Parent Perspectives on Messages to Be Delivered After Nutritional Assessment in Pediatric Primary Care Practice

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PURPOSE

Guidelines for the prevention of childhood overweight and obesity call for annual assessment of nutritional status and counseling on healthy lifestyles.[1] This pilot study tested an office systems change approach[2] to engage practices in applying methods for rapid identification and documentation of nutritional status, and methods for assessment of and counseling on family dietary and physical activity patterns. This article presents lessons learned from parent focus groups that reviewed proposed handouts to be used by clinicians to promote healthy dietary and physical activity habits for families.

METHODS

The project applied a practice systems intervention and cross-sectional evaluations at preintervention and postintervention periods to measure office systems processes, care delivery, and parental responses to care delivery. The intervention focused on the education of clinicians and staff regarding assessment of the nutritional status of children and implementation of the routine use of tools (growth charts, chart prompts, and handouts) to promote the assessment and counseling process. The project was conducted in 4 diverse pediatric practices belonging to the Pediatric Practice Research Group, a Chicago-based primary care research network.[3] Two practices served low-income clients, and the other 2 served privately insured patients.

Culturally sensitive, age-appropriate handouts were developed to guide and reinforce counseling recommendations for health supervision. A team of nutrition experts developed basic handout models including advice on parental modeling, physical activity, dietary practices, and television viewing. Seven handouts specific to age-group and nutritional status (underweight or normal weight/overweight) were developed and discussed in the focus groups. Handouts that discussed children younger than 2 years included sections on development and feeding. Handouts for older children and their parents had 4 sections. The first section encouraged parents to be active (eg, take the stairs or walk to the store) with their children and to model a healthy way to live. The second section focused on the child's physical activity and included suggestions on ways to be active in the home and community. For underweight children and younger children, this section was titled "Get Moving Every Day!" For the older children who were not underweight, this section was titled "Get Sweaty Every Day!" A goal of 20 to 30 minutes of daily active exercise for children aged 6 years or older was recommended. The third section was titled "Turn Off the TV!" It called for limiting television and computer time to 1 to 2 hours per day. The final section was titled "Eat Healthy as a Family!" and focused on meal structure and dietary content.

We used 3 focus groups, including low- and middle-income English- and Spanish-speaking black, Hispanic, and white parents, to assess reactions to the proposed handouts. The focus groups' comments were audiotaped, transcribed, and reviewed for content. Two members of the nutrition team categorized focus group responses and presented these to the research team, which later revised the handouts accordingly (the revised versions can be found at http://www.childrensmrc.org/pprg/resources).

LESSONS LEARNED

Parents thought that handouts provided needed information, but that achieving some of the suggested behaviors would be difficult. Parents stated, "This talks about how it's supposed to be … but me as a parent, it's not like that," and "Eating as a family is like the

hardest thing to do on this list, which is funny because it's also the most important thing, I think." Another parent commented that the suggestion "start the day with breakfast" was good because it gives the message of "at least try." These quotes highlight the fact that parents are aware of recommendations but face barriers implementing them and need suggestions about how to accomplish goals in small, manageable steps.

Many parents believed that handout concepts and counseling should strongly present health consequences. One parent stated, "If you eat this, this is going to happen. If you eat this other way, this is going to happen." Others suggested, "…lack of exercise can give you a heart attack…," and "Tell parents what could happen if they don't follow good eating habits. For example, getting obesity and diabetes and heart disease and hypertension and stuff like that." Counseling focused on health consequences is the strategy recommended for those in the precontemplation stage of change.[4] Given the focus groups' responses, parental readiness to change regarding family habits may be in earlier stages than has been reported in adult populations about their own dietary behaviors.[5] Because children may be less able to understand and respond to health messages that present future consequences,[6] using this strategy for children or when the child and parent are counseled jointly needs further evaluation.

Most parents agreed that they model health behaviors for their child. They liked the statement "Parents lead the way." They agreed that it meant leading by example. Some of their comments included, "It means it's not what we say, it's what we do," "Parents are teachers. If you don't teach them, someone else will," and "… the kids are always doing what you are doing, and saying what you are saying, so you have to be careful what you say or do because the child is always … mocking [imitating]." Reminding parents that they are role models is important,[7] as parents believed that this point may enhance their willingness to make behavior changes. There are no studies that have identified effective strategies for pediatric clinicians to enhance parental modeling of healthy dietary and physical activity habits.

Written messages had multiple interpretations for parents. They worried about how children would respond to the physical activity message "Get sweaty every day." Most parents didn't like the use of the word sweaty. Some commented, "Girls don't want to get sweaty, stinky. I would suggest 'get your heart pumping every day,'" and "I don't like the use of the word sweaty because that means something sexual."

Parents wanted dietary information specific to their child's needs. They suggested including items such as "Ask your pediatrician how many calories your child should have," or "Ask your pediatrician what is a good balanced meal according to each child's needs." Parents liked the idea of presenting "quick ideas, for example, start a day with a bowl of cereal." Parents believed that handouts were a starting place for clinician instruction and that personalization to the individual family and child was necessary.

Parents were hesitant about recommendations to limit TV viewing and computer use, in part because they believed that some TV and computer use is educational and useful for getting general information. Parents thought that the suggestion to limit television viewing to 1 to 2 hours per day was too restrictive. One parent stated, "Getting the children into other activities is difficult. Children want to watch more television. They don't want to go outside." Also, parents reacted to "limiting screen time" by suggesting separating the recommendation of computer and television time. Parents perceived that there is a beneficial educational component in TV viewing, as supported by research.[8] "There are some times when computer is educational and for homework," one parent said. Parents preferred that "a suggestion will be limit the time and the type of programs." There are no published reports of parental responses to clinical guidelines to limit television-viewing time for children.[9] Further examination of parental response in this area is needed with revisions of guidelines to account for the inclusion of media methods in the educational process.

CONCLUSION

Parental responses to handouts promoting healthy dietary and physical activity habits revealed the complexity with which recommendations can be interpreted and, for some topics, disbelief that such recommendations are possible or wise. Clinicians will need to interpret health behavior recommendations in light of parental beliefs and provide suggestions for small steps for behavior change. Counseling strategies for parents and children are likely to differ, and ways to effectively counsel both parties jointly need to be explored.

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The Action Plan Project: Discussing Behavior Change in the Primary Care Visit

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PURPOSE

Often, clinicians fail to discuss health-related behaviors during ambulatory visits.[1] An action plan is a structured tool that may assist clinicians in initiating such discussions.

An action plan is an agreement between a patient and a caregiver that the patient will attempt a concrete, specific behavior change; for example, a patient may choose to walk twice around the block after lunch on Mondays, Wednesdays, and Saturdays. Action plans are designed to accomplish a small behavior change with a high likelihood of success rather than a large change that is difficult to achieve. According to several studies, when patients can achieve a small success, their self-efficacy (self-confidence in the capacity to make positive lifestyle changes) increases; self-efficacy has been correlated with improved health-related behaviors and clinical outcomes.[2-5]

The objective of the Action Plan Project was to determine the following: (1) whether primary care clinicians would use a new method—the "action plan discussion"—to encourage patients to set goals for health behavior change, (2) whether this new method could be successfully accomplished in the 15-minute primary care visit, (3) whether clinicians found the method to represent an improvement over previous behavior change discussions with their patients, and (4) whether patients would adhere to their behavior change goals.

This preliminary paper summarizes the methods used to investigate these questions and some lessons learned. Detailed results are forthcoming.

METHODS

Forty-three primary care clinicians at 8 primary care sites (4 safety-net clinics and 4 private practices) in the San Francisco Bay Area participated in the project. Clinicians received a 45- to 60-minute training session to describe the intervention and intervention tool—the