



Following Suit: Using *Conversation Cards* for Priority Setting in Pediatric Weight Management

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ABSTRACT

Objective: To describe families' selections of *Conversation Cards* (CCs), a priority-setting tool in pediatric weight management, and examine CC-related differences based on families' anthropometric and sociodemographic characteristics.

Methods: A retrospective medical record review was conducted of 2- to 17-year-olds with obesity and their families who enrolled in a pediatric weight management clinic between January, 2012 and September, 2016.

Results: Medical records of 146 children were included. On average, families selected 10 ± 6 CCs (range, 3–32 CCs); only 50% of families ($n = 73$) indicated perceived readiness to make healthy changes. Adolescents (vs children) revealed less healthy eating behaviors ($P = .001$) and physical activity habits ($P = .002$). Goal setting was perceived to be a motivator across several sociodemographic characteristics (all $P < .05$).

Conclusions and Implications: The CCs were useful in describing families' priorities. The diversity of issues identified by families highlighted the importance of multidisciplinary expertise in pediatric weight management.

Key Words: family, goals, lifestyle, motivation, pediatric obesity, healthy eating, physical activity (*J Nutr Educ Behav.* 2017;49:588-592.)

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INTRODUCTION

Obesity is a complex public health issue that influences the health and well-being of an increasing number of children and adolescents¹ and remains a difficult topic for many health care providers (HCPs) and families to discuss.² Health care providers expressed difficulty in counseling families with regard to weight management as well as nutrition and physical activity habits.² In particular, they reported a range of barriers, including a lack of motivation, time, and support services.³ Along these

lines, HCPs identified a need for educational tools to support their clinical work in pediatric weight management, especially with regard to enabling constructive conversations and informing care.^{4,5}

In 2012, *Conversation Cards* (CCs)⁶ were developed to foster priority setting for behavior change for families enrolled in pediatric weight management and to stimulate communication and collaboration between HCPs and families. As such, CCs were developed and applied for 2 primary reasons: first, to help families think about and prior-

itize key challenges and issues that they believed were relevant to pediatric weight management; and second, to serve as practical points of reference for HCPs at treatment initiation and during future clinical encounters, which could assist in tailoring treatment plans for families based on their priorities that often evolved over time.

Informed by a knowledge synthesis⁷ and qualitative data,⁸ a deck of CCs contained 44 cards organized across 6 categorical suits, including communication, interpersonal relationships, nutrition, parenting, physical activity, and weight management. The cards included a number of common topics (eg, child behavior, child-parent relationship, role of HCPs) in which families often desired support. Each card contained an individual statement within 1 of the suits and was worded positively (eg, Ongoing contact with our clinician keeps us motivated) or negatively (eg, I feel overwhelmed and lack support). *Conversation Cards* were well received by families and HCPs and were easily integrated into the practices of HCPs working in pediatric weight management.⁶

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The purpose of the current study was to investigate families' use of CCs in a family-centered, multidisciplinary pediatric weight management clinic. More specifically, the objectives of this medical record review were to describe families' selections of CCs and examine whether family characteristics varied according to the number and type of CCs selected.

METHODS

This study was a cross-sectional, retrospective medical record review. The researchers optimized methodological rigor along with data accuracy and completeness when retrieving information by adhering to established recommendations for performing medical record reviews (eg, using a standardized electronic form for data collection, training a data abstractor and data auditor, completing an independent data audit).⁹ Data retrieved from medical records were established after team meeting consultations (MK, SD, and GDCB). The data abstraction form was created and managed using Excel (Office 2016 for Mac; Microsoft Corp., Redmond, WA) and consisted of variable entries organized in an order similar to that found in the original medical records. The form was modified as needed, after a 1-day training period of the data abstractor and data auditor, which included (1) a revision of the included variables and the format of the abstraction form, (2) pilot-testing the abstraction form using a random sample of data from 5 medical records, and (3) a joint revision of the coding and consensus on any discrepancies (eg, clear operationalization of variables, consistency in data recording styles).

Data Collection

Data were retrieved from all families (consecutive sampling) who enrolled in pediatric weight management at the Pediatric Centre for Weight and Health between January, 2012 and September, 2016 and whose medical records contained CC-related information. The clinic provided care to 2- to 17-year-olds with an age- and sex-specific body mass index (BMI) \geq the 85th percentile¹⁰; all children included in the current study satisfied these criteria.

After referral for weight management by local physicians, families attended a monthly group-based orientation session in which they were informed about available services at the clinic. At this time, CCs were made available to attendees. A clinical or research team member instructed families to select and document the cards that reflected their priorities (enablers or challenges) for weight management; families were not limited by the number of cards they could choose. Upon completion, families' card choices were collected and inserted into children's medical records, which allowed HCPs to gain insight into families' priorities before their first clinical appointment. Baseline anthropometric (eg, children's height and weight) and sociodemographic (eg, ethnicity, family income) data were retrieved from children's medical records using a standardized protocol.^{11,12} To optimize data accuracy and rigor, a 10% random sample of records was audited independently (by SD) after all data were retrieved (by MK). Across all variables, there was high internal consistency (Cronbach $\alpha = .89$) and reproducibility (intraclass correlation coefficient = 0.89). Any discrepancies were discussed by MK and SD, verified, and agreed on by consensus. This study received research ethics approval by the Human Research Ethics Board at the University of Alberta (Edmonton, Alberta) and operational approval from Alberta Health Services (Stollery Children's Hospital, Edmonton, Alberta).

Data Analysis

Children's height (in centimeters) and weight (in kilograms) were used to calculate BMI, BMI percentiles, and BMI z-scores. Descriptive statistics (eg, means, SDs, proportions) were performed for anthropometric, sociodemographic, and CC data. Differences in CC selections (frequency and type) were examined across the following groups: (1) age at baseline assessment, <13 years (children) vs ≥ 13 years (adolescents); (2) sex, male vs female; (3) ethnicity, Caucasian vs non-Caucasian; (4) weight status, overweight (+1 BMI SD units) and obese (+2 BMI SD units) vs severely obese ($\geq +3$ BMI SD units)¹⁰; (5) enrollment status, discharged vs active; (6) dropout time point, <7

vs ≥ 7 months (median split¹³); (7) parental education, postsecondary vs less than postsecondary; and (8) household income, $< \$80,000$ vs $\geq \$80,000$ (CDN). Group differences for categorical data were examined using chi-square test of independence or Fisher's exact test, where applicable. SPSS (version 24.0; SPSS, Inc, Chicago, IL) was used for data analysis, and group differences at $P < .05$ were considered statistically significant.

RESULTS

This medical record review yielded a sample of 146 participants for inclusion (Table), which represented 48% of the total sample ($N = 307$) of children who enrolled in the clinic during the study time frame. Parents were primarily female (89%) and Caucasian (69%); approximately one half completed postsecondary education (51%) and had an annual household income of $\geq \$80,000$ (CDN) (46%). On average, families selected 10 ± 6 cards (range, 3–32 cards), including equal proportions of positively and negatively worded cards. When CCs selected by families were grouped according to suit and rank-ordered from most to least popular, they were organized accordingly (percentage of total selected cards): nutrition (25%), physical activity (24%), parenting (24%), interpersonal relationships (23%), communication (20%), and weight management (19%). Each of the 44 cards in the deck was selected at least 7 times. The top 5 most frequently selected CCs (Figure) included (1) families' readiness to make healthy changes ($n = 73$; 50%), (2) the benefit of involving children and adolescents in discussions ($n = 61$; 42%), (3) the importance of children and adolescents in sharing their thoughts ($n = 59$; 40%), (4) wanting to learn how to make healthy foods fun ($n = 57$; 39%), and (5) the desire for a specially trained fitness instructor to work with children and adolescents ($n = 56$; 38%).

Categorical analyses generated a number of noteworthy differences among groups based on their card selections. Specifically, (1) compared with children, a greater proportion of adolescents disliked exercising ($\chi^2 = 9.4$; $P = .002$) and bought fast food in the absence of their parents

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