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Recommendations from Parents to Improve Health Services for Managing Pediatric Obesity in Canada

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Title: Recommendations from Parents to Improve Health Services for Managing Pediatric Obesity in Canada

Running Title: Improving Pediatric Weight Management

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Weight and Health in Edmonton, AB; Centre for Healthy Weights: Shapedown BC in Vancouver, BC; Metabolism, Obesity, and Health Program in Hamilton, ON; Healthy Weight Clinic in Montreal, QC) for their assistance with participant recruitment and all of the research assistants (Jasmine Dhaliwal, Biagina-Carla Farnesi, Evett Huie, Jennifer Kwan, Lisa Watt, and Vivian Vaughn Williams) for their assistance with data collection.

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ABSTRACT

Objective: Although parents are uniquely positioned to offer first-hand insights that can be used to improve health services for managing pediatric obesity, their perspective is under explored. Our objective was to characterize parents’ recommendations for enhancing tertiary-level health services for managing pediatric obesity in Canada.

Methods: Semi-structured, one-on-one interviews were conducted with parents of children who initiated treatment at one of four Canadian tertiary-level, multidisciplinary weight management clinics. Parent perspectives were elicited regarding the strengths and weaknesses of the health services they received as well as areas for potential improvement. Interviews were audio-recorded and transcribed verbatim. We used qualitative description as the methodological framework and manifest content analysis as the analytical strategy.

Results: Parents (n=65; 88% female; 72% Caucasian; 74% with at least some post-secondary education; 52% >$50,000 CDN household income) provided a range of recommendations that were organized according to health care (i) accessibility, (ii) content, and (iii) delivery. The most common recommendations included increasing scheduling options (44%, n=29), tailoring services to families’ needs and circumstances (29%, n=19), placing greater emphasis on physical activity (29%, n=19), altering program duration (29%, n=19), incorporating interactive elements (25%, n=16), information provision (25%, n=16), and providing services at sites closer to participants’ homes (24%, n=15).

Conclusions: Parents’ recommendations to enhance health services for managing pediatric obesity concerned modifiable factors related accessibility, content, and delivery of care. Further research is needed to evaluate whether implementing suggested recommendations improves
clinically-relevant outcomes including attrition, quality of care, and success in weight management.

What’s New
The study shed light on parents’ recommendations to improve services for managing pediatric obesity. Findings highlighted the need to consider modifiable factors related to access, content, and delivery of care to enhance retention in treatment and optimize health and weight outcomes.
INTRODUCTION

The high prevalence of childhood overweight and obesity in Canada\textsuperscript{1} and the US\textsuperscript{2} is cause for concern given the negative physical and psychosocial consequences associated with excess weight.\textsuperscript{3-6} Lifestyle and behavioral interventions for managing pediatric obesity can be effective;\textsuperscript{7} however, attrition is high,\textsuperscript{8} which limits the potential health benefits that families can derive from care. High attrition suggests that additional research is necessary to better understand families’ needs and preferences that can be applied, in turn, to inform and enhance health services for managing pediatric obesity.

Given parents’ prominent role in program initiation and ongoing participation, responsivity to parent recommendations is critical for optimizing services and retention.\textsuperscript{9} Seeking parents’ input is also consistent with the philosophy of family-centered care and aligns with best practices in pediatric weight management.\textsuperscript{10} Some studies have reported parent perspectives related to pediatric weight management, but the feedback solicited was to evaluate specific intervention approaches,\textsuperscript{11,12} barriers to treatment,\textsuperscript{13,14} and reasons for attrition.\textsuperscript{15-20} Much less attention has been paid to exploring parents’ recommendations for improving services beyond the US, which is highly relevant given country-to-country differences in demographics, culture, and health services delivery and funding. Further, most studies have been limited to the perspectives of families who withdrew from treatment; it is reasonable to expect that their opinions will differ from those who successfully completed an intervention. Therefore, the purpose of our study was to characterize the recommendations that parents of children who either discontinued or terminated care made to improve health services for managing pediatric obesity in four multidisciplinary clinics across Canada.
METHODS

Design

This study was part of a larger project designed to understand families’ decisions to initiate, continue, and terminate tertiary-level pediatric weight management.\textsuperscript{21,22} Qualitative description formed the overarching methodological framework of the study, an approach that is most appropriate when a straightforward conceptual description of a social phenomenon (e.g., reasons attributed to healthcare decisions) is sought to inform practice.\textsuperscript{25}

Settings

Parents were recruited from four Canadian multidisciplinary clinics (Pediatric Centre for Weight and Health [PCWH; Edmonton, AB], Centre for Healthy Weights: Shapedown BC [BCCH; Vancouver, BC], Growing Healthy Weight Management Program [GHP; Hamilton, ON], and Healthy Weight Clinic [HWC; Montreal, QC]. The PCWH at the Stollery Children’s Hospital provides one-on-one, multidisciplinary (medical, nursing, psychology, nutrition, physical activity) support to all enrolled children and families; some parents also choose to participate in a complementary, group-based intervention. Clinical outcome data from the PCWH have been reported.\textsuperscript{23} At British Columbia Children’s Hospital, Shapedown BC is a behavioral weight management program that helps children, teens and their families recognize and overcome their challenges to active living and healthy eating. This program is provided by BC health authorities, in partnership with participating YMCAs and recreation centres, and includes a general practitioner, dietitian and psychologist.\textsuperscript{24} The GHP at McMaster Children’s Hospital is one of the oldest and largest pediatric weight management programs in Canada. The clinic includes a multi-disciplinary team (medical, nursing, psychology, dietary and pediatric...
exercise physiology) that offers one-on-one counselling, augmented with groups sessions, to children and youth. The HWC is based at the Montreal Children's Hospital and offers guidance on lifestyle changes for children of all ages who are perceived to have co-morbidities related to their excess weight. Clinical care is complemented by a community-based, lifestyle modification program that is available for lower income families.

Although services across participating clinics varied somewhat by type, length, mode of delivery, and content, they shared a similar focus on family-centered care and combined behavioral and cognitive techniques offered by a multidisciplinary team to enhance lifestyle habits and improve psychosocial and physical outcomes. In addition, all clinics were structured similarly insofar as health services were provided in children’s hospitals that were at no expense to families (aside from transportation, parking, and/or time away from work) since provincial healthcare systems fund most health services delivery in Canada.

**Participants**

Parents were eligible for participation if (i) they were a primary caregiver of a child referred by a physician for weight management services, (ii) their child was 10-17 years old at the time of referral, (iii) their child attended at least one clinic appointment within the last six months at one of the four clinics, and (iv) their child had an age- and sex- specific body mass index (BMI) ≥85th percentile. Children referred to tertiary-level care for pediatric weight management in Canada can be either overweight or obese (BMI >85 percentile) and aged 2 to 17 years. Families included in our study had either discontinued or completed care. Eligible parents were contacted by telephone and invited to participate in the study. A $100 (CDN) gift
card to a local grocery or department store was offered as a token of appreciation for participation. As multiple sites across Canada were involved in the study, we aimed to recruit 20 participants per site (10 discontinuers and 10 completers) to ensure data saturation, diversity, and a better definition of patterns of responses. Approvals were granted by research ethics boards at the University of Alberta, University of British Columbia, Hamilton Health Sciences/McMaster University, and McGill University prior to data collection.

**Data Collection**

Data were collected using in-depth, semi-structured, individual interviews conducted in person with parent only by trained research assistants. Interviews were held from 2011 to 2013 in a quiet place at referred clinics and lasted ~60 minutes each. The interview guide (Online Table 1) was initially developed by members of the research team with expertise in qualitative methods, obesity, and pediatric health services; and refined throughout the process of data collection. Interviewers at the four sites maintained regular communication with the research team, both informally (e.g., emails) as issues arise and formally during planned team meetings to discuss the interviewing process (e.g., inter-personal challenges, communication strategies, interview guide refinement) and ensure the integrity, depth, and breadth of data collection. Open-ended questions and probes were used to inquire about enrollment, orientation session, care received, perceived areas of program strength and weakness, and recommendations for program improvement. Using a standardized case report form, demographic (e.g., date of birth, sex) and anthropometric (e.g., height, weight) data were collected from children’s medical records that were maintained in each of the clinics.
Data Analysis

Interview data were audio-recorded, transcribed verbatim, managed with NVivo 10 (QSR, Melbourne, Australia), and analyzed using content analysis. This analytical strategy aims to produce a conceptual summary of textual data and encompasses three main steps: preparation, organizing and reporting. Preparation includes defining the unit of analysis (e.g., individual interviews) and deciding whether content analysis will be inductive, deductive, latent or manifest. Organizing involves open coding and categorization of developed codes and reporting includes proper definition of study population and context, and demonstration of the reliability of findings and interpretations (e.g., use of illustrative quotes). Manifest content analysis was performed given that the study focused on the recommendations that parents explicitly formulated to enhance health services for pediatric weight management. Initially, transcripts of interviews conducted in the four sites were read thoroughly in a central location and explicit parent recommendations were highlighted by two researchers (MT and AMR). Next, identified recommendations were discussed and refined with the research team and a preliminary coding scheme was developed. This coding scheme was then independently used by these two researchers to code the entire data set and new codes were assigned when necessary. Results of coding were discussed with AP and GB. Disagreements regarding assigned codes to parents’ recommendations were address by consensus. After the appropriateness of assigned codes was reviewed, categories were developed to group identified recommendations and written descriptions of categories were generated. Categories were also discussed with the research team to ensure that recommendations grouped into each category referred to the same issue and were different from those grouped into other categories. Finally, frequency of each recommendation was calculated. Although internal validity of content analysis can be assessed either through face
validity or agreement coefficients,\(^{28}\) consensus among researchers regarding coding and categorization was chosen to ensure trustworthiness given that researchers will always interpret qualitative data according to their perspective.\(^{40}\) Further, to enhance the quality and transparency of our research, we completed the consolidated criteria for reporting qualitative research (www.equator-network.org/reporting-guidelines/coreq; see Online Table 2).

**RESULTS**

Out of 272 eligible families contacted, 65 (24%) participated in our study (Edmonton [n=19], Vancouver [n=20], Hamilton [n=20], Montreal [n=6]). Most non-participants passively refuse participation; those who actively declined indicated that timing and lack of interest in the study were the main reasons. Slightly more than half of families (n=36; 55%) completed a structured weight management intervention while the remainder (n=29; 45%) discontinued care prematurely. Families who discontinued care attended an average of 8 clinic visits. Four of the families included in this study attended one session. Families’ demographic and anthropometric data are provided in Table 1. Parent recommendations to improve pediatric weight management programs were grouped into three categories: (i) access to care, (ii) content of care, and (iii) delivery of care (see Table 2). Because our analyses did not reveal any substantial differences in parents’ recommendations across our four study sites or based on whether participants completed or discontinued programming, interview data are presented in aggregate form.

**Access to Care**

Participants made three primary recommendations related to improving clinic accessibility, suggesting that (i) evening and weekend appointment times should be offered, (ii)
programs and appointments should not take place during dinner time, and (iii) a greater variety of appointment and program times should be offered. Participants also mentioned that programs and appointments should take place at sites closer to their homes, including smaller communities outside of larger metropolitan areas. Finally, parents felt that offering free parking and/or bus tickets would enhance access to care.

Content of Care

A number of parents recommended that clinics should focus more on issues related to physical activity including (i) having fitness equipment available so that children could exercise as part of their clinical care, (ii) teaching proper exercise techniques and suggesting exercise routines for children to apply at home, and (iii) partnering with community-based fitness centers to offer subsidized gym memberships.

Parents also recommended that clinic staff provide more information relevant to (i) nutrition, (ii) cooking and meal preparation, (iii) their children’s health, including metabolism, cholesterol levels, and blood pressure, and (iv) how to access other relevant community programs. Parents suggested that programs should strive to reduce repetition as well as offer more educational resources for them and their children.

Further, parents felt that clinical staff should address weight-related issues more directly. Parents also believed that clinics should track participants’ weight, body measurements, and goal achievement more frequently.

Finally, participants felt that clinics should place greater emphasis on psychological services related to obesity. More frequent visits with psychologists were also endorsed in order to more fully support positive mental health among families.
Delivery of Care

Parents made a number of recommendations regarding the delivery of care within clinics. Specifically, they recommended individualized care, expressing that health services should be tailored to families’ needs. Parents suggested that clinicians should perform an initial assessment to determine families’ needs and expectations, which could be addressed subsequently during clinic appointments and interventions. Depending on individual preferences, participants also suggested offering options for group and individual care. In addition, parents recommended that clinics should be more responsive to different cultures, diversity in socioeconomic status, and children with special needs.

Duration of care emerged from our data as well. On one hand, some felt that interventions should be shorter. Conversely, others advocated for longer programming. Other parents recommended that health services should be extended to include follow-up sessions.

Parents felt that more interactive elements would enhance enjoyment and participation in care. Specific recommendations were to (i) include more practical, hands-on activities (e.g., cooking classes, field trips), (ii) text message or email children throughout the week to check-in, and (iii) provide feedback on children’s weight loss and other progress.

Parents also endorsed more opportunities for their children to interact with their peers. According to parents, this could take the form of (i) peer support groups, (ii) recreational group activities with other families, and (iii) past program participants attending programs to interact with current participants and offer firsthand accounts of their successes.

Finally, participants suggested that clinics should offer more opportunities for parents and children to participate together rather than separately. Similarly, parents suggested that clinics should offer opportunities for siblings to participate. Even when working with individual
children, parents commented on the need for clinicians to consider the dynamics and circumstances of the whole family.

**DISCUSSION**

The purpose of our study was to characterize parent recommendations for improving health services for managing pediatric obesity across several multidisciplinary, tertiary-level clinics in Canada. Parents, which included mothers and fathers who completed care as well as those who dropped out prematurely, provided varied, practical recommendations, many of which could be implemented to help enhance care accessibility, content, and delivery for managing pediatric obesity.

With respect to accessibility, parents emphasized the value of having a greater variety of scheduling options from which to choose. This finding is consistent with other studies in weight management that cited limited appointment options as a challenge,\textsuperscript{15-20} an issue that is common among individuals managing chronic illnesses.\textsuperscript{30} Similarly, parent recommendations regarding clinic location and support for transportation reinforced previous reports that characterized these factors as barriers to accessing care and reasons for attrition.\textsuperscript{14,15,19,20} Access to health services is an important quality metric\textsuperscript{31} that has catalyzed efforts to improve aspects of supply (providing health services) and demand (seeking health services) in health services delivery.\textsuperscript{32} The evaluation of different strategies (e.g., videoconferencing, telephone counseling) to improve accessibility to health services for managing obesity has shown positive results regarding feasibility and acceptability, particularly for rural families with limited access to treatments.\textsuperscript{33,34} In-person strategies including same-day appointments, walk-ins, and after-hours access have improved accessibility in other areas of health care\textsuperscript{35} and have the potential to enhance family
engagement in obesity management and reduce the risk of attrition. The ubiquity of digital technologies in our personal and professional lives highlights the potential for innovative platforms that enable families to connect with and gain professional support from clinicians. Some evidence suggests that the use of multiple, coordinated strategies that include modifying elements of supply and demand may be superior to singular approaches.

Parents made a number of recommendations related to clinic content, some of which have been reported previously. For example, a lack of exercise and physical activity programming for children and families has been reported as a reason for attrition. Similarly, parents have endorsed the desire for increased mental health support as well as structured meal planning and nutrition information. Participants in our study also expressed interest in having more detailed information regarding their children’s medical issues as well as community-based resources and services, which have not been documented as often in the literature. In contrast to organizational or structural factors that parents mentioned, some clinic and clinician-level recommendations may be more realistic and feasible for clinicians and clinic administrators to implement, although there is likely to be some between-clinic variability in how information about children’s health concerns (e.g., verbal communication only vs verbal and a written report given to families) and community-based resources (e.g., general information only vs refer family to service and follow-up) are shared with families. Some parents recommended an increased focus on weight and support to track changes in health and lifestyle habits over time. Indeed, a number of evidence-based behavior change techniques (e.g., maintaining diet records, goal-setting) can help individuals to make and sustain healthy lifestyle changes. However, it can be challenging to translate evidence into changes in practice, especially since clinicians and families can hold different views about strategies that can facilitate behavior change and because some
parents prefer to focus on making healthy lifestyle choices rather than weight loss and obesity per se. The potential mismatch between clinicians’ and families’ views underscores the importance of establishing open communication, trust, rapport, and shared decision-making in pediatric weight management. Motivational Interviewing is particularly suitable for this purpose since as a patient-centered form of communication, it allows patients and clinicians to explore values, interests, and concerns, negotiate treatment goals and courses of actions, and enhance motivation to change.

Assessing families’ individual needs and expectations at the onset of treatment might help to reduce attrition and optimize outcomes. Our observation that some parents recommended interventions of shorter duration while others suggested longer might reflect variability in their clinic experiences since the clinical sites in our study varied somewhat in the types and lengths of interventions they offered locally. It is notable that parent recommendations related to program duration did not vary according to whether families completed treatment or not. Parents’ recommendations should be viewed in light of evidence that suggests ≥25 hours of contact between families and clinicians is linked with improved weight status in children with obesity. In our clinical experience, very few families receive this high intervention dose. Recommending shorter interventions may reflect competing demands and busy lives of families, lower parental readiness and motivation for treatment or unrealistic expectations about weight management; however, the meaning of shorter or longer treatment for parents warrants further exploration. Consistent with previous studies, our data suggested that parents valued a menu of health services for obesity management, which allows them to negotiate treatment options according to their readiness, expectations for care, and circumstances. In our experience, developing a range of therapeutic options is labor intensive for clinicians (e.g., time, personnel,
expertise), but can be very beneficial for families because it serves to connect families with a broader community of resources, tools, and services that can support families over time and across settings.

Our study was not without limitations. First, transferability of findings may be limited due to social-demographic characteristics of interviewed parents who were English speaking, primary Caucasian, and educated beyond high school. Second, some parents of children who discontinued care seemed to be insufficiently informed about the characteristics and number of services available to them. Third, although parents were encouraged to recommend changes to enhance weight management services, social desirability bias may have prevented full disclosure of recommendations, especially those related to sensitive issues including care delivery. Lastly, our analyses might have been enhanced by including the perspectives of children as well as those of clinicians which have been suggested as a valuable source of information to improve treatment and outcomes.\(^{40}\)

**CONCLUSION**

Parents offered many recommendations to enhance modifiable aspects of accessibility, content, and delivery of care. However, the efficacy of suggested changes to improve weight management services and families’ engagement in care remain to be examined. The variability of needs, preferences, and circumstances observed across families challenges the one-size-fits-all approach to pediatric weight management because it neither accurately reflects the chronic, complex nature of obesity nor the diverse needs and desires of families who seek health services. Priority should be given to implementing and evaluating recommendations that clinicians and
program administrators regard as feasible and potentially effective strategies to optimize participation in health services for managing pediatric obesity.
REFERENCES


30. Fradgley EA, Paul CL, Bryant J. A systematic review of barriers to optimal outpatient specialist services for individuals with prevalent chronic diseases: what are the unique and common barriers experienced by patients in high income countries? *Int J Equity Health* 2015;14:52.


Online Table 1. Interview guide.

- Who referred you and why?
- Was there anything positive or negative about the referral process that stood out to you?
- What could health care professionals have done better when referring your child to the clinic?
- What were your feelings after the orientation session and what should have been done differently?
- Who made the decision to come to the program and why?
- What did you expect from the program? Were your expectations met?
- What motivated you to keep coming back or to stop coming?
- What were the strengths of the program?
- What were the weaknesses of the program? Was there anything you were unhappy with?
- What do you think would help other families want to come and stick with the program?
- What are the things that health care professionals could do to make it easier to initiate and continue care?
Table 1. Anthropometric and demographic characteristics of parents and children.

<table>
<thead>
<tr>
<th></th>
<th>Parents (n=65)</th>
<th>Children (n=65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>46.1 ± 6.9</td>
<td>14.3 ± 2.0</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>163.6 ± 8.6</td>
<td>163.2 ± 12.1</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>86.8 ± 25.0</td>
<td>87.2 ± 26.5</td>
</tr>
<tr>
<td>Families with overweight children (n;%)</td>
<td>29; 46%</td>
<td></td>
</tr>
<tr>
<td>Families with obese children (n;%)</td>
<td>34; 54%</td>
<td></td>
</tr>
<tr>
<td>Body mass index (BMI; kg/m²)</td>
<td>31.8 ± 8.2</td>
<td>32.0 ± 6.7</td>
</tr>
<tr>
<td>BMI percentile</td>
<td>-</td>
<td>98.2 ± 2.4</td>
</tr>
<tr>
<td>BMI z-score</td>
<td>-</td>
<td>2.58 ± 0.70</td>
</tr>
<tr>
<td>Sex (n; %)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>57; 88%</td>
<td>32; 49%</td>
</tr>
<tr>
<td>Male</td>
<td>8; 12%</td>
<td>33; 51%</td>
</tr>
<tr>
<td>Ethnicity (n; %)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>47; 72%</td>
<td>44; 68%</td>
</tr>
<tr>
<td>Non-Caucasian</td>
<td>16; 25%</td>
<td>19; 32%</td>
</tr>
<tr>
<td>Education (college/university or higher)</td>
<td>48; 74%</td>
<td>-</td>
</tr>
<tr>
<td>Family income (&gt;50,000/y CDN)</td>
<td>34; 52%</td>
<td>-</td>
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</table>
Table 2. Summary of parents’ (n=65) recommendations to improve health services for managing pediatric obesity.

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Key Messages</th>
<th>Supporting Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>Scheduling</td>
<td>• Offer evening and weekend appointments.</td>
<td>“I personally think it would be a big improvement if they would offer clinic times in the evenings for parents who are working.” (Mother of an overweight girl who did not complete the program)</td>
</tr>
<tr>
<td></td>
<td>(44%; n=29)</td>
<td>• Avoid appointments that take place during suppertime.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Offer a greater variety of appointment times.</td>
<td></td>
</tr>
<tr>
<td>Program location</td>
<td>Provide services in sites closer to participant homes.</td>
<td>“There’s no reason that they always have to come to the hospital…you can have satellite locations…so it’s easier to get to.” (Mother of an obese girl who did not complete the program)</td>
<td></td>
</tr>
<tr>
<td>(24%; n=15)</td>
<td></td>
<td>• Offer free parking</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provide bus tickets</td>
<td>“If the program can provide valid parking…you don’t need to worry.” (Mother of an overweight boy who did not complete the program)</td>
</tr>
<tr>
<td>Transportation</td>
<td>(18%; n=12)</td>
<td>• Provide access to on-site fitness equipment.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Have clinicians demonstrate exercises and suggest exercise routines.</td>
<td>“Honestly, I was expecting a little more out of the fitness part of it…if you come into a place and you’re gonna get a workout, I think that would really be helpful.” (Father of an obese girl who did not complete the program)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Have programs partner with fitness centers</td>
<td></td>
</tr>
</tbody>
</table>
Information provision (25%; n=16)  
- Provide more nutrition information.  
- Offer information regarding cooking and meal preparation.  
- Provide more details regarding children’s medical health.  
- Give information regarding access to community fitness programs.  
  “I would have liked more in terms of what programs are out there…it’s hard to come upon things for kids” (Mother of an obese girl who completed the program)

Weight and progress tracking (15%; n=10)  
- Have clinicians address weight directly.  
- Track weight, body measurements, and goal achievement more frequently.  
  “I didn’t feel that the issue of weight loss was as central an issue. And I realize that’s philosophically the approach they take, but I was really hoping there might be a little bit more.” (Mother of an obese girl who completed the program)

Psychological services (13%; n=9)  
- Have clinicians emphasize the psychological aspects of obesity.  
- Offer more frequent appointments with psychology professionals.  
  “I would try and put in a little more in depth the counseling part of it, to get to the root of the problem maybe…see what’s going on, like why are you guys overweight...” (Father of an obese boy who did not complete the program)

Delivery of Individualized care  
- Assess families’ needs and expectations at

“I think each person needs to have their
<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendation</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care (29%; n=19)</td>
<td>Offer group and individual programming.</td>
<td>“Provide more services specific to that person’s needs.” (Mother of an obese boy who completed the program)</td>
</tr>
<tr>
<td></td>
<td>Be more responsive to family diversity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(e.g., culture, socioeconomic status, special needs).</td>
<td></td>
</tr>
<tr>
<td>Duration (29%; n=19)</td>
<td>Offer programs that are shorter in duration.</td>
<td>“Perhaps some of it could be more condensed, so a shorter timeframe, but more intense use of time.” (Mother of an obese girl who completed the program)</td>
</tr>
<tr>
<td></td>
<td>Offer programs that are longer in duration.</td>
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<td></td>
<td>Extend programs to include follow-up sessions.</td>
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<tr>
<td>Interactive elements (25%; n=16)</td>
<td>Include more practical and/or hands-on activities.</td>
<td>“I think with kids making it more interactive… and more hands on… like trying to cook a meal.” (Mother of an overweight boy who did not complete the program)</td>
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<td>Check in with families throughout the week via text message or email.</td>
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<td>Provide interactive feedback on weight loss and progress.</td>
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<td>Peer contact (21%; n=14)</td>
<td>Offer peer support groups.</td>
<td>“If they had some type of group that was set up and the kids could go… they’re socializing with kids that have the same problems… they’re working out, they’re having fun, and they’re also talking to peers.” (Mother</td>
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</table>
Family inclusivity (21%; n=14)

- Have parents and children participate together rather than separately.
- Permit siblings to participate in programs.
- Consider whole family dynamics and circumstances.

“I personally think you need to have a holistic look…a good understanding of the family dynamics together.” (Mother of an overweight boy who completed the program)

of an obese girl who did not complete the program)