these concerns have mostly gone unchallenged; my article considered which conclusions can—and cannot—be drawn from such arguments. It is crucial to these debates that we take into account not only that smokers have become heavily stigmatized,[1] but also how closely smoking has come to be associated with several forms of disadvantage, including class and poverty,[2] racial and ethnic minority status,[3] and poor mental health[4] (a recent article in *AJPH* also emphasizes the high smoking rates among sexual and gender minorities[5]).

As Dawson and Maziak emphasize, the denormalization of smoking has of course been driven by a range of factors beyond public health policy and regulation, including a better understanding of its risks and harms. However, denormalization is also an explicit goal in many tobacco control strategies and has been endorsed by bodies such as the World Health Organization.[6] That many factors outside of public health policy have contributed to negative perceptions of smokers does not relieve policymakers and public health experts of the responsibility to anticipate possible stigmatizing effects of the strategies they advocate and to make a reasoned judgement about whether any such effects are acceptable. AJPH

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ATTITUDES OF HEALTH CARE PROVIDERS TOWARD LGBT PATIENTS: THE NEED FOR CULTURAL SENSITIVITY TRAINING

This letter is in response to the article written by Sabin et al. concerning the implicit and explicit attitudes of healthcare providers toward lesbian and gay patients in the September 2015 issue.[1] The minimal education that health care providers receive in cultural sensitivity in treating sexual minorities is pertinent because it may be a contributing factor to health disparities within the lesbian, gay, bisexual, and transgender (LGBT) community.[1,2] Research conducted between 2009 and 2010 on 150 medical schools within the United States and Canada reported that only five hours of total medical program hours were dedicated toward LGBT content.[2] According to Johnson and Nemeth, after experiencing providers' discriminative attitudes and biases, lesbian patients sought health knowledge via the Internet instead of attaining a professional recommendation,[3] which can lead to misinformation from unreliable sources. Others disguised their sexual orientation or avoided seeking further care altogether, which can delay health screenings,[3] resulting in an undiagnosed or exacerbated untreated medical illness.[1] The authors' research is appreciated because results highlight the need for change in public health policy that would require clinical training in cultural competency for health care providers in all disciplines when treating sexual minorities[1,3]; thus, obliging the Hippocratic Oath to treat all patients with respect[4] and dignity. AJPH

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SABIN AND RISKIND RESPOND

Garrison and Ibanez emphasize an important point made in our article; that health care providers receive minimal education in cultural sensitivity toward treating the lesbian, gay, bisexual, transgender, and questioning communities. Generally, across disciplines, there is a lack of attention to developing core competencies in knowledge and clinical skills for treating this health disparity population.

Research shows that there is a need to teach health care providers who are in training about competent care of sexual minority populations but that many educators themselves do not have the knowledge and skills to teach this information.[1–3] With curriculum revision under way in many fields, it is time to develop core competencies in knowledge about the health of the lesbian, gay, bisexual, transgender, and questioning populations and core clinical competencies in care of the lesbian, gay, bisexual, transgender, and questioning communities.

This content should be integrated throughout educational programs in all clinical and nonclinical health sciences disciplines. Integrating this content in nonclinical health sciences training will provide a foundation that is likely to assure inclusion of

lesbian, gay, bisexual, transgender, and questioning populations in future health and health care disparities research. There is a need to develop and evaluate impact of educational models that effectively integrate knowledge and skills related to health care of sexual minority populations longitudinally across curricula in all health sciences disciplines. AJPH

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CATEGORIZATION OF FREQUENT EMERGENCY DEPARTMENT USE IN AN INSURED HOMELESS POPULATION

The recent article by Lin et al. provides an important analysis of frequent emergency department (ED) visits and hospitalizations among individuals who are homeless and have Medicaid.[1] They presented interesting findings regarding implications for Medicaid expansion in this population, such as potential adoption of the Health Home option. However, their definitions of frequent ED visits and hospitalizations were not clear, even though these were their outcomes of interest. The authors specified that they were going to focus on the number of events rather than classify individuals as low or high users. Later, they referred to "frequent hospitalizations or ED visits" for the regression analysis, but no clear definition was provided. What was the definition of "frequent" that the authors used in this analysis? We know from experience at the University of Florida that some people frequent the ED as often as three times per day.

Individuals who use the ED frequently have typically been classified in the literature as users with four or more ED visits in a one-year period.[2–6] Considering this, it seems unusual that in the results, three to five ED visits were grouped together. Their categorization seems arbitrary, as no justification was provided for this grouping. Could the authors please explain what was taken into account when categorizing these variables? This is important to consider, since the current grouping may actually include both nonfrequent ED users and frequent ED users. Literature has shown that these two groups are significantly different and should be differentiated to reduce frequent ED use.[2,4] AJPH

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LIN ET AL. RESPOND

We appreciate Milani's question regarding the definition of frequent emergency department (ED) visits in our article. According to several articles cited by Milani, along with the studies cited by these articles, thresholds range from as few as two to 12 or more visits per year. Although many studies use four or more ED visits to define frequent ED use for the general population, there is currently no commonly agreed upon definition as noted in these articles and literature. The threshold depends on the purpose of the study, the distribution of data, and the consideration of policy implications. Homeless individuals experience much higher health care utilization than the general population.[4,5] The average number of ED visits in our study reached four visits per year and a group of individuals showed high ED use. Therefore, we classified homeless individuals into four groups (0, 1–2, 3–5, and ≥ 6 ED visits). These four groups were significantly different, which is consistent with existing literature.

Furthermore, the patterns of incremental changes in population characteristics along with increased ED use did not present an obvious single threshold to separate the study population. Instead of simply dichotomizing the study population, we modeled the number of ED visits as count data to avoid losing important information, particularly for extremely high users. Results were presented in incidence rate ratios, which represent the ratio of the count of ED visits for the variable of interest to its reference group. For example, the number of ED visits for individuals with co-occurring schizophrenia and substance use disorders was almost eight times higher than for those without behavioral health disorders. In other words, the former group experienced much more frequent ED visits than the latter group when other variables were held equal.

The high health care utilization for homeless individuals prompted us to examine the number of events rather than relying on the conventional dichotomous group approach. Along with the descriptive analysis