



Original article

Two Tailored Provider Curricula Promoting Healthy Weight in Lesbian and Bisexual Women



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ABSTRACT

Purpose: Provider curricula to reduce potential weight bias or stigma in treating lesbian and bisexual (LB) women who are overweight or obese were pilot-tested in two unique settings. Trainings used LB cultural competency and motivational interviewing techniques to improve provider–patient interactions.

Methods: Two training formats were used: Clinic Format and Academic Format. Clinic Format training was pilot tested at Lyon-Martin Health Services, a Program of HealthRight360, a community health center serving women, lesbians, and transgender people in San Francisco and in two community settings. Academic Format training was pilot tested by the Mautner Project of Whitman-Walker Health with physicians, medical residents, and students at Georgetown, George Washington, Howard, and Vanderbilt Universities. Both programs measured provider knowledge and attitude change. **Results:** Both programs saw significant percentage point gains in knowledge about LB women's avoidance of health care based on body size. Participants in the Academic Format program saw the greatest gain in knowledge about understanding health care avoidance (30 percentage point increase), whereas Clinic Format program participants gained most in understanding how to appropriately discuss weight loss with patients (23 percentage point increase).

Conclusions: Both programs increased provider knowledge about the barriers to health care facing LB women who are overweight and obese, reducing the potential for future negative interactions. However, the two programs differed in how they conceptualized the relationship between weight and health, likely contributing to differences in knowledge gain among participants at each site. Future studies should test differences between the two formats across site type or staff baseline knowledge differences.

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Lesbian and bisexual (LB) women face at least two potential barriers to health care. The first barrier is their sexual orientation. Lack of a common vocabulary about non-heterosexual relationships and discomfort with discussing sexual activities may impede providers' ability to communicate effectively with LB women (Hinchliff, Gott, & Galena, 2005; Kelley, Chou, Dibble, & Robertson, 2008; Portz et al., 2014). In addition, medical personnel may not be knowledgeable about the health care issues affecting this population because lesbian, gay, bisexual, and transgender (LGBT) health issues are rarely included in medical

school curricula and/or during postgraduate and residency training programs (Moll et al., 2014; Obedin-Maliver et al., 2011). Patients who perceive that their providers lack full understanding, or who fear ridicule or rejection, may not disclose their sexual orientation, resulting in inadequate care (Stein & Bonuck, 2001). Provider presumptions of heterosexuality and/or the use of noninclusive language (e.g., wife vs. partner) may cause a patient to feel alienated and may make the achievement of the best treatment outcomes difficult (Steele, Tinmouth, & Lu, 2006).

The second barrier stems from the higher obesity rates in LB women compared with heterosexual women (Bowen, Balsam, & Ender, 2008; Conron, Mimiaga, & Landers, 2010; Ward, Dahlhamer, Galinsky, & Joestl, 2014). Weight bias or weight stigma refers to negative attitudes about overweight and obese persons that negatively impact interpersonal interactions

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(Brownell, Puhl, Schwartz & Rudd, 2005). Weight bias can be common among health care professionals (Puhl & Brownell, 2006). Clinicians openly admit to negative attitudes toward obese patients, and many express dissatisfaction in caring for obese patients (Hebl & Xu, 2001; Jay et al., 2009; Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). This bias can result in reduced quality of care (Teachman & Brownell, 2001). Thus, stigma and discrimination related to sexual orientation and gender identity may be compounded by stigma related to weight and body size, particularly in the clinical setting (Drabble, Keatley, & Marcelle, 2003). Literature reviews (Eliaison et al., 2015) and focus group studies with LB women (Garbers et al., 2015) indicate that it is not uncommon for LB women to have experienced negative interactions with health care providers about their weight.

Few interventions have been published addressing weight and fitness-related health disparities among LB women. To address this research gap, the United States Department of Health and Human Services, Office on Women's Health funded a coordinated multisite initiative: *Healthy Weight in Lesbian and Bisexual Women: Striving for a Healthy Community*. One aspect of this initiative was a focus on provider training to address systemic health care inequalities for LB women who are overweight or obese (referred to as “women of size”), and to address the gap in the literature for provider training on weight bias (Institute of Medicine, 2011).

This paper describes the development, implementation, and evaluation of two curricula (Academic Format and Clinic Format) designed to improve providers' cultural competency and motivational interviewing (MI) skills to enhance their ability to provide high-quality care to LB women of size. Clinic Format provider training was pilot tested among both staff and medical providers at Lyon-Martin Health Services (LMHS), a Program of HealthRight360, a community health center serving women, lesbians, and transgender people in San Francisco. Academic Format training was pilot tested by Mautner Project of Whitman-Walker Health with physicians, medical residents, and medical students at Georgetown, George Washington, Howard, and Vanderbilt Universities. Both curricula targeted the potential social stigma LB women face owing to their sexual orientation and weight. Both programs used the cultural competency components and MI techniques described below. However, the trainings used two different approaches to describe the relationship between weight and health. The Clinic Format used the *Health At Every Size* model (Bacon, 2010). This model is a weight-neutral approach to health that focuses on intuitive eating (responding to body cues for hunger/fullness), enjoyable movement, and the multidimensional nature of health. The Academic Format used a more traditional medical model of weight and health, where weight loss is an important component of achieving health for overweight or obese patients.

Cultural Competency

Both curricula incorporated cultural competency training. Cultural competency in health care can be defined as the acknowledgement of cultural differences in health care, assessment of cross-cultural relations, and knowledge of stigmas faced by a particular group given one or more aspects of their identity (e.g., race, class, gender, religion, or sexual orientation; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Cross, Bazron, Dennis, & Isaacs, 1989; National LGBT Cancer Network, 2014). Cultural competency training aims to increase both

knowledge and skills to improve an individual's ability to effectively interact with different cultural groups (Beach et al., 2005). Cultural competency should be an ongoing process for health care providers, who need to “work within the cultural context of the client” (Campinha-Bacote, 2002, p. 181). An open and positive acknowledgement of sexual orientation may assist providers in establishing the necessary rapport with LB women of size. This rapport would facilitate providers' ability to address weight or weight-related issues compassionately and with a focus on health behaviors that may impact weight, rather than on weight itself (Cahill et al., 2014; Clifford et al., 2015; Puhl & Brownell, 2006; Robison, 2005).

Motivational Interviewing

Both curricula introduced participants to MI techniques. MI has been shown to be an effective behavior change technique for many health behaviors, including smoking cessation and increasing patient engagement (Armstrong et al., 2011; Hettema & Hendricks, 2010; Lundahl & Burke, 2009). MI prescribes the use of nonjudgmental and supportive statements to establish a positive environment in which individuals are empowered to reflect on and make decisions about their lives (Emmons & Rollnick, 2001). MI techniques include using reflective listening, allowing resistance to change, and supporting self-efficacy. Rather than trying to convince clients to change, providers trained in MI elicit arguments for change from the clients themselves. These techniques help clients to explore and resolve ambivalence, develop self-efficacy, and set personal goals. MI is generally presented in 1-to-3-day workshops, although this varies widely across MI trainings; research recommends MI inclusion repeatedly across medical school and provider training curricula as a patient-centered care practice (Söderlund et al., 2011). As of the date of this paper, there were no published studies on the use of MI with LB women of size.

Materials and Methods

Formative Focus Groups

Before trainings were implemented, both programs conducted focus groups to ask LB woman who are overweight or obese and age 40 and over about their experiences with a variety of health issues, including medical provider interactions around health and weight (Fogel, Young, & McPherson, 2009; Garbers et al., 2015; Mautner Project: The National Lesbian Health Organization, 2011). Institutional review board clearance was obtained at each institution before contact with participants. LMHS conducted five focus groups before Clinic Format training with a total number of 28 participants between March and April 2013. The Mautner Project conducted one focus group before Academic Format training with nine participants in the Spring (2013) to confirm and augment data from previous work that contributed to the development of the current project. The need for a patient-centered approach—both by health care providers and intervention implementers—was a central theme that emerged from these focus groups. Participants rejected the tendency to “shame” or “blame” health status on weight, preferring an approach that provides tailored guidance to ameliorate the barriers LB women face at the individual, interpersonal, community, and societal levels.

Curriculum Development

Curricula were initially developed separately in accordance with demonstrated needs and the differing perspectives of each program. However, key training components overlapped (see Figure 1). Midway through the training, the two programs compared curricula and integrated additional components.

Academic Format Provider Trainings

The Academic Format program was based on an existing curriculum, *Removing the Barriers*, which focuses on training medical providers and frontline staff to be more culturally competent about issues affecting their LGBT patients (Mautner Project: The National Lesbian Health Organization, 2011). Learning activities designed to draw attention to the issues of overweight and obesity in LB women were added to this existing curriculum.

The Academic Format training curriculum was presented in person by program staff to a range of medical professionals including practicing physicians, residents, and medical students; 39 students and 27 physicians and residents (66 total) completed pretests and posttests. Participants were recruited via convenience sampling through student groups or department-based groups on each campus. Trainings were 60 minutes long and took place at Georgetown, George Washington, Howard, and Vanderbilt Universities.

Four objectives were addressed during these trainings: 1) define the diversity of the LB population, 2) identify the individual, structural, and institutional factors that affect access to care among the lesbian, bisexual, and transgender population, 3) use MI techniques such as asking open-ended questions, reflective listening, and change talk for addressing patient issues related to obesity, and 4) identify barriers that might interfere with applying principles of cultural competency and MI to their

provider practice while developing solutions for addressing these barriers.

Academic Format trainings began by developing an understanding of the language, behaviors, stigma, and cultural barriers often experienced by LB women. Attention to language was essential to the Academic Format curriculum because of the initial impact and lasting effect of speech. Inclusive language, such as use of the word “partner” or “spouse” was emphasized, whereas other terms such as “lesbian,” “bisexual,” “gender identity,” and “sexual orientation” were defined for providers.

This training helped providers focus on primary areas for assessing a client’s current readiness for behavior change, including:

- Previous attempts at weight loss,
- What worked for the client in past attempts versus what did not,
- Anticipated family support and possible challenges,
- Attitudes towards physical activity, and
- Potential barriers to change (e.g., availability/affordability of healthy food sources).

The Academic Format was presented primarily as didactic lecture material with additional skills development exercises. Participants developed skills through role playing, using sample dialogue and LB-specific examples to help providers develop talking points for their own client practice. Academic Format participants completed pretests and posttests immediately before and after training to assess changes in knowledge and attitudes.

Clinic Format Provider Trainings

Clinic Format trainings consisted of a two-part curriculum based on *Health at Every Size™* (HAES) principles (Bacon, 2010).

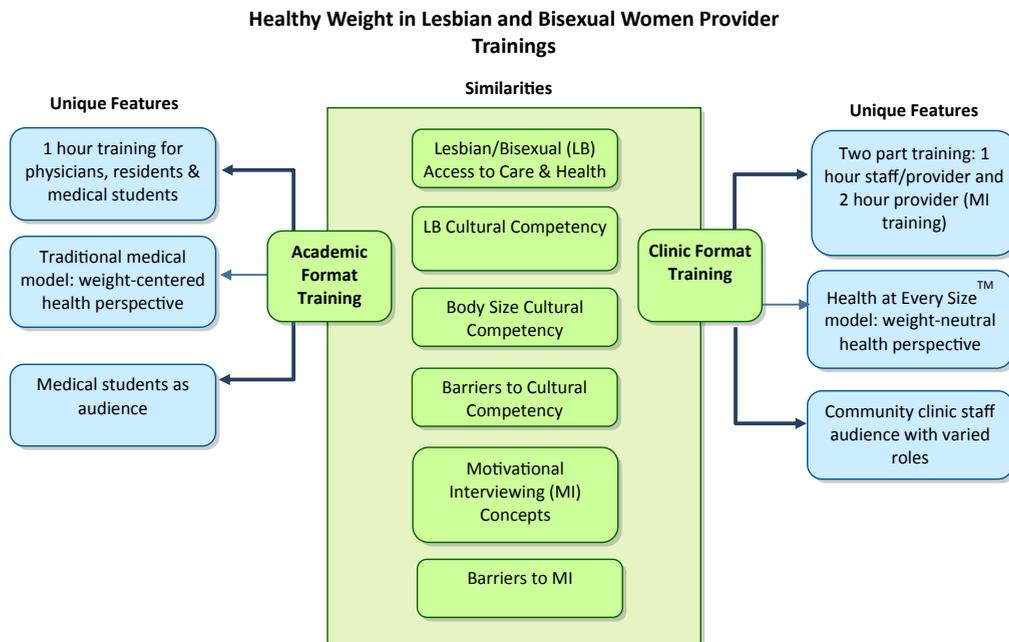


Figure 1. Provider training components for the Office on Women’s Health healthy weight project teams.

This curriculum was pilot tested at LMHS and then offered in two community clinic settings; all were in-person trainings presented by program staff. The evaluation of the single site training using chart review methods is described in a separate manuscript (Ingraham, Minnis & Harbatkin, unpublished data). Key objectives addressed in the Clinic Format trainings were to 1) increase health center staff knowledge of body size diversity and cultural competency; 2) identify barriers LB women who are overweight or obese face in accessing competent and safe medical care; and 3) discuss how to make the clinic a safe and welcoming environment for LB patients who are overweight or obese.

Clinic Format training had two components. The first component was a 1-hour training session on body size diversity designed for any health center staff member who interacted with patients, from front desk staff to medical assistants to licensed primary care and mental health providers. This baseline cultural competency course was intended to be completed before provider-specific training and presented in didactic lecture format with group discussion activities. It did not include LB components, because LMHS staff were expected to have existing cultural competency on LGBT issues as a condition of hire. The training did include debunking stereotypes about obese patients, reviewing HAES principles, and reviewing what makes a health care setting both safe and friendly to patients who are obese. Clinic Format training also included interactive discussion of current policies at the center and how these policies could be improved for patients of size.

The second, 2-hour Clinic Format course at LMHS was designed to teach primary care providers, nurses, and medical assistants how to use MI techniques such as motivation and commitment scales and brief action planning to encourage positive patient behavior change. Designed to build on cultural competency training around body size, this training used MI tools to practice conversations with patients and associated documentation/charting practices. This training was a brief, lecture-style review of MI tools followed by role playing using LB women case examples. Training was attended by clinical care teams, including medical assistants, registered nurses, and nurse practitioners at LMHS.

Information about LB cultural competency was added to the Clinic Format curriculum at LMHS after the program was pilot tested. The curriculum was revised in collaboration with the Academic Format team.

Data presented in this paper are from two Clinic Format trainings outside of LMHS after the curriculum was revised with the Academic Format team. The first community Clinic Format training was conducted in partnership with the California Area Health Education Center program and included 12 staff members at the San Francisco Community Clinic Consortium. The second community Clinic Format training included 22 staff members in Bay Area community health clinics who were part of the San Francisco Community Clinic Consortium AmeriCorps program. A common, standardized pretest/posttest was developed for the revised 1-hour staff training in August and September of 2014; 26 of 34 community participants completed the pretest and the posttest.

Data Analysis

Both the Academic and Clinic Format programs assessed changes in provider knowledge and attitudes about LB barriers to care using a 10-item pretest and posttest measure. Additional

evaluation questions related to MI were included in the posttest to assess intent to change and barriers to change for MI components. Changes in individual participant knowledge (within-person change) before and after trainings were assessed using McNemar's test for paired samples. Differences in participant knowledge between trainings at pretest and posttest were assessed using Fisher's *t* test.

Results

Academic Format Results

Participants in the Academic Format program ($n = 66$) increased their knowledge about the barriers to health care for LB women and learned skills that can facilitate culturally appropriate care for their patients (Table 1). Participants in this program demonstrated significant gains in knowledge about delays in health care for LB women (30 percentage point increase in correct responses from pretest to posttest) and women who are overweight (22 percentage point increase). Knowledge of the unique preferences of LB women regarding questions on patient intake forms (10 percentage point increase) and alcohol use among LB women (28 percentage point increase) also showed significant increases. Gains were also seen in half of the MI knowledge questions (questions 6–10), although this population of medical students and residents seems to have had a high pretest level of knowledge about MI, which may or may not be representative of the average community physician.

Clinic Format Results

Participants in the Clinic Format trainings who completed pretest and posttest evaluations ($n = 26$) reported increased knowledge about patient experiences of LB women and of people of size (Table 1). Participants reported statistically significant increases in knowledge of health care avoidance owing to body size (23 percentage point increase) and patient motivation to lose weight (12 percentage point increase). Additionally, Clinic Format participants reported increased knowledge that universal weight loss instructions for all LB patients from health care providers are not helpful (23 percentage point increase). There were no changes on questions related to patient weight loss motivations or MI goal setting.

Whereas Academic Format training focused on the traditional medical model that promotes weight loss for health improvements in patients who are obese, Clinic Format training attempted to incorporate a more weight-neutral approach using HAES. This is reflected in the vastly different responses for evaluation questions focused on weight loss. In the Academic Format program, participants increased their knowledge on six of the eight questions from pretest to posttesting, compared with three of the eight questions at the Clinic Format program. However, the statistical power for detecting changes at the Clinic Format program is limited owing to the small number of participants. Consistent with MI principles, Academic Format training included information that providers should not directly instruct their patients who are overweight or obese to lose weight. For Academic Format programs, the proportion of participants who correctly identified this information (question 7) increased significantly from pretest to posttraining. It is important to note that participants at the Clinic Format trainings had significantly higher correct knowledge about question 7 at baseline (only 9% of Academic Format participants answered

Table 1
Provider Knowledge and Attitudes Assessments About Cultural Competency and Motivational Interviewing

Knowledge, Attitudes, and Skills Questions	Academic Format (n = 66)			Clinic Format (n = 26)			Academic vs. Clinic	Academic vs. Clinic
	Pretraining, n (%)	Posttraining, n (%)	McNemar p value†	Pretraining, n (%)	Posttraining, n (%)	McNemar p value†	Fisher's Exact Test, Baseline‡ p Value	Fisher's Exact Test, Posttraining‡ p value
Q1. Lesbians and bisexual women may avoid health care because they don't trust the practitioner to be culturally competent.								
Agree*	40 (61)	60 (91)	<.001	20 (77)	23 (88)	.25	<.001	.709
Disagree/neutral	26 (39)	6 (9)		6 (23)	3 (12)			
Q2. Overweight and obese women often delay or avoid health care if they feel their health care provider holds a bias against women who are large.								
Agree*	48 (73)	63 (95)	.003	20 (77)	26 (100)	.03	<.001	.556
Disagree/neutral	18 (27)	3 (5)		6 (23)	0 (0)			
Q3. Most lesbian/bisexual women would appreciate intake forms that ask patients if they are heterosexual/lesbian/bisexual/transgender.								
Agree*	45 (69)	55 (85)	.01	—	—	Not asked	Not tested	Not tested
Disagree/Neutral	20 (31)	10 (15)		—	—			
Q4. I don't believe I should ask my patients about their sexual identity.								
Disagree*	55 (86)	60 (94)	.18	10 (45)	14 (64)	.2	<.001	.0015
Agree/neutral	9 (14)	4 (6)		12 (55)	8 (36)			
Q5. Lesbian and bisexual women are more likely than other women to overuse alcohol.								
Agree*	26 (39)	44 (67)	<.001	—	—	Not asked	Not tested	Not tested
Disagree/neutral	40 (61)	22 (33)		—	—			
Q6. Most overweight/obese patients are not motivated to achieve a healthy weight.								
Disagree*	43 (67)	42 (66)	NS	14 (56)	17 (68)	.05	.337	1.000
Agree/neutral	21 (33)	22 (34)		11 (44)	8 (32)			
Q7. Physicians/nurses should always instruct their overweight/obese patients to lose weight.								
Disagree*	6 (9)	19 (29)	.001	15 (58)	21 (81)	.03	<.001	.005
Agree/neutral	60 (91)	47 (71)		11 (42)	5 (19)			
Q8. Asking if a patient is motivated to lose weight is an important component to helping a patient to lose weight to improve their health.								
Agree*	60 (92)	61 (94)	NS	19 (73)	20 (77)	NS	.034	.029
Disagree/neutral	5 (8)	4 (6)		7 (27)	6 (23)			
Q9. Patients who are advised by their physician how to modify their behavior to lose weight are more likely to lose weight than those who do not get this advice.								
Agree*	49 (78)	57 (90)	.04	12 (46)	15 (58)	NS	.006	.001
Disagree/neutral	14 (22)	6 (10)		14 (54)	11 (42)			
Q10. Setting long-term goals is helpful in encouraging a patient to lose weight.								
Agree*	53 (82)	54 (83)	NS	16 (62)	17 (65)	NS	.059	.092
Disagree/Neutral	12 (18)	11 (17)		10 (38)	9 (35)			

Abbreviation: NS, not significant.

Bold p values are statistically significant at the $p < .05$ level.

* Preferred answer choice.

† McNemar's test of within-person change.

‡ Fisher's exact test of distribution of preferred answer, by site; Clinic Format site.

correctly at baseline, compared with 58% at Clinic Format trainings).

Discussion

Two unique pilot trainings were created to improve the cultural competency and MI skills of health care providers. Goals of the trainings were to improve medical providers' ability to provide high-quality care to LB women who are overweight or obese. However, curricula of the two trainings—Academic Format and Clinic Format—differed greatly in how the relationship between weight and health was conceptualized. Clinic Format trainings used the Health at Every Size™ model and the Academic Format trainings used a traditional model that focuses on weight loss for health improvements.

Results of the Academic Format trainings showed gains in provider knowledge in a traditional format that is adaptable to multiple clinical training environments. It also complements existing MI training offered at an increasing number of medical schools and follows current medical models on treating obesity.

The two-part Clinic Format trainings offered flexibility in terms of audience time and participation level based on expertise, skill level, and position within a clinic environment. The main challenge faced by this program was covering all the necessary topics in a timely manner. LB cultural competency trainings on sexual orientation and gender identity can fill a

1-hour presentation without addressing body size or MI techniques. Although MI requires extensive and repetitive trainings to master completely, simple techniques covered in the trainings (e.g., the use of motivation scales and Brief Action Planning) can be taught in shorter segments. Similar to the challenges of the Academic Format trainings, prioritizing this kind of training among competing demands for medical staff time can be difficult.

Participants in both trainings demonstrated the most change on questions about patient–provider interaction and LB women's avoidance of care, and the least amount of change on the questions related to MI techniques. This aligned with the current training curriculum, which assumed background knowledge of MI basics.

When asked which activities they planned to engage in as a result of this training, most participants indicated intent to seek additional resources about MI, encourage their clinical staff to get more MI training, improve the clinic environment for patients who are overweight, and educate others about cultural competency issues faced by LB patients and patients of size.

In both trainings, the most common barriers to making these changes were 1) not having enough time and 2) not having take-home educational resources for patients. Providers reported that the trainings could be longer to include more time for MI techniques, such as using motivation scales, role plays, and general discussion.

As with most studies testing provider curriculum impact, we did not test actual changes in provider or staff behaviors or patient outcomes. Owing to small sample sizes in both programs and a lack of demographic data collection, we were also unable to test for differences between participant characteristics in relation to their shifts in knowledge. Although our participants did have statistically significant changes, the magnitude of change was small. This was likely owing to a high level of existing knowledge on sexual orientation cultural competency specifically among some providers in our study, although this did vary widely by training location and audience.

Future studies of curriculum impact should include provider behavior or patient impact measures to examine curriculum efficacy. For example, pilot testing of the Clinic Format curriculum at LMHS included a chart review evaluation of MI techniques before and after training and found that providers (nurse practitioners and registered nurses) did show a small but significant increase in usage of MI tools with patients, but short appointment times were a primary barrier (Ingraham, Minnis & Harbatkin, unpublished data).

Moving forward, the most successful parts of each curriculum could be combined into one program and tested with other health care providers or trainees. The combined curriculum would emphasize the core components shared across both trainings: the importance of cultural competency with regard to sexual orientation and body size, and the use of MI as a key tool in respectful, patient-centered care. Additionally, cultural humility could be presented as a next step beyond cultural competency. Cultural humility incorporates self-reflection and life-long learning about other cultures into the cultural competency model, raising ongoing awareness about cultural aspects that may impact health behavior (Prasad et al., 2016). Other potential curriculum aspects include an online training component, such as a self-guided webinar, that could be distributed to a wide variety of audiences that interact with LB women in health care settings, including clinicians currently in practice. Another suggestion is the development of printed material on this topic for both health care providers and LB patients who are overweight or obese.

Implications for Policy and/or Practice

Future research should explore the best ways to incorporate LB women's needs for inclusive, culturally sensitive health care that focuses on health rather than weight, while also including medical provider training on the role of weight as one component of health. Future trainings should also evaluate how and whether other patient factors (e.g., race, class, or religious beliefs) should be addressed in cultural competency training to improve health care for LB women of size. Addressing the diversity and intersections of client identities could greatly enhance provider education programs of this nature.

Additionally, while some quality measures, particularly body mass index, may be required as part of a physical examination by organizations such as the [National Center for Quality Assurance \(2015\)](#), these measures should be implemented carefully. Researchers have criticized body mass index as a measure of health (Tomiyama et al., 2016), and suggest that emphasizing body mass index reduction via weight loss could negatively impact the patient experience for LB women (Hunger, Major, Blodorn, & Miller, 2015).

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