Health Care Providers’ Perception of the Barriers in Practice In Addressing Childhood Obesity

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Health Care Providers’ Perception of the Barriers in Practice In Addressing Childhood Obesity

Abstract
Childhood obesity has been identified as a major health problem in America. It has been deemed a social and economical problem that has significantly impacted the health of American youth (Small, Anderson, & Melnyk, 2007). The prevalence of childhood obesity has been associated with the development of chronic illnesses in the pediatric population, such as diabetes type 2 and hypertension, which more commonly impacted adults. Health care providers are essential to intervening with obese children in an appropriate environment. Currently there are barriers in communication on this topic dilemma between parents and health care providers.

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Health Care Providers’ Perception of the Barriers in Practice
In Addressing Childhood Obesity

By

Ernestine Iona Brown

Submitted in partial fulfillment of the requirements for the degree
M.S in Advanced Practice Nursing

Supervised by

Dr. Christine Nelson-Tuttle

Wegmans School of Nursing
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Summary

Introduction: Childhood obesity has been identified as a major health problem in America. It has been deemed a social and economical problem that has significantly impacted the health of American youth (Small, Anderson, & Melnyk, 2007). The prevalence of childhood obesity has been associated with the development of chronic illnesses in the pediatric population, such as diabetes type 2 and hypertension, which more commonly impacted adults. Health care providers are essential to intervening with obese children in an appropriate environment. Currently there are barriers in communication on this topic dilemma between parents and health care providers.

Background: A committee on childhood obesity developed guidelines with the contribution of medical experts from different organizations (Barlow and the expert committee, 2007). The recommendations calls for universal assessment of a child weight status in addition to prevention.

Purpose: The purpose of this project is to assess the barriers in practice that are hindering communication between health care providers (physicians and nurse practitioners), and parents about the topic of childhood obesity.

Methodology: An eight question survey was distributed to pediatric health providers including physicians and nurse practitioners, to assess their perception and identify internal barriers that hinder communication with parents regarding a child’s weight status in practice. The participants were chosen via a purposeful sampling method. Demographic information including their licensed title, place of practice, and years of experience were also collected. No identifying information was collected. Informed consent and permission were obtained prior to distribution of the survey. The project was approved by the St. John Fisher College (SJFC) Institutional
Review Board. SPSS was utilized to analyze the data. Descriptive statistics were developed based on the survey responses.

**Results:** A total of nine surveys were returned to the researcher (5 Family Nurse Practitioners, 2 Pediatric Nurse Practitioners, and 2 Family Physicians). Most respondents have greater than ten years of practice experience. Forty-four percent of the practitioners had between 0-5 years of experience. In addition, fifty-six percent of the participants came from family practice, twenty-two percent came from pediatric practices, and twenty-two percent came from school based health centers. The majority of the providers (89%) described pediatric obesity as a concern in their practice, and answered they would begin discussion when the BMI is 25-30. For the two providers who use growth charts, they stated the discussion depends on the trend of the growth or how the “height and weight lines up on the chart.” The results showed providers were very aware of the potential consequences of childhood obesity: 56% identified hypertension, 89% percent identified diabetes, and 67% identified joint or mobility issues, and 1 respondent stated “PCOS.” Many barriers were identified by the providers including lack of: reimbursement, time in practice, parental involvement, and resources. However, providers were generally comfortable if they had to discuss the issue with caregivers.

**Conclusions:** Providers are identifying childhood obesity as a concern in their practice. However, barriers were identified that hindered communication with parents. The data revealed in this sample, sixty-six percent of the total respondents admitted to only addressing childhood obesity either “sometimes” or “seldom.” However, since most of the providers were employed in a family practice, there may have been lack of opportunities or consistent exposure to obese children. This study may benefit from replication to a larger sample size.
Implication for Advanced Practice Nursing: Nurse Practitioners and physicians should be cognizant of the barriers in practice that hinder care of obese children. Appropriate education should be obtained to decrease the impact of internal and external barriers.
Chapter I

Introduction

Childhood obesity is a relevant economic and social topic that impacts many families in America. Healthy People 2020 objective for the nation includes to “reduce the proportion of children and adolescents who are considered obese. Obesity contributes substantially to the prevalence of preventable illness and premature deaths of Americans in the United States in addition to the increase cost of health care services (Small, Anderson, & Melnyk, 2007).

Pediatric providers are often the most critical and essential link to addressing childhood obesity. Health care providers in primary care rely on their unique relationship with caregivers in addressing health care needs and anticipatory guidance of future growth and developmental milestones. Even with the most respectful provider relationships, childhood obesity is a difficult topic to discuss in health care settings due to stigmas and barriers. Factors may include inexperience of providers and perceptions and opinions of parents and other caregivers of the child. In addition, education and teaching is often not reimbursed by insurance companies which may conflict with the philosophy of practices in a consumer driven economy. Currently, the literature suggest there is a disconnection between parents and health care providers with discussion of childhood obesity. According to Benson, Baer, & Kaelber (2009), pediatric obesity is relatively under diagnosed and guidelines are often not followed by health care providers.

Additional evidenced based literature is needed to address protocols for providers to work with families to significantly impact the awareness of obesity in children and decrease the incidence in this health care issue. According to Goodell, Pierce, Bravo, & Ferris (2008),
“developing new approaches to communicating the diagnosis and implications of overweight during early childhood, health providers are more likely to be able to work collaboratively with parents to prevent and treat overweight during early childhood” (pg. 1548). In addition to identifying obesity in children, it can also create an education moment for parents to change significant eating patterns that have deteriorated the typical diet.

While there have been studies on this topic and national guidelines have been established, currently there is limited research available that compares the perceived barriers in practice of physicians and nurse practitioners in addressing childhood obesity in the primary care setting.

**Background**

National guidelines were established by a multi-collaborative expert panel to provide clinicians with protocols to prevent, identify, treat, and manage childhood obesity in practice. Barlow and the expert committee (2007) identify the pediatric primary care provider as integral in preventing and detecting childhood weight abnormalities. As frequently demonstrated in the literature, parents are unaware of their child’s weight status or potential consequences (Bowne, 2009, Chiang, Molin, Byrd, and Crawford 2009). Thus, primary care visits are often the only opportunities for identification and communication of potential weight problems and anticipatory guidance.

Presently, the consensus guidelines recommend standard assessment for all children for childhood obesity. In addition to a yearly well child check, recommended guidelines includes encouraging all health care providers assess the weight status of all children including measurement of weight, height, and BMI with documentation on a standard growth chart.
Children ages 2-18 years old should be considered obese with a BMI greater than 95th percentile for age or BMI greater than 30. However, discussion regarding potential weight problems should be addressed, and interventions should be in place before a child is categorized as overweight. According to further recommendations by Barlow and colleagues (2007), weight management and lifestyle issues should be discussed with patients at every visit despite current weight status. Additionally, the experts recommend yearly assessment of dietary and exercise patterns to assess for risk behaviors and to provide anticipatory guidance (Barlow et al, 2007).

In addition, it is recommended that clinicians should be aware of the multiple medical co-morbidities that affect obese children and screen per the guideline or as appropriate. It further states that a staged based protocol should be implemented with partnership with parents/caregivers to manage the child’s weight and reduce future sequela.

Theoretical framework

Hildegard E. Peplau (1991) developed the Theory of Interpersonal Relations that describes the desired relationship between health care providers, particularly nurses, and the patient. She states, “Nursing is a human relationship between an individual who is sick, or in need of health services, and nurse especially educated to recognize and to respond to the need for help” (pg 6). Peplau identifies four phases of the nurse-patient relationship: orientation, identification, exploitation, and resolution. The theory also identifies the role of the nurse throughout the engagement process with the client: stranger, resource person, teacher, and surrogate. According to this theory, the health care provider must assess and be aware of their
own short-comings and internal barriers in order to effectively engage in a patient-nurse relationship

**Purpose**

The purpose of this masters’ project is to assess the perception of health care providers regarding the social, personal, and institutional barriers of addressing childhood obesity with caregivers in a primary care setting. The results of this project may increase knowledge of the current disconnect between health care to effectively communicate with care providers about childhood obesity.
Chapter II

Literature Search

An extensive review of the literature relevant to this topic was conducted in many databases: CINAHL, Official Journal of the American Academy of Pediatrics, SAGE Journal Online, and Pub Med. Inclusion criteria included articles published in English language, published since 2000, and related to health care providers. Many keywords were utilized to identify relevant articles including communication, overweight, obesity, nurse, provider, physician, nurse practitioner, practice, and childhood obesity. Full text, meta-analysis and synthesis, quantitative and qualitative articles were sought and included. Exclusion criteria included articles not empirical research, not published in English language, full-text not available, and subjects out of accepted population, goals/measures were in descriptive terms only, and dissertations. A literature search was performed in the databases of relevant material. Approximately 200 articles were found; eight were used for the purpose of this literature review based on the appropriateness to this project. Some articles were excluded to avoid saturation of similar results.

Review of the Literature

Larsen, Mandleco, Williams, & Tiedman (2006), sought to describe the individual prevention practice of nurse practitioners regarding childhood obesity. This work assessed the difference in awareness of clinical practice guidelines between practice setting, experience,
specialty, and demographics. In addition, the barriers to implementing prevention guidelines were also assessed to further investigate disconnection between provider and parent.

The researchers mailed a questionnaire, consent and demographic form to 607 licensed advanced practice nurses. Inclusion criteria in the survey included being licensed as a NP, practiced in a pediatric or family primary care setting, and seeing patients aged 2-20 years. The results of the questionnaire yielded 99 (34%) nurse practitioners participants, including Pediatric Nurse Practitioners (PNP) and Family Nurse Practitioners (FNP). The demographics of the participants varied. It concluded that practitioners in family or general pediatric practices were not consistently following the guidelines by using the body mass index (BMI)-for-age to screen children for childhood obesity. However, Pediatric Nurse Practitioners were more likely than Family Nurse Practitioners to utilize the guidelines set forth for childhood obesity by the American Academy of Pediatrics (AAP). The barriers to implementing health promotion with overweight children included parental attitudes, the American lifestyle, and lack of resources of both the NP and family.

Childhood obesity requires a multidisciplinary approach involving multiple health care professionals and resources for management. Story, Neumark-Stzainer, Sherwood, Holt, Sofka, Trowbridge, & Barlow (2002) examined the health care practices of 202 pediatricians, 293 pediatric nurse practitioners and 444 registered dieticians. The major objective of the study was to evaluate the health care professional perception regarding barriers, perceived skill level, and training needed for the management of childhood obesity.
A questionnaire was mailed to a random sample of health care professionals nationally. The majority of the providers (75%-93%) deemed childhood obesity as a condition that needs intervention. Additional data yielded that 83%-93% of the participants questioned believed childhood obesity impacted the quality of life of children. The barriers cited by the practitioners included lack of motivation from the patient themselves, lack of parent involvement, reimbursement and lack of support services. However, most of the providers with greater than 6 years of experience did express desire for additional training on the topic.

Socioeconomic and cultural status of clients can substantially limit the ability of providers to effectively implement guidelines in treating childhood obesity. Boyle, Lawrence, Schwarte, Samuels, & McCarthy (2009) assessed how health care providers addressed childhood obesity in practice, and their readiness to promote change in policies to prevent it. The study collected responses by a self-administered survey of health providers which included nurses, physicians, dieticians, nurse practitioners, medical assistants, and community health workers. Stakeholder interviews were also conducted with health care facility administration, staff of the local health department, and insurance representatives. Response rate included 248 health care provider participants for the survey and 56 stakeholder interviews.

Frequency distributions were utilized to report the data along with descriptive statistics. The majority of providers (65%) indicated they used pediatric visits as a teaching moment to encourage health eating patterns and health behaviors to parents. However, 90% of providers associated lack of parental interest and the environmental influence, such as school, home, and neighborhoods, as a barrier to successful management of childhood obesity. In addition, the results of the study demonstrated that the providers believed that community resources may be
more effective in the outreach to families in addressing childhood obesity. More than 75% of the stakeholders, however, felt providers should be more accountable in addressing the childhood obesity epidemic. The consensus of the stakeholders was that health care providers should be proactive in the development of programs and policies.

Barlow & Dietz (2002) studied a variety of pediatric providers who recognized childhood obesity as a relevant physical and psychosocial concern. Two questionnaires and two reminders were sent out to members of professional group. A convenience sampling method was utilized. The study researcher assumed that the responders to the questionnaire were more apt to be concerned about childhood obesity because of the perceived inconvenience of the questionnaire length and time of the provider. The study has a 19-33% response rate. The practice of the responders contradicted their concerns of childhood obesity as the majority of the participants were less likely to initiate discussion about childhood obesity treatment with family if the child did not have a present medical condition. The resistances in providing care including lack of motivation of parent, time, and reimbursement. Provider expressed a need for additional behavioral counseling to initiate appropriate discussion between parents.

Moyers, Bugle, & Jackson (2005) examined the perception of school nurses regarding obesity in children of ethnic minorities in elementary and middle school. A questionnaire was distributed to a random sample of 250 nurses from a professional school health organization. The results of the survey showed that the respondents believed normal weight was important to a child’s health. However, 65% of the respondents had a perceived hardship in addressing parents about the topic. The majority of respondents to the questionnaire did not feel confident in their ability to help children lose weight despite their position as a school nurse. Many of the respondents agreed that
the school should be the primary resource in addressing childhood obesity an evaluation of their meal program and curriculum.

The school nurses deemed themselves very knowledgeable about prevention, intervention and risk factors, yet one-third of the participants did not recommend treatment measures. Another half of the participants gave counseling to overweight children and referrals only when initiated by the parents. The results showed that nurses believed counseling is not feasible, support is deficient, and proficiency in skill is lacking.

Allen, Touger-Decker, O’Sullivan-Maillet, & Holland (2003), sought to examine the pediatricians who belonged to the national pediatric organization in the state of New Jersey. The purpose of the study was to assess the participant’s obesity management practices, factors that influenced their practice and other variables that influence the management of obesity in their patient population. The survey was distributed to 1246 providers; with 424 respondents or a 29% participation rate in the study. The majority of the providers came from primary pediatric sites, however, 16.54% of the participants practiced within subspecialties. Additional information obtained was length of residency, fellowship training, and the number of patients seen in a typical day.

The results showed that the providers were very aggressive in managing an obese child once evaluated including referrals to dietitians. However, the providers described patient compliance, time, reimbursement constraints, and patient interest as the four most common barriers to obesity management. The participants also stated that the practice management tools
were inadequate and additional resources such as educational tools and seminars should be provided for assistance.

Provider’s perception of a child’s weight can also significantly impact their willingness to intervene during critical periods. Johnson, Clark, Goree, O’Connor, & Zimmer (2008) examined providers in Denver, Colorado who worked closely with Mexican American families. The study sought to describe the provider’s perception of the Mexican American infant feeding practices and obesity. Participants were chosen and placed into two focus groups. The first focus group participants were drawn from a public health primary care clinic and a WIC office. The second focus group participants were drawn from another WIC Clinic and a public health immunization clinic. Multiple health care professionals including dieticians, physicians, and counselors were represented in the focus groups with 40% from a Mexican-American background. Relevant themes established in the results include providers perceived “chubby” babies as healthy in relation to the culture of Mexican Americans whereas using “overweight” and “obese” will be deemed as offensive to mothers. The health care providers were ambivalent in their role of discussing childhood obesity despite considering childhood obesity a problem in their practice area. The researchers recommended that the providers in this setting provide a consistent message about eating practices and activity level.

A study by O’Brien, Holubkov & Reis (2004), supports the belief that provider are not identifying obese children at a younger age despite meeting criteria of obesity per the study requirements which stemmed from national organizations. The study was conducted where the practice patient population is 70% African American. The results showed that preschool children were correctly being identified as obese. Despite meeting the criteria per growth charts or weight
percentile, there was rarely any documented follow-up or plan of care noted in the chart. In addition, only 13% of the providers followed the guidelines in ordering laboratory tests per the American Academy of Pediatrics for evaluation in obese children at older age despite the trend of adolescent morbidities following children into adulthood. The study researchers describe the results as “disheartening” due to the potential sequela of childhood obesity that may be prevented with appropriate screening.

Lastly, communication between health care provider and parents is essential to reach out and intervene with any overweight and obese child. Mikhailovich & Morrison (2007) compiled a review of the literature that examines factors influencing communications between providers and parents about childhood obesity. The purpose of the review of literature was to establish a basis for communicating childhood obesity between the two parties and addressing the seriousness of the disease. The study describes challenges to communication between parents and health care providers in discussing childhood obesity. Articles in the review concluded that physicians or other health care providers may have biases against overweight people including children. Many overweight children have overweight parents, and the bias and lack of sensitivity can cause disconnect between the parties. In addition, the review concluded that many providers feel uncomfortable or are unprepared to address childhood obesity in their practice because a lack of skill and experience. The article recommends that providers become better educated and prepared to address the population needs.

Summary

The review of the literature revealed that health care providers are not closely following guidelines for childhood obesity screening and that barriers to effective communication between
providers and caretakers exist. However, previous research did not fully assess the communication and internal barriers in both nurse practitioners and physicians as primary care providers. This project will seek to continue to assess these barriers in practice with addressing childhood obesity in both physicians and nurse practitioner pediatric providers.

Chapter III

Methodology

Participants were chosen by a purposive convenience sampling method. Personal contacts of the investigator and family and pediatric practices utilized by the Wegmans’ School of Nursing for clinical precepting were utilized as a method of gaining participants. Additional participants were chosen from a database of providers who are current members of professional nursing organizations.

Data Collection Methods

The investigator developed questionnaire consisted of eight questions. This questionnaire was evaluated by faculty of the St. John Fisher College for expert review and face validity checks as part of the research process. The survey tool Zoomerang was utilized to distribute the questionnaire to participants over a 3 week period.

Demographic information obtained from participants included number of years of experience, licensure title, and type of employment. However, no personal identifying information was collected in the survey. Identifying or personal information, such as email address or IP address, was not linked with the survey tool in order to preserve confidentiality.
The researcher gauged the interest in the survey by first electronically sending a letter of introduction, and notifying the potential participants of the survey and its purpose. An electronic informed consent with the debriefing form was sent to potential participants. The questionnaire link was sent to providers via email after permission was given. A disclaimer, as approved by the IRB, was noted in the email stating, “By clicking on the link and completing this survey, informed consent will be assumed. You are free to stop participating in this survey and have your responses withdrawn at any time.” The URL was sent via the St. John Fisher College webmail system to ensure confidentiality and no disclosure of email address or ISP via the survey tool. Interaction did not occur with the provider during the completion of the survey, and the individual responses were and will not be shared with colleagues or peers. It was expected the survey would take approximately 10 minutes, and it was not expected to cause stress or constraints on the participants.

**Sample**

The survey was distributed to 50 potential health care providers. These subjects were chosen by utilizing a purposive sampling technique.

**Inclusion Criteria**

Inclusion in the study included participants fluent in English and cognitive understanding of pediatrics health topics. In addition, study participants had to be currently employed in a primary care setting as a provider to pediatric clients from newborn to 18 years of age who presents with their parent or guardian for healthcare. Additionally, providers were licensed as a Family Nurse Practitioner (FNP), Pediatric Nurse Practitioner (PNP), Family Physician or Pediatrician.
Exclusion Criteria

Exclusion criteria included health care providers without significant exposure to the pediatric population and/or lack fluency of the English language. Participants were chosen from multiple pediatric based practices to avoid saturation of data, to capture a variety of demographic mix, and to reduce sampling bias.

Data Analysis

The software SPSS was utilized to assist in data analysis. Data was entered into the computer system to analyze pertinent demographic information and to establish descriptive correlation data. The researcher categorized themes of the written responses from the participants as a method of analyzing the data and to draw conclusions.

Human Subject Protection

Collected surveys will kept by the researcher password protected on the survey tool for three years. The survey link was directly emailed to the participants to avoid any disclosure by the survey tool of email address or IP address. All responses on the online survey tool will be kept protected by password known only by the researcher. Transfer of the numerical data onto a password protected computer for data analysis will not be linked to any personally identifying demographic information (as none was collected).

Approval to conduct this project was obtained by the St. John Fisher College Institutional Review Board.
Chapter IV

Results

The online survey was distributed to fifty providers in both pediatric and family practices in Upstate and Western N.Y. Nine participants completed the survey which yielded a return rate of 18%. The survey participants included five Family Nurse Practitioners (FNP), two Pediatric Nurse Practitioners (PNP), and two Family Physicians. No Pediatricians completed the survey. The years of experience for the survey participants varied also. Forty-four percent of the participants had between 0-5 years of experience. An additional twenty-two percent of the participants had 11-15 years of experience. And lastly, thirty-three of the participants in this project had over sixteen years of experience.

The providers in this survey worked in diverse locations. Five providers in the survey were employed in a family practice setting. Two providers in the survey practiced in a pediatric based practice. The remainder of the providers described their practice as an adolescent or school based health setting.
Figure 1. An estimate (in percentage) of the ethnic groups encountered in practice on a typical day by the providers.

Table 1
Assessment of Level of Concern of Childhood Obesity in Practice

<table>
<thead>
<tr>
<th>License Title</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Nurse Practitioner</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pediatric Nurse Practitioner</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family Physician</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 1 - 89% percent of participants considered childhood obesity a significant concern in their practice.

Figure 2. An estimate of the BMIs’ of the pediatric patients served by the providers

Figure 3. An estimate of the weight percentile of the pediatric patients served by the provider
The providers in the survey were asked at which BMI they would initiate discussion about BMIs and health. One-hundred percent of the providers who utilizes BMI (7) in practice stated they would begin discussion when the BMI is 25-30. For the two providers who utilize weight percentile charts stated, “it depends on the height percentile and how they line up” and “it depends on the age of the child and pattern of growth.”

The participants in the survey was also asked about the potential consequences of childhood obesity that were concerning in their management of childhood obesity in practice. The results showed eighty-nine percent of the participants were concerned about diabetes, sixty-seven percent were concerned about psychosocial concerns, fifty-six percent of the providers were concerned about hypertension, and forty-four were concerned about joint and mobility issues that may arise. When asked for any other potential consequences, one respondent stated “PCOS” is also potential concern in their practice.

The providers cited many barriers in practice that may contribute to communication barriers with parents. Sixty-six percent chose lack of parental involvement/resistances, forty-four percent chose lack of external resources, forty-four percent chose lack of knowledge, thirty-three percent chose lack of support from practice, forty-four percent chose lack of time, twenty-two percent chose reimbursement issues, twenty-two percent chose lack of experience, and twenty-two percent could not identify any barriers. When asked for any additional comments, two providers cited “caregiver weight issues” and “parents are never present for appointments” as two barriers.
The participants were asked how often they discuss childhood obesity in practice. The results of the survey showed consistent results amongst all the potential results. Thirty-three percent of the respondents states seldom, thirty-three percent states sometimes, and thirty-three percent states often. No participants in the survey answered VERY often or “it depends.”

When asked to describe their comfort level in addressing childhood obesity many providers expressed being comfortable about communicating in practice about the topic. Thirty-three percent of the providers described their comfort level as “very comfortable,” twenty-eight percent described themselves as “comfortable,” and twenty-two percent described themselves as “somewhat comfortable.”
Chapter V

Discussion

The purpose of this project was to determine health care providers’ perception of the barriers of addressing childhood obesity in practice. The facilitation of discussion in practice about obesity in children is often dependent on the providers’ assessment of the child’s weight status and communication of their findings with caregivers. The results of this master project showed the majority of participants described childhood obesity as a major concern in the pediatric population. In addition, the majority of the participants in this project cited diabetes, hypertension, and psychosocial concerns as concerning potential consequences of childhood obesity. Despite this result, only 44% of the participants were very comfortable initiating discussing childhood obesity in practice.

In addition, many barriers were identified including lack of time in practice, parental interest, lack of reimbursement, and decreased support from external resources. This is consistent with similar results from Larsen, Mandleco, Williams, & Tiedman (2006) and Allen, Touger-Decker, O’Sullivan-Maillet, & Holland (2003) who studied potential barriers in communicating in their studies also. Thus, it is not alarming, but disappointing that since when asked how often the practitioner discusses childhood obesity, most of the participants answered either “sometimes” or “seldom. As a result, potential barriers negatively impact providers willingness to address the dilemma in with parents.

Conclusions
There are barriers in practice that hinder communication amongst providers and caregivers in addressing childhood obesity. Despite eighty-nine percent of the providers in this survey identifying childhood obesity as a concern in their pediatric population and correctly identified potential consequences, a total of sixty-six percent of participants admitted to addressing childhood obesity in practice with caregivers either “seldom” or “sometimes.”

In comparison to previous studies, there was not a consistent relationship with years of experience of the provider and their ability to identify barriers in practice or comfort level. On the contrary, the more experienced providers in this survey did admit to addressing weight-related issues with parents more often than less experienced providers. However, practice sites and available opportunities may have influenced the result of this survey item.

**Limitations**

The response rate for the survey included only 9 participants who primarily practiced in family practices where there are a variety of age groups. This may impact the exposure to pediatric population and childhood obesity itself. In addition, the sample size only included 9 participants. As a result, it would not be appropriate to generalize the findings of this survey to all health care providers’ practice despite its consistency with previous studies in the literature. The survey was also saturated with Family Nurse Practitioners who answered the survey characteristically the same. Furthermore, the lack of participation of pediatric restricted providers such as pediatricians and pediatric nurse practitioners may have given an inaccurate assessment of current practice.

Additionally, inclusion criteria were limited to providers in primary care settings. Pediatric patients are often seen amongst specialists who impact the health care decisions of their patients.
Often pediatric patients are not seen yearly by primary care providers which hinders continuity of care and relationships, thus comfort with communication with parents.

**Recommendations**

Further recommendation for nursing research is replicating this project utilizing a larger sample size. In addition, future research on this topic can look to assess the difference between nurse practitioners and physicians in their perception of the barriers in communicating childhood obesity in practice. Further evaluation should include physician assistants and residents as they often found in practice with pediatric clients too.

**Implications for Advanced Practice Nursing**

Childhood obesity is a definite concern in practice with providers in this study and in similar literature. Advanced practice nurses are vital in educating families, especially caregiver, about the importance of diet changes and potential consequences distorted eating patterns in adulthood. Guidelines as outlined by Barlow and the expert committee (2007) should be followed thoroughly. Lastly, nurse practitioners should identify personal and interpersonal barriers in their practice that may hinder communication of this topic with caregiver and children when appropriate. Providers should participants in education offerings in order to start current with new recommendations for childhood obesity prevention, treatment, and education.

**Dissemination**

The results of this project were disseminated in a master project through St. John Fisher College. Future distribution of the study results may include a poster presentation, paper
presentation or manuscript. No personally identifiable information was obtained and the information was analyzed in aggregate only.

References


Appendix I

Questionnaire

Demographic Information (circle one):

Credentials Type (Circle one):

1. Family Nurse Practitioner (FNP)
2. Pediatric Nurse Practitioner (PNP)
3. Pediatrician (MD or DO),
4. Family Physician (MD or DO)

Number of years of experience as Nurse Practitioner or Physician in primary care?

1.0-5
2. 6-10
3. 11-15
4. 16+

Type of Practice?:

1. Family Practice
2. Pediatric Practice
3. Other____________

1. In your estimates, what percentage of each ethnic group(s) listed below do you serve in your practice on a typical day?

1. African Americans _________
   0-25%/_______
   26-50%_______
   51-74%_______

2. Hispanic/Latino _________
3. Asian _________
4. Native American _________
5. Black/African American _________
6. Other Ethnicity _________
7. White _________
HEALTH CARE PROVIDERS

75-100%______

2. Caucasians ________
   0-25%______
   26-50%______
   51-74%______
   75-100%______

3. Hispanics/Puerto Ricans ________
   0-25%______
   26-50%______
   51-74%______
   75-100%______

4. Native Americans_______
   0-25%______
   26-50%______
   51-74%______
   75-100%______

5. Asian/Americans___________
   0-25%______
   26-50%______
   51-74%______
   75-100%______
6. Other (please specify)_____

   0-25%_____

   26-50%_____

   51-74%_____

   75-100%_____  

2. Would you describe childhood obesity as a significant concern in your pediatric population?  
   Circle One:  
   Yes
   No
   Unsure

3. On estimate, what percentage of your pediatric population have the following BMIs?:  
   1. BMI= less than 25__________
      0-25%/_____
      26-50%_____
      51-74%_____
      75-100%_____  
   2. BMI= 25-30_______
      0-25%/_____
      26-50%_____
      51-74%_____
      75-100%_____  
   3. BMI=31-35______
      0-25%/_____
      26-50%_____


51-74%_______
75-100%_______

4.BMI=36+___________

0-25%/_______
26-50%_______
51-74%_______
75-100%_______

5. Not sure

OR

If your office uses growth charts and does not calculate BMI, on estimate, what percentage of your pediatric population have the following weight percentile?:

1. Less than the 50th percentile

0-25%
26-50%
51-74%
75-100%

2. 51st-60th percentile

0-25%
26-50%
51-74%
75-100%

3. 65th-75th percentile

0-25%
26-50%
51-74%
75-100%

4. 80th-90th percentile
4. At what BMI would you begin discussion about a potential weight problem in pediatric patients? Circle one:

1. BMI=25-30
2. BMI=31-35
3. BMI=36-40
4. BMI greater than 40

Other (please explain)__________________________________________________
___________________________________________________________________

OR

If your office focuses on weight percentile, at what percentage do you begin discussion about a potential weight problem?: Circle one:

1. 75\textsuperscript{th} - 80\textsuperscript{th} Percentile
2. 85-90\textsuperscript{th} Percentile
3. 95\textsuperscript{th} - 100\textsuperscript{th} percentile

5. What potential consequences of childhood obesity are most concerning to you in your management of care with pediatric patients? May choose more than one:

1. High blood pressure
2. Diabetes
3. Psychosocial concerns
4. Joint and mobility issues
5. Other (please specify)___________________________

6 How often do you initiate discussion with caregivers regarding concerns about their child weight status? Circle One:

1. Seldom
2. Sometimes
3. Often
4. Very Often
5. It depends (please comment)___________________________

7. What barriers, if any, do you encounter in your practice in addressing concerns about a child’s weight? Please rank if there is more than one:

1. Parents lack of interest/involvement/resistance_______
2. Lack of time_______
3. Reimbursement issues_______
4. Lack of support from external resources (please identify)________________________
5. Lack of knowledge about resources_______
6. Lack of support from practice_______
7. Lack of experience with childhood obesity_______
8. I cannot identify any barriers_______
9. I am currently comfortable discussing weight issues with parents at this time._______

8. What is your level of comfort in addressing childhood obesity with caregivers in your practice?
1. Not comfortable

2. Somewhat comfortable

3. Comfortable

4. Very Comfortable

Any additional comments for the researcher on this topic?

Appendix II
February 4, 2011

Ernestine Brown
51 Rustic Street
Rochester, NY 14609

Dear Ms. Brown:

Thank you for submitting your research proposal to the Institutional Review Board.

I am pleased to inform you that the Board has approved your Expedited Review project, “Health Care Providers’ Perception of the Barriers that Hinders Care of Obese and Overweight Children in Practice.”

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at 385-5262 or by e-mail to emerges@sjfc.edu, or if unable to reach me, please contact the IRB Administrator, Jamie Mosca, at 385-8318, e-mail jmosca@sjfc.edu.

Sincerely,

Eileen M. Merges, Ph.D.
Chair, Institutional Review Board

File No: 2060-012011-10

Copy: OAA IRB
IRB: Approve expedited.doc
Date & Signature – Researcher

Decision of Institutional Review Board

Reviewed by: Nancy Williams, PhD, WHNP

Subcommittee Member #1

Date 1/23/11

Subcommittee Member #2

Date 1/24/11

[ ] Approved  [ ] Not Approved

Comments:

[ ] No Research The proposed project has no research component and does not need to be in further compliance with Article 24-A.
[ ] Minimal Risk The proposed project has a research component but does not place subjects at risk and need not be in further compliance with Article 24-A.
[ ] Research & Risk The proposed project has a research component and places subjects at risk. The proposal must be in compliance with Article 24-A.

Chairperson, Institutional Review Board

Date 2/3/11