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RESEARCH ARTICLE

Assessing the LGBT cultural competency of dementia care providers

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Abstract

Introduction: Although dementia risk factors are elevated in lesbian, gay, bisexual, and transgender (LGBT) older adults and are perpetuated by a lack of cultural competency, no known studies have quantified LGBT cultural competency among dementia care providers.

Methods: Dementia care providers (N = 105) across the United States completed a survey consisting of the 7-point Likert LGBT-Development of Clinical Skills Scale.

RESULTS: Dementia care providers reported very high affirming attitudes (M = 6.67, standard deviation [SD] = 0.71), moderate knowledge (M = 5.32, SD = 1.25), and moderate clinical preparedness (M = 4.93, SD = 1.23). Compared to previously published data, they reported significantly lower knowledge than medical students. There were no differences compared to psychiatry residents.

Discussion: The current state of dementia care providers' LGBT cultural competency has significant, yet modifiable, gaps. Better education, including more LGBT patient exposure, is necessary to improve the care being provided to members of the LGBT community impacted by dementia illness.

KEYWORDS
attitudes, cultural competency, dementia, knowledge, LGBT, medical students, preparedness, providers, psychiatry residents

1 | BACKGROUND

A number of acronyms are used to refer to sexual and gender minorities as a group. Each of the letters in these acronyms represents a specific sexual and/or gender minority. Because studies of sexual orientation and gender identity (SOGI) include various combinations of sexual and gender minorities, in this article, these abbreviations are used with precision.

The number of older lesbian, gay, bisexual, and/or transgender (LGBT) community members who are and who will be impacted by dementia is significant, as are the current and projected costs of caring for them. Approximately 2 to 4 million older adults identify as LGBT. The combination of an aging US population and increasing levels of disclosure and acceptance over time, the number of older adults who openly identify as LGBT is expected to at least double by 2030.[1] Likewise, nearly 20% of LGBT older adults aged 65 and older are living with dementia. It is estimated that by 2030, the number of LGBT older adults with dementia will surpass 1 million.[2] The current annual costs associated with caring for LGBT older adults living with dementia is projected at $17 billion.[3]

1.1 | Discrimination

Many LGBT older adults endure various forms of stigma and discrimination at interpersonal, institutional, community, and policy levels. Social disparities include many LGBT older adults living alone due to estrangement from families, being childfree, perceiving discrimination from peers and providers within aggregate living communities, and experiencing scarce LGBT-specific community resources.[4] Economic disparities include many LGBT older adults encountering financial barriers, living at or below the federal poverty level, and having poor access to health care.[5] Particular subpopulations, such as bisexual and transgender people, racial and ethnic minorities, and individuals living with human immunodeficiency virus (HIV), have even greater rates of marginalization.[5,6] For instance, LGBT older adults living with HIV often confront "triple stigma" with antigay prejudice, ageism, and public misconceptions about HIV.[7] Using a minority stress model framework,[8] accumulating experiences of this stress over time can lead to internalized homophobia and transphobia and eventually manifest as physical and mental health disparities. Indeed, LGBT older adults have higher rates of poor physical and mental health, disability, substance use (such as alcohol and tobacco), and HIV seropositivity compared to cisgender, heterosexual older adults.[5,6]

1.2 | Cognitive decline

There is a paucity of data regarding cognitive decline in the older LGBT population. Theoretically, LGBT older adults face risk factors (many modifiable) that are known to increase cognitive impairment and dementias, such as limited social and caregiver support, social isolation, discrimination, and chronic medical conditions including higher rates of cardiovascular disease, hypertension, diabetes, heavy smoking and alcohol use, and depression.[3–5,9] Most of these studies have been limited, however, by a focus on subjective cognitive decline (SCD) within LGBT older adults cross-sectionally. Past studies have suggested that 25% to 75% of LGBT older adults endorse SCD; people who are of color, depressed, HIV+, and have functional impairment are more likely to report SCD.[3,9]

One subgroup of the LGBT community that has received special attention regarding neurocognitive health are those individuals living with HIV. HIV-associated neurocognitive disorder (HAND) refers to the spectrum of neurocognitive dysfunction associated with HIV infection.[10] Although combination antiretroviral therapy (CART) has resulted in improved life expectancies and a dramatic decline in rates of opportunistic infections, HAND continues to be associated with significant morbidity. The proportion of individuals with HAND among the population of individuals living with HIV is estimated to be between 15% and 55%. Even though this proportion is similar to before the widespread use of CART, a trend toward milder symptoms has been observed.[10]

Despite many LGBT older adults experiencing dementia risk factors, the association between LGBT identity and cognitive decline remains unclear. One cross-sectional study[11] found a lack of association between LGBT identification and SCD, and another[12] found a lack of association between LGBT identity and mild cognitive impairment and dementia. More studies are required to elucidate the impact of LGBT identity on cognitive decline.

HIGHLIGHTS

- This is the first study that measures the lesbian, gay, bisexual, and transgender (LGBT) cultural competency of dementia care providers.
- Gaps in LGBT preparedness and knowledge, especially in transgender care, were identified.
- Dementia care providers reported higher clinical preparedness but lower basic knowledge than medical students.
- More education, including patient exposure, is needed to improve the LGBT cultural competency of dementia care providers.

RESEARCH IN CONTEXT

1. **Systematic review**: The authors reviewed the literature using traditional sources. While no known studies have attempted to quantify dementia care providers' lesbian, gay, bisexual, and transgender (LGBT) cultural competency, there are a few studies that have reported negative attitudes and a lack of LGBT knowledge and preparedness among long-term service and support providers (such as residential care community staff, nursing assistants, and social workers).
2. **Interpretation**: Our findings characterized dementia care providers' LGBT cultural competency, noting gaps in clinical preparedness and knowledge about LGBT health care, especially in transgender care.
3. **Future directions**: While this study's sample reflects the diverse workforce involved in dementia care, future studies using larger, more diverse samples (e.g., including unlicensed dementia care providers and unpaid dementia care givers) are required to confirm these results. Additionally, future studies should create easily deliverable LGBT cultural competency trainings specifically focused on LGBT aging and dementia and analyze the short-term and long-term effects that increased patient exposure and education have on LGBT cultural competency.

1.3 | Culturally competent care

Although significant progress has been made over the past decade, a significant proportion of health-care providers report that they did not receive any LGBT education while they were students and/or trainees.[13] While the amount of LGBT education for health-care providers is limited, specific training about how to provide culturally sensitive care to members of the LGBT community appears to be even less.[14–16] Unfortunately, disparities may be perpetuated or even exacerbated by this lack of cultural competency among health-care providers including those who work as caregivers for individuals living with dementia.

Disparities also endure, in part, because LGBT older adults often conceal their SOGI and avoid health-care providers altogether due to fear and/or experiences of mistreatment and diminished quality of care. They may fear that providers will not value or even recognize their "families of choice" and same-sex partners.[17] As such, LGBT older adults desire having LGBT-trained staff for their long-term health-care needs.[1,17] Long-term service and support providers (such as residential care community staff, nursing assistants, and social workers) themselves report a lack of LGBT-specific knowledge and training as well as negative attitudes about and discomfort caring for LGBT older adults.[1] Regarding persons with dementia, patients may demonstrate increasingly less easily understood SOGI expression due to impairments in social skills, language, behavior, and cognition.[18] LGBT older adults living with dementia may even go through personality changes and a loss of identity as the disease progresses.[2]

1.4 | Cultural competency within dementia care

Coupled with the aforementioned high rates of social, economic, and health-care disparities among LGBT older adults, it is imperative that health-care providers for patients living with dementia (henceforth, collectively referred to as "dementia care providers") understand these risk factors and the marginalization that LGBT older adults with dementia may face. Possessing and conveying this knowledge and understanding promotes rapport with patients and their family members and helps initiate preventive measures at the individual patient level.

Despite the importance that cultural competency may have on health outcomes, no known studies have attempted to quantify and identify gaps in dementia care providers' LGBT cultural competency. As such, this study sought to: (1) characterize dementia care providers' cultural competency (via the tenets of clinical preparedness, attitudes, and knowledge), (2) evaluate how demographic and experiential variables influence their cultural competency, and (3) compare dementia care providers' cultural competency to the cultural competency of medical students[15] and psychiatry residents.[14] We hypothesized that dementia care providers would endorse positive attitudes and lower knowledge and preparedness concerning LGBT health care. We also posited that sexual minority, that is, lesbian, gay, bisexual, and queer (LGBQ), dementia care providers would report higher cultural competency scores than heterosexual peers. Last, given the historical lag of LGBT education integration into health-care curricula,[14–16] we postulated that while dementia care providers would endorse higher preparedness than medical students, they would report similar attitudes and less knowledge; moreover, we presumed there would be no differences in cultural competency between dementia care providers and psychiatry residents.

2 | METHODS

2.1 | Participants and procedure

Participants in this study were dementia care providers who were recruited via listservs of the US Alzheimer's Disease Research Centers (ADRCs) and American Association for Geriatric Psychiatry (AAGP). The study's survey was e-mailed to all US ADRCs (n = 32)[19] and AAGP, requesting that administrative staff forward this e-mail to their dementia care providers. Responses were collected between August 2019 and March 2020. Because participants could not be identified, this study was granted exemption by the Indiana University Institutional Review Board (IRB, Protocol #1907051526). Participation was voluntary and anonymous, and initiation and completion of the survey constituted consent of participation.

2.2 | Instrument

A 29-item self-report, anonymous, cross-sectional survey of demographics, experiential variables, and the LGBT-Development of Clinical Skills Scale (LGBT-DOCSS)[20] was used. Eight demographic factors (i.e., age, gender identity, sexual orientation, race, ethnicity, degree, specialty, and "region" of employment) were collected. Three experiential variables were assessed: years of practice, percentage of patients aged 65 years and older, and percentage of patients diagnosed with dementia. Dementia care providers were also asked if there was anything else that they would like to share regarding LGBT health care.

The LGBT-DOCSS is an 18-item self-assessment for health-care providers. Items are 7-point Likert scales (1 = strongly disagree, 4 = somewhat agree/disagree, 7 = strongly agree), eight of which are reverse scored. An overall mean score averages all items ("Overall LGBT-DOCSS"), while each subscale ("Clinical Preparedness," "Attitudinal Awareness," and "Basic Knowledge") averages select items. Higher scores indicate higher levels of clinical preparedness and knowledge and less prejudice regarding LGBT patients.

2.3 | Analysis

Results were analyzed using SPSS Statistics 26. Per their respective state of employment, providers were collapsed in geographic regions as defined by the US Census Bureau. Internal consistencies were calculated for LGBT-DOCSS scales. Frequencies and means were

computed for demographics, experiential variables, LGBT-DOCSS scores, and individual LGBT-DOCSS items. Paired sample *t*-tests were conducted to assess differences in LGBT-DOCSS scores and similar LGBT-DOCSS items that differed based on LGBT subpopulation. Multiple linear regression models were analyzed to predict LGBT-DOCSS scores based on demographic and experiential variables. Differences in LGBT-DOCSS scores across demographic and experiential variables were analyzed using bivariate analyses, such as independent samples *t*-tests and analyses of variance. Because there is no previous research concerning dementia care providers' LGBT cultural competency (especially with the LGBT-DOCSS), LGBT-DOCSS scores were compared between dementia care providers, medical students,[15] and psychiatry residents[14] using independent sample *t*-tests. The intent of these comparisons was to provide a context for interpretation of dementia care providers' cultural competency scores. Last, select quotes from dementia care providers were showcased to highlight the themes of LGBT patient exposure and formal education. Statistical significance was set at $\alpha = 0.05$.

3 | RESULTS

3.1 | Demographic and experiential variables

A total of 105 dementia care providers completed the survey (Table 1). Providers represented 56.3% of the 32 ADRCs, 21 states, and all US regions. The majority were in their forties, cisgender women, heterosexual, White, and not Hispanic or Latino. Just under half had a doctor of medicine (MD) degree, approximately one third had a doctor of philosophy degree, and the remaining respondents represented a variety of other health-care professions. Providers had been in practice several years with many patients aged 65 years and older and diagnosed with dementia (Table 2).

3.2 | LGBT-DOCSS scores

Internal consistencies were high for all LGBT-DOCSS scales (Overall LGBT-DOCSS: $\alpha = 0.83$, Clinical Preparedness: 0.87, Attitudinal Awareness: 0.87, and Basic Knowledge: 0.77). The Overall LGBT-DOCSS mean score was moderate (Table 3). Dementia care providers reported significantly higher Attitudinal Awareness compared to Basic Knowledge ($t[104] = 10.621$, $P < 0.001$) and Clinical Preparedness ($t[104] = 13.755$, $P < 0.001$); they also reported significantly higher Basic Knowledge than Clinical Preparedness ($t[104] = 2.429$, $P = 0.017$). There were perceptual differences between LGBT subpopulations. For instance, dementia care providers reported significantly less adequate clinical training and supervision, experience, and competence to assess transgender patients compared to lesbian, gay, and bisexual (LGB) patients (Figure 1).

TABLE 1 Demographics (N = 105)[a]

	M (SD) or n (%)
Age	44.32 (11.68)
Gender identity	
Cisgender man	38 (36.2%)
Cisgender woman	54 (51.4%)
Non-binary	1 (1.0%)
Other[b]	12 (11.4%)
Sexual orientation	
Bisexual	5 (4.8%)
Gay	9 (8.6%)
Heterosexual	88 (83.8%)
Lesbian	2 (1.9%)
Queer	1 (1.0%)
Race	
Asian/Asian American	8 (7.6%)
Black/African American	2 (1.9%)
White	92 (87.6%)
Other[b]	3 (2.9%)
Ethnicity	
Hispanic or Latino	7 (6.7%)
Not Hispanic or Latino	98 (93.3%)
Degree	
MD	49 (46.7%)
NP	6 (5.7%)
PhD	32 (30.5%)
PsyD	7 (6.7%)
RN	1 (1.0%)
SW	4 (3.8%)
Other[b]	6 (5.7%)
Specialty	
Family medicine	4 (3.8%)
Geriatrics	19 (18.1%)
Internal medicine	2 (1.9%)
Neurology	22 (21.0%)
Nurse practitioner	4 (3.8%)
Nursing	2 (1.9%)
Psychiatry	18 (17.1%)
Psychology	23 (21.9%)
Social work	4 (3.8%)
Other[b]	7 (6.7%)
Region[c]	
Midwest	35 (34.0%)
Northeast	24 (23.3%)

(Continues)

TABLE 1 (Continued)

	M (SD) or n (%)
South	29 (28.2%)
West	15 (14.6%)

Abbreviations: MD, doctor of medicine; MS, master of science; NP, nurse practitioner; PA, physician assistant; PhD, doctor of philosophy; PsyD, doctor of psychology; RN, registered nurse; SW, social worker.
[a]N = 105 for all variables except: region (n = 103).
[b]For "other" categories:.
•Gender identity: other (n = 12).
•Race: American Indian & White (n = 1) and other (n = 2).
•Degree: MS (n = 1), other (n = 4), and PA (n = 1).
•Specialty: midwifery (n = 1) and other (n = 6).
[c]As defined by the US Census Bureau.

TABLE 2 Experiential variables

	M (SD) or n (%)
Years in practice	13.52 (11.67)
Proportion of patients who are 65 years and older	
0%–20%	12 (11.4%)
20%–40%	10 (9.5%)
40%–60%	10 (9.5%)
60%–80%	22 (21.0%)
80%–100%	51 (48.6%)
Proportion of patients who are diagnosed with dementia	
0%–20%	39 (37.1%)
20%–40%	18 (17.1%)
40%–60%	25 (23.8%)
60%–80%	16 (15.2%)
80%–100%	7 (6.7%)

3.3 | Subgroup differences

There were no significant regression equations found for any LGBT-DOCSS scores. There were significant differences in LGBT-DOCSS scores, except Attitudinal Awareness, between heterosexual and LGBQ dementia care providers, such that LGBQ dementia care providers reported higher scores: Overall LGBT-DOCSS (M = 5.62, SD = 0.71; M = 6.10, SD = 0.54; t[103] = −2.659, P = 0.009), Clinical Preparedness (M = 4.83, SD = 1.24; M = 5.45, SD = 1.04; t[103] = −1.928, P = 0.057), and Basic Knowledge (M = 5.14, SD = 1.23; M = 6.22, SD = 0.92; t[103] = −3.415, P < 0.001), respectively. There were no significant differences in LGBT-DOCSS scores across the other demographic and experiential variables other than cisgender men (M = 5.37, SD = 1.12) reporting significantly higher Clinical Preparedness (P = 0.009) than cisgender women (M = 4.70, SD = 1.23), F(2,102) = 4.002, P = 0.021, and dementia care providers with an MD degree (M = 5.04, SD = 1.20) reporting significantly lower Basic Knowledge than dementia care providers with non-MD degrees (M = 5.57, SD = 1.25), t(103) = −2.216, P = 0.029.

3.4 | Comparisons among dementia care providers, medical students, and psychiatry residents

There were significant differences in LGBT-DOCSS scores, except for Attitudinal Awareness, between dementia care providers and medical students, such that dementia care providers reported higher Overall LGBT-DOCSS and Clinical Preparedness and lower Basic Knowledge than medical students (Figure 2). There were no differences in LGBT-DOCSS scores between dementia care providers and psychiatry residents.

4 | DISCUSSION

This study is the first known to quantify dementia care providers' cultural competency in LGBT health care. Primary aims of this study were to characterize dementia care providers' level of clinical preparedness, attitudes, and knowledge about LGBT care, evaluate how demographic and experiential variables influence their LGBT cultural competency, and compare their cultural competency to previously published cultural competency of medical students[15] and psychiatry residents.[14]

We found that dementia care providers reported very high affirming attitudes and only moderate knowledge and clinical preparedness. This finding is similar to previous research that has shown that while primary care providers endorse positive attitudes about treating the LGBT population, they often lack general knowledge about LGBT health care (scoring a mere 50% accuracy on knowledge questions) and do not feel well informed on specific LGBT patient needs, management, and referral options.[16] Although not included in this study, long-term service and support providers (such as residential care community staff, nursing assistants, and social workers) also report a lack of LGBT-specific knowledge; feeling unprepared; and, somewhat surprisingly, negative attitudes, which may be related to inadequate training as less than one third have received any type of LGBT cultural competency training.[1]

Perhaps the positive attitudes among dementia care providers here may present an opportunity for these providers to recognize a need for self-improvement through LGBT person exposure and education. Indeed, previous studies have indicated that exposure to LGBT persons and LGBT training can increase more positive attitudes, empathy, knowledge, and preparedness among long-term care providers and even promote organizational changes.[1,17] Given that LGBQ dementia care providers reported higher cultural competency scores, likely partially due to personal values and clinical experiences, this finding affords another opportunity for provider self-improvement. For instance, cisgender, heterosexual dementia care providers could draw upon the personal experiences and cultural competency of LGBT colleagues to identify deficiencies and institute interpersonal, intradepartmental, and perhaps institutional change concerning LGBT health equity. As four participants in this study stated eloquently:

> *I've learned more from friends than from my job. (Participant #1)*

TABLE 3 LGBT-DOCSS[a] score means

Clinical Preparedness	M (SD)	Attitudinal Awareness	M (SD)	Basic Knowledge	M (SD)
I would feel unprepared talking with a LGBT client/patient about issues related to their sexual orientation and/or gender identity.[b]	5.37 (1.70)	I think being transgender is a mental disorder.[b]	6.45 (1.22)	I am aware of institutional barriers that may inhibit transgender people from using health-care services.	4.87 (1.83)
I have received adequate clinical training and supervision to work with transgender clients/patients.	3.97 (1.76)	A same sex relationship between two men or two women is not as strong and committed as one between a man and a woman.[b]	6.86 (0.56)	I am aware of institutional barriers that may inhibit LGB people from using health-care services.	4.76 (1.82)
I have received adequate clinical training and supervision to work with LGB clients/patients.	4.70 (1.76)	LGB individuals must be discreet about their sexual orientation around children.[b]	6.21 (1.50)	I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals.	5.76 (1.38)
I have experience working with LGB clients/patients.	5.39 (1.60)	When it comes to transgender individuals, I believe they are morally deviant.[b]	6.80 (0.71)	I am aware of research indicating that transgender individuals experience disproportionate levels of health and mental problems compared to cisgender individuals.	5.89 (1.39)
I feel competent to assess a person who is LGB in a therapeutic setting.	5.83 (1.23)	The lifestyle of a LGB individual is unnatural or immoral.[b]	6.71 (0.90)		
I feel competent to assess a person who is transgender in a therapeutic setting.	5.07 (1.53)	People who dress opposite to their biological sex have a perversion.[b]	6.81 (0.77)		
I have experience working with transgender clients/patients.	4.22 (1.87)	I would be morally uncomfortable working with a LGBT client/patient.[b]	6.88 (0.49)		
Total	4.93 (1.23)		6.67 (0.71)		5.32 (1.25)

Abbreviations: DOCSS, Development of Clinical Skills Scale; LGB, lesbian, gay, and bisexual; LGBT, lesbian, gay, bisexual, and transgender.
[a]Scores are averages on 7-point Likert scales (1 = strongly disagree, 4 = somewhat agree/disagree, 7 = strongly agree); for the Overall LGBT-DOCSS: M = 5.70, SD = 0.71.
[b]Reverse scored items.

> … *[S]ince I'm not LGBTQ myself, I may have a lack of knowledge of certain questions to ask. (Participant #2)*

> *There are not enough educational opportunities for clinicians who already have their training. (Participant #3)*

> *I … have not had close to enough education and experience to be fully competent in treating these individuals… I realize the responsibility to become competent is mine. I realize that my lack of training is in part due to the healthcare disparity that LGBTQ individuals face. (Participant #4)*

With regard to the transgender population, dementia care providers reported very low transgender-specific clinical preparedness (such as receiving adequate clinical training and supervision and having competence), especially compared to their preparedness in treating LGB patients. This discomfort with transgender care specifically mimics several past studies that have demonstrated that providers are woefully underprepared to care for transgender patients compared to cisgender, heterosexual, and even LGB patients.[14,16,21]

Regarding how dementia care providers' cultural competency compared to other health-care professionals, we analyzed LGBT-DOCSS scores among these providers, medical students, and psychiatry residents. Compared to medical students, dementia care providers reported higher clinical preparedness but less knowledge. Given that these providers had 13.5 years of clinical experience, it would not be surprising if dementia care providers would report feeling more prepared about most, if not all, patient populations compared to medical students with much less patient exposure (i.e., typically less than 4 years). Seemingly paradoxical to feeling more

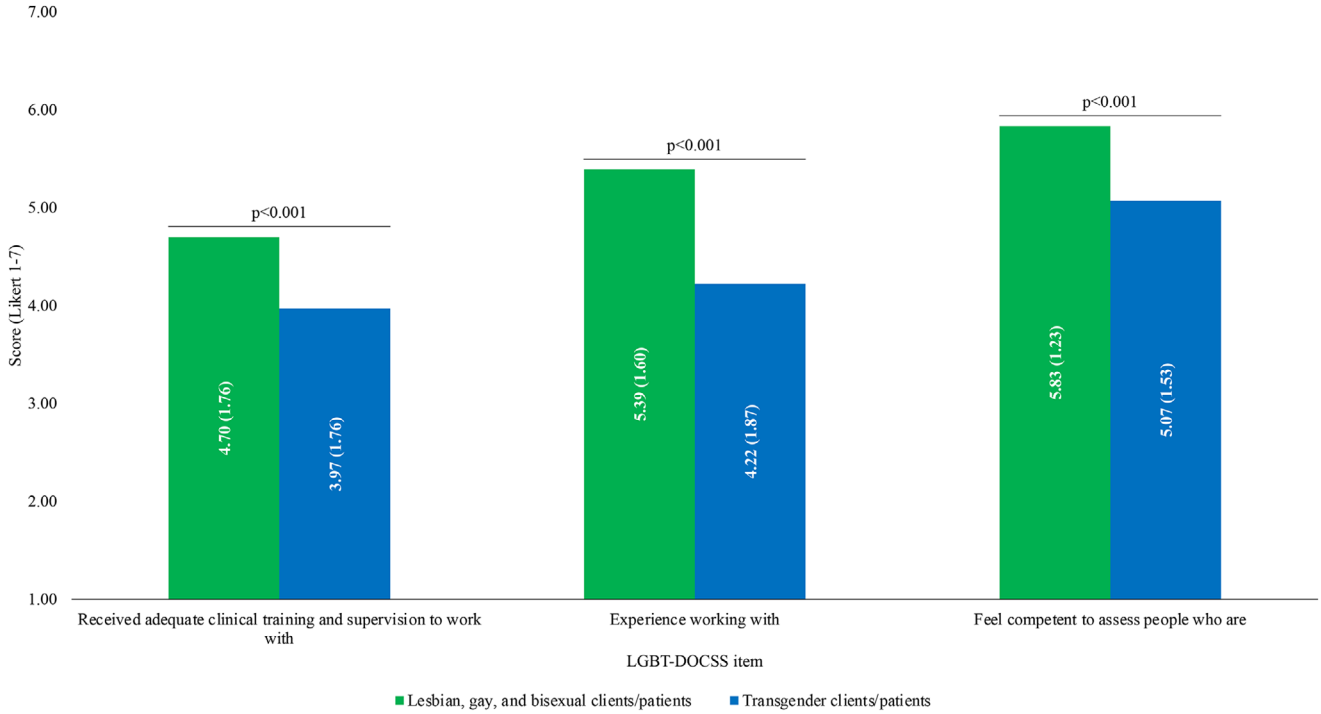

FIGURE 1 LGB versus transgender clinical perceptions. LGBT-DOCSS scores are means on 7-point Likert scales. Higher scores are indicative of higher levels of clinical preparedness and knowledge and less prejudicial attitudes regarding LGBT patients. Similar LGBT-DOCSS items that differed based on patient type (i.e., LGB vs. transgender) were analyzed using paired sample *t*-tests to determine whether there were clinical perceptual differences between LGBT subpopulations. Dementia care providers reported significantly less adequate clinical training and supervision (t[104] = −6.559), experience (t[104] = −6.920), and competence (t[104] = −7.178) to assess transgender patients compared to LGB patients. LGB, lesbian, gay, and bisexual; LGBT, lesbian, gay, bisexual, and transgender; DOCSS, Development of Clinical Skills Scale

prepared, dementia care providers endorsed less knowledge than medical students.

Of note, despite calls to action by several national organizations including the Association of American Medical Colleges, Joint Commission, and American College of Physicians to improve LGBT cultural competency education and training, only minimal progress with the integration of LGBT education into health-care curricula has occurred over the past 20 years.[14–16] Dementia care providers, especially those who completed their training before this national attention on cultural competency, may have never received any LGBT education. Interestingly, we found that there were no differences between dementia care providers and psychiatry residents. In a separate subgroup analysis (data not shown), we compared only dementia care providers with an MD degree to psychiatry residents (who have the same or similar degree) and found comparable results. This lack of difference may parallel the reasoning mentioned above, that is, that there is a severe lack of continuing LGBT training for dementia care providers beyond medical and residency education. Some opportunities for education and training regarding LGBT cultural competency after training completion are emerging. For example, though not specifically focused on caring for LGBT individuals living with dementia, Felsenstein reported that a computer-based module coupled with a panel discussion resulted in 72% of primary care clinic staff members reporting being more prepared to provide LGBT culturally sensitive care.[22]

4.1 | Practice implications

Albeit sparse, written recommendations and resources regarding how dementia care providers can support LGBT older adults living with dementia do exist, which may lead to better cultural competency.[3,18,23] For example, applying person-centered care; using neutral language and communication; creating safe spaces to discuss sexual orientation, gender identity, and the coming out process; including families of choice and same-sex partners in health-care decisions; providing vetted LGBT educational materials and resources; and empowering patients and their caregivers to engage in LGBT advocacy are all practices that can lead to LGBT older adults feeling a part of welcoming, affirming environments. Additionally, there are several national organizations (such as OutCare Health, the National LGBT Health Education Center, the Gay and Lesbian Medical Association, and the Human Rights Campaign) which provide many LGBT resources as well as on-demand and live LGBT cultural competency education.

4.2 | Research implications

The heterogenous pool of participants in this study, including geriatricians, neurologists, nurses, primary care physicians (family medicine and internal medicine providers), psychiatrists, psychologists, and

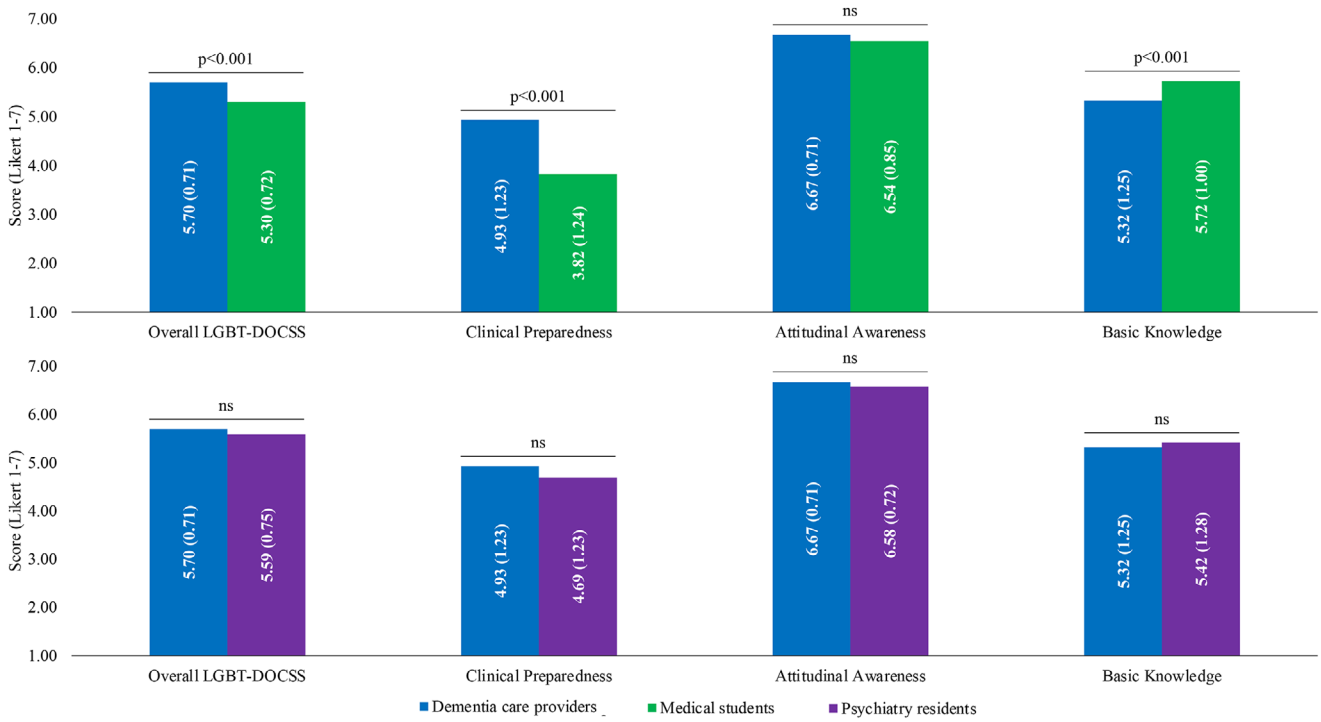

FIGURE 2 LGBT-DOCSS scores among dementia care providers, medical students, and psychiatry residents. LGBT-DOCSS scores are means on 7-point Likert scales. Higher scores are indicative of higher levels of clinical preparedness and knowledge and less prejudicial attitudes regarding LGBT patients. Differences in LGBT-DOCSS scores among dementia care providers, medical students, and psychiatry residents were analyzed using independent samples *t*-tests. There were significant differences in LGBT-DOCSS scores, except Attitudinal Awareness, between dementia care providers and medical students, such that dementia care providers reported higher Overall LGBT-DOCSS (t[1043] = 5.407) and Clinical Preparedness (t[1043] = 8.644) and less Basic Knowledge (t[1043] = -3.845) than medical students. There were no differences in LGBT-DOCSS scores between dementia care providers and psychiatry residents. Abbreviations: LGBT, lesbian, gay, bisexual, and transgender; DOCSS, Development of Clinical Skills Scale

social workers, reflects the diverse workforce involved in dementia care.[24] Future studies, however, are required to confirm these study results with larger, more diverse sample sizes (e.g., including unlicensed dementia care providers and unpaid dementia caregivers) to determine the impact of demographic and experiential variables on LGBT cultural competency. For example, while past studies have demonstrated that demographic variables—such as sexual orientation and gender identity—were significant predictors for cultural competency scores,[14,15] interestingly those findings were not replicated in the regression models of this study. Additionally, the quantity and quality of LGBT patient exposure and education necessary to promote high LGBT cultural competency for dementia care providers (and providers in general) is unknown. Future studies should create easily deliverable LGBT cultural competency trainings specifically focused on LGBT aging and dementia and analyze the short-term and long-term effects that increased patient exposure and education have on LGBT cultural competency. Additionally, future studies examining how welcoming the lived experiences and cultural competency of LGBT dementia care providers, who are themselves members of the LGBT community, could lead to improvements in LGBT cultural competency among cisgender, heterosexual peers.

4.3 | Limitations

Notable study limitations exist. First, the sample size is small, heterogenous (in terms of degree, specialty, and experientials), and limited to professional caregivers. Second, this study relied on convenience sampling and the nature of data collection did not permit calculation of a response rate. Dementia care providers with biases toward sexual and gender minorities may have chosen not to participate, and LGBT dementia care providers may have been more likely to respond. Likewise, unlicensed dementia care providers and unpaid dementia caregivers, who make up the majority of the dementia care workforce,[24] were not included in this study. Thus, the generalizability of these results to the much larger, diverse dementia care workforce is unknown. Third, the amount of experience working with LGBT patients was not assessed. In previous research from one of this article's authors,[16] the percentage of LGBT patients cared for by primary care providers has been evaluated, but anecdotal experience has shown that many, if not most, providers assume 1% to 10% of their patients are LGBT, likely because this is the estimated range for the general population.[25] Additionally, research has demonstrated that less than half of providers actively inquire about SOGI.[16] Not

asking about SOGI status results in these providers not being able to report accurately the amount of experience they may have acquired. For this and related reasons, the authors elected not to include this variable. Finally, only 209 medical doctors were polled in the initial LGBT-DOCSS validity analyses,[20] and thus the question of the LGBT-DOCSS's applicability to dementia care providers is, so far, informed by this study alone.

4.4 | Conclusions

Dementia care providers are uniquely positioned to understand stigma and discrimination among LGBT older adults, potentially reduce and/or prevent cognitive decline with preventive measures, and advocate for healthy SOGI expression and LGBT health-care equity. In this study, dementia care providers reported only moderate clinical preparedness and knowledge about LGBT health care, especially with transgender-specific care. Respondents did, however, endorse strong positive attitudes about the LGBT population, which may invite an avenue for recognition for self-improvement. The results of this study demonstrate that the level of LGBT cultural competency among dementia care providers has significant, yet modifiable, gaps. More LGBT patient exposure and education (e.g., through patient panels and cultural competency trainings) are necessary to improve dementia care providers' provision of care for the LGBT population.

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CONFLICTS OF INTEREST

The authors declare no competing interests.

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