

Tools and resources for preventing childhood obesity in primary care: A method of evaluation and preliminary assessment



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ARTICLE INFO

Article history:

Received 3 August 2015

Received in revised form 30 November 2015

Accepted 10 December 2015

Keywords:

Children

Lifestyle

Pediatric obesity

Prevention

Primary care

Healthcare providers

Resources

Tools

ABSTRACT

Objectives: To pilot-test a mixed methods approach to evaluate tools and resources (TRs) that healthcare providers (HCPs) use for preventing childhood obesity in primary care, and report a preliminary descriptive assessment of commonly-used TRs.

Methods: This mixed methods study included individual, semi-structured interviews with purposefully-sampled HCPs in Alberta, Canada; interviews were digitally recorded and analyzed thematically (phase I). Two independent reviewers used three assessment checklists to evaluate commonly-used TRs (phase II). HCPs provided feedback on our coding scheme and checklist data (phase III).

Results: Three themes described how HCPs ($n=19$) used TRs: purpose of use (e.g., clinical support), logistical factors (e.g., accessibility), and decision to use (e.g., suitability). The latter theme overlapped with constructs of suitability on the checklists. Overall, participants used 15 TRs, most of which scored 'average' on the checklists.

Conclusion: Phases I and II provided unique insights on the evaluation of TRs used for preventing childhood obesity. Criteria on the checklists overlapped with HCPs' perceptions of TR suitability, but did not reflect logistical factors that influenced their use of TRs.

Practice implications: Developers of TRs should collaborate with HCPs to ensure that subjective and objective criteria are used to optimize TR suitability in the primary care setting.

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1. Introduction

1.1. Tools and resources

Tools and resources (TRs), which for the purpose of this paper included clinical or educational programs and handouts, have been used across a number of disciplines with the goal to improve patients' awareness, knowledge, and health-related outcomes. Specifically, TRs are used to educate patients on various health conditions and concerns, as well as to support healthcare providers (HCPs) across a variety of clinical tasks. Despite the ubiquity of TRs in the world of healthcare, there is a lot of heterogeneity regarding

evaluation. Assessment checklists have been developed and utilized to assess the suitability of TRs, but they have yet to be applied to TRs used for childhood obesity prevention, and it is unknown how ratings compare with HCPs' perceptions of suitability.

1.2. Childhood obesity prevention & primary care

Primary care represents most families' first point of contact with the healthcare system, which often includes healthcare delivery from a multi-disciplinary team of professionals. The clinical priorities of primary care are also well-aligned with the prevention of chronic diseases, such as obesity [1], and HCPs play an integral role in preventing childhood obesity in this setting [2]. Although an increasing number of HCPs counsel children and families on obesity prevention [3,4], a number of barriers can impact their clinical work in this area, including a lack of useful patient education materials and clinical tools [5,6]. HCPs have also

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reported a need for “better tools” [7], particularly related to screening children’s weights, counseling on obesity prevention, and improving coordination and communication with subspecialties for referrals [3,7].

To date, TRs used to prevent childhood obesity in primary care have been used to educate children [8] and parents [9] on obesity-related topics, including making and maintaining healthy lifestyle habits [10]. HCPs also use TRs when counseling families [11], assessing children’s lifestyle behaviors [12], and screening children’s weight status [13], which include food guides [14], national guidelines for physical activity [15], and body mass index growth charts [16]. Contemporary TRs have been designed to help HCPs in (i) counseling families on obesity management [17], (ii) communicating children’s weight status [18], and (iii) screening for childhood obesity using eHealth strategies [19].

Although a variety of TRs are available to educate families and support HCPs in preventing childhood obesity, little is known regarding their use and suitability in clinical practice. Of the studies done to assess the suitability of TRs, foci have been limited to general pediatric educational materials [20] and printed resources related to physical activity [21]. In addition, such studies have evaluated TRs using only assessment checklists; to our knowledge, no studies have employed a mixed methods approach to quantitatively assess suitability, which refers to the extent that materials are understood and accepted by patients [21], and qualitatively explore HCPs’ use of TRs, including both cognitive (*e.g.*, perceived need) and contextual (*e.g.*, implementation) factors. Our mixed methods study included a dominant qualitative strand (phase I) that informed data collection in a supplementary quantitative strand (phase II), followed by participant feedback (phase III). Specifically, our objectives were to (i) pilot-test a mixed methods approach to evaluate TRs that HCPs use for preventing childhood obesity in primary care (primary aim), and (ii) report a

preliminary descriptive assessment of commonly-used TRs (secondary aim).

2. Methods

2.1. Phase I: qualitative strand

2.1.1. Data collection

Participants were eligible if they met the following criteria: (i) currently employed as a HCP, (ii) had at least two years clinical experience, (iii) provided clinical care to children and families that included childhood obesity prevention, and (iv) used at least three TRs related to the prevention of childhood obesity in clinical practice. Participants were purposefully sampled to achieve diversity in experience and expertise, which we believed would offer rich, in-depth, and multifaceted perspectives on their use of TRs. Participants were recruited (Fig. 1) through their professional affiliations with Alberta Health Services, the University of Alberta, and the Edmonton Oliver Primary Care Network. Snowball sampling was used to continue recruitment of participants until data saturation was achieved. Participants who identified as eligible for study participation were recruited by telephone or email. One week prior to scheduled interviews, participants were contacted to complete an online survey (SurveyMonkey Inc.) that queried their clinical discipline, years of experience in clinical practice, information about the TRs they used for childhood obesity prevention, and of the TRs they listed, which ones were used for patient education and clinical support purposes.

Our semi-structured interview guide (Supplementary material) included 13 questions with follow-up examples and probes. The guide was developed by (i) identifying and evaluating relevant literature, (ii) organizing questions thematically (*e.g.*, context, likability), and (iii) confirming the inclusion and exclusion of

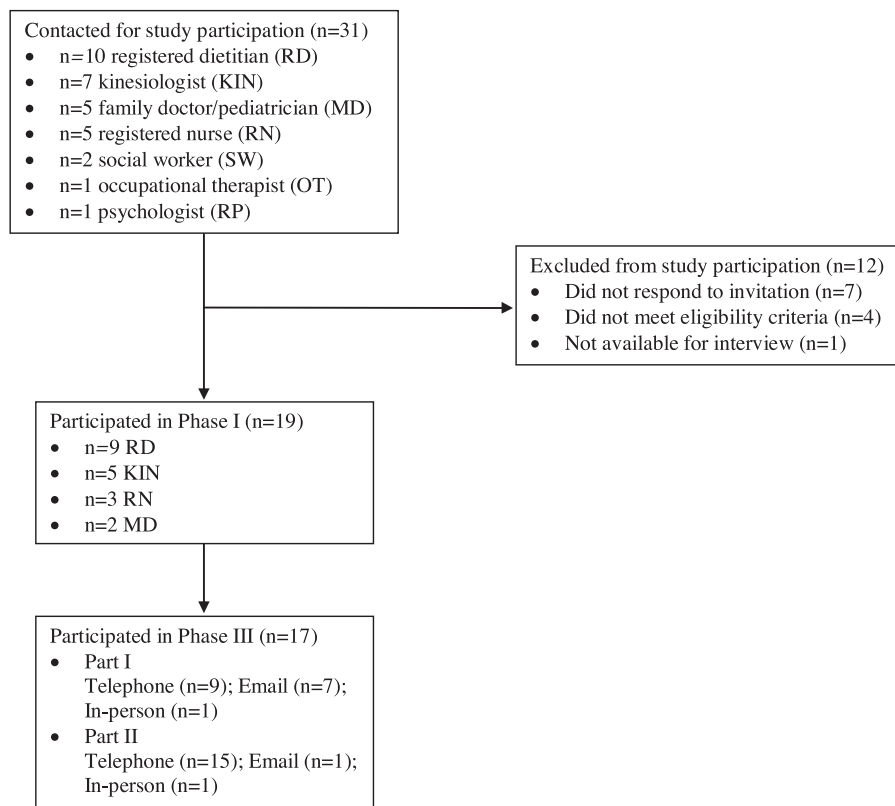


Fig. 1. Flow diagram of participant recruitment (phases I & III).

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