

‘That would have been beneficial’: LGBTQ education for home-care service providers

Andrea Daley MSW PhD
Judith A. MacDonnell RN PhD

What is known about this topic:

- Health services access barriers contribute to health disparities for lesbian, gay, bisexual, transgender and queer (LGBTQ) people.
- Lack of service provider knowledge related to LGBTQ health needs and service experiences creates barriers to health services.
- Service provider LGBTQ education is a necessary response to this barrier.

What this paper adds:

- Addresses a gap in the existing LGBTQ health services access research literature with its exclusive focus on the home-care sector.
- Professionally diverse home-care service providers have limited and uneven access to LGBTQ education.
- Transformative learning towards shifting deeply held beliefs and values and interprofessional education strategies offer possibilities for meaningful LGBTQ education.

Abstract

This paper reports qualitative findings from a pilot study that explored the lesbian, gay, bisexual, transgender and queer (LGBTQ) education needs of home-care service providers working in one large, urban Canadian city. The pilot study builds upon research that has documented barriers to health services for diversely situated LGBTQ people, which function to limit access to good-quality healthcare. LGBTQ activists, organisations and allies have underscored the need for health provider education related to the unique health and service experiences of sexual and gender minority communities. However, the home-care sector is generally overlooked in this important body of research literature. We used purposeful convenience sampling to conduct four focus groups and two individual interviews with a total of 15 professionally diverse homecare service providers. Data collection was carried out from January 2011 to July 2012 and data were analysed using grounded theory methods towards the identification of the overarching theme, ‘provider education’ and it had two sub-themes: (i) experiences of LGBTQ education; and (ii) recommendations for LGBTQ education. The study findings raise important questions about limited and uneven access to adequate LGBTQ education for home-care service providers, suggest important policy implications for the education and health sectors, and point to the need for anti-oppression principles in the development of education initiatives.

Keywords: health services access, home-care, interprofessional education, LGBTQ, service provider education exclusive focus on the home-care sector.

Introduction

Research conducted in the Canada, the United States and United Kingdom has documented barriers to health services that function to limit access to good quality health care for diversely situated lesbian, gay, bisexual, transgender and queer (LGBTQ) people (Guasp & Taylor, 2013, Fredriksen-Goldsen et al., 2011, Fish, 2010, Stein et al., 2010, Quinn, 2006, Steele et al., 2006, Peterkin & Risdon, 2003, Brotman et al., 2002, Mathieson et al., 2002). Health services access barriers include heteronormative practices and policies including assessment/intake forms that fail to include same-sex relationship status options and rely on the male/female gender binary. More generally, institutionalized heterosexism, biphobia, transphobia, and lack of provider knowledge related to LGBTQ health needs and health services experiences have been implicated in the delay of preventative care, the failure to return for follow-up appointments, and a general reluctance to report health issues for LGBTQ communities. The existing research literature has identified access barriers that may be common across sexual (LGBQ) and gender (T) minority categories, but also those specific to particular categories. In terms of the latter, increasingly researchers are documenting the health services access experiences and related barriers that are unique for transgender people (Grant et al., 2010, Bauer et al., 2009, Sperber et al., 2005, Gapka et al., 2003). In addition, access barriers associated with intersections between sexual orientation and gender identity and other marginalized identities including race, ethnicity and culture, poverty and disability have been examined (Fish, 2008, Author, 2006, Brotman & Ryan, 2004, Brotman et al., 2002). In sum, health services access barriers have been described as contributing to health disparities for diversely-situated LGBTQ individuals (HSE National Social Inclusion Governance Group, 2009, Quinn, 2006, Bowen et al., 2004, Boehmer, 2002).

In response, academic and community-based researchers, and LGBTQ activists,

organizations and allies have underscored the need for health service provider education and training related to the unique health and service experiences of sexual and gender minority communities. Often, calls for education and training initiatives are focused on service providers within hospital, long-term care and public health sectors (GLBT Health Access Project, 2014, Porter & Krinsky, 2014, Lambrese & Hunt, 2013, Reygan & D’Alton, 2013, Rogers et al., 2013, Hanssmann et al., 2008, Knochel et al., 2012, OPHA, 2011, Bell et al., 2010, Author, 2005, Clark et al., 2001). Similarly, research literature on the LGBTQ learning needs of service providers has addressed health-related professional education programs such as medicine (Author, 2012, Obedin-Maliver, 2011), nursing (Hardacker et al., 2013, Lim & Bernstein, 2012, Author, 2009), and social work (Johnston & Stewart, 2013, Author, Fredriksen-Goldsen et al., 2011). A review of the literature suggests that education and training initiatives are often conceptualized within a cultural competency framework, and delivered in workshop formats ranging from one to six hours while incorporating different learning components including small discussion groups, written materials, LGBTQ-identified speakers and videos. They often include a number of topics such as LGBTQ-related terminology and concepts, information on barriers to health care services and health disparities, and sector-, service-, or illness-relevant information (e.g., aging and long-term care, palliative care, HIV, youth and mental health).

Notwithstanding the significance of this research, a review of the LGBTQ health services access literature suggests limited research that has examined the LGBTQ education and training experiences and needs of health care professionals providing home-based health care (HBHC) to sexual and gender minority people. It may be likely that similar service provider education and training experiences and needs are shared across the geographies of institution-based and home-based health care; however, it is also conceivable that the place of *home* in HBHC care may raise

distinct client experiences and associated education and training needs for service providers. Indeed, the uniqueness of providing care in the home is recognized in the nursing literature that interrogates the position of the nurse during home-based patient-nurse interactions (Öresland et al., 2013; Santos & Cameron, 2010; Milton, 2005). While this body of literature does not address LGBTQ homes in particular, the research literature on ‘queer homemaking’ offers important insight into the unique place that ‘home’ may hold for LGBTQ people for the formation, expression, and affirmation of non-heteronormative sexual and gender identities and gender non-conforming same-sex relationship dynamics (Pilkey, 2013; Gorman-Murray, 2012; 2007; Kentlyn, 2008). Gorman-Murray (2007) states in reference to gay men and lesbians, for example, that “the home takes on a heightened importance as a space where they can enact non-heterosexual identities and relationships with some degree of freedom” (p. 3). Importantly, within the scant body of research that reports on the HBHC experiences of LGBTQ people, it is noted that the margin of ‘freedom’ within LGBTQ homes and the potential for self expression and affirmation is indeed encroached upon by the hostility of some service providers, resulting in LGBTQ people censoring displays of affection including touching, holding and kissing one another (Kia, 2012). This paper constitutes an effort to address the gap in the existing LGBTQ health services access literature by reporting qualitative pilot data on the LGBTQ education needs of HBHC service providers working in one large, urban city in Ontario, Canada.

Context

In Ontario, 14 Community Care Access Centres (CCACs) coordinate publicly funded home-care. In 2012/2013, 653,730 clients received home-care services funded by the CCACs with seniors (age 65+) constituting over half the client population (58%) along with adults (19-64 years) (27%) and children (15%) (Ontario Home-care Association, 2014). CCACs employ

care coordinators, often with the professional designation of nurse and to a lesser extent social worker, physiotherapist and occupational therapist to determine client eligibility, co-ordinate and evaluate service delivery, and link clients to community resources. During the referral process level of need is assessed using CCAC-specific program and personal support assessment tools. Importantly, a review of these tools indicates the exclusion of demographic questions that would allow for LGBTQ client self-identification. A variety of for-profit and not-for-profit service provider agencies are contracted by each CCAC through a competitive procurement process. Care is predominately delivered by personal support workers (72.3%) and nurses (23.9%) with a smaller number of clients receiving care from occupational (1.5%), physio (1.3%), speech language (0.7%) therapists and social workers (0.14%) and dieticians (0.15%) who work for CCAC contracted service provider agencies (Ontario Home-care Association, 2014).

Methods

This research used a qualitative design with purposeful convenience sampling for home-care service providers from the following interdisciplinary professional groups: personal support work, nursing, therapists (social work, occupational therapy), and CCAC care coordinators. In order to develop understanding of the similarities and differences in LGBTQ education needs among interdisciplinary providers in relation to HBHC and LGBTQ people, we conducted four focus groups and two individual interviews with a total of 15 participants.

Recruitment

We began recruitment in the spring of 2010 with the local CCAC, given its well established professional connections to home-care service agencies and also recruited for participants through LGBTQ-focused list serves, and by posting electronic flyers to relevant home-care agencies. Inclusion criteria included: 1) being a member of one of the selected professional

groups: personal support worker, nurse, social worker, occupational therapist or CCAC care coordinator; 2) employed within a service provider organization contracted by the local CCAC; and 3) currently engaged in the provision of HBHC. A small honorarium was provided for participants, as well as funding to cover child care expenses. Ethics approval was received from the relevant research ethics boards through the submission and review of the project's ethics protocol.

Data collection and analysis

Data collection occurred from January 2011 to July 2012 with in-person or teleconference focus groups and individual interviews lasting from 90-120 minutes. To minimize the impact on data of power dynamics based on interprofessional hierarchies, focus groups were profession-specific with one focus group each for personal support workers, nurses, therapists (social workers and occupational therapists) and care coordinators. Individual interviews were conducted with one PSW and one care coordinator. Prior to each interview the researcher obtained written informed consent and participants completed a demographic questionnaire. Semi-structured interviews addressed: participants' understanding of LGBTQ health issues, education on LGBTQ people and home-care specific access concerns, and dynamics in provider interactions that are supportive or create barriers for LGBTQ inclusive care. A clinical scenario of a gay man receiving home-care was used to foster reflection and dialogue on care provision. Data was transcribed, anonymized and stored securely at the host university.

Analysis was undertaken using a critical lens to identify themes emerging from the qualitative data. To maintain confidentiality all transcripts were anonymized through the deletion or systematic transformation of all names and other specifically identifying information. A minimum of two researchers independently coded the transcripts line by line (first level codes). Using focused coding and constant comparative method from grounded theory first level codes

were further refined and organized into categories (Charmaz, 2000; 2006). Theoretical coding was implemented as a means of linking the codes that emerged from the process of focused coding, and further developing the relationship between categories. In keeping with a grounded theory approach, memo-writing was performed in an effort to elaborate processes, assumptions, and actions throughout the data analysis process. Coding was facilitated through the use of Nvivo qualitative analysis software. Steps were taken to ensure that neither individuals nor organizations are identified in the reporting of findings.

To ensure the credibility of the analysis process and findings we carefully outlined the parameters in which data was collected including accurately defining inclusion criteria for the participant sample as described above, and following participant recruitment strategies and interview protocols. Confirmability of research outcomes was addressed through a careful and critical evaluation of whether data confirmed the general findings through critical questioning among the researchers' of their interpretations and analysis of interview data (Marshall & Rossman, 1995).

Findings

Participants

Fifteen home-care service providers participated representing diverse professional groups; 4 personal support workers, 5 registered nurses, 1 social worker, 1 occupational therapist, and 4 CCAC coordinators (1 with nurse practitioner credentials and 3 with social work credentials). They ranged from new graduates to well-experienced providers with 10-20 years of experience. Seven participants self-identified as racialized including Black (2) and Filipino (4) with the remaining participants not specifying a racial, ethnic, and/or cultural identity; 4 participants

identified as LGQ and 10 as heterosexual and cis-gendered, meaning that they identify with the gender and sex they were assigned at birth (Bauer et al. 2009).

Themes

Analysis of narratives yielded themes that suggested that participants had diverse understandings of whether or not LGBTQ people had unique health issues. Participants identified a gamut of relevant health issues ranging from barriers to disclosure, discrimination experienced by both patients (e.g., homophobia, transphobia) and home-care workers (e.g., racism), and as well as social isolation, stigma and broader-based notions of family and support as relevant. It is important to note that notwithstanding participants' identification of these relevant health issues that most expressed uncertainty about knowing when they were in the home of an LGBTQ person. Participants attributed the "invisibility" of LGBTQ people in HBHC to their being closest based on age (seniors) and assumptions of heterosexuality, geography with "uptown LGBT clients more in the closet than their downtown peers" (OT01) and not being asked by service providers about their sexual orientation and/or gender identity. In the absence of an explicit disclosure on the part of LGBTQ clients, participants often inferred sexual orientation based on observing interactions between a client and an informal caregiver and viewing pictures in clients' homes (PSW01, PSW03). Whether participants knew they were in an LGBTQ home, or not, they failed to articulate understandings of the significance of the place of home for LGBTQ identity formation, expression and affirmation as potentially impacted by their presence for the provision of care.

In this paper we focus on two sub-themes under the main theme of 'provider education' including home-care service providers: 1) experiences of LGBTQ education; and, 2) recommendations for LGBTQ education. 'Provider education refers to participants' descriptions of their LGBTQ education opportunities in health-related professional education programs,

employment in home-care agencies, and through other forums such as the media and community-based workshops. While community-based workshops may more likely fall under the term “training” rather than “education”, we mainly use the term “education” rather than “training” in thematic analysis following Gibbs, Brigden, & Hellenberg (2004), who consider training as one of four components of education and for whom “education” is holistic in nature and attends to values and principles.

Experiences of LGBTQ education

Very few participants identified opportunities for LGBTQ education during their formal health-related professional education, with personal support workers noting a complete absence of opportunity. Of those participants who did participate in education opportunities, they described them as limited in terms of breadth and depth, and therefore, in their applicability in a practice context. For example, a social work participant stated:

I remember studying the social determinants of health and how that related to people from the LGBT community ... that was something that made me always remember that they face more barriers to health care. I think it would have been good for me to have more of a cross cultural perspective, like learning about LGBT immigrants, working with seniors. (SW01)

Some participants suggested that professional program-based information about LGBTQ care provision was limited in breadth by its focus on very specific medical and sociopolitical events as they were narrowly perceived to be related to LGBTQ health, for example, HIV/AIDS:

“When I went to school HIV just happened ... we were trained to be more cautious” (OT01).

Importantly, this sentiment was not uncommon among participants; on several occasions, participants representing different provider types and in different focus groups asserted that there is a need for home-care service providers to protect themselves from LGBT-patients because of

their association with HIV/AIDS. This was offered as a rationale for knowing their clients' sexual orientation/ and/or having opportunities for LGBTQ education.

Similarly, participants described limited learning opportunities within their places of employment with access varying by professional group. Participant responses suggest that regulated professionals including nurses, social workers, occupational therapists and CCAC care coordinators are more likely to have access to LGBTQ education, albeit minimal, compared to unregulated personal support workers. No personal support worker participants identified having access to LGBTQ education in their places of employment: "A lot of the information that we should have, especially as health workers, we don't" (PSW02). PSW participants often explained lack of education in their places of employment in relation to the perceived absence of LGBTQ clients:

They [place of employment] haven't the focus on LGBT because it is very rare ... in my five years I only noticed one client that was [LGBT]. (PSW01)

It [transgender client] is once in twenty years ... it's not like it is something that I am doing, you know, for 40 people over the years. (PSW04)

While personal support worker participants identified lack of LGBTQ learning opportunities, they described access to broad-based diversity training in relation to particular areas of care, such as palliative care and "the different rituals of different cultures" (PSW04) about death and dying. Personal support worker participants' expressed frustration with the absence of opportunity for LGBTQ education within employment contexts that manage to ensure regularly scheduled mandatory training for other work related skills such as safety and body fluid precautions, transfers and lifts:

And we have tons of training in our agency ... countless courses and things ... but honestly, I can't say or think of anything that was directed to that [LGBTQ] group. (PSW04)

I don't think there's much training for that [LGBTQ]. There isn't any. I mean we get repetitively trained or refreshed on body fluids and lifts and transfers and safety, but nothing about [LGBTQ]. (PSW03)

Within this context of mandatory training, and notwithstanding the perceived absence of LGBTQ clients, personal support workers expressed a desire and need for LGBTQ education in order to build their practice skills in relation to the provision of care to these communities.

While access to LGBTQ education was more likely among the regulated professional groups, there were reported variations across groups. Some participants described receiving cultural competency training through their home-care agencies that included minimal LGBTQ content:

Formally, it is within that cultural competency session and it is woven through all of our orientation ... about being lesbian or gay, you know, about making assumptions about individuals based on what they look like ... you know, based on our values and backgrounds. (CC04)

Participants spoke of opportunities to learn about LGBTQ communities that emerged from the initiative of invested colleagues rather than from organizational leadership (e.g., administrator).

One social worker employed in an agency working with seniors stated:

There was a couple of us from my agency who linked with [LGBTQ Seniors Group] and from that we both did training ... we took what we learned and provided in-services to different departments within our agency. (SW01)

Another participant described a similar history of provider initiated education vis-à-vis a workshop for providing care to transgender people:

Several years ago a trans[gender] client was transitioning and the personal support worker agency was refusing. We [participant and colleague] decided we needed some training, so we contacted some speakers who did two half days. (CC03)

Participants described LGBTQ education as necessary and useful; however, they noted the limitations of one-off opportunities:

That was 10 years ago or 9 years ago or even 8 years ago ... I can't remember and there really hasn't been anything since. (CC03)

We had someone else come in to speak about aging issues for lesbian and gay seniors in nursing homes ... but we haven't had anything for a while. I think it's time to revive that. (CC04)

Unlike the experiences of social worker and care coordinators described above, the occupational therapist and nurse participants indicated that they had no LGBTQ learning opportunities in their workplaces.

I don't think I have anything specific to this group [LGBTQ], but you know, we have training geared towards specific minorities ... people who are physically disabled or you know those kinds of things, but geared towards LGBT ... I've never had specific training on that. (OT01)

I think if you want more [LGBTQ] training ... you've got to do your own education ... you got to do your own researching. (RN05)

As suggested above, in response to lack of education opportunities some participants sought opportunities elsewhere:

I've had to sort of find what opportunities are out there on my own and then put in a request to somehow get funding or the day off to attend them. (CC02)

I have to look up research to follow my practices, so I go by best practice guidelines ... there is very little. (CC01)

Participants also described being informed about LGBTQ health services access "problems" through the news media:

... the [name of newspaper] on the weekend focused on the problem of lack of money in home-care ... seniors being stuck in the hospital ... and people in the LGBT group forced to go back into the closet because they're not well received in the hospital. (OT01)

Importantly, the focus groups themselves offered an educational, especially with the use of a case-based scenario to prompt discussion. Two nurse participants agreed upon examining a home-care scenario focused on a gay man's life, that education on the social determinants of health held potential for helping providers understand the complexity of factors at the individual and social levels that shape LGBTQ health.

Participants' Training Recommendations

Some participants expressed concern about home-care agencies implementing LGBTQ-related practices in the absence of adequate education for home-care service providers. In the excerpt below, a participant makes reference to her reaction during a team meeting focused on the introduction of sexuality-related questions on an organization's intake form:

I raised my hand and said, 'my concern is that we have never asked this question before and I'm looking around and I get a feeling that most these people [colleagues] are uncomfortable with asking this question and I think we should have a discussion on how to discuss this issue [asking about sexuality].' It was not very well received ... the individual who was facilitating the group said, 'well, you know, you should be able to handle it, you know, you're all professionals.' I understand that [name of organization] wants this and I think it's wonderful ... I fully appreciate the question being on [the intake form], but we've gone from 0 to 100 and didn't stop in-between. People came over to me afterwards and said, 'I'm just not going to ask the question.' (CC02)

Lack of access to LGBTQ education appeared, from the perspective of this participant, to mean that organizations were not well-enough prepared to address health-related issues for LGBTQ communities:

They were giving out a protocol about asking all women about abuse and I remember having a meeting with all the nurses and the manager and I asked why are we only asking women about this issue, and they said, 'well that who is affected most. I said well in whose research because as we all know there are barriers that involve LGBT people identifying abuse. (CC02)

A participant in the focus group of nurses pointed to the need for well-planned and resourced (e.g., time) provider education by underscoring the implications and challenges of deeply held beliefs and knowledge for both new hires and well-experienced employees, stating, "we have all these old habits ... and they can change ... [but] it is very hard to change old habits completely" (RN03).

Given the expressed concerns, participants clearly identified LGBTQ learning components and topics that would be useful towards the enhancement of their practice skills. For personal

support workers, access to “training courses” generally, along with agency financial support was identified as a necessary and urgent recommendation. More specifically, forums that include speakers from LGBTQ communities was seen as a useful strategy for reducing potential fear and enhancing comfort and ‘professionalism’: “I do not feel I am a professional in dealing with them ... I would like to have a [LGBGQ] speaker come and give us some more information” (PSW01).

A starting topic for LGBTQ education identified by some participants was debunking assumptions of heterosexuality made by home-care service providers: “I think that training is extremely important for all staff just to be made aware that not all clients will be heterosexual” (SW01). Other participants identified the use of appropriate language by home-care service providers as an important education topic as language has the potential to convey comfort and non-judgement:

I think a great thing would be to teach the service providers and the organization appropriate language to make anybody ... whether they have identified or not ... know that I will take care of you, I will not judge you, I will be comfortable, I will not discriminate against. (CC03)

Included in the notion of “appropriate language” was training related to the acronyms associated with sexual and gender minority communities, such as, “LGBTQ”:

Whenever there’s training done there is always a surprisingly large amount of people that still have to go over the letters and say, ‘what does this mean’ and ‘what does that mean.’ (SW01)

Discussion

The participants of this pilot study identified an overall lack of, and need for, LGBTQ education in relation to the provision of HBHC to LGBTQ people. Participants described a paucity of education in both regulated and unregulated health-related professional education programs and within HBHC employment contexts (e.g., home-care agencies). This main study

finding is clearly aligned with the existing LGBTQ health services access literature that identifies lack of provider knowledge as a barrier to good quality care for LGBTQ communities, and that advocates for service provider education as a necessary response.

While there appears to be variability in terms of access to education across regulated health professional programs, overall access to repeated opportunities that offer both breadth and depth in terms of LGBTQ health and health services access experience is limited. In the absence of adequate opportunities and associated concerns, participants articulated LGBTQ-education recommendations that are closely aligned with learning components and topics identified in the existing literature including, for example, LGBTQ-identified speakers and LGBTQ-related terminology and concepts.

Limitations of the study include challenges related to the small sample size and recruitment of diverse home-care service providers. While personal support worker, nurse, and CCAC care coordinator participants were more strongly represented, social work and occupational therapist participants were less so. In part, difficulty recruiting social HBHC generally, with the majority of home-care provided by personal support workers, nurses and care coordinators. Our sample size of 15 participants allowed for theoretical saturation in relation to the overarching theme of ‘provider education’ and associated subthemes; however, the small sample size of each professional group prevented us from conducting an in-depth analysis of the differences in LGBTQ learning needs between provider groups. In addition, while some of our participants self-identified as LGQ, we were unable to make direct linkages to sexual and/or gender identity and participant excerpts when reporting the findings. This is an important limitation in that LGQ participants may have more knowledge of LGBTQ health and health services access experiences

based on lived experience and/or participation in LGBTQ communities compared to non LGBTQ participants.

Notwithstanding these limitations, the pilot study offers an important contribution to the LGBTQ health services access literature by offering an exclusive focus on the LGBTQ education needs of professionally diverse HBHC service providers. Emerging from the pilot data are important questions related to lack of LGBTQ content across health-related professional education programs generally, and support for home-care-specific continuing education opportunities and the breadth and depth of existing opportunities. In terms of the former, our findings point to important policy implications for both the education sector and health sector. At a policy level, Ministries responsible for education and health must consider whether funding formulas adequately provide resources for comprehensive educational programs that prepare health care professionals to respond to the diverse and complex health needs and health service experiences of *all* service users, including LGBTQ service users. This includes attending to curricula development in postsecondary health-related programs that specifically address practice issues that are unique to the place of home as a distinct care context. At a very basic level, our findings raise questions about the extent to which content about HBHC is included in postsecondary health-related programs (e.g., a HBHC-related course). At a pedagogical level, and what is less visible in participants' recommendations for LGBTQ education is explicit attention to approaches to education based on anti-oppression principles that are aligned with emancipatory outcomes and processes that foster transformative learning which have been described in some literature as necessary for shifting deeply held beliefs and values. That is, these findings raise questions about the home-care-specific content and process of diversity education that is structured in a way that can prompt deep learning on an emotional level that is

needed to shift heteronormative practices. For example, the development of a home-care-specific diversity education program that moves beyond a competency-based approach that centres sexual and gender minority subjects as ‘different’, towards the inclusion of content and processes that “denaturalise(ing) heteronormative assumptions of home” (Pilkey, 2012, p. 160) and facilitate HBHC service providers’ critical thinking about the potential deleterious impacts of HBHC on the distinct meaning and purpose of ‘home’ for LGBTQ identity formation, expression and affirmation. While this implication may also be relevant to continuing education initiatives, postsecondary health-related programs more likely have the capacity and resources available to explore the transferability and applicability of these theoretically-informed ideas in the provision of day-to-day HBHC.

Finally, given our finding that professionally diverse service providers have uneven access to LGBTQ education within health-related education programs Ministries responsible for education may also consider the nature of relationships between health-related professional programs within and across postsecondary institutions. More specifically, this finding points to the potential usefulness of interprofessional education strategies (Canadian Interprofessional Health Collaborative, 2007) that encourage collaborative and integrative learning across what have traditionally been professional divides (Lapidos, Christiansen, Rothschild, & Halstead, 2002). In this regard, social work programs that foster the development of practice skills for social justice, anti-oppression and equity work within health settings, among others, may serve as important resources in interprofessional education contexts.

In terms of LGBTQ continuing education initiatives, the research findings raise questions related to the development of thoughtful structures for continuing education and training that respond to the unique context of HBHC. First, uneven access to LGBTQ education opportunities

within postsecondary education programs between unregulated personal support workers and regulated nurses, social workers and occupational therapists suggest the need for an immediate response from CCACs and contracted service provider agencies to prioritize LGBTQ continuing education initiatives for personal support workers. Second, the logistics of and resources required for coordinating comprehensive continuing education initiatives for community-based, professionally diverse staff that is geographically mobile and dispersed constitutes a significant challenge. The catchment regions of many Ontario-based CCACs and their contracted service provider agencies span vast urban, rural and remote areas. Geographical mobility and distance along with increased use of advanced computer and teleconferencing technology may mean that staff are less likely to participate in face-to-face meetings at service provider agencies.

Continuing education initiatives within this HBHC context may present as a logistical challenge generally; however, it is conceivable that the low priority given to LGBTQ continuing education initiatives within the context of HBHC as suggested by study participants exacerbates this challenge. In addition, while online training modules may offer a partial solution to the specific challenge of logistics, arguably the complex and sensitive nature of LGBTQ education content and associated teaching strategies may not be amenable to this form of ‘distance’ education.

Conclusion

This pilot study addresses a gap in the LGBTQ health services access research literature with its exclusive focus on HBHC and the education experiences of service providers. While the pilot data is limited in its transferability, the main findings that professionally diverse home-care service providers have limited and uneven access to adequate LGBTQ education constitutes a significant contribution towards future research on eliminating access barriers to HBHC for LGBTQ communities. Moreover, we draw out implications of this main finding for service

provider education that are specific to the HBHC context and the place of home as a distinct care context. While the data supports existing LGBTQ health services access literature that identifies LGBTQ education strategies as an important and necessary response to LGBTQ access barriers associated service provider lack of knowledge about sexual and gender minority communities, it also calls for consideration of unique approaches to address the HBHC context.

Acknowledgements

This study was supported by the Interprofessional Education Initiatives Fund, Faculty of Health, York University, Toronto, Canada. The authors thank the participants of the study for sharing their experiences and insights, as well as Alisa Grigorovich, Emily McDonald and Natasha Tutt for their support on the project.

Conflicts of interest

No conflicts of interest have been declared.

References

Bauer, G.R., Hammond, R., Travers, R., Kaay, M., Hobenadel, K.M., & Boyce, M. (2009). "I don't think this is theoretical; this is our lives": How erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS care*, 20(5), 348-361.

Bell, S. A., Bern-Klug, M., Kramer, K. W.O., & Suanders, J.B. (2010). Most nursing home social service directors lack training in working lesbian, gay, and bisexual residents. *Social Work in Health Care*, 49(9), 814-831.

Boehmer, U. (2002). Twenty years of public health research: Inclusion of lesbian, gay, bisexual, and transgender populations. *American Journal of Public Health*; 92(7), 1125-1130.

Bowen, D.J., Bradford, J.B., Powers D., et al. (2004). Comparing women of differing sexual orientations using population-based sampling. *Women and Health*, 40, 19-34.

Brotman, S., & Ryan, B. (2004). An intersectional approach to queer health policy and practice: Two-Spirit people in Canada. *Canadian Diversity*, 3(1), 59-64.

Brotman, S., Ryan B, Jalbert Y, et al. (2002). The impact of coming out on health and health care access: the experiences of gay, lesbian, bisexual, and two spirit people. *Journal of Health and Social Policy*, 15(1), 29.

Canadian Interprofessional Health Collaborative. (2007). *Interprofessional education and core competencies: Literature review*. Author: Vancouver, BC.

Charmaz K. (2000) Grounded theory: objectivist and constructivist methods. In: Norman K. Denzin & Y.S. Lincoln (Eds.) *Handbook of qualitative research* (2nd edition), pp. 509–535. Sage, CA.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. Thousand Oaks: Sage.

Clark, M.E., Landers, S., Linde, R., & Sperber, J. (2001). The GLBT health access project: A state-funded effort to improve access to care. *American Journal of Public Health, 91*(6), 895-896.

Daley, A. (2010). Being recognized, accepted and affirmed: self-disclosure of lesbian/queer sexuality within psychiatric and mental health service settings. *Social Work in Mental Health, 8*(4), 336–355.

Dobinson, C., MacDonnell, J., Hampson, E., Clipsham, J. & Chow, K. (2005). Improving access and quality of public health services for bisexuals. *Journal of Bisexuality 5*(1), 39–78.

Fish, J. (2010). Promoting equality and valuing diversity for lesbian, gay, bisexual and trans patients. *RCGP Journal InnovAIT, 3*(6) pp. 333-338.

Fish, J. (2008) Navigating Queer Street: Researching the intersections of LGBT health. *Sociological Research Online, 13*(1). Retrieved January 6, 2014 from: <http://www.socresonline.org.uk/13/1/12.html>.

Fredriksen-Goldsen, K.I., Kim, H.H., Emler, C.A., Muraco, A., Erosheva, E.A., et al. (2011). *The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual, and Transgender Older Adults*. Seattle, WA: Institute for Multigenerational Health.

Fredriksen-Goldsen, K.I., Woodford, M.R., Luke, P., & Gutiérrez. (2011). Support of sexual orientation and gender identity content in social work education: Results from national surveys of U.S. and anglophone Canadian faculty. *Journal of Social Work Education, 47*(1), 19-35.

Gapka, S., Raj, R., et al. (2003). Trans health project (position paper). Toronto, ON: OPHA.
Gardner, B. (2008). *Health Equity Discussion Paper*. Toronto Central LHIN: Government of Ontario.

(GLBT) *Gay, Lesbian, Bisexual and Transgender Health Access Project*. (2010). Retrieved January 6, 2014 from <http://www.glbthealth.org/CommunityStandardsofPractice.htm>.

Gibbs, T., Brigden, D., & Hellenberg D. (2004). The education versus training and the skills versus competency debate. *SA Fam Pract*, 46(10), 1-6.

GLBT (1999) *Gay, lesbian, bisexual and transgender health access project*. Available at: <http://www.glbthealth.org/CommunityStandardsofPractice.htm> (accessed on 6/1/2014).

Gorman-Murray, A. (2012). Queer politics at home: Gay men's management of the public/private boundary. *New Zealand Geographer*, 68, 111-120.

Gorman-Murray, A. (2007). Reconciling self: Gay men and lesbians using domestic materiality for identity management. In N. Stead & J. Prior (Eds.), *Queer Spaces: Centre and Peripheries*. (pp. 1-7). Sydney: UTS.

Grant, J.M., Mottet, L. A., & Tanis, J. (2010). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Retrieved January 2, 2014 from http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.

Guasp, A., & Taylor, J. *Experiences of Healthcare: Stonewall Health Briefing*. U.K: Stonewall Publishing. Retrieved January 6, 2014 from: <http://www.healthyives.stonewall.org.uk/lgb-health/briefings/default.aspx>.

Hanssmann, C., Morrison, D., Russian, E. (2008). Talking, gawking, or getting it done: Provider trainings to increase cultural and clinical competence for transgender and gender-nonconforming patients and clients. *Sexuality Research & Social Policy*, 5(1), 5-23.

Hardacker, C.T., Rubinstein, B., Hotton, A., & Houlberg, M. (2013). Adding silver to the rainbow: the development of the nurses' health education about LGBT elders (HEALE) cultural

competency curriculum. *Journal of Nursing Management* (9 pages). Retrieved January 6, 2014 from: <http://onlinelibrary.wiley.com.ezproxy.library.yorku.ca/doi/10.1111/jonm.12125/pdf>

HSE National Social Inclusion Governance Group. *LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People*. (2009). Retrieved January 6, 2014 from: http://www.glen.ie/attachments/HSE_LGBT_Health_Report.PDF.

Johnston, L.B., & Stewart, C. (2013). Still among the missing? A content analysis of LGBT articles in social work journals, 1998-2009. *Journal of Gay and Lesbian Social Services*, 25(2), 232-243.

Kentlyn, S. (2008). The radically subversive space of the queer home: 'Safety house' and 'neighbourhood watch'. *Australian Geographer*, 39(3), 327-337.

Kia, H. (2012). "I'm part of this family": how five care-giving partners of gay men story their experiences. *Journal of Gay and Lesbian Social Services*, 24, 140-157.

Knochel, K.A., Croghan, C.F., Moone, R.P., & Quam, J. (2012). Training, geography, and provision of aging services to lesbian, gay, bisexual, and transgender older adults. *Journal of Gerontological Social Work*, 55(5), 426-443.

Lambrese, J.V., & Hunt, J. (2013). Mental health needs of sexual minority youth: A student-developed novel curriculum for healthcare providers. *Journal of Gay & Lesbian Mental Health*, 17(2), 221-234.

Lapidos, S., Christiansen, K., Rothschild, S., & Halstead, L. (2002). Creating interdisciplinary training for health care professionals: The challenges and opportunities for home health care. *Home Health Care Management & Practice*, 14, 338- 343.

Lim, F.A., & Bernstein, I. (2012), Promoting awareness of LGBT issues in aging in a baccalaureate nursing program. *Nursing Education Perspectives*, 33(3), 170-175.

MacDonnell, J.A. (2009). Fostering nurses' political knowledges and practices: education and political activation in relation to lesbian health. *Advances in Nursing Science* 32(2), 158–172.

MacDonnell, J.A. & Macdonald, G. (2011). Arts based critical inquiry in nursing and interdisciplinary professional education: guided imagery, images, narratives, and poetry. *Journal of Transformative Education* 19(4), 203–221.

Mathieson, C., Bailey, N., & Gurevich, M. (2002). Health care services for lesbian and bisexual women: some Canadian data. *Health Care for Women International*, 23, 185-196.

Marshall, C. & Rossman, G. (1995). *Designing qualitative research* (2nd Ed.). London, GB: Sage Publications Inc.

Milton, C. L. (2005). The metaphor of nurses as guests with ethical implications for nursing and healthcare. *Nursing Sciences Quarterly*, 18(4), 301-303.

Mulé, N., Ross, L.E., Deeprase, B., Jackson, B., Daley, A., Travers, A. & Moore D. (2009). Promoting gender and sexually diverse health and wellbeing in policy. *International Journal for Equity in Health* 8 (18), 11.

Obedin-Maliver, J., Goldsmith, E.S., Stewart, L., White, W., Tran, E., Brenman, S., Wells, M., Fetterman, D.M., Garcia, G., & Lunn, M.R. (2011). Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *The Journal of the American Medical Association*, 306(9), 971-977.

Ontario Home-care Association. Retrieved on March 20, 2014 from <http://www.homecareontario.ca/public/about/home-care/system/facts-and-figures.cfm>.

(OPHA) Ontario Public Health Association Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgendered, Two-Spiritied, Intersex, Queer and Questioning Equity

Workgroup. (2011). *A Positive Space is a Healthy Place: Making Your Community Health Centre or Public Health Unit Inclusive to Those of all Sexual Orientations and Gender Identities*. Toronto: Author. Retrieved January 6, 2014 from: <http://www.opha.on.ca/resources/SexualHealthPaper-Jun06.pdf>.

Öresland, S., Lutzén, K., Norberg, A., Rasmussen, B. H., & Määttä, S. (2013). Nurses as 'guests' – a study of a concept in light of Jacques Derrida's philosophy of hospitality. *Nursing Philosophy, 14*, 117-126.

Peter E. (2002) The history of nursing in the home: revealing the significance of place in the expression of moral agency. *Nursing Inquiry 9*, 65–72.

Peterkin, A., & Risdon, C. (2003). *Caring for Lesbian and Gay People: A Clinical Guide*. Toronto: University of Toronto Press.

Pilkey, B. (2013). LGBT homemaking in London, UK: The embodiment of mobile homemaking imaginaries. *Geographical Research, 51*(2), 159-165.

Porter, K.E., & Krinsky, L. (2014). Do LGBT aging trainings effectuate positive change in mainstream elder service providers? *Journal of Homosexuality, 61*(1), 197-216.

Quinn, S. (2006). *Accessing Health: The Context and the Challenges for LGBT People in Central and Eastern Europe*. ILGA-Europe. Retrieved January 6, 2014 from: http://www.ilga-europe.org/home/how_we_work/previous_projects/health_project.

Reygan, F.C.G., & D'Alton, P. (2013). A pilot training programme for health and social care professionals providing oncological and palliative care to lesbian, gay and bisexual patients in Ireland. *Psycho-Oncology, 22*, 1050-1054.

Rogers, A., Rebbe, R., Gardella, C., Worlein, M., & Chamberlin, M. (2013). Older LGBT adult training panels: An opportunity to educate about issues faced by the older LGBT

community. *Journal of Gerontological Social Work*, 56(7), 580-595.

Rutherford, K., McIntyre, J., Daley, A. & Ross, L. (2012). Development of expertise in LGBT mental health service provision: a qualitative study. *Medical Education*, 46, 903–913.

Santos Salas, A., & Cameron, B. L. (2010). Ethical opening in palliative home-care practices. *Nursing Ethics*, 17(5), 655-665.

Sperber, J., Landers, S., & Lawrence, S. (2005). Access to health care for transgendered persons: Results of a needs assessment in Boston. *International Journal of Transgenderism*, 8(2/3), 75-91.

Steele, L. S., Tinmouth, J. M., & Lu, A. (2006). Regular health care use by lesbians: a path analysis of predictive factors. *Family Practice*, 23, 631-636.

Stein, G.L., Beckerman, N.L., & Sherman, P. (2010). Lesbian and gay elders and long-term care: Identifying the unique psychosocial perspectives and challenges. *Journal of Gerontological Social Work*, 53(5), 421-435.

Source of Funding: Interprofessional Education Initiatives Fund, Faculty of Health, York University, Toronto, Canada