



ELSEVIER

School-Based Health Center Providers' Treatment of Overweight Children



Heather Aldrich PhD^a, Bonnie Gance-Cleveland PhD, RNC, PNP, FAAN^{a,*},
Sarah Schmiede PhD^b, Danielle Dandreaux PhD^c

^aCollege of Nursing, University of Colorado Anschutz Medical Campus, Aurora, CO

^bDepartment of Biostatistics and Informatics, University of Colorado Anschutz Medical Campus, Aurora, CO

^cCenter for Improving Health Outcomes in Children, Teens, and Families, College of Nursing and Health Innovation, Arizona State University, Phoenix, AZ

Received 2 April 2014; revised 15 May 2014; accepted 16 May 2014

Key words:

School-based health centers;
Childhood overweight and
obesity treatment;
Guideline adherence

This descriptive study was to determine self-reported treatment practices of school-based health center (SBHC) providers when caring for overweight/obese children. Providers ($N = 33$) from SBHCs in 6 states (AZ, CO, NM, MI, NY, and NC) completed a baseline survey before being trained on obesity recommendations. SBHC providers reported patient/parent barriers to be more significant to treatment than clinician/setting barriers ($p < 0.0001$). Most providers (97%) indicated childhood overweight needs treatment, yet only 36% said they initiate treatment in children who do not want to control their weight. SBHC providers also did not commonly refer overweight/obese children to specialists.

© 2014 Elsevier Inc. All rights reserved.

OBESITY AND RELATED chronic illnesses threaten the health of children in epidemic proportions and are especially concerning in ethnic minority populations. Overweight is defined as a body mass index (BMI) greater than or equal to the 85th percentile, but less than the 95th percentile and obesity is a BMI greater than or equal to the 95th percentile (Barlow, 2007; Ogden & Flegal, 2010). The National Health and Nutrition Examination Survey monitors the prevalence of overweight and obesity in the United States and the most recent data indicated that 34% of children 6–11 years old are overweight or obese and 18% of those are obese (Ogden, Carroll, Kit & Flegal, 2014). There has been no significant change in the prevalence of obesity for this age group over the past 10 years (Ogden et al., 2014). Health disparities are

also prevalent in the national statistics—of the children aged 6–11, 38% of non-Hispanic blacks and 46% of Hispanics are classified as overweight or obese compared to 29% of non-Hispanic white children (Ogden et al., 2014).

In a recent study by Cunningham, Kramer, and Narayan (2014), using data from the Early Child Longitudinal Study, the heights, weights, and demographic variables of 7738 children were followed from kindergarten through eighth grade. This study found that the prevalence of overweight and obesity increased as children get older. The data indicated that 12.4% of children entering kindergarten were obese, and by the time the children reached eighth grade, 20.8% were obese. Additionally, this study found Hispanic children had a higher prevalence of obesity at all ages compared to non-Hispanic white children; and by third grade, non-Hispanic black children had a significantly higher prevalence of obesity than non-Hispanic white children. Children from the wealthiest 20% of families were also found to have a lower prevalence of

* Corresponding author: Bonnie Gance-Cleveland, PhD, RNC, PNP, FAAN.
E-mail address: bonnie.gance-cleveland@ucdenver.edu.

obesity in kindergarten than those of other socioeconomic groups, and these differences increased through eighth grade (Cunningham et al., 2014).

Poor, underserved, and ethnic minority youth have been shown to be most at risk for obesity and related chronic conditions (Freedman, Khan, Serdula, Ogden & Dietz, 2006), which can lead to increased risk of diabetes, hypertension, cardiovascular disease, and some cancers as an adult (Park, Falconer, Viner & Kinra, 2012; Reilly & Kelly, 2011). School-based health centers (SBHCs) provide care to the underserved populations. SBHCs are clinics housed in or linked to a school that provide integrated care with medical, mental health, social services, and sometimes dental health services on the school campus, making this an ideal setting for reaching those most affected by obesity-related health disparities (Keeton, Soleimanpour & Brindis, 2012). According to the most recent survey by the School-Based Health Alliance, there are approximately 1930 SBHCs in the United States (Lofink et al., 2013). By increasing accessibility to health care on school grounds, SBHCs have been shown to positively influence a variety of physical and mental health outcomes for children and adolescents including immunizations, oral health, asthma, reproductive health, health promotion, and illness prevention (Keeton et al., 2012).

Expert panels have published evidence-based guidelines for the prevention and treatment of childhood obesity (Barlow, 2007; NAPNAP, 2006). The guidelines include methods to encourage healthy eating, increase activity, and decrease inactivity using family-centered counseling such as motivational interviewing and culturally-sensitive care. Despite the publication of these guidelines, research suggests that adherence to following obesity treatment guidelines is poor among primary care providers (Mazur et al., 2013; Rausch, Perito & Hametz, 2011; Sharifi et al., 2013).

SBHCs serve a population of children who have a high-risk of obesity and related chronic conditions, yet little is known about overweight/obesity treatment practices of SBHC providers. The purpose of this study was to describe the self-reported treatment practices of SBHC providers in six states prior to a larger intervention study training providers on the current obesity care guidelines. Specific research questions included: (1) What were the attitudes and barriers to treatment of overweight/obese children seen in SBHCs? (2) When did providers in SBHCs initiate treatment for overweight/obese children? (3) How did providers approach treatment of overweight/obese children and when did they refer children for specialist care?

Methods

Sample

Providers ($N = 33$) were recruited from SBHCs in six states: Arizona ($n = 7$), Colorado ($n = 4$), Michigan ($n = 5$), New Mexico ($n = 6$), New York ($n = 5$), and North Carolina

($n = 6$). To be included, providers had to serve children 5–12 years old at their SBHC, and a mixture of urban and rural clinics were recruited. Human subject approval was obtained following Institutional Review Board (IRB) protocol for each location (Dandreaux et al., in press).

Data Collection

Providers completed the International Life Science Institute (ILSI) Research Foundation Assessment of Overweight in Children and Adolescents survey using Teleform bubble sheets (Verity Software Inc, Vista CA). The survey assesses attitudes, barriers, skills, approaches to assessment, and treatment methods of practitioners who work with overweight/obese children or adolescents. Providers' self-reported responses to the treatment-related questions will be presented in this paper. The term overweight in the survey includes any patient with a BMI greater than or equal to the 85th percentile, unless otherwise indicated. Most survey questions use a 5-point Likert scale for practitioners to rate their responses (most of the time, often, sometimes, rarely, and never). Additional details on the survey development can be found in a paper by Trowbridge and colleagues (Trowbridge, Sofka, Holt & Barlow, 2002).

When complete, providers mailed or faxed their survey back to the research team. The Teleform bubble sheets were scanned using optical character recognition software into an SPSS database (Version 20, Armonk, NY). All scans were verified for accuracy by a research assistant and a random sample of 20% of the scanned results were double checked by another research team member.

Data Analysis

For survey questions using five Likert scale categories, the five categories were collapsed to three—most of the time/often, sometimes, rarely/never. Most of the time was combined with often and rarely with never since clinical implications for the different categories were minimal. Descriptive statistics were calculated for ILSI survey questions and provider demographic characteristics. For barriers, a mean composite was created for patient/parent-related barriers and clinician/setting-related barriers, and then means were compared using a paired samples *t* test. Data analysis was conducted in SAS (Version 9.2, Cary, NC).

Results

Provider Demographics

Thirty-three providers completed the ILSI survey. The majority of providers were female (94%), with one male (3%) and one survey missing data (3%) on gender. The

Download English Version:

<https://daneshyari.com/en/article/2665679>

Download Persian Version:

<https://daneshyari.com/article/2665679>

[Daneshyari.com](https://daneshyari.com)