



# Constraints to implementing guidelines for the identification, assessment, and management of childhood obesity in the clinical care setting: Prevention and treatment framework

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## ARTICLE INFO

### Keywords:

Child obesity  
Health care providers  
Prevention and control  
Risk assessment

## ABSTRACT

The “Pathway for the Identification, Assessment and Management of Overweight and Obese Children & Youth” was developed to support healthcare providers in identifying and treating childhood obesity in British Columbia (Canada).

**Purpose:** The study aimed to determine the feasibility and effectiveness of using the Pathway in clinical settings. **Methods:** 13 healthcare providers (7 family physicians, 2 pediatricians, 2 registered dietitians, and 2 nurse practitioners) assessed the Pathway and participated in semi-structured interviews in 2015. A direct constant comparative analysis guided the coding of the interviews in the NVivo 9 software.

**Results:** The interviews uncovered the complexity of factors that influenced practices of healthcare providers. Three broad issues were identified as required if the “Pathway” were to be used and fully implemented in practices. First, the “Pathway” needs to be modified in terms of how it is presented and explained and be supplemented with appropriate documentation and resources for its implementation. Second, the constraints that limit implementation need to be addressed and should include a focus on both individual (i.e., the healthcare providers themselves) and environmental (i.e., factors within and outside of providers' organizations) factors. Lastly, there is a need to establish processes and/or infrastructure for adapting the “Pathway” to the local context as resources and supports vary by organizations and regions.

**Conclusion:** Healthcare providers should be involved in screening and managing childhood obesity. Addressing the challenges found in this study will enable healthcare providers to take a more active role in addressing childhood obesity in their day to day practices.

## 1. Introduction

Childhood obesity has been identified as a serious health concern in Canada and worldwide (Belanger-Ducharme and Tremblay, 2005). According to a recent survey, almost 1 in 3 Canadian children between the ages of 5 to 17 are either overweight or obese (Roberts et al., 2012). As a result, these children are at increased risk for a series of health issues such as type 2 diabetes, cardiovascular risk factors, hypertension and psychological issues (Singh et al., 2008; Going et al., 2011; Zalesin et al., 2008; Hopkins et al., 2011; Reilly et al., 2003).

As the majority of children seek medical treatment from their family physician (Mazur et al., 2013), the primary care setting provides an ideal opportunity for screening and treating for childhood obesity.

More specifically, about 84% of Canadians aged 12 or older reported having a regular family physician with between 8 in 10 contacting their doctor per year (Statistics Canada, 2013). Therefore, early detection of weight-related health issues by physicians is ideal since childhood obesity often tracks into adulthood (Singh et al., 2008).

Despite limitations that are well recognized, Body Mass Index (BMI) is accepted as a screening tool for obesity (Centers for Disease Control and Prevention, 2012). However, measurement of BMI is rarely undertaken for obesity screening in children (Hopkins et al., 2011; Mazur et al., 2013; He et al., 2010). Instead, 90% of healthcare providers report relying on their professional judgment (visual cues) to assess patients at risk for obesity which has led to many inadequate assessments of child weight status (He et al., 2010; Spurrier et al., 2006). In the past,

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<https://doi.org/10.1016/j.pmedr.2018.08.016>

Received 16 April 2018; Received in revised form 2 August 2018; Accepted 26 August 2018

Available online 30 August 2018

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only a small number of healthcare providers (30%) have reported using the recommended BMI-for-age-reference tool for classifying overweight/obesity (He et al., 2010). Despite recognizing the need to screen for childhood obesity, healthcare providers have identified the following barriers, including: beliefs in their capability to address the problem efficiently, lacking the skillsets to counsel children and their families about weight management, discomfort in dealing with weight related issues, being unable to engage parents on this issue, and lack of reimbursement for counseling and managing obesity in their practice (Hopkins et al., 2011; Mazur et al., 2013; Rand, 2014; Story et al., 2002; Krebs et al., 2007). However, when physicians have been specifically trained to address childhood obesity in their day to day practice, they were more likely to measure BMI, report BMI percentiles, and follow obesity prevention guidelines (Klein et al., 2010; Shaikh et al., 2013).

The most recent set of guidelines (2015) put forth by the Canadian Task Force for Preventive Healthcare (Care CTFoPH, 2015) provides recommendations for growth monitoring and the prevention and management of overweight and obesity in children and youth in primary care. To assist practitioners in interpreting these recommendations, Child Health BC (CHBC) worked with key provincial partners to arrive at consensus on the key components to include in a care pathway for overweight and obese children and youth in British Columbia Canada (BC). As a result, the “Pathway for the Identification, Assessment and Management of Overweight and Obese Children & Youth” (see Appendix A) was developed. Specifically, the “Pathway” is a tool that guides healthcare providers in the assessment of BMI, lifestyle habits (physical activity, nutrition, and sedentary behaviours), risk factors (family history and health history), and motivational readiness to change health behaviours. Healthcare providers move along the “Pathway” based on their assessments and are given various courses of action to help the child and their families live a healthier lifestyle. Therefore, the “Pathway” has the potential to be a valuable resource in the healthcare setting when it comes to managing obesity.

The purpose of this qualitative study was to understand the factors that facilitate or impede the implementation of the “Pathway” in various healthcare practice settings within British Columbia (BC). In particular, the study focused on healthcare providers' perspectives with regards to the ease of using this tool in their practice as well as their perceptions of barriers and facilitators to implement the tool in their practice.

## 2. Methods

### 2.1. Participants

Healthcare providers in BC were invited to participate in the study, if they met the following inclusion criteria: be a family physician, general pediatrician, nurse practitioner, or registered dietitian who sees an average of five or more patients per week between the ages of 2–17 years, fluent in English, and able to implement or try out the “Pathway” in their practices. Recruitment of healthcare providers in BC was initiated through means of purposive sampling and presentations made by members of the project advisory committee. A total of 32 healthcare providers were initially invited to participate in the interviews (41% response rate). Initially, we planned to interview 15 healthcare providers (8 family physicians, 2 pediatricians, 2 registered dietitians, and 3 nurse practitioners); however, recruitment was stopped at 13 since theoretical saturation was reached. Additionally, representation of healthcare provider selection was ensured across different practice settings (urban, suburban, and rural) (see Table 1).

### 2.2. Protocol

Healthcare providers were provided with the “Pathway” and were asked to implement it in five or more pediatric patients. The “Pathway” provided a visual guide for healthcare providers in identifying,

**Table 1**  
Demographic characteristics of healthcare providers (N = 13).

		N (%)
Types of provider	Family physicians <sup>a</sup>	7 (53.8%)
	Pediatricians	2 (15.4%)
	Registered dietitians	2 (15.4%)
	Nurse practitioners	2 (15.4%)
Location of practice	Urban	7 (53.8%)
	Suburban	3 (23.1%)
	Rural	3 (23.1%)
Years of experience	1 to 10 years	7 (53.8%)
	11 to 20 years	1 (7.7%)
	21 + years	5 (38.5%)
Sex	Male	5 (38.5%)
	Female	8 (61.5%)

<sup>a</sup> Note: we interviewed 1 family practice resident as the informant had interest in implementing the “Pathway” during the family practice rotation.

managing, and treating childhood obesity (see Appendix A). The “Pathway” was supplemented with: 1) a 1-page explanation to support implementation in practice, 2) a list of provincial programs providers can refer their patient to or patient can self-refer themselves to (i.e. the MEND and Shapedown BC programs were in-person programs that provide lifestyle modification interventions and the HealthLink BC Eating and Activity Program for Kids was a telephone counseling program (see Appendix A for further description of these programs); and 3) a link to a website that included resources for both practitioners and families. Importantly, the province ensured that all providers/families would have access to at-least one program. Semi-structured interviews commenced after each provider had gained practical experience with its use. Interviews began by asking participants questions about the “Pathway” and what they currently do in their practice. The second set of questions, informed by Diffusion of Innovations Theory (Rogers, 2003; Rogers, 1983; Rogers, 1995), asked participants to discuss specific attributes that facilitated or limited implementation of the “Pathway” (i.e., relative advantage, complexity, observability, compatibility, and usability of the tool within their practice). The second set of questions, informed by Organizational Theories (Steckler et al., 2002), asked participants to identify characteristics of their environment that impede or facilitate implementation. Concepts included in the interview were *organizational capacity* to implement the “Pathway”, *environmental influences* that affect the implementation of the “Pathway”, *linkage systems and agent* and their ability to refer their patients to other healthcare providers, and *level of institutionalization* of the “Pathway” (i.e. implementing the “Pathway” as routine practice in their practice). The last set of questions, informed by Social Cognitive Theory (Bandura, 2001), asked participants whether they felt they had the skills or resources to implement the “Pathway.” These questions focused on the participant's behavioural capacity and self-efficacy or confidence in using the “Pathway.”

The principal investigator along with another research member conducted the interviews from the end of February 2015 to the end of July 2015. The 60-min interviews were administered via telephone or in-person. Each healthcare provider received a monetary incentive for their participation based on sessional fees for each profession.

This study protocol was approved by the University of British Columbia Children's and Women's Research Ethics Board (H14-01735) as well as by the Vancouver Island Health Authority, Provincial Health Services Authority/Interior Health, and the Fraser Health Authority Ethics Board.

### 2.3. Data analysis

Interviews were recorded with permission from providers and transcribed verbatim. The principal investigator along with two staff coded the first three interviews to develop the coding scheme and

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