, concepts, and theories of cultural competency in further detail.

Exploring Sources of the LGBT Cultural Competency Policy Problem

The topical literature does not indicate a single or definitive cause for the lack of LGBT cultural competence in healthcare. Extensive evidence exists on several potential contributing factors.

Researchers document LGBT discrimination by physicians and medical students, and note a common theme of discomfort and disdain toward LGBT patients in educational and professional environments; there is no indication of major progress toward improving LGBT healthcare (Pizer, Sears, Mallory & Hunter, 2012; GLMA, 2011). Other evidence suggests that many physicians provide incompetent LGBT healthcare despite perceiving themselves as providing adequate treatment (GLMA, 2011).

Pizer, Sears, Mallory and Hunter (2012) argue that improving LGBT healthcare quality requires an increase in the numbers of LGBT care providers, but federal and state inaction against LGBT workplace discrimination impedes progress toward that goal. In a published literature review that appeared in a peer-reviewed journal, Betancourt, Greene, Carrillo and Ananeh-Firempong (2003) conclude that cultural competency results in part from ensuring that the population of healthcare providers and leaders represents the vulnerable patient populations they seek to serve.

The practitioner literature promotes a picture of delayed LGBT cultural competency as a function of earnest, but plodding, AMA leadership. The AMA President in 2005 announced that AMA would work with the Association of American Medical Colleges (AAMC) to improve the quality of LGBT healthcare instruction provided by medical schools. However, the most recent AAMC guidelines (2005) only include sexual orientation and gender treatment issues as a subpart in one of its nineteen recommendations for promoting cultural competency in medical school. The AAMC sub-recommendation on LGBT competency is insufficient because it is based on Licensing Committee on Medical Education (LCME) accreditation standards for general cultural competence that fail to mention or incorporate any LGBT specific issues (AAMC, 2005). In 2010, five years after signaling intention to work with AAMC to promote LGBT cultural competency education, AMA told the IOM that the AMA had yet to secure support of the LCME

and the American Council on Graduate Medical Education (ACGME) for including LGBT material in medical school cultural competency classes. As the largest association of medical doctors in the United States, AMA and its leaders surely knew in 2005 that medical schools consider guidelines of both the AAMC and the LCME when establishing course curriculum (AMA, 2010a). Because the AMA stands out as a supporter of LGBT cultural competency and recognizes that the lack of LGBT competency constitutes a problem in need of amelioration, benign neglect constitutes one sources of the LGBT cultural competency deficit.

AMA membership issues may contribute to the perceived delay in education related improvements. In addition to the discriminatory views and patient treatment observed of AMA members (GLMA, 2011), the organization confronts a decline in membership numbers due to the concentration of new doctors in medical specialties instead of in general practice. This downward trend reduces the numbers of AMA members and increases the number of members in specialty related associations such as American Pediatrics Association and American College of Obstetricians and Gynecologists (Ibrahim & Morganstern, 2005). Fewer members equates to less dues revenue for AMA, which may lead to delays in LGBT cultural competency reforms. Despite the slow pace of action, AMA pursues unilateral action to produce sensitive and competent LGBT care by furnishing LGBT cultural competency training videos to over 50,000 medical students and practitioners.

<div align="center">Thesis Question and Flow of Thesis</div>

Thesis Question

Given the concerns about LGBT health disparities, access and quality noted above, this thesis seeks to understand how government officials can support LGBT cultural competency. This thesis aims to foster that understanding by answering a focused policy question: What can policymakers do to improve LGBT cultural competency of physicians?

Flow of Thesis

In a five-chapter format, this thesis explores policy options for improving LGBT cultural competency. Chapter 1 presents the issue narrative, identifies critical elements of the topic, states the thesis question, describes the benefits of LGBT cultural competency, and reviews literature relevant to the policy options that this thesis seeks to produce. In Chapter 2, I introduce evaluative and practical criteria used in this thesis to assess the potential policy options for addressing the LGBT cultural competency deficit of physicians. Chapter 3 identifies and details the policy options. I transition to the analytical stage in Chapter 4 by conducting the Criteria Alternatives Matrix process, which is the method employed in this thesis to evaluate and rate options to improve LGBT cultural competency. In Chapter 5, the thesis concludes with final evaluation and recommendation of suggested policy options.

Literature Review

The research and practitioner literature that I cite in this thesis reflects a variety of sources. Over one hundred literature reviews, original qualitative and quantitative studies, government reports, theoretical articles, legislative and public agency documents, private agency documents, and other sources informed the literature review for this thesis. This literature review begins with a discovery of LGBT cultural competency theory and methods. The parts of this section relate to the evaluative criteria that judge the potential policy responses in Chapter 4. I detail each criterion in Chapter 2, but this section indicates how the criteria relate to the relevant policy issues under consideration. The first criterion, sustainability, relates to the theory and methods relating to cultural competency. Equity, which is the criterion that follows, regards bias, equity and disparity concerns regarding LGBT healthcare. The final evaluative criterion, efficiency, pertains to cost concerns. At the end of this review, I present the conclusion to Chapter 1 and the transition to Chapter 2.

Sustainability Concerns: Cultural Competency Defined and Described

There is an established record – in theory and practice – of utilizing cultural competence in healthcare settings (Beach et al., 2005). Policymakers and practitioners initially promoted cultural competence training to help physicians and patients jointly overcome cultural healthcare barriers that relate to race, ethnicity, gender, age, and language (Like, Steiner & Rubel, 1996), but LGBT competency fell short of being included in the definition of cultural competence at that time (McNair & Hegarty, 2010; Peterkin & Risdon, 2003; GLMA & LGBT Health Experts, 2001). Although early cultural competency efforts may have lacked commitment on LGBT health topics, the public value of general cultural competency cannot be understated. For example, IOM (2011) notes that at least 175 studies attest to the prevalence of race and ethnic healthcare disparities, which include disease prevalence and predisposition within or among race and ethnic groups. Examples of those disparities include disproportionately high rates of prostate cancer in African American men, doctor-patient communication barriers, problems with treatment adherence, and cultural differences that may enhance risky health behaviors (Beach et al., 2005).

This thesis differentiates between the two valid but distinct forms of cultural competency by splitting them into two types. The first type, general cultural competency, addresses legitimate and critical health issues of various cultures, races, ethnicities, genders, age groups, and linguistic groups. The second type, LGBT cultural competency, aims to address all aspects of the general type while adding elements critical to responsible and effective care of LGBT patients (GLMA, 2006). To impart clarity on the ensuing discussion about the policy concerns surrounding LGBT cultural competency and healthcare, I offer comprehensive research-based terminology that conveys the key qualities of LGBT groups. Heterosexual people are those whose attraction and sexual activity exclusively, or primarily, involves people of the opposite sex; lesbian refers to women whose attraction and sexual activity exclusively, or primarily, involves other women; gay

refers to men whose attraction and sexual activity exclusively, or primarily, involves other men; bisexual relates to a person who possesses a consistent attraction, but not necessarily sexual activity with, both sexes; transgender includes people whose sense of gender identity, which is the internal sense of the gender they identify themselves with, differs from the gender they possessed at birth and also includes transsexual people who have transformed surgically from one gender to another (Woodiel & Brindle, 2008; Kaiser Permanente, 2004; Dean et al., 2000). Gender expression relates to outward demonstrations of gender identity and may involve gender reassignment surgery or hormone treatment. Research also indicates that physicians need to look beyond standardized definitions of sexual orientation, gender identity and gender expression because patients may not fit precisely into a typical heterosexual or LGBT status. Understanding the differences between transgender and intersex – a term that describes one born with multiple gender or genital traits – helps physicians provide patients from both groups with competent healthcare (Dean et al., 2000).

Clear definitions of both general cultural competence and LGBT-specific cultural competence indicate points of commonality and interoperability of the two variations. Although researchers note cultural competency includes both clinical and administrative aspects of the healthcare system (Betancourt et al., 2003), this thesis pertains solely to competency of physicians. IOM (as cited by IOM, 2011, p. 65) offers a succinct definition of general, non-LGBT cultural competence: "a set of skills that allows providers to give culturally appropriate high quality care to individuals of cultures different from their own." Turner, Wilson & Shirah (2006) further define general cultural competence:

> Cultural competency is defined as a set of knowledge, attitudes, and skills that can be demonstrated by an individual under specific conditions and evaluated on predetermined standards based on the premise of respect for individuals and differences and the implementations. Usually a tandem process of personal and professional transformation occurs during the journey toward cultural competency and mastery. Even when one has

attained mastery, learning and evaluating ones cultural skills should be an ongoing process. (p. 62)

The Gay and Lesbian Medical Association (GLMA, 2006) provides a basis for creating a definition of LGBT cultural competency by merging characteristics of general cultural competence and LGBT-specific cultural competence. The GLMA cultural competence guide (2006) validates the practice of applying general cultural competence to the LGBT patient population because of rich cultural diversity with respect to race, ethnicity, culture, language, gender, age, religion and more within the LGBT community. GLMA (2001) also gives credence to the value of combining general and LGBT cultural competence by recommending that LGBT cultural competence training programs and clinical practitioners apply key principles of care relevant to mastering the core competencies necessary for appropriate medical treatment of all groups. Skills that doctors apply in providing competent LGBT care include providing a welcoming care environment; establishing doctor-patient trust to facilitate open discussion of health concerns, eliminating assumptions when reviewing the sexual history of patients; screening for tobacco, alcohol and substance abuse, and mood disorders, because of their disproportionate prevalence among the LGBT population; asking questions pertinent to risk factors for each LGBT group; and, preventive or curative medicine tailored to the non-LGBT needs of each. According to Dean et al. (2000), patients need comprehensive care regardless of sexual orientation or gender identity factors, but those factors are inextricable from an effective treatment strategy aimed at comprehensive care for LGBT people. Therefore, LGBT cultural competency must allow providers to address and account sexual orientation and practices, and gender and expression among patients.

After considering the multivariate elements involved in defining LGBT cultural

competency, I offer a comprehensive and inclusive definition that aligns the elements and

variations of cultural competency discussed herein:

> LGBT cultural competency is the ability to know and understand that LGBT patients
> have personal, general and LGBT-specific medical issues; willingness and ability to
> offer a welcoming care environment to LGBT patients whether they have come-out or
> not; commitment to establishing trust with patients; using non-judgmental inquiries to
> obtain information about sexual practices and history; screening for medical, mental,
> substance abuse and domestic violence issues; deducing and dispensing person- and
> group-specific preventive care; a set of knowledge, attitudes, and skills that can be
> demonstrated by an individual under specific conditions and evaluated on predetermined
> standards based on the premise of respect for individuals and differences and the
> implementations.

Sustainability Concerns: Cultural Competency Training Models

There are four main modes of teaching cultural competency: medical school education

(Obedin-Maliver et al., 2011), medical residency education (IOM, 2011), on the job training

(Kaiser Permanente, 2004) and formal continuing medical education (Levin & Mayer, 2010).

Training generally occurs in an individual setting, such as a webinar (HRC, 2012a), a formal or

informal classroom setting, or a treatment setting (Kelley, Chou, Dibble & Robertson, 2008). I

list other modes of providing for LGBT cultural competency of physicians in Chapter 3. Content

of the courses may reflect the health topics relating to divergent age groups. Despite the diversity

of resources available, a shortfall of LGBT cultural competency training and expertise remains

(Cochrane & Mays, 2007; Mravcak, 2006).

This thesis focuses on cultural competence of current and future physicians serving

LGBT patients. Care settings where physicians need to become culturally competent to serve the

LGBT populations include hospitals, primary and tertiary (i.e., specialty) care, preventative care,

rehabilitative care and long-term care (Jillson, 2002). Future physicians tend to receive LGBT

patient instruction or experience in either the classroom-based or experience-based medical

school education modes (Obedin-Maliver et al., 2011). Training these eventual providers may occur in a purely educational environment or in a clinical patient care setting. Existing doctors seek to gain competency mostly through continuing medical education (CME) courses. CME educates on LGBT content in two main ways: stand-alone training modules fully dedicated to LGBT issues and modules that interweave LGBT healthcare issues into either general cultural competency courses or other CME courses (Levin & Mayer, 2010). LGBT competency training for prospective or practicing physicians may be elective or mandated. Researchers report that some forms of LGBT competency training have promise for improving health outcomes and doctor-patient relations (Kelley, Chou, Dibble & Robertson, 2008), but there are no known empirical studies that validate the strength of any particular educational delivery model.

Equity Issues: Social Costs from Stigma and Bias Relating to the LGBT Cultural Competency Deficit

LGBT patients confront stigma, bias and health disparities when accessing healthcare services. In a medical setting, the term "LGBT stigma" refers to the negative perception of LGBT groups promoted by intolerance and unequal treatment from medical systems and providers (GLMA, 2006). Stigma discourages LGBT patients from scheduling or attending doctor visits and it reduces the quality of care they receive (Turner, Wilson & Shirah, 2006; GLMA and Lesbian, Gay, Bisexual and Transgender [LGBT], health experts, 2001). Stigma may take the form of individual or group discrimination. When providers exacerbate stigma – intentionally or not – patients are less likely to seek and receive care, which reduces LGBT health equity (Jillson, 2002; IOM, 1993). LGBT people who identify with other vulnerable, stigmatized social or population groups experience elevated pressure from stigma (IOM, 2011).

Studies have explored issues relating to health provider bias directed at LGBT patients. Although it has been almost forty years since the American Psychiatric Association (APA)

removed homosexuality from its official catalog of disorders, the Diagnostic and Statistical

Manual (DSM), the APA did not recognize homosexuality as normal behavior until 1987

(Drescher, 1998). Despite the APA validation of same sex relationships, medical doctors retain

bias against LGBT patients. A 1986 survey by Mathews, Booth, Turner and Kessler found that

40% of providers expressed discomfort in serving lesbian or gay patients. Twenty years later,

physician bias lessened and willingness to treat LGBT client groups advanced (Smith &

Mathews, 2007). However, other studies corroborate the findings of widespread bias toward

LGBT patients and LGBT physicians. When the Gay and Lesbian Medical Association (GLMA)

conducted its first national survey of lesbian, gay and bisexual medical doctors, 52% of survey

participants reported seeing gay or lesbian patients receive subpar care or denied care specifically

because of their real or perceived sexual orientation, and 88% reported seeing physicians make

disparaging comments about gay patients (Schatz & O'Hanlan, 1994). For that survey, the term

"perceived sexual orientation" refers to primary care settings in which a physician who

discriminates against LGBT patients exhibits bias by assuming the sexual orientation of a patient

without seeking to clarify the orientation of the patient. Although not captured in the survey, a

different type of perception about sexual orientation may be susceptible to bias and lead to

problematic patient outcomes. A patient who does not self-perceive as lesbian, gay or bisexual,

but engages in sexual activity with one or more people of the same sex, risks complications from

sexual activity if the attending physician avoids questions about homosexual health practices

because of bias (Starks, Nadler, Sagrestano & Sarvela, 2009). In 2009, GLMA joined with the

AMA for a follow up to the 1994 survey. In the revised study, two-thirds of respondents noted

that they rarely, sometimes or often saw physicians make disparaging comments about LGBT

patients and 20% had witnessed physicians disrespecting patients LGBT relationships (GLMA,

2011).

Equity Issues: LGBT Health Quality, Disparities and Weaknesses in Care

LBGT people experience substandard care due to biases and deficiencies in the capacity of health professionals to provide competent care (Mayer, Bradford, Makadon, Stall, Goldhammer & Landers, 2008). The gap between patient needs and physician capacity results partially from a lack of LGBT training in medical education (McNair & Hegarty, 2010; Peterkin & Risdon, 2003). For example, many clinicians believe incorrectly that the sexual orientation of a patient is irrelevant to the care of that patient (Hinchliff, Gott & Galena, 2005) despite the existence of extensive health policy findings that LGBT health outcomes are greatly influenced by sexual orientation and transgender considerations (Mayer et al., 2008; GLMA, 2006).

A substantial portion of the critical health challenges experienced by LGBT people are identical to the challenges experienced by the general population, but many additional challenges and disparities present significant health concerns to LGBT patients (IOM, 2011; GLMA, 2006). Areas where LGBT people experience health disparities include: cancer, sexually transmitted diseases, anxiety and depression, long-term care, relationship violence and risk behaviors such as tobacco or substance abuse, safe sex practices, and suicide ideation (Hoffman, Freeman & Swann, 2009; GLMA, 2006; Peterkin & Risdon, 2003). Cancer disparities involve anal intraepithelial neoplasia and anal cancer in men resulting largely from exposure to the human papillomavirus (HPV) (Park & Palevsky, 2010); ovarian and endometrial cancers in lesbians because the low rates of pregnancy or birth control pill usage among lesbians increase the odds of developing those reproductive system cancers (Perez & Luquis, 2008); lung cancer among all LGBT people – particularly lesbians because they exhibit elevated rates of smoking that exceed the average for all women and increase with age (Gruskin, Greenwood, Matevia, Pollack & Bye, 2007); and, breast cancer among transgender individuals due to long term or cut-rate gender replacement treatment such as black market silicone injections (Peterkin & Risdon, 2003;

Futterweit, 1998). In an analysis of California Health Interview Survey data regarding cancer incidences, researchers found that gay men reported cancer incidences that are two times the rates reported by heterosexual men (Boehmer, Miao & Ozonoff, 2011). Lesbian and bisexual women, in the same survey, reported rates of cancer that are similar to the rates reported by heterosexual women, but lesbian and bisexual women were twice as likely to report moderate or poor health after their cancer went into remission. Risky safe sex practices may lead LGBT people to experience disproportionately high rates of many diseases including bacterial vaginosis among lesbians (Marrazzo, Thomas, Fiedler, Ringwood & Fredricks, 2010), human immunodeficiency virus (HIV) in gay men, HIV and syphilis cases in men who have sex with men (Centers for Disease Control, 2007) and hepatitis in transgender people, which often occurs as a result of unsafe or unsanitary non-medical gender reassignment therapies (Woodiel & Brindle, 2008). For transgender people, stigma and bias have a chilling effect on health disparities such as discrimination in insurance coverage, exclusion or denial of health insurance coverage and insufficient and inappropriate health treatment (HRC, 2012b).

Bias and stigma sometimes produce negative health effects among LGBT patients and groups. According to GLMA (2006) behavioral health problems, including anxiety, depression and suicide ideation, often result from real or perceived bias and stigma. Bias and stigma materialize through instances of discrimination directed at LGBT people, and perceived bias or stigma result from an LGBT person internalizing the pressure and fear associated with discrimination that they have witnessed or experienced. Although researchers note that the rates of these psychological conditions appear to be higher than the general population, there is little research on the topic (GLMA, 2006).

Cultural competency training shows promise for helping physicians reduce bias, gain familiarity, and provide better care to their LGBT clientele (Sanchez, Rabatin, Sanchez, Hubbard

& Kalet, 2006). In a study of 75 second-year medical students, researchers found that augmenting medical school curriculum with an LGBT patient care module instilled in medical students increased comfort and competency with LGBT health issues (Kelley, Chou, Dibble & Robertson, 2008).

Efficiency Issues Relating to the LGBT Cultural Competency Shortfall

In addition to the social equity costs of poor cultural competence, inefficient provision of LGBT healthcare produces myriad economic costs to both healthcare consumers and the healthcare system (GLMA, 2001). One area of the healthcare system where LGBT patients experience neither competence nor parity is in the area of health insurance. For example, the health insurance system reports disproportionately high rates of uninsured and underinsured LGBT people and the lack of insurance has produced health disparities (IOM, 2011). Using California Health Interview Survey data for 2001, 2003 and 2005, Ponce, Cochran, Pizer and Mays (2010) found that "Partnered gay men are nearly half as likely (42 percent) as married heterosexual men to get employer sponsored dependent coverage, and partnered lesbians have an even slimmer chance (28 percent) of getting dependent coverage compared to married heterosexual women" (p. 1545). Due to disparities in health insurance coverage, LGBT patients – especially those in partnered relationships – are likely to experience a substantially greater economic burden than non-LGBT patients experience when it comes to paying for healthcare treatment (Kaufman, 2007). This is particularly true for transgender patients (HRC, 2012b).

When LGBT patients with limited or no insurance seek or obtain healthcare, they sometimes ration their number of initial and follow up visits to health providers, which leads to uncoordinated care. Because they often must pay out of pocket when publicly funded health resources are unavailable, some LGBT patients see multiple providers to find the lowest fee and frequently present to emergency rooms for healthcare needs, which prevents the patients and the

healthcare system from accruing the cost benefits associated with a traditional doctor-patient relationship (Mayer et al., 2008). Patients in that situation are also severely constrained in their ability to pay for prescription drugs (GLMA, 2006).

Efficiency costs also exist for LGBT patients who have health insurance or otherwise possess resources to secure consistent care (IOM, 2011). To the extent that cultural competency results in LGBT patients seeking regular visits to a consistent medical office, research indicates multiple potential cost benefits. First, initial doctor visits minimize undiagnosed illnesses and increase the likelihood that patients receive preventative care and screening, which may reduce long-term health expenses for patients, providers and insurers (Forrest & Starfield, 1996). Second, competent care in medical offices engenders trust with LGBT patients, which is critical to the cost savings calculus, and decreases the need for emergency, specialized or critical care (IOM, 2011). Although no data exists for the direct cost impact resulting from different types of care utilization by the LGBT population, research on general population utilization habits offers instructive data. Reid et al. (2010) reviewed medical group expenditure data regarding healthcare utilization for insured patients and found cost savings associated with reducing instances of patients seeking care outside of their primary care office. Described in per-patient cost magnitudes, Reid et al. (2010) concluded that emergency room care is 2.5 times more expensive than primary office care, specialty care is 3.6 times more expensive than primary office care, and inpatient hospitalizations are 8.8 times more expensive than primary care visits.

Insurance and utilization issues aside, one reason that LGBT patients confront high medical costs is the marginal increase in money that they need to spend on healthcare because they suffer from high propensities of certain health conditions. Some of these costs may be avoidable through culturally competent preventative care (IOM, 2011). For example, lesbians and bisexual women appear to have an increased risk of breast and cervical cancers. Some

observers report that predisposition to cervical cancer among lesbians occurs in part because culturally incompetent providers make inaccurate assumptions, and take incomplete patient histories, about sexual activity, which is a key competency deficiency because sexually transmitted diseases may cause cervical cancer (GLMA, 2006; Matthews, Brandenburg, Johnson & Hughes, 2004). Causes for higher rates of breast cancer are unknown, but some researchers have noticed higher rates of smoking, obesity and other forms of substance abuse among lesbians and wonder if biological influences including personal habits may elevate lesbian breast cancer and other cancer rates (Boehmer, Bowen & Bauer, 2007; Mravcak, 2006). Moreover, rates of breast cancer elevate for women who spend minimal or zero months breastfeeding during the course of their lives, which is a risk factor for lesbians due to lower rates of childbearing and breastfeeding compared to the general population (Zaritsky & Dibble, 2010). Transgender health disparities are costly and involve issues like medical interactions with gender replacement surgery and higher risk of hormone related cancers resulting from hormone therapy (Futterweit, 1998).

Evidence indicates that mental health challenges and substance abuse problems among LGBT persons exacerbates physical health problems (Cochran & Mays, 2007). Specific presentments of substance and mental health conditions include: enhanced levels of substance abuse involving tobacco, alcohol and illicit drugs, and higher risk of diseases associated with abuse and overuse of those substances such as heart disease, lung cancer and pancreatic disorders. Depression, anxiety, and post-traumatic stress disorder are also common among LGBT patients and cultural competency is required to treat those disorders because they are often produced by the social stigma and isolation related to sexual orientation and gender identity or expression (GLMA, 2006). LGBT people also confront violent assaults, homophobia, biphobia, transphobia, discrimination and harassment simply because of their sexual orientation, gender identity or gender expression.

Conclusion

This chapter introduces the policy issue of LGBT cultural competence of physicians. I establish the public value of the topic by detailing support from within policy and practitioner environments. Descriptions of LGBT cultural competence and the rationale for improving physician competency provide basis for the thesis question, which centers on options for policymaker action. The literature review explores the social and economic costs of incompetent care and offers a context for understanding how cultural competency holds promise for sustainably, equitably and efficiently ameliorating extensive deficiencies and disparities in LGBT healthcare. Next, Chapter 2 unveils the criteria I use in this thesis to assess the potential policy actions aimed at improving the LGBT cultural competency of physicians.

Chapter 2

CRITERIA FOR EVALUATING LGBT CULTURAL COMPETENCY

POLICY OPTIONS IN HEALTHCARE

In Chapter 1, I frame the policy problem and review relevant research and practitioner literature pertaining to LGBT cultural competency. In this chapter, I chronicle and convey the research and process relating to criteria-based public policy analysis, and detail the proposed set of criteria that I will use to evaluate and rate the policy options considered in this thesis. Setting principles for criteria selection bolsters removal of subjectivity from the evaluation process.

The Role of Criteria in Developing and Evaluating Policy Proposals

In research and academic literature on policy analysis, criteria selection comprises one of several steps in developing solutions to problems. Munger (2000) delineates policy analysis as a five-point process consisting of "problem formulation, selection of criteria, comparison of alternatives, consideration of political and organizational constraints, and implementation and evaluation of the program" (p. 144), and describes criteria as "the bases for judging or choosing…the premises for analysis, for saying that one alternative is better than the other" (p. 8). MacRae and Wittington view criteria as "ethical considerations concerning what is good for individuals in general or for society – such as years of life, health, education, happiness or cost-reduction – or what is morally right." Bardach (2005) depicts criteria selection as a core action in the process of evaluating projected outcomes.

How to Select Criteria

Bardach (2005) and Munger (2000) concur that strong policy analysis relies on programming outcome oriented criteria into any evaluation process aimed at resolving public problems. MacRae (1993) likewise advises comparing policy options against dichotomous, outcomes-based, evaluative criteria to develop comprehensive policy solutions.

MacRae and Whittington (1997) suggest a set of guiding principles for choosing among criteria to analyze policy issues and options. Those principles are:

> Using ends rather than means as criteria; using quantified measures to facilitate trade-offs; ensuring completeness of the set of criteria to be used; avoiding overlap among criteria if they are to be summed; and, choosing clear and appropriate measures for criteria. (p. 81)

MacRae (1993) offers a similar list of considerations to apply when selecting both criteria and options: completeness; focus on ends, not means; multiple options including the status quo; fullness of information to avoid biased selection; and, use quantifiable criteria to aid comparisons and conclusions.

Selecting Criteria

Researchers suggest several criteria appropriate to this thesis. MacRae (1993) observes that the core criteria of "efficiency and equity, or effectiveness and cost" (p. 292) satisfy the test of completeness and produce information useful to broad conceptualization potential policy outcomes. Jackson and Waters (2005) review literature and programs on public health interventions and recommend inclusion of equality and sustainability as evaluative criteria.

After analysts apply evaluative criteria and judge outcomes of potential policies based on relevant benchmarks, Bardach (2005) cautions policy analysts to consider the practical implications of outcomes through criteria such as "legality, political acceptability, robustness under conditions of administrative implementation, and improvability" (p. 31). Munger (2000) similarly suggests assessing potential policies using political and organizational feasibility criteria after assessing the strengths and weaknesses of policies with respect to evaluative criteria. While political feasibility (i.e., probability of legislative passage) and organizational feasibility (i.e., administrative, regulatory and industry support and enforcement) considerations help analysts and policymakers determine the practicality of policy options, neither criteria provides analysts with

material to evaluate the effectiveness of policy options. Even when these feasibility criteria

warrant consideration, analysts must recognize that political and social pressures for action

fluctuate (Moore, 1995), which complicates forecasts of political and organizational feasibility.

 Table 2.1 follows the subsequent sections on evaluative and practical criteria. Readers

may refer to Table 2.1 for a summary of each criterion and introduction of relevant analytical

questions that I use in Chapter 4 to evaluate and rate the public policy options presented in

Chapter 3.

Evaluative Criteria Used in this Thesis

Efficiency

 Chapter 1 reflects on efficiency within the context of LGBT cultural competency,

demonstrates cost effects relating to patients, providers and the health system at large, and

establishes a connection between insufficient efforts to address LGBT healthcare disparities and

inefficient care. Bardach (2005) reports that policy analysts widely and frequently employ

efficiency to serve as an evaluative criterion. While researchers suggest economic considerations

underlie efficiency concerns, the concept of cost only composes one facet of efficiency analysis.

According to Munger (2000), inefficiencies often result when the political process fails to

resolve, or inadequately resolves, conflicts between market forces and policy experts about

efficiency. Munger (2000) offers a definition of efficiency, "A particular matching of resources

to uses is efficient if and only if there exists no better alternative allocation of those same

resources" (p. 32). To determine efficient allocation, Munger (2000) suggests measuring

efficiency of a proposed policy against the Pareto criterion, which stipulates that a proposed

policy "is efficient or optimal unless there exists an allocation of resources that everyone prefers"

(p. 51). However, Wassmer (2002) notes that satisfying the Pareto criterion is improbable in a

public policy context and suggests that a more appropriate standard to apply is Kaldor-Hicks

efficiency, which gauges whether total benefits of a new policy allow for reducing costs to affected parties. Wassmer (2002) describes Kaldor-Hicks succinctly as a measure of whether a proposed policy will deliver the most "bang for the buck" (p. 58). I employ the Kaldor-Hicks approach, and not the Pareto criterion.

Evaluating the efficiency of proposed policy options also requires understanding process related inefficiencies involved a policy problem that involves more than just financial cost analyses. Munger (2000) describes how this consideration contributes to questioning the efficiency of a policy regarding physician LGBT cultural competency: "Markets fail if governments create, or fail to remove, impediments to market processes" (p. 242).

Equity

The U.S. Office of Minority Health (2011b) defines health equity as "attainment of the highest level of health…with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities" (Top Paragraph), and calls for action to reduce health disparities. Bias, stigma, health disparities and substandard care for LGBT patients remain problematic, which demonstrates the health inequities they face.

In a refereed literature review used by international health experts to develop evaluative criteria for assessing health policy interventions, Jackson and Waters (2005) echo the findings of other researchers that equity constitutes a valuable criterion for evaluating policy proposals (Bardach, 2005; Munger, 2000; MacRae and Whittington, 1997; Zecky and Stokehauser, 1978). Measuring equity or equality, however, involves multivariate considerations. Jackson and Waters (2005) recommend taking an ethical approach when establishing new health equity interventions to ensure that equality for disadvantaged patient groups does not inadvertently produce inequalities for other patient groups. To that end, equality measures must incorporate

transparency into the evaluative process to support determination of how a health intervention affects patients across the board.

Sustainability

Hawe (as cited in Jackson & Waters, 2005) argues that the sustainability of proposed public health interventions merits inclusion with other evaluative criteria because common measures fail to provide insight into the long-term operational viability of a policy proposal. Jackson and Waters (2005) report that sustainability criteria seek to evaluate and project whether a policy will be durable, agile and satisfy its program effectiveness objectives. Bardach (2005) suggests that sustainability is determined by the robustness and improvability of a policy. Green (as cited in Jackson & Waters, 2005) recommends that health policies and interventions promote development of care provider skills.

<div align="center">Practical Criteria Used in this Thesis</div>

Political Feasibility

Munger (2000) lists identification and analysis of political and organizational constraints as one sequence in his five-point process for vetting policy proposals. The political feasibility criterion answers the question of "will elected officials vote for the proposal and make it law?" (p. 15). According to Bardach (2005) two impediments to gauging political feasibility include 1) discerning the multiple means and motivations available to politicians that may prevent policy enactment, and 2) the fact that "the analyst generally cannot get accurate information on the likely reaction to a proposal until it is proposed" (p. 15). Kingdon (2003) observes that elected officials respond to multifarious forms of feedback and that gauging feasibility accurately requires recognition of those mixed influences; moreover, the possibility that elected officials may agree on the presence of a policy problem yet differ on the set of solutions further complicates the feasibility calculus.

Organizational Feasibility

This criterion shares common attributes with political feasibility (Munger, 2000), but entails enactment hurdles endemic to the administrative or bureaucratic structure of the policy environment. As such, organizational feasibility analysis amounts to a projection of reactions from appointed officials and government employees who stand to implement the proposed policy. In the context of this thesis, it can also refer to the organizational infrastructure surrounding medical school education, medical residency environments, continuing medical education, employment-based training settings. While organizational feasibility offers insight on the likelihood of enacting policies and the constraints associated with implementing policies, analysts possess imperfect information to estimate accurately the eventual degree of organizational support or opposition.

As noted in the preceding discussion on the sustainability criterion, Bardach (2005) argues that robustness and improvability relate to determining the sustainability of a policy, but Bardach describes robustness and improvability measures as constituents of practical criteria. In the analytical criteria developed in this thesis, I draw a distinction between criteria that assess organizational capacity (i.e., sustainability) and support (i.e., organizational feasibility) of policy options. Elements of robustness and improvability that I apply to this practical criterion include assessment of: 1) influential bureaucratic entities and personalities, 2) internal and external political pressures on the proposed policy implementers, and 3) influences within the agency structure of the implementers. One area where organizational feasibility holds direct relevance pertains to institutional flexibility. Given the potential for varying degrees of implementer involvement with the policy options that this thesis seeks to study, organizational feasibility analysis produces critical feedback in discovering how administrative or leadership considerations may guide a policy in practice.

Table 2.1: LGBT Cultural Competency Criteria Summary Definitions and Analytical Questions

CRITERION (Evaluative or Practical	SUMMARY DEFINITION OF CRITERION	CRITERION-RELATED ANALYSIS QUESTION
Efficiency (Evaluative)	Aligns government policies for market correction with cost-effective solutions for improving LGBT cultural competency that reduce costs paid by providers and patients in a manner that creates net total benefits for all parties even if some new or continuing costs accrue.	Given the research that this thesis presents regarding efficiency costs presented by deficiencies in LGBT healthcare, health screening, disease or disorder prevention, and health access, how well do policy options produce economic and other efficiency benefits in a manner that shows promise for outweighing new or continuing costs, to parties involved while effectively addressing the policy problem?
Equity (Evaluative)	Resolves deficiencies in LGBT cultural competency care in a manner that preserves or improves general cultural competency and core competencies relating to all forms of healthcare.	Given the research that this thesis presents regarding equity costs presented by deficiencies in LGBT healthcare, health screening, disease or disorder prevention, and health access, what are the strengths and weaknesses of each option for producing an equitable care environment that improves LGBT cultural competency? ?
Sustainability (Evaluative)	LGBT cultural competence policies are implemented, maintained and improved, if necessary, through policy provisions that create and support robust actualization and enforcement.	Given the research that this thesis presents on sustainability costs related to deficiencies in LGBT healthcare, health screening, disease or disorder prevention, and health access, what are the strengths and weaknesses of each option for producing viable, persistent, durable program effectiveness for physician LGBT cultural competency?
Political Feasibility (Practical)	Consensus or majority support among participants in the political environment for physician LGBT cultural competency policy options.	Given the research that this thesis presents regarding preferences, alliances and conflict among participants in political channels of the policy environment, what is the feasibility of enacting a policy on this topic?
Organizational Feasibility (Practical)	Consensus or majority support among participants in the administrative environment for physician LGBT cultural competency policy options.	Given the research that this thesis presents regarding preferences, alliances and conflict among participants in regulatory channels of the policy environment, what is the feasibility of implementing a policy on this topic?

As described in the introductory paragraphs of this section on criteria selection, Table 2.1, above, summarizes the definitions of criteria. In this three-column table, the left column lists the evaluative and practical criteria, the middle column provides the operationalized definition of the criteria, and the right column contains the criteria-based questions I employ in Chapter 4 to evaluate and rate policy options described in Chapter 3.

Conclusion

This chapter provides the research-based context for selecting criteria that support a comprehensive evaluation of policy options for improving LGBT cultural competence. I presented the theory and process behind discovery of appropriate criteria and detailed the set of evaluative and practical criteria I will use analyze the potential policymaking options. The following chapter identifies and assembles the group of policy options under consideration for improving LGBT health and cultural competency.

Chapter 3

IDENTIFYING AND DESCRIBING POLICY OPTIONS FOR IMPROVING

LGBT CULTURAL COMPETENCY IN HEALTHCARE

In Chapter 1, I describe, define and present evidence of the policy problem at hand. Chapter 2 formally establishes and refines the research-based criteria for judging potential policy responses. In this chapter, I identify the potential policy options that this thesis considers and evaluates for use in addressing the shortfall in culturally competent LGBT healthcare.

Potential Options for Improving LGBT Cultural Competency

This section identifies and describes LGBT cultural competency policy options available to policymakers. Each level of government enjoys authority sufficient to institute and enforce various options. The options described in this chapter concentrate on state actions because states have taken a primary role on policies regarding general cultural competency. Therefore, the options presented in this chapter and evaluated in subsequent chapters focus on state options for policy solutions.

Cultural competency enhancement processes focus mostly on training related measures, which may occur through in-person or virtual formats. Environments for obtaining cultural competency include medical school and residency courses, continuing medical education, employer provided learning environments, and self-guided learning (Ibrahim & Morganstern, 2005). The majority of medical education, residency, CME and employer-based courses involve some form of physician lecture and culminate in an assessment or exam (IOM, 2009). Alternate teaching and learning formats include conferences, workshops, classes, webinars, online tutorials, computer program modules, podcasts, videos, and other formats; self-guided courses frequently do not count toward academic or professional credit (Dolan, 2012; Accreditation Council on Continuing Medical Education [ACCME], 2011; Thom, Tirado, Woon & McBride, 2006;

Medical Board of California, n.d., United States Office of Minority Health, n.d.1). Other

approaches to cultural competency (Woodiel & Brindle, 2008; Peterkin & Risdon, 2003) focus on

informal methods that deliver informative content on best practices guidelines without

incorporating an educational element or measurement. Some methods of verifying cultural

competency, such as post-residency examinations for state licensure or specialty practice

certification, place pressure on physicians and physician educators to become culturally

competent without extending a mechanism to achieve competency. I now present a description of

policy options for improving LGBT cultural competency of physicians and discuss the benefits

and constraints of each. After the final option is detailed, Table 3.1 presents a brief description of

each option for quick reference.

Mandating Changes to Medical School Education Curriculum

This option allows future physicians to achieve LGBT cultural competency in a few

different ways. With guidance from the Association of American Medical Colleges (AAMC) and

the American Medical Association (AMA), the Licensing Committee on Medical Education

(LCME) establishes essential curriculum standards that medical schools must follow to obtain

and retain accreditations to educate future doctors (Ibrahim & Morganstern, 2005). Medical

school students in LCME-accredited schools receive at least 130 weeks of medical education over

four years (Licensing Committee on Medical Education [LCME], 2012). During the first two

years of medical school, education occurs mostly in a classroom environment with minimal

clinical exposure to patients. Elements of supervised clinical study, but not direct patient

treatment, occur during the final two years of medical school. Medical schools may, but are not

required to, offer limited LGBT cultural competency through addition of a stand-alone course,

weaving the topic into existing courses, or creating a clinical training component. Medical

education is a common environment for LGBT cultural competency training (Dahan, Feldman & Hermoni, 2008).

Although states do not control accreditation agencies, states do possess legislative avenues for imposing LGBT cultural competency requirements on medical schools. Regardless of the potential merit of LGBT cultural competency, policymakers may encounter opposition to medical education mandates on the part of university stakeholders who philosophically object to external regulation on autonomy grounds (Dee, 2011).

Another aspect of this option relates to its somewhat limited application. Although 98% of public and private medical schools fall under the purview of state – not federal – regulation (Contreras, 2009), many states opt against regulating private non-profit institutions in any way (California Postsecondary Education Commission, 2005). A medical education mandate may only affect public institutions because some states do not have a mechanism or precedent for mandating action of private medical schools (CPEC, 2005).

Medical school curriculum involves a complex, interdependent network of educators, accrediting bodies and government. If policymakers move to dictate the subjects taught in university courses, they must be mindful of ensuring that medical students receive sufficient coverage of all subjects and content necessary to graduate, prepare for licensing exams, and provide competent patient care as residents.

Mandating Inclusion of LGBT Competency Training in Medical Education Residencies

This option integrates LGBT competency training with direct student-patient contact (LCME, 2012). Both LCME and the Accreditation Council for Medical Education (ACGME) play a role in accrediting the teaching hospitals and other healthcare environments that administer residency programs, and ACGME works in consort with an AMA organization – Residency Review Committees – to prepare residents for careers in up to 133 medical specialties (Ibrahim &

Morganstern, 2005). Residencies consist of three- to seven-year assignments in clinical care settings where medical students assist supervising physicians and provide direct treatment to patients. Residencies, which permit medical students to spend time alone with patients, differ from the fully supervised clinical exposure that occurs during medical school. The first year of a residency, called an internship, allows students to gain experience applying medical school training in a clinical setting. Medical students may or may not acquire a residency attached to the medical school they attended. Residencies in hospital settings occur in teaching hospitals, but residencies may also take place in clinical outpatient settings. Residents obtain ongoing training through methods similar to CME classes.

Based on growing evidence that residents experience fatigue from long shifts on clinical duty, medical schools have been encouraged to reduce the number of hours residents spend in patient care. According to Nuckols, Bhattacharya, Miller Wolman, Ulmer, and Escarce (2009), fatigue among residents increases medical errors and decreases opportunities to learn on the job. However, a longitudinal study of orthopedic surgery residents examined the issue of resident fatigue from 2003-2009 and found that decreasing clinical hours fails to increase the amount of sleep for medical residents and decreases their overall healthcare competency – whether they are fatigued or not – by reducing the raw amount of time they serve patients (Pittman, 2004). Iglehart (2010) estimates that the fatigue problem will intensify in 2014 when federal healthcare reform takes effect and the number of patients seeking hospital care increases. It is unknown whether the fatigue and patient population concerns mean that medical residents will have more, less or the same amount of time to learn subjects like LGBT cultural competency.

A benefit of this option centers on its ability to integrate LGBT competency training with student-patient contact. Beach et al. (2005) conclude that cultural competency training is most

effective when providers learn it in both a classroom and clinical environment, and both of those routes for delivering cultural competency are available during medical residencies.

Mandating Continuing Medical Education (CME) of Physicians

CME is a commonly used tool for mid-career physicians to remain competent in general, specialized and emerging areas of care (Ibrahim & Morganstern, 2005). Depending on whether a CME provider offers a course in multiple states or in one state, either a national or a state accrediting body will accredit the course. The national accreditation agency is the Accreditation Council on Continuing Medical Education (ACCME). Statewide physician groups such as state chapters of AMA typically sponsor state accrediting agencies. Accreditation policies at the national level factors input from groups like AMA, the American Hospital Association and the Federation of State Medical Boards (FSMB), which is a nationwide association of state agencies that regulate physicians. Physicians take CME courses for myriad professional reasons including personal interests, compliance with expectations of professional associations to which they belong, or advancement within or across medical specialties (Graves, Like, Kelly & Hohensee, 2007; Ibrahim & Moganstern, 2005). CME occurs throughout the career of a physician. Courses appear to be the most popular CME format, with 44% of nationally-accredited and 82% of intrastate accredited CME courses occurring in formal lecture based settings (IOM, 2009). Physicians risk punishment, including license revocation, for not meeting CME mandates.

Legislatures and government agencies each impose CME mandates and often enforce the mandate by making license renewal contingent upon completion of the required CME (Graves, Like, Kelly & Hohensee, 2007). States may choose among multiple CME formats when designing the mandate. For example, states may opt to require a stand-alone LGBT cultural competency course, increase the relevant LGBT content in multiple CME courses, or elect to pursue a combined approach. The general cultural competency mandate in California allows

more flexibility in CME course design than does the proscriptive New Jersey mandate (American Medical Association [AMA], 2010; State of New Jersey, 2010). Six states require providers to receive general cultural competency training. No state requires LGBT-specific CME courses or course content (United States Office of Multicultural Health, n.d.1), although the inclusive definition of diversity in the California legislative mandate on cultural competency has been interpreted to allow for weaving LGBT cultural competency into other CME courses (Institute on Medical Quality, 2012). There is a recent trend among states to implement statutory mandates. Of the sixteen states with statutes that require CME, eight states approved 14 courses in the last five years (Krupa, 2012). Physician groups, including AMA, express opposition about requiring CME through legislation (Krupa, 2012; Landers, 2009).

Mandating that Physician Employers Furnish Medical Education Opportunities or Provide Guidelines for LGBT Cultural Competency

This option places on physician employers the mandate to provide opportunities for their physician employees to enhance LGBT cultural competency. Types of cultural competency interventions that physician employers already operate include traditional lecture-based classes; informal classes; self-guided media programs; clinical learning settings; or, furnishing a set of LGBT-specific care guidelines. Kaiser Permanente (2004) and the New York City Health and Hospitals Corporation (2011) are examples of two physician employers that provide general and LGBT cultural competency training to their employees. No substantial differences exist between employer centered training modules and CME.

Hospitals have previously expressed opposition to a legislative CME mandates. Kaiser Permanente – one of the physician employers that voluntarily provides LGBT competency training – filed an opposition letter with the author of a proposed legislative mandate in California, Senate Bill 747 (2011), because the legislation, which was vetoed, would have

mandated LGBT competency CME training. The letter indicates that Kaiser opposes legislative

mandates for physician training.

Human Rights Campaign (HRC) annually surveys LGBT training policies of hospitals

and health systems in the U.S and reported recently that 245 of the hospitals it surveyed (67.2%

of respondents) provide LGBT cultural competency training (HRC, 2012a). Although the sample

of 245 hospitals falls well below the 4,985 total hospitals that operate in the United States, the

true level of LGBT training provided by physician employers may well be higher. HRC (2012a)

indicates that the number of hospitals that provide LGBT education and other types of LGBT

patient care increased from 2011 to 2012, which may mean that a significant number of hospitals

accept the notion that preparing providers to better serve the LGBT population is a vital

healthcare objective. However, data collection limitations prompt questions about the

representativeness of the HRC data sample. The concerns stem, in part, from the fact that

voluntary participation of survey participants may mean that LGBT-friendly institutions are more

likely to participate in the survey than are their counterparts whose policies are less welcoming

toward lesbian, gay, bisexual and transgender people. Another survey limitation, which

complicates year-over-year comparisons, results from HRC revising in 2012 the criteria for what

constitutes competency training. Moreover, the survey results from four large health systems,

whose facilities comprise over one-third of the survey group, somewhat dominate survey

responses. If we withdraw those facilities from the sample, then the proportion of surveyed

hospitals that provide training falls from 67.2% to 50.1%.

Adding LGBT Content to Medical Licensing or Specialty Examinations

Another option relates to inclusion of LGBT patient care content on examinations

required to become a licensed or specialized physician. This option distinguishes itself from

other options discussed above because it has the effect of placing pressure on medical schools and

CME providers to help prospective and existing physicians improve LGBT cultural competency. All state boards that grant medical licenses use the United States Medical Licensing Examination (USMLE) as a method of gauging whether a medical resident meets the qualifications of earning a license to practice medicine. The National Board of Medical Examiners (NBME), a private sector organization, has sole control over USMLE content (National Board of Medical Examiners [NBME], n.d.). NBME works with the Federation of State Medical Boards (FSMB), an association of 70 state medical and osteopathic licensing and regulatory boards, to tailor examination questions to meet the needs of medical regulatory and licensing bodies. NBME and FSMB sponsor jointly Post-Licensure Assessment System (PLAS) exams that measure physician competence in specialty areas, such as orthopedics or dermatology, and both organizations have authority over the test content (Federation of State Medical Boards [FSMB], n.d.).

Policymakers seeking action on LGBT cultural competency may wish to request or compel FSMB to pursue inclusion of LGBT topics in the USMLE, the PLAS, or the Special Purpose Examination (SPEX), which evaluates competency following a hiatus in professional licensure. USMLE already incorporates examination questions and themes relating to competencies for serving cultural, gender, linguistic and different age groups, which provides a potential precedent for this option (FSMB & NBME, 2012).

Status Quo: Let the Current Process Take Its Course

Munger (2000) advises policymakers to consider extending existing policies when weighing new options for addressing policy problems. This approach facilitates recognition of areas in which the prevailing policy environment shows promise and effectiveness, and it may reduce cost associated with implementing alternate strategies.

The status quo option consists of public and private sector interventions aimed at delivering and improving lesbian, gay, bisexual and transgender cultural competency. A

considerable portion of the status quo involves voluntary training and measurement of physician and health system competence and sensitivity. All of the existing programs noted in this chapter that improve the LGBT cultural competency of physicians are constituents of the status quo.

Table 3.1: Summary Description of Each Policy Option

	POLICY OPTIONS FOR IMPROVING LGBT CULTURAL COMPETENCY OF PHYSICIANS	SUMMARY IDENTIFICATION AND DESCRIPTION OF HOW EACH POLICY OPTION MAY BE ENACTED AND IMPLEMENTED THROUGH STATE LEGISLATIVE MANDATES
I.	Mandating Medical School Education	Require state funded institutions to either include a specific medical school course or incorporate into all courses material on LGBT cultural competency.
II.	Mandating Medical Residency Education	Require state funded medical residencies to either include a specific continuing education course on LGBT cultural competency.
III.	Mandating Continuing Medical Education	Require physicians to receive CME.
IV.	Mandating Employer Education or Guidelines	Require employers to either provide education or dispense treatment guidelines to physicians.
V.	Adding Questions to Licensing or Specialty Exams	Require state medical boards to work with medical licensing and specialty examination entities to develop exam questions that test for LGBT cultural competency.
VI.	Status Quo	Continue incremental movement in public and private sector toward LGBT cultural competency without developing state laws to accelerate and intensify correction of reported LGBT cultural competency deficits in the healthcare marketplace.

Conclusion

Chapter 3 identifies the policy options that receive further consideration in subsequent chapters. In Chapter 4, which follows, I utilize the Criteria Alternatives Matrix process to analyze the options presented in Chapter 3 against the evaluative and practical criteria described in Chapter 2. In Chapter 5, I summarize the results, identify policy tradeoffs and offer recommendations for policy action and further study based on the analytical process presented in Chapter 4.

Chapter 4

ASSESSING THE OPTIONS: ANALYSIS AND EVALUATION

This thesis employs the Criteria Alternatives Matrix (CAM) tool of qualitative and quantitative policy analysis to assess policy options for improving physician LGBT cultural competency. A CAM, according to Munger (2000), aids policy analysts by providing a system that arranges complex factors into an accessible problem-solving rubric. The signature component of a CAM is a data table that conveys criteria-based ratings for the options under review.

Qualitative and Quantitative CAM Analysis Stage One:

Assessment and Rating of Policy Options

Before commencing the quantitative portion of the CAM analysis, I evaluate and rate each option based on how I expect it to perform, if implemented, with respect to evaluative and practical criteria. Table 3.1 lists the analytical questions that I apply to each option to project the outcome and Table 4.1 conveys the five point scale I use in this chapter to rate each option. The rating scores, which reflect the comprehensive strength and weakness that I project each option to demonstrate in practice relative to each criterion, consist of: 5 = very strong; 4 = strong; 3 = moderate; 2 = weak; and 1 = very weak. Wassmer (2002) promotes this rating system as an effective component of criteria-based evaluation.

Next, I conduct the assessment that produces the qualitative and quantitative ratings for each option with respect to each criterion. The qualitative ratings are comprised of verbal rating (i.e., weak) and quantitative ratings are comprised of a numeric rating (i.e., 2). I devote a section to each option and use a paragraph within each option to produce a rating based on criterion-specific assessment. Because Table 4.1 only defines very strong and very weak ratings, I describe the rationale for qualitative and quantitative criteria-based ratings for each option at the

conclusion of the criteria-specific paragraphs. After the assessments conclude, I organize the

information into data tables and, introduce two additional CAM stages – criteria weighting and

sensitivity analysis.

Table 4.1: Rating Scale for Analyzing Options Based on Evaluative and Practical Criteria

Criteria	Interpretation of Ratings	
	5 – Very Strong	1 – Very Weak
Efficiency	Expected to produce optimal LGBT cultural competency in a manner that achieves the most "bang for the buck" and uses resources in ways in a manner that shows promise for outweighing new or continuing costs, to parties involved while effectively addressing the policy problem.	Expected to entail costly or inefficient modes of LGBT training and produce ineffective processes or results for ameliorating externalities.
Equity	Expected to produce optimal LGBT competency by curtailing disparities, neutralizing health effects of bias and stigma, and improve overall LGBT healthcare quality.	Expected to insufficiently enhance LGBT competency, or detract from overall LGBT healthcare quality, without reducing LGBT disparities, bias or stigma.
Sustainability	Expected to produce robust, viable, persistent, long-term, and, if necessary, agile policies and program effectiveness for developing LGBT cultural competency among physicians.	Expected to produce policy changes that deliver minimal and potentially ineffectual or porous program effectiveness or outcomes.
Political Feasibility	Expected to align or satisfy optimally all participants and interests active that are currently, or may be, present in the political environment.	Expected to engender significant opposition, displeasure, or discord among existing or future participants in the political environment that risks failure to enact a mandate.
Organizational Feasibility	Expected to gain commitment, support or satisfaction among current or prospective participants and interests in the administrative environment.	Expected to produce disdain, opposition, and dissatisfaction among current or prospective participants and interests in the administrative environment that risks failure to enact a mandate.

Evaluating and Rating Efficiency, Equity, Sustainability and Feasibility of Mandating Changes to Medical School Education Curriculum

Expenses likely to result from this option include costs tied to faculty development, which may be necessary to ensure that medical students receive accurate and current information on LGBT cultural competency and to educate faculty on efficacious training models and modes. However, faculty may share some of the development costs if they receive LGBT cultural competency training through CME requirements associated with their physician licensure renewals. A recent study noted that employers pay about 58% of CME costs and physicians pay about 42% (CME, 2009), which indicates the possibility of cost sharing for faculty development. If the costs for cultural competency group modules are an indicator of medical education costs, a video based learning package costs a few hundred dollars with supplemental materials included (California Endowment, 2003). Aside from the costs of training programs, negative cost effects result from the potential that enhanced LGBT cultural competency expectations will require curricular changes that complicate efforts of medical schools to comply with LCME accreditation standards. Medical schools have recently confronted sanctions or loss of accreditation from LCME, which require costly corrective measures, for failing to meet accreditation standards (Krupa, 2011a). If medical schools cannot redirect spending to comply with this mandate, they may seek to develop adequate funding though student fee increases or surcharges because medical schools commonly establish parity between increased institutional costs of education and increased student tuition burdens (American Medical Student Association, n.d.). However, Thomas (2009) argues that medical education occurs in multiple ways, which allows for minimizing costs during the curriculum process. Given the support of HHS for LGBT cultural competency education, it may eventually be possible to obtain LGBT competency training free for both faculty and students if the federal government provides free online LGBT education in

the same way that it provides free online general cultural competency training (United States Office of Multicultural Health, n.d.2). State costs from applying this mandate on publicly funded medical schools may include program, administration and enforcement expenses unless non-public resources fund those activities. Costs are not the only factor when it comes to gauging efficiency. This option performs well on the question of whether it will efficiently correct the policy problem it seeks to ameliorate. For example, medical school students are likely to retain the knowledge and skills they build through this option and reduce negative externalities of incompetent care (IOM, 2003). Because this assessment of efficiency, which reflects findings of research and practitioner literature, indicates moderate weakness regarding costs and moderate strength regarding the efficiency for this type of solution, I rate the overall efficiency of this option as moderate.

Equity benefits of this option center on early interventions to remove existing or potential provider bias and stigma early in the process of becoming a physician (Kripalani, Bussey-Jones, Katz & Genao, 2006). These benefits present substantial strengths considering the major effect of provider bias and stigma on LGBT health disparities and barriers to care. Early acquisition of LGBT competency skills provides a foundation for sensitive and strong LGBT patient care that can last throughout the career of a physician, but expanding the LGBT competency focus beyond the LCME baseline will necessitate some reduction in general competency or other forms of health equity. At the very least, this option offers multiple channels for improving physician LGBT competency. Because this assessment of equity, which reflects findings of research and practitioner literature, indicates extreme equity strengths in some areas and weak to moderate strength in other areas, I rate the overall equity of this option as strong.

Although medical school deans have noted that LGBT cultural competency training at most universities warrants improvement (Obedin-Maliver et al., 2011), the long held values of

academic freedom and autonomy present potential obstacles to enforcement and improvability during formative and implementation stages. However, if legislators enact this option in a manner that allows for flexibility in implementation, robustness may increase by incenting greater statutory adherence despite reducing specificity of the law. On a different note, states tend to regulate public and private medical schools differently and some states do not regulate private institutions at all (California Postsecondary Education Commission, 2005), which reduces robustness of enforcement and may present a statutory barrier to mandate enactment. A concern relating to long-term durability of this policy indicates that front-loading LGBT cultural competency education at the earliest possible point in the career of a physician presents the risk that competency may wane. With respect to improvability, medical schools have demonstrated the ability to progressively, if incrementally, enhance the focus on critical areas of physician competency including cultural competency and alter both curriculum and education methods when student learning or retention falls short of objectives (Kripalani, Bussey-Jones, Katz & Genao, 2006). Because this assessment of sustainability, which reflects findings of research and practitioner literature, indicates some extreme weakness with respect to robustness and strength on improvability, I rate the overall equity of this option as moderate.

Extensive political feasibility pressures confront this option. The Association of American Medical Colleges (AAMC) (Ibrahim & Morganstern, 2005), which represents all medical schools, already has taken steps in the direction of this option and may argue that government mandates are counterproductive or unnecessary. Individual public and private medical schools may oppose this option on the same lines and on cost, accreditation, and autonomy concerns. Medical schools, physicians, and accrediting agencies may all place some sort of pressure on legislators, governors, or state medical regulatory boards to oppose the mandate. In addition, medical schools affected by the mandate may engage influential members

of the greater campus community, including university officials and alumni, to lobby officials

from the legislative and executive branches to oppose enactment. Based on similar LGBT

cultural competency legislation proposed in California, supporters may include individuals,

organizations, physicians and researchers who back policies aimed at reducing LGBT health

disparities (California State Senate Assembly Committee on Business, Professions and Consumer

Protection, 2011). Because the opposition is likely to be strong, and because the support network

failed to overcome substantial opposition to secure enactment the California legislation, I project

the political feasibility of this option to be weak.

Organizational feasibility of this option confronts multiple questions. Public university

governing board members may be responsive to a medical school mandate approved by the

Governor who appointed them, but they may work to prevent its enactment. If enacted,

compliance may be minimal based on preferences within higher education culture for institutional

autonomy. Moreover, if this mandate applies solely to public institutions, enforcement entities

may come under pressure from the regulated medical schools to minimize any negative impacts

during the enactment or implementation process or delay implementation until allocation of a

budget augmentation for compliance. Multiple agencies – state regulatory boards, medical school

governing boards, campus wide administration, and medical school leadership – may be involved

in the regulatory structure, which complicates implementation absent unifying leadership

(Wilson, 1989). Because the opposition is likely to be strong, and because several extreme

weaknesses diminish organizational feasibility, I project the political feasibility of this option to

be very weak.

Based on the evaluative and practical criteria-based assessment noted above, the medical

school option receives the following scores: Efficiency, moderate – 3; Equity, strong – 4;

sustainability, moderate – 3; political feasibility, weak – 2; and, organizational feasibility, very weak – 1.

Evaluating and Rating Efficiency, Equity, Sustainability and Feasibility of Mandating Inclusion of LGBT Competency Training in Medical Education Residencies

This option may increase costs to teaching hospitals, but costs for faculty development and resident learning may potentially be very low as noted above in assessing the medical school mandate option. However, because residencies entail a greater focus on mixing lecture-based learning with experiential learning (Ring et al, 2008) costs may be marginally higher for this option compared with the medical school option. For this option, learning to become LGBT competent not only entails educational costs, but also it may produce costs if the additional learning time exacerbates resident fatigue. Nuckols et al. (2009) remind us that while residencies offer solid learning environments, the IOM has already proposed a menu of fatigue reforms that could create costs of $3.2 million per teaching hospital. State cost pressures for the medical school and medical residency options are similar. With respect to non-cost efficiency matters, this option denotes strengths and weaknesses. One possible weakness is the potential in this option for fatigue related learning lapses, which may reduce quality of care to all patients including LGBT clients, to occur by raising the overall course load. Another key non-cost of this option is the efficient learning opportunity it offers; residents are in a unique position to master LGBT cultural competency skills because as soon as they learn and become comfortable with the curriculum, they can put their new skills to work with the first appropriate patient. Because this assessment of efficiency, which reflects findings of research and practitioner literature, indicates some extreme weakness regarding costs and weak to moderate strength regarding the non-cost efficiencies for this type of solution, I rate the overall efficiency of this option as weak.

Similar to the medical education option, this option allows physicians to become competent with LGBT healthcare, and reducing health disparities, early in their careers. However, policymakers should be mindful that surveys have indicated that bias and discrimination remain prevalent within the medical practice (GLMA, 2011; Schatz & O'Hanlan, 1994) and residents may need both training in LGBT health issues and in neutralizing anti-LGBT sentiment among colleagues and supervisors. Furthermore, a mandate in this area could produce an unintended reduction in the ability of residents to master general and specialty treatment skills and other health equity skills by dedicating more time to a confined form of resident education. Because this assessment of equity, which reflects findings of relevant literature and components of the medical school option assessment, indicates balanced strengths and weaknesses regarding this option, I rate the overall equity of this option as moderate.

Sustainability questions surround the robustness, implementation and improvability of this option. First, with respect to the sustainability considerations of residency hours and increased fatigue and medical errors, teaching hospitals may opt to call for discontinuation, not improvement, of this mandate if it exacerbates fatigue or errors without producing verifiable, countervailing LGBT health benefits. Considering that LGBT health data are poorly collected (IOM, 2011), this dynamic does not bode well for sustainability. Second, with the level of federal funding for teaching hospitals experiencing wide fluctuations in recent years, the stability of medical residencies may experience some weakness and instability in the coming years (Iglehart, 2010). In a situation like that, the implementation of this option projects to be somewhat unstable. Because this assessment of sustainability, which reflects findings of research and practitioner literature, indicates overall weakness regarding this option, I rate the sustainability of this option as weak.

The political feasibility constraints described for the medical school option apply to this option as well. In addition, fervent opposition to this proposal may exceed the medical school opposition because teaching hospitals outnumber medical schools nationally by more than 2:1. Because the similarity between the political feasibility factors for this option and the research-based background of the medical school option, and given the added pressure of federal funding fluctuations and resident fatigue issues, I project that teaching hospitals and other providers of medical residencies will fervently oppose this mandate despite the value of improving LGBT healthcare. Therefore, I rate the political feasibility of this option as very weak.

This option faces extensive doubts with respect to organizational feasibility. Teaching hospital administrators and leaders of other residency programs prepare residents for both general and specialty competencies, which dominates their attention to curriculum implementation (Ibrahim & Morganstern, 2005). With that in mind, I project that teaching hospitals will be unlikely to actively promote and implement mandates attached to this option. Furthermore, regulating both public and private medical education environments places on state agencies an entirely new level of medical education oversight (Contreras, 2009), which presents challenges in selecting and empowering one or more enforcement agencies. Even under ideal funding conditions, I expect strong opposition to the enactment and implementation of this mandate based on the presumption that the educational goal of residency programs pertains to promoting core competencies measured through the USMLE. Because this assessment of organizational feasibility, which includes findings of relevant literature, indicates extreme weaknesses regarding this option, I rate the overall organizational feasibility of this option as very weak.

Based on the evaluative and practical criteria-based assessment noted above, the medical residency option receives the following scores: Efficiency, weak – 2; Equity, moderate – 3;

sustainability, weak – 2; political feasibility, very weak – 1; and, organizational feasibility, very weak – 1.

Evaluating and Rating Efficiency, Equity, Sustainability and Feasibility of Mandating Continuing Medical Education of Physicians

Efficiency costs and benefits of this option are balanced. Boissoneau (1980) points out that government mandates often produce high costs, which, in the case of continuing medical education mandates, may lead to the undesirable consequence of physicians delaying compliance with this mandate. Conversely, this option is efficient on the topic of non-cost problem solving efficiency because, unlike the medical school and residency options, it allows for uniformly reducing costly incompetence of all physicians. This option exposes the state to limited costs if policymakers place the CME requirement on doctors and enforce it through current administrative processes, which receive funding from physician licensing fees. Using IOM (2009) estimates that physicians pay an average of $1400 per year for approximately 30 CME units, and assuming that an LGBT CME mandate would entail the same number of units – 6 units – as the New Jersey cultural competency mandate, I project that this mandate would cost physicians $282 ($1400 / 30 = $47; $47 x 6 units = $282). The true cost to physicians may be lower if fewer units are required or if the CME course is required infrequently or only once during the career of each physician. However, the $1400 spent on CME by physicians was only 42% of the total expenditures on CME during the year of analysis, which means that the $282 total may have a true price tag of slightly over $650. Part of the adjusted price tag involves money spent by pharmaceutical and medical device companies to entice physicians to their product-centered lectures with free and reduced course fees (IOM, 2009). Because this assessment of efficiency, which entails programmatic and cost factors, indicates moderate effects in costs and market corrective impacts, I rate the overall efficiency of this option as moderate.

This option involves multiple equity considerations. Many physicians originally procured medical education in an era when students received biased and inaccurate, if any, information about LGBT healthcare (GLMA, 2011). CME allows those physicians to receive an initial infusion of LGBT competency and offers the potential for refresher courses over time. In so doing, this option not only offers a mechanism to reduce bias, stigma and misinformation about LGBT patients, but it also begins to obviate a long standing neglect within the medical profession that permitted ongoing insufficient inaccurate information on the topic (GLMA, 2006). Research indicates that the equity benefits of this option are very strong, which produces a rating of very strong for this option.

Any state that wishes to pursue this option must confront considerable sustainability concerns. One example of legislative mandates in this area indicates the connection between statutory language and its effect on the robustness of a policy in practice. When California passed a cultural competency law that was unspecific about LGBT competency, the Institute for Medical Quality (IMQ) (2012), which accredits intrastate CME providers, implemented the bill according to its perception of the law. Recently, IMQ curtailed the amount of LGBT cultural competency training required of physicians to ensure adequate physician competency in all areas of general care. Permissive and unclear statutory language stand out as the likely culprits for both the lack of clarity on how to promote LGBT cultural competency and the ongoing perception among LGBT patients that physicians remain largely misaligned with LGBT cultural competency skills. Therefore, the experience in California provides direct feedback that CME mandates need to lay out specific requirements to achieve desired objectives. On the other hand, specificity of mandate language in a new policy may have the undesired effect of reducing the improvability and robustness of the option in practice by tying the hands of agencies, entities and individuals subject to the policy (Bardach, 2005). Because this assessment of sustainability uses research and

practitioner examples to indicate multivariate weaknesses of this option, it receives a rating of weak.

Assessing the political feasibility of this option involves considerations found in research and practice. Physicians stand out as one of the most influential interest groups in politics. Statewide physician associations and local medical societies participate in the political realm and in the policy environment. AMA and other physician groups have openly expressed opposition to all legislative CME mandates (Krupa, 2012) and the California Medical Association even opposed an LGBT-specific mandate proposal (California State Senate, 2011a). Elected officials typically seek endorsements from physician groups and from influential physicians, and the tendency to curry favor within the medical community may discourage legislators from supporting mandates that physicians oppose. Governors and regulatory agencies also work closely with physician groups and it may be difficult to sign a bill that physicians oppose. There is strong support for this option in the LGBT community. LGBT physicians, organizations, individuals and subject area experts will press hard for establishing a CME mandate. On strict policy grounds, this option may appeal to policymakers mindful of reducing state costs, but cost effects on physicians and CME providers may countervail the benefits of low fiscal impact to government. After considering relevant factors based in research and practice, and noting the failure of a similar proposal in California, the political feasibility of this option receives a rating of weak.

Organizational feasibility concerns are substantial. Governors appoint the board members and agency leaders who set and implement organizational agendas. While some appointees and civil service staff may act independently of gubernatorial preferences, governors have extensive sway over executive branch activities. Therefore, the support or opposition that a governor imparts on an LGBT cultural competency mandates influences greatly the

organizational feasibility of an option (Bardach, 2005). Physicians appointed to serve on

regulatory boards and physician groups, which have demonstrated vehement opposition to CME

mandates, may pressure governors, regulatory board members, and board staff, to pursue

implementation in a way that reduces disadvantages presented to physicians. Moreover,

physicians actually control some aspects of regulation because intrastate CME accrediting bodies

in some states are auxiliaries of statewide physician associations. The research and examples of

policy initiatives similar to this option indicates extensive weaknesses, which produces a rating of

very weak organizational feasibility for this option.

Based on the criteria-based analysis above, the CME option receives the following

scores: Efficiency, moderate – 3; Equity, very strong – 5; sustainability, very weak – 1; political

feasibility, weak – 2; and, organizational feasibility, very weak – 1.

Evaluating and Rating Efficiency, Equity, Sustainability and Feasibility of Mandating that

Physician Employers Furnish Medical Education Opportunities or Provide Guidelines for LGBT

Cultural Competence

This option presents the potential for strong problem-solving value and somewhat high

efficiency costs. On the problem-solving front, this option demonstrates high efficiency because

it places the mandate on the health industry, which would benefit from reductions of the high

financial cost for the externality that the mandate seeks to correct (IOM, 2011). However, the

fact that this option seeks to mandate a practice that already exists to a small degree minimizes

the force of assertions that this option presents a new set of problem-solving value. Moreover,

concerns that this option will duplicate existing practices calls into question whether this option

entails an efficient use of public resources. On the economic cost front, significant questions

arise. Costs emanate from the potential for employers to shift focus from profit-oriented

educational activities to unpaid mandates. In 2007, physicians and other elements of the medical

industry spent $2.54 billion on CME courses in the Unites States; hospitals and health systems received $105 million to provide CME courses and produced a profit of $4.7 million (IOM, 2009). This breakdown indicates the likelihood of reducing health education profits of physician employers by placing mandates on the employers to assure LGBT cultural competency of the physicians they employ. Therefore, increasing educational mandates on employers may produce an efficiency cost by devoting CME profits to unprofitable activities. Another efficiency cost might occur if a mandate based on this option requires employers to shift expenditures away from patient care and into competency education, but this could be a short-term cost if competency training reduces financial cost effects of inadequate LGBT care that are borne by employers. State costs for enforcement may be high, but policymakers may elect to apply a low cost, but low effectiveness, program. Other costs may include compliance for taxpayer-funded hospitals. Because this research aided assessment of efficiency issues surrounding this option, including moderate corrective implications and weak, but largely quantifiable, costs to both public and private interests, I rate the overall efficiency of this option as weak.

Equity benefits of CME training also apply to this option. Much like the CME mandate, this option helps assure training of physicians previously unexposed to formal LGBT cultural competency materials (HRC, 2012a). Moreover, an equity-based strength unique to this option is the potential to foster a culture of acceptance for LGBT patients and their health issues by creating the basis for physicians in the same workplace to communicate knowledgably on LGBT cultural competency (GLMA, 2006). Another key aspect of equity in a healthcare context regards the need to ensure that health quality improvements provided to one group do not come at the expense of health quality of another group. Given the fact that hospitals that provide LGBT competency have not been found to reduce general competency or reduce health equity of non-

LGBT groups, this option appears to be strong in this regard. Because the research cited herein

demonstrates the strong equity value of an employer mandate, this option receives a strong rating,

Rating the sustainability of this option presents multiple challenges. First, employers are

not responsible for assuring the continuing education of their workforce, which means that states

do not have a process in place to ensure compliance with this option. Second, a mandate based

on this option will need to state the size and type of employer that will be subject to the mandate

provisions. If the mandate exempts small businesses for cost reasons, the mandate will need to

include a measure for assuring the LGBT competency of their employees, which may be a low-

cost, low-effectiveness solution such as written guidelines (Peterkin & Risdon, 2003). The

hallmarks of sustainability are projecting the robustness and improvability of a policy option, but

no research or data exist on those areas. Given the lack of information regarding the

sustainability of this option, it receives the rating of very weak.

Political feasibility of this option centers on the question of who bears the cost of the

mandate. Employers, faced with a potential loss to educational profits, will likely express

opposition to this option and may sway elected officials loyal to employers in the communities

that they serve. Conversely, legislators may conclude that the health industry possesses the

wherewithal to absorb a mandate of this nature. Legislatures have demonstrated a willingness to

promote employer mandates in many industries, including the healthcare sector. Policymakers

may perceive this option as cost conscious because costs will be borne by employers who, in turn,

will accrue cost benefits from improved healthcare and reduced disparities for LGBT patients.

Given the lack of any strong record of support for the political feasibility of this option, which

may unlikely to come from LGBT advocacy groups considering that employers have been noted

to already be supplying LGBT competency training, this option receives the rating of weak.

One concern about the organizational feasibility of this option relates to the potential for involvement of multiple agencies in implementing this option. Physician employers receive regulation from corporate oversight agencies and healthcare oversight agencies. Therefore, support and promotion for this proposal may exist in one agency, but not in another, and agency capture may present multiple layers of complexity. When multiple agencies are involved, organizational effectiveness faces challenges. Similar to the CME option, parties affected by implementation of an employer mandate may seek to undermine or marginalize it through relationships with regulatory entities (Wilson, 1989). Governors naturally possess ultimate control over the organizational feasibility, which may fluctuate depending on how they feel about an LGBT cultural competency mandate or an employer mandate. Low government costs attached to this option may comprise another projected benefit, but state costs may arise depending on the enforcement regimen, if any, built into the mandate. The research and examples of pertaining to the organizational feasibility of this option indicates multiple weaknesses, and after factoring in minor strengths, this option receives the rating of weak.

Based on the criteria-based analysis above, the employer mandate option receives the following scores: Efficiency, weak – 2; Equity, strong – 4; sustainability, very weak – 1; political feasibility, weak – 2; and, organizational feasibility, weak – 2.

Evaluating and Rating Efficiency, Equity, Sustainability and Feasibility of Adding LGBT Content to Medical Licensing or Specialty Examinations

This option includes efficiency cost benefits and non-cost problem solving concerns. This option is not costly to government for enactment or enforcement. Because there is no evidence that cultural competency examination questions have created any costs on medical schools, residencies or CME providers and recipients, there is no indication that this option will present any such costs. However, the reason this option is not costly regards the lack of

government control over this option. Because private sector forces, including the NBME and USMLE, largely control this option by virtue of their proprietary authority over exam content (FSMB, n.d.; NBME, n.d.), government does not have a mechanism to ensure that it ameliorates successfully the healthcare deficits that policymakers seek to correct. States can mandate medical boards to collaborate with examination organizations, but no branch of government holds authority over the examination organizations. Because problem-solving weaknesses appear to outweigh the efficiency cost strengths, I rate the overall efficiency of this option as weak.

There are limited equity benefits from this proposal because it does not assure physicians of receiving comprehensive training about LGBT patient needs. The limited nature of the questions on general cultural competency currently included in the USMLE (FSMB & NBME, 2012) indicates that this option fails to ensure that physicians acquire keen understanding of the many care environment and treatment dynamics – ranging from patient intake processes to complex physician consultations about patient sexual history. Although examination questions may require some understanding of LGBT health topics, exam takers may confine their learning to written LGBT competency guidelines instead of obtaining interactive or experiential modes of learning, which the research literature portray as effective means of acquiring competency. Based on the research and practitioner literature referenced in this assessment, and considering that most of the considerations presented above indicate equity weaknesses of this option, this option receives the rating score of weak.

Sustainability concerns exist for both robustness and improvability. Regarding robustness, states have no official input at all for the USMLE (NBME, n.d.), but states do have limited input into PLAS specialty exams. Even the limited power of states, as noted in the efficiency section, confronts further limits by virtue of the fact that states can only act in consort through the FSMB and not alone. Furthermore, the FSMB and NBME only revise an

examination question infrequently, which constitutes a limit on improvability. Given that new physicians prefer increasingly to seek careers in specialty areas instead of general medicine (Ibrahim & Morganstern), physicians may take specialty exams early in their careers. A potential robustness concern proceeds from this trend. To the extent to which that transition grows more common, less time will lapse between taking the USMLE and the PLAS, which means that LGBT assessment will be front loaded during the careers of many physicians and the mid-career reminders of LGBT competency content will diminish. Based on the assessment of this option, which involved consideration of robustness and improvability concerns rooted in research and practitioner literature, I rate this option as weak.

There is no literature or data on the political feasibility of this option. Although there is no known or projected opposition, this option attracts little to no support. LGBT advocacy and physician groups have promoted methods of providing actual education or information to current or prospective physicians (HRC, 2012a; GLMA, 2006). Although, this route offers a mechanism for policymakers to improve LGBT cultural competency without attracting opposition from major health industry stakeholders, supporters and advocates of LGBT cultural competency will argue against this because government ultimately retains little control over the outcomes that this option seeks to deliver. Because this section clearly indicates the weaknesses of this option, this option receives the rating of weak.

By the nature of this option, there are multiple doubts about organizational feasibility. Even if legislation mandates that a state medical board take action, there is no mechanism to determine how to negotiate with other states in developing examination policies of the FSMB. Therefore, it is impossible to ensure through mandate the inclusion of specific questions on medical examinations such as the USMLE or PLAS. In addition, this option may lead to unchecked implementation powers for state agencies. For example, if representatives of a state

medical board oppose the type of questions that the legislature mandates them to try to include in examinations, the representatives could revise the questions by themselves or in collaboration with counterparts from other states. The same dynamic of unchecked implementation powers may apply to a governor wants state medical board leaders to curtail or revise certain aspects of the mandate. Based on the research-based elements factored into this analysis of organizational feasibility, this option receives a rating of very weak.

Based on the criteria-based analysis above, the employer mandate option receives the following scores: Efficiency, weak – 2; Equity, weak – 2; sustainability, weak – 2; political feasibility, weak – 2; and, organizational feasibility, very weak – 1.

Evaluating and Rating Efficiency, Equity, Sustainability and Feasibility of the Status Quo

This option presents little government program related costs at either the state or federal level. Costs are present in the private sector; some employers, educators and physician groups provide physicians with LGBT cultural competency skills. In turn, those skill providers may countervail their costs to the extent that the LGBT competency they impart translates into efficient LGBT patient care and outcomes. Patients also receive cost benefits from status quo efforts to improve physician competency because competent LGBT healthcare requires fewer doctor visits, fewer searches for competent care, fewer emergency room visits and less bias, stigma and discrimination (GLMA, 2006). However, government officials (HHS, 2011) and medical experts (IOM, 2011) argue that prevalent inefficiencies, of the policy problem variety, persist with respect to LGBT healthcare disparities. These inefficiencies have led to calls for widespread LGBT cultural competency of physicians. In essence, the failure of government and market forces to correct the LGBT cultural competency deficit has continued to force unmitigated costs onto patients, providers and the health system and industry as a whole. Although substantial, these costs remain unquantifiable because of poor information collection and

reporting on behalf of public agencies and private entities. This compact assessment of cost-based and problem solving efficiency issues identifies a balanced array of strengths and weaknesses present in the status quo, but I rate the overall efficiency of this option as weak due to government and practitioner pronouncements that the existing state of LGBT cultural competency education is insufficient.

Existing policies and proposals entail favorable trends toward LGBT equity. Major medical education and profession groups, and physicians themselves are steadily becoming more competent and supportive of LGBT competency training (GLMA, 2011). An additional strength in the equity category emerges from the fact that many of the strategies currently used to elevate equity under the status quo are the same strategies that policy options described above may seek to mandate. However, gaps in cultural competency allow stigma, bias and deficits in the quality of care to continue destabilizing LGBT health equity (IOM, 2011). Considering the merits and shortfalls of equity elements presented in this brief assessment, which includes the reputable medical expert finding that LGBT health equity remains elusive under the status quo, this option receives a weak rating.

Recent sustainability actions under the status quo do not currently appear to be robust. The AMA (Levin & Mayer, 2010) provides instructional videos while LCME and AAMC call for increased cultural competency in medical schools (LCME, 2012) and residencies (Ring, et al., 2008), but these learning channels are cursory and are updated infrequently. Moreover, the trend in CME is to transition away from stand-alone courses and instead infuse LGBT competency into general courses and general cultural competency courses. Given the fact that LGBT health specialists have argued that LGBT-centered training presents the best tool for making physicians both comfortable and competent to care for LGBT patients (GLMA, 2006; GLMA and LGBT

Health Experts, 2001), and given the insufficient progress toward improving the results of LGBT competency training, the sustainability of this option earns a weak rating.

With groups like AMA and AAMC calling attention to the value of LGBT cultural competency, and with agencies like HHS (2011) and the IOM (2011) calling for LGBT cultural competency enhancements, it is politically infeasible for supportive elected officials to reject taking some form of action. However, confronted with the downsides of other options, including avoidance of adversarial dynamics involving influential interest groups, maintaining the status quo may present some appeal to policymakers. Considering the recommendations of government and practitioner groups to improve cultural competency, and recognizing that the supporters and opponents of legislative mandates may cancel each other out, the political feasibility of retaining the status quo receives a weak rating.

Organizational feasibility includes considerations such as whether participants in the implementation of a policy will support enactment, implementation and improvement of the policy. One organizational feasibility concern regards the fact that medical school deans, who serve as medical school agency implementers for the status quo, have added hours of LGBT content while failing to provide above average coverage of LGBT health topics (Obedin-Maliver, 2011). Another concern centers on the delays of the AMA, which plays an agenda-setting role in both medical education and CME (Ibrahim & Morganstern, 2005). Five years lapsed between the time that the AMA called for LGBT cultural competency education (Hill, 2005) and the time when the AMA produced a public plan to help physicians become competent and to help medical educators deliver LGBT competency to students and residents (Levin & Mayer, 2010). Given the examples of organizational infeasibility for the status quo in both academic and practitioner environments, I rate this option as weak.

Based on the criteria-based analysis above, the employer mandate option receives the following scores: Efficiency, weak – 2; Equity, weak – 2; sustainability, weak – 2; political feasibility, weak – 2; and, organizational feasibility, weak – 2.

Qualitative and Quantitative CAM Analysis

Transition from Stage One to Stage Two: Criteria Rating and Weighting

In this section, I implement the quantitative CAM process. A CAM offers three key stages to facilitate transparent, ethical and objective policy assessments: quantitative rating of qualitative analysis, quantitative criteria weighting and quantitative sensitivity analysis (Wassmer, 2002; Munger, 2000). The first stage began in the last section where I assigned criteria-based rating scale scores to qualitative assessments.

Criteria weights establish a quantitative ranking for each criterion and project the performance of policy options with respect to the rankings. The purpose of weighting is to determine whether the overall rating of options changes if certain criteria are more or less highly valued (Wassmer, 2002; Munger, 2000).

Efficiency assumes the role of the most heavily weighted criterion. Although the extensive literature review for this thesis found less data on efficiency issues than was found for other criteria, it is a basic fact of economic efficiency that the public and private sectors operate with limited resources. Therefore, the efficiency risks of squandering scarce resources on a costly or inadequate option are significant. Economic efficiency concerns align with efficiency concerns relating to externality corrections. For example, failing to direct resources wisely may inadvertently create new gaps or exacerbate existing gaps in quality and access of LGBT healthcare. Furthermore, failed policies may not be readily reformed; policymakers may believe that they have addressed a problem adequately even though evidence later shows that the policy response was insufficient (Kingdon, 2003). In addition, inefficient policies have the potential to

make health access problems even worse. Patients need to be able to see a physician to receive medical care. For these reasons, and because of the ability for efficiency to reduce costs associated with inequities, efficiency receives priority

Equity takes the second spot in weight listing. The key factor here is the fact that social inequities experienced by, and directed at, LGBT patients constitute a major foundation for the poor healthcare quality that they receive. The inequities cut across all healthcare service and regulatory lines including educational, governmental and clinical environments. Equity also receives a high rating because of the potential health damage to patients that exists because of the LGBT cultural competency deficit.

Sustainability is the third-ranked criterion. Strong points of sustainability include its ability to promote durable, improvable and effective policy solutions, but it receives a weight lower than other criteria because of the inherent difficulty in knowing whether the success or failure of a given policy relates to the policy itself or whether it proceeds, in whole or in part, from external factors or influences. However, sustainability incorporates elements essential to projecting policy outcomes and it remains a valuable evaluative criterion.

Political feasibility is the fourth-rated criterion. Because it is a practical criterion, and fails to offer any insight on the expected effectiveness of a policy in practice, I assign it a weight lower than the three evaluative criteria. One key component of this criterion relates to the receptiveness of policymakers to direct and tertiary influences present in the policy environment. These influences not only influence whether a bill becomes law, but may influence the content of legislative mandates. Furthermore, once a mandate becomes law, it is powerful symbol of social values and an indicator of political feasibility elements at work.

Organizational feasibility places at the bottom of the criteria weights, but it remains a critical barometer. This criterion provides a lens through which policy analysts project how

policymakers and policy implementers may react to a proposed policy, but it rates low in part because organizational leaders are often too responsive to external interests. For example, public agencies are susceptible to manipulation by political players and interested stakeholders through agency capture (Wilson, 1989). This remains a crucial criterion because organizational feasibility is an essential consideration long after the policy enactment.

Table 4.2 lists the criteria weights that I apply to the quantitative CAM analysis. I list the criteria in the left column and provide the criteria weights in the right column. The weights sum to 1.0 to allow for transparent calculations in both the CAM tables that I use to evaluate and rate the options and in the sensitivity analyses, which comprise the third stage of the quantitative CAM analysis. These weights factor with the quantitative ratings developed in the preceding assessment section to produce a ranking of policy options based on evaluative and practical criteria.

Table 4.2: Criteria Weights Applied in the CAM

Criteria	Criteria Weights
Efficiency	.30
Equity	.25
Sustainability	.20
Political Feasibility	.15
Organizational Feasibility	.10
Total	1.0

Qualitative and Quantitative CAM Analysis Stage Two:

Performing Evaluative and Practical Criteria Weighting

Next, in Table 4.3, I apply the weights to the evaluative and practical criteria. When utilizing the CAM method, the conventional approach is to provide all criteria weighting in a single point of reference to provide readers with a reliable point of reference to access the comprehensive, quantified results of the policy analysis process. In addition to the averaged total

score provided at the bottom row of the table, each cell in Table 4.3 states the weight adjusted scores. After dividing this table between evaluative and practical criteria in Tables 4.4 and 4.5, I will discuss the results and advance to stage three of the CAM. Each non-shaded data cell contains a three-tier list of figures. The top number in each data cell is the quantitative rating elicited from the assessment performed in stage one of the CAM. For the middle number in each cell, the number inside the parenthesis is multiplied by the number above, which produces a product reflected in the bottom figure located to the right of the equal (=) symbol.

Table 4.3: Weighted Quantitative CAM Analysis Using All Criteria

CRITERIA	OPTION 1: Med. School Changes	OPTION 2: Med. Residency Changes	OPTION 3: Continuing Medical Education Changes	OPTION 4: Physician Employer Changes	OPTION 5: Exam Changes for New, Existing Physicians	OPTION 6: Status Quo
Efficiency	3 (.30) = .90	2 (.30) =.60	3 (.30) =.90	2 (.30) =.60	2 (.30) =.60	2 (.30) =.60
Equity	4 (.25) =1.00	3 (.25) =.75	5 (.25) =1.25	4 (.25) =1.00	2 (.25) =.50	2 (.25) =.50
Sustainable	3 (.20) =.60	2 (.20) =.40	2 (.20) =.40	1 (.20) =.20	2 (.20) =.40	2 (.20) =.40
Political Feasibility	2 (.15) =.30	1 (.15) .15	2 (.15) .30	2 (.15) .30	2 (.15) .30	2 (.15) .30
Organizational Feasibility	1 (.10) =.10	1 (.10) 10	1 (.10) .10	2 (.10) .20	1 (.10) .10	2 (.10) .20
TOTAL	.83	.58	.85	.60	.50	.50

Because this thesis divides the analytical criteria into two categories – evaluative and practical – that relate to distinct components of policy analysis, I present the subsequent criteria analyses in two separate tables. In Tables 4.4 and 4.5, I bifurcate the results reflected Table 4.3 and apply the weights to the quantitative criteria-based ratings for each policy option. In addition

to the averaged total score provided at the bottom row of the table, each cell in Tables 4.3 and 4.4 states the weight adjusted scores.

Table 4.4: Weighted Quantitative CAM Analysis Using Evaluative Criteria

CRITERIA	OPTION 1: Med. School Changes	OPTION 2: Med. Residency Changes	OPTION 3: Continuing Medical Education Changes	OPTION 4: Physician Employer Changes	OPTION 5: Exam Changes for New, Existing Physicians	OPTION 6: Status Quo
Efficiency	3 (.30) = .90	2 (.30) =.60	3 (.30) =.90	2 (.30) =.60	2 (.30) =.60	2 (.30) =.60
Equity	4 (.25) =1.00	3 (.25) =.75	5 (.25) =1.25	4 (.25) =1.00	2 (.25) =.50	2 (.25) =.50
Sustainable	3 (.20) =.60	2 (.20) =.40	2 (.20) =.40	1 (.20) =.20	2 (.20) =.40	2 (.20) =.40
TOTAL	.83	.58	.85	.60	.50	.50

Table 4.5: Weighted Quantitative CAM Analysis Using Practical Criteria

CRITERIA	OPTION 1: Med. School Changes	OPTION 2: Med. Residency Changes	OPTION 3: Continuing Medical Education Changes	OPTION 4: Physician Employer Changes	OPTION 5: Exam Changes for New, Existing Physicians	OPTION 6: Status Quo
Political Feasibility	2 (.15) =.30	1 (.15) .15	2 (.15) .30	2 (.15) .30	2 (.15) .30	2 (.15) .30
Organizational Feasibility	1 (.10) =.10	1 (.10) 10	1 (.10) .10	2 (.10) .20	1 (.10) .10	2 (.10) .20
TOTAL	.20	.125	.20	.25	.20	.25

As reflected in the averaged total weighted scores noted in Table 4.3, the weighted quantitative CAM analysis using all criteria, the CME and medical school mandate options receive the highest scores with respect to evaluative criteria. The employer mandate and

examination question options come next with tied total scores more than 25% below the two top scoring options. The medical residency option trails the employer and examination options closely, and the status quo option lags more than 40% below the top total score.

The averaged total scores for the practical criteria produce a different ordering of the options. The status quo, which rated last regarding evaluative criteria, shares the top spot along with the employer mandate option in the weighted quantitative CAM analysis using practical criteria noted in Table 4.4. Three options – medical school changes, CME and examination questions – share identical scores that are 20% below the top rated options. Medical residencies claim the lowest ranked spot at 50% below the top total score.

<div align="center">Qualitative and Quantitative CAM Analysis Stage Three:</div>

<div align="center">Sensitivity Analysis</div>

The third stage of the CAM process that I employ, sensitivity analysis, offers policy analysts an alternate route for testing the integrity and subjectivity of their conclusions, and for bringing previously undetected considerations to the surface. Sensitivity analysis occurs in multiple ways. I will employ a format that consists of two additional rounds of quantitative CAM analyses. Each round will apply adjusted criteria weights to each options determine what, if any, variance occurs among options. In each round, I increase or decrease the weights for evaluative and practical criteria to test the variance of scores under multiple conditions.

There are several differences between the initial weighs and the sensitivity analysis weights. The first adjustment in weights, noted in Table 4.5, reorders the evaluative criteria and expands the difference among practical criteria. Equity becomes the highest weighted evaluative criteria, sustainability is second and efficiency assumes the lowest adjusted weight. For practical criteria, I expand the divergence in weights between political feasibility and organizational feasibility and assign a significantly higher weight to political feasibility. The second weight

adjustment applies additional sensitivity to the weighting process by reordering the evaluative and

practical criteria, assigning divergent weights to evaluative and practical criteria, placing the

highest weight on sustainability and placing the lowest weight on equity. Practical criteria

weights also change substantially. Organizational feasibility, which was 50% lower than political

feasibility in stage two and 400% lower in the first weight adjustment, is weighted higher than

political feasibility by a factor of three. Tables 4.6 and 4.7 convey the results of the first round of

the sensitivity analysis and Tables 4.8 and 4.9 convey the second round results.

Table 4.6: Sensitivity Analysis Criteria Weights

Criteria	Initial Criteria Weights	First Adjusted Criteria Weights	Second Adjusted Criteria Weights
Efficiency	.30	.150	.225
Equity	.25	.350	.200
Sustainability	.20	.250	.375
Political Feasibility	.15	.200	.050
Organizational Feasibility	.10	.050	.150
Total	1.0	1.0	1.0

Table 4.7: First Adjusted Criteria Weights Applied to Evaluative Criteria with Weight Emphasis

on Evaluative Criteria

CRITERIA	OPTION 1: Med. School Changes	OPTION 2: Med. Residency Changes	OPTION 3: Continuing Medical Education Changes	OPTION 4: Physician Employer Changes	OPTION 5: Exam Changes for New, Existing Physicians	OPTION 6: Status Quo
Efficiency	3 (.150) = .450	2 (.150) =.300	3 (.150) =.450	2 (.150) =.300	2 (.150) =.300	2 (.150) =.300
Equity	4 (.350) =1.40	3 (.350) =1.05	5 (.350) =1.75	4 (.350) =1.40	2 (.350) =.700	2 (.350) =.700
Sustainable	3 (.250) =.750	2 (.250) =.500	2 (.250) =.500	1 (.250) =.250	2 (.250) =.500	2 (.250) =.500
TOTAL	.87	.62	.90	.65	.50	.50

Table 4.8: First Adjusted Criteria Weights Applied to Practical Criteria with Weight Emphasis on Evaluative Criteria

CRITERIA	OPTION 1: Med. School Changes	OPTION 2: Med. Residency Changes	OPTION 3: Continuing Medical Education Changes	OPTION 4: Physician Employer Changes	OPTION 5: Exam Changes for New, Existing Physicians	OPTION 6: Status Quo
Political Feasibility	2 (.200) =.400	1 (.200) =.200	2 (.200) =.400	2 (.200) =.400	2 (.200) =.400	2 (.200) =.400
Organizational Feasibility	1 (.050) =.05	1 (.050) =.05	1 (.050) =.05	2 (.050) =.10	1 (.050) =.05	2 (.050) =.10
TOTAL	.225	.125	.225	.250	.225	.250

The first round of adjusted weighting does not change the ordering of the top ranked options in either the evaluative or practical criteria-based sensitivity analyses. Table 4.6 indicates that placing a heavy weight on criteria, raising the sustainability score by 20% and significantly lowering the weight on efficiency failed to produce any change in the ranking of the options compared with the initial stage of evaluative criteria weighting. In Table 4.7, total scores indicate that no change occurred among ranking of the options based upon practical criteria-based calculations, but ranking political feasibility significantly higher than organizational feasibility reduced the difference between top tier ranked options and second tier ranked options from 20% to 10%.

I convey the second round of the sensitivity analysis in Tables 4.8 and 4.9. In this round, I depart from both the initial weighted analysis performed in stage two and the first round of the weight-adjusted analysis by placing sustainability as the top weighted criterion and equity as the lowest weighted criterion. This round tests the sensitivity of total scores for each option based on extreme weight ordering.

Table 4.9: Second Adjusted Criteria Weights Applied to Evaluative Criteria with Weight

Emphasis on Practical Criteria

CRITERIA	OPTION 1: Med. School Changes	OPTION 2: Med. Residency Changes	OPTION 3: Continuing Medical Education Changes	OPTION 4: Physician Employer Changes	OPTION 5: Exam Changes for New, Existing Physicians	OPTION 6: Status Quo
Efficiency	3 (.225) =.675	2 (.225) =.450	3 (.225) =.675	2 (.225) =.450	2 (.225) =.450	2 (.225) =.450
Equity	4 (.200) =.800	3 (.200) =.600	5 (.200) =1.00	4 (.200) =.800	2 (.200) =.400	2 (.200) =.400
Sustainable	3 (.375) =1.125	2 (.375) =.750	2 (.375) =.750	1 (.375) =.375	2 (.375) =.750	2 (.375) =.750
TOTAL	.87	.60	.81	.54	.53	.53

Table 4.10: Second Adjusted Criteria Weights Applied to Practical Criteria with Weight

Emphasis on Practical Criteria

CRITERIA	OPTION 1: Med. School Changes	OPTION 2: Med. Residency Changes	OPTION 3: Continuing Medical Education Changes	OPTION 4: Physician Employer Changes	OPTION 5: Exam Changes for New, Existing Physicians	OPTION 6: Status Quo
Political Feasibility	2 (.050) =.100	1 (.050) =.050	2 (.050) =.100	2 (.050) =.100	2 (.050) =.100	2 (.050) =.100
Organizational Feasibility	1 (.150) =.150	1 (.150) =.150	1 (.150) =.150	2 (.150) =.300	1 (.150) =.150	2 (.150) =.300
TOTAL	.125	.08	.125	.200	.125	.200

As detailed in Table 4.8, the second weight-adjusted sensitivity analysis indicates that placing higher weight on sustainability and lower weight on equity produces a change in the total scores and ranking among the top options. The medical school mandate replaced the CME

mandate as the top ranked policy option with respect to evaluative criteria. While Table 4.9

conveys the same overall ranking of the options compared to the previous weighted analyses

based on practical criteria, placing enhanced weight on organizational feasibility cements and

expands the advantage for the employer and status quo options.

<div align="center">Conclusion</div>

This chapter employs the CAM method of qualitative and quantitative policy analysis to

assess, evaluate and rate the LGBT cultural competency policy options presented in this thesis.

Chapter 5, which follows, discusses the results of the CAM process, confronts tradeoffs that I

identified after performing the CAM, and encapsulates the content and findings of this thesis into

alternative recommendations for potential action by policymakers.

Chapter 5

RESULTS, TRADEOFFS, RECOMMENDATIONS AND CONCLUSIONS

Brief Restatement of Problem

Across the United States, a thriving multilayered system of education enriches current and prospective physicians with general and specialized core competencies. In recent decades, medical educators and health industry stakeholders emphasized the importance of integrating cultural competency into the myriad forms of physician training. Within the last several years, policy environment participants, industry leaders, and relevant research and practitioner literature issued calls to assure the LGBT cultural competency of medical students and providers. However, study and survey data, federal and state policymakers, and LGBT advocacy groups have concluded that LGBT cultural competency deficits and health disparities remain pervasive. LGBT patients experience substandard care, bias, barriers to health access, and low provider competency when seeking healthcare. These deficiencies combine to produce inefficient, inequitable, unsustainable and infeasible healthcare conditions that exacerbate health disparities and increase costs to patients, providers and the healthcare system.

The purpose of this thesis centers on exploring options available to policymakers for improving LGBT cultural competency of hospital and primary care physicians. I address that policy question through review and analysis of literature, data, decision-making criteria and potential policy options relevant to the policy problems surrounding LGBT cultural competency in healthcare.

Brief Synopsis of Tradeoffs Associated with the Policy Options

Evaluated, Rated, and Recommended in the Thesis

This thesis assents with the conclusion found in public policy literature that policy options strong on evaluative criteria, not practical criteria, constitute the preferred set of possible

problem solutions. The two options that performed best with respect to evaluative criteria are mandating changes to medical school curriculum and continuing medical education that enhance the LGBT cultural competency of physicians. While the rankings of options based on practical criteria remained constant regardless of weight changes, two options – employer mandates and the status quo – consistently retained a higher rank than other options.

However, the design and progression of this thesis must undergo additional scrutiny in this chapter to identify any previously unstated weaknesses or tradeoffs. For example, the existence of tradeoffs emerges as a possibility based on the fluctuation among the highest rated option pursuant to the sensitivity analysis noted in Table 4.8. Moreover, in Chapter 4 I use highly subjective criteria to assess and rate each policy option due to the lack of data on LGBT health issues and the impact of physician cultural competency on LGBT health. Although the analysis performed throughout this thesis takes root in relevant research and practitioner literature, studies, surveys and findings, any original conclusion stated in this document may be subject to bias, uncertainty or shortcomings in research of the thesis author. To validate the findings of this thesis, and to minimize the impact of any undetected or unconsidered element, I now convey tradeoffs associated with each option. These tradeoffs involve elements not previously disclosed in this thesis and not specifically noted in the relevant literature. The subsequent section on recommendations entails tradeoffs connected with the policy options that this thesis has already explored.

Tradeoffs from Mandating Changes to Medical School LGBT Cultural Competency Education Curriculum

Policymakers encounter multiple considerations beyond their control when placing a mandate on medical schools to deliver physician cultural competency with LGBT healthcare issues. First, policymakers and medical schools cannot predict who, or how many, medical

students will become physicians, which presents both cost-based and externality-based efficiency concerns. Second, on sustainability grounds, researchers characterize this option as promoting career-long competency, but no one can guarantee that medical students will retain LGBT cultural competency throughout their career. Third, medical students seeking to secure highly sought after general or specialty residencies may avoid attending medical school in a state with enhanced LGBT cultural competency curriculum and attend medical schools known to have a more traditional curricular approach well suited to prized residencies. This consideration has the potential to limit the equity benefits of this option by depriving patients of receiving LGBT-sensitive care from physicians who were among the brightest and most ambitious medical students. Finally, because medical school students often perform their medical residencies out of state, any state that sets this mandate may not be ensuring the LGBT competency of physicians who will practice in other states.

Tradeoffs from Mandating Inclusion of LGBT Competency Training in Medical Education Residencies

If the potential exists for medical students to fall short of retaining the LGBT cultural competency education they receive during medical school, the potential is even greater with respect to the medical residency option due to the multiple learning and clinical demands of residents. Moreover, adding an LGBT-centered course to the rigorous residency schedules may inadvertently produce a backlash against LGBT healthcare from residents who already experience documented fatigue. In pursuing this option, policymakers may set an undesired precedent of governing residency programs. Given the funding instability associated with federal support of residency programs, teaching hospitals and other resident hosts may pressure state governments to backfill lost federal funding if states expect residency programs to provide LGBG cultural competency.

Tradeoffs from Mandating LGBT Cultural Competency Continuing Medical Education (CME) of
Physicians

One presumed strength of CME mandates regards the ability of this option to ensure that all physicians learn LGBT cultural competence. This presumption is only true if CME mandates apply to all specialty physicians, including those who have no direct patient contact. In addition to the question of which physicians should be affected, states must also determine what point or points in the career of a physician produce optimal opportunities to master LGBT competency. For example, if orthopedists seek exemption on the basis that femurs do not have sexual orientation, will they be prepared to engage in discussions about advance directives with a same-sex significant other of a patient who remains unexpectedly unconscious following anesthesia related to bone surgery? Should a CME course be required one time during three consecutive two-year license renewal cycles? Should CME occur in regular five year intervals? Or should CME only occur once during the career of a physician?

Tradeoffs from Mandating that Physician Employers Furnish Medical Education Opportunities
or Provide Guidelines for LGBT Cultural Competency

One perplexing tradeoff is that employers may be less likely to provide continuing medical education in a variety of areas if they must remain agile enough to respond to government mandates. Another key tradeoff is the difficulty of ensuring when physicians will receive the training mandated under this option. Establishing an enforcement scheme presents a whole set of tradeoffs. Will employers who fail to provide the mandated competency be penalized? If so, will the penalty be financial? In addition, how will government ensure that physician employees receive the training associated with this mandate? And when, or how often, will they receive it?

Tradeoffs from Adding LGBT Cultural Competency Content to Medical Licensing or Specialty Examinations

One tradeoff is that standardized exams may measure the test taking capacity of physicians as much as they measure the competency for serving LGBT clients. On another note, because each state possesses only one of fifty voices within the FSMB, it would be counterproductive under current circumstances for the FSMB representative for a state to have biases or phobias against LGBT groups. Such anti-LGBT sentiment would be particularly problematic for the representative of a state that has mandated its medical board to seek changes in examination questions.

Tradeoffs from the Status Quo

A major tradeoff with allowing the status quo to continue unchecked relates to the matter of ethics. Government has a track record of intervening when the private sector fails to produce ethically desirable results. This is evidenced in LGBT workplace protection laws approved by multiple states. If state governments fail to assert a policy solution to an issue that the federal government cites as worthy of improvement, the authority of states to correct market failures based on ethical considerations may erode.

Brief Review of Recommendations

Recommendation 1: Mandating Changes to Medical School Education Curriculum

This option was consistently ranked a close second in each evaluative CAM analysis performed in Chapter 4 and was the top ranked option in the second evaluative sensitivity analysis. The evaluative criteria-based rating of this option is balanced and rates as moderate or higher in every category. Like all of the options, medical school education curriculum mandates show weaknesses in the practical criteria of political and organizational feasibility. However, this option may appear to be stronger than others because more LGBT-specific research and data exist

on the effectiveness, equity and sustainability of this option than exist for any of the other options. Based on the high evaluative ratings for this option and the CME option, the mid-grade practical rankings for this option and the CME option, and considering the tradeoff that medical students may practice in a state other than the one in which they attend medical school, the recommendation here is to consider mandating or to mandate both medical school LGBT-centered curriculum and one or more CME courses on LGBT cultural competency.

Recommendation 2: Mandating Inclusion of LGBT Competency Training in Medical Education Residencies

This option produced mid-grade rankings in evaluative criteria analyses and the lowest rankings in practical criteria analyses throughout Chapter 4. In both the qualitative assessment in Chapter 4 and the previous tradeoff section in this chapter, several constraints and concerns arise within each category of analysis. Another concern is that a large body of research on medical residencies notes limits and constraints and a smaller collection of research attests to the educational value of residencies. The fact that the research literature on residency lacks depth with respect to LGBT cultural competency adds to the doubt that this option will produce the desired result. The recommendation here is not to pursue this option.

Recommendation 3: Mandating Continuing Medical Education (CME) of Physicians

This option consistently posted the top evaluative rankings in Chapter 4 except during the second sensitivity CAM analysis and posted mid-level scores on the practical feasibility criteria throughout the series of CAM analyses. On the individual evaluative criteria, this option rated very strong in equity, moderate in efficiency and weak on sustainability. The low sustainability rank accounts for the fact that this option fell from the top rank in the second evaluative sensitivity analysis, which placed a high emphasis on sustainability. Policymakers aiming to produce robust, improvable policies may be tempted to give pause about implementing this

option based on its sustainability weakness and concomitant shortcomings in organizational

feasibility. However, given that this option meets or exceeds the ratings of the medical school

option in all but one area, and showed the highest cumulative ratings in all but one CAM analysis,

the recommendation here is to consider implementing or implement this option in a manner that

produces LGBT cultural competency of physicians through mandating one or more CME courses

during the span of their careers.

Recommendation 4: Mandating that Physician Employers Furnish Medical Education

Opportunities or Provide Guidelines for LGBT Cultural Competency

Reflecting on the CAM analysis rankings for employer mandates, there is only one

criteria – equity – in which this option achieved a ranking higher than weak. It posted a mid-level

score in all but one CAM analysis. In the second sensitivity analysis, this option ranked among

the lowest options because of its extremely low rating on sustainability. However, this option

scored high on practical feasibility criteria. In comparison to CME, the other mid-career training

option, this option scored lower in every evaluative category and only secured a higher rating in

organizational feasibility. Another concern about this option relates to questions about the

enforcement and compliance complexities that implementers would face. The recommendation

here is not to pursue this option.

Recommendation 5: Adding LGBT Content to Medical Licensing or Specialty Examinations

This option showed weakness in every evaluative and practical category of analysis.

However, this option entails fewer legislative and administrative constraints because it does not

require costly or complex private sector mandates or public sector implementation. Proscriptive

statutory expectations of state medical boards enhance the chances of success for mandates in this

area. Representatives of medical boards may also have a better chance of eliciting support among

the NBME and other members of the FSMB if the authorizing statute is clear and precise. The

recommendation is not to pursue this option, but this is the best backup option if the medical

school and CME mandate options fail or are not pursued after careful consideration.

Recommendation 6: Status Quo

   The status quo option received a weak rating for all evaluative or practical criteria.

Although consistently rated lowest in evaluative analyses, this option persistently occupied the

top ranking in political and organizational feasibility. Therefore, it would be easy for state

policymakers to sit back and let a patchwork of incremental federal, private sector and

educational improvements to the LGBT cultural competency of physicians develop. This option

typifies the utility of bifurcated evaluative and practical criteria CAM analyses. The split format

allows policymakers to place the comparatively high feasibility rankings of this option against the

comparatively low evaluative rankings. Given the weakness of this option with respect to

efficiency, equity and sustainability, policymakers can clearly determine that this option is not

worthwhile simply because it is easy. Because federal government officials and medical experts

called for LGBT cultural competency improvements without respect to the prevailing status quo,

which amounts to a rejection of this option, the recommendation is not to pursue this option.

<div align="center">Conclusion</div>

   This thesis provides an informative and analytical view of a persistent healthcare deficit

that affects a vulnerable population. The narrative in Chapter 1 explains the policy and social

relevance of the shortfall in LGBT cultural competency, describes and defines key elements,

explains the source of the problem and relies on research and practitioner literature to proceed

toward evidence-based analysis and problem solving. Chapter 2 expands on the analytical criteria

introduced in Chapter 1. In the process, a blueprint for assessing potential policy options

emerged. Chapter 3 introduces research-based policy options pertinent to reducing the negative

externalities of physician deficits in LGBT cultural competency. The formal analysis and

decision-making framework is the charge of Chapter 4. All of the thesis elements combine in Chapter 4 to produce qualitative and quantitative assessments of the solution set for the LGBT cultural competency shortfall. In this chapter, I restated the policy problem, recapped the thesis content, identified the remaining undisclosed tradeoffs and utilized the results of the Chapter 4 analysis to produce policy recommendations to close the LGBT cultural competency gap among physicians.

Throughout this thesis, I have relied heavily on qualitative research due to the low number of quantitative experimental studies or surveys on any aspect of LGBT cultural competency in the United States. The quantitative studies found in the research literature focus mainly on medical schools and most studies are at least four years old. While HHS and IOM have called for increased collection of LGBT health data, collecting data on multiple forms of LGBT cultural competency provider training and patient experiences comprise another worthwhile goal that has promise for identifying modes and options for improving LGBT cultural competency of physicians.

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