

Cultivating a Weight-Inclusive Environment in Student Health

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Main Points

- Weight stigma is highly prevalent in the healthcare sector. Weight stigma, along with rapid environmental and social changes, can be a driving factor for college-aged students to engage in disordered eating patterns.
- Cultivating a weight-inclusive healthcare environment can decrease anxiety and stress related to medical appointments.
- Educational and evidence-based resources focusing on a weight-inclusive environment can create a positive shift in staff members' understanding of blind weights and internalized weight bias.
- Future recommendations for this project include continued staff education, consistent EMR templates for all visit types, and patient-specific educational materials.

Background and Purpose

Weight stigma is classified as stereotyping a person by their body type, weight, or size (National Eating Disorders Association [NEDA], n.d.). While weight stigma is present in all sectors, it is highly prevalent among today's healthcare professionals (Abbott et al., 2022). This increase in weight stigma among healthcare professionals can be linked to obtaining one's weight as a standard of practice at medical appointments (Froreich et al., 2021). Being openly weighed at medical appointments can lead to increased levels of anxiety and stress, as well as harm one's overall self-esteem and mental health and can even lead individuals to delay or avoid medical appointments (Froreich et al., 2021; Winter et al., 2023). Weight stigma is of particular concern in the college-age group as this population is at increased risk of developing disordered eating habits due to rapid environmental changes, academic stress, and societal pressure through

social media outlets (Tavolacci et al., 2020; Jiotsa et al., 2021). Weight-centered healthcare facilities can be detrimental to this young population as they can increase levels of anxiety and decrease self-worth, thus leaving the individual at a higher risk of engaging in disordered eating habits or avoiding medical appointments altogether (Froreich et al., 2021).

This DNP project aimed to educate college health facilities on the importance of cultivating a weight-inclusive environment, such as incorporating blind weigh-ins. Blind weigh-ins involve the patient being weighed without seeing the scale, removing the potential for weight-based discrimination and providing resources to address weights during medical appointments sensitively. This practice respects the patient's autonomy and helps to reduce the anxiety and stress associated with weight measurement.

Methodology

This DNP project was conducted at a large public university in Eastern North Carolina. The target population included the university's clinic staff: nurses, providers, front desk personnel, and college students enrolled in undergraduate and graduate courses. An educational PowerPoint presentation was created using literature and evidence-based resources provided by the University of Connecticut (UConn) RUDD Center for Food Policy and Health (n.d.). The PowerPoint focused on internalized weight bias, weight stigma within healthcare, and ways to incorporate weight-inclusive policies within the healthcare setting. A pre-survey assessed the staff's knowledge of internalized weight bias and attitudes toward incorporating blind weights within their clinic. A post-survey assessed if the education provided increased staff knowledge and focused on how likely staff were willing to change their practices. Pre- and post-chart reviews were conducted over 11 weeks (excluding one week due to spring break) to assess if, after the education, there would be an increase in the number of patients who were blindly

weighed, as well as the number of visits where providers discussed weight with their patients. Four hundred eighty charts were reviewed for pre-education data and 419 for post-education data. Educational flyers, reminder emails, and blind weight cards were also utilized to increase awareness of weight-inclusive policies.

Pre- and post-survey results were recorded and analyzed through Qualtrics. Results were then entered into Excel for easier viewing. Pre- and post-education chart reviews were performed utilizing the university's electronic medical record. Charts were randomly selected to help avoid any unintentional biases. Information from data collection was documented in a secured Excel spreadsheet. Data collected within the Excel spreadsheet included gender, race, BMI, visit type, provider type, how they were weighed (blinded or visible), and if weight was discussed and documented during their visit. Pre- and post-intervention data was compared using percentages.

Results

- Post-education survey results showed an increase in knowledge regarding internalized weight bias, the importance of weight-inclusive policies in healthcare, and an increase in understanding of the blind weight method.
- Post-education chart reviews did not show an increase in the number of blind weights or the number of patient visits where weights were discussed with the providers. However, this does not diminish the positive impact of the project's results. The significant increase in the staff's knowledge and understanding of weight-inclusive policies in healthcare is a promising sign for future improvements.

Project Strengths and Limitations

Strengths of this project include:

- Staff willingness to implement change
- Involvement of project partners
- Accessibility to data

Limitations of this project include:

- Timing
- Small sample size
- Staff and provider hesitation
- Inconsistent EMR templates
- Limited resources

Implications

While the project did not significantly increase the number of patients being blindly weighed or the number of visits where weights were addressed, it yielded several positive outcomes. The project site received grant money to purchase a blind weight scale, a significant step towards becoming a weight-inclusive healthcare facility. Clinic staff were equipped with evidence-based resources to use in their daily interactions with patients. Moving forward, this project could be easily replicated in college health facilities across the United States and any primary care office, ushering in a new era of healthcare. Future recommendations for this study include mandating staff to complete an internalized weight bias questionnaire to help eliminate any unattended biases that may arise. Additionally, it is recommended that facilities utilize consistent chart templates for all visit types to ensure accurate data collection and analysis.

Conclusion

As mentioned above, while this project did not increase the number of blindly weighed patients, it did increase overall staff knowledge and acceptability of a weight-inclusive environment. This project led to permanent changes within the facility, with the addition of a certified blind weight scale and the opportunity to obtain a second scale soon. These changes demonstrate the facility's commitment to a weight-inclusive healthcare environment.

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