Empowering Clinicians as Advocates Against Childhood Obesity

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ABSTRACT

Obesity and overweight affect nearly one in three American children and adolescents. Clinicians can undertake a range of steps to encourage healthy behaviors, from patient and parent counseling to advcating for policy and environmental changes in their community. A curriculum of targeted to California clinicians demonstrates that online continuing medical education can promote awareness of these issues as well as practice-based changes.

BACKGROUND

About a third of US children and adolescents are overweight or obese. [NIDDK 2012; Ogden 2012] Obesity and overweight are associated with dyslipidemia, metabolic syndrome, early onset of puberty, obstructive sleep apnea, fatty liver disease, and other conditions. [August 2008] Within California, rates of overweight and obesity have plateaued in recent years, but the incidence varies widely by county. [CCPHA 2011]

Strategies to address childhood obesity include prevention and intervention approaches at the patient, family, and community level, as well as tactics that affect cultural environments and policy adoption. Clinicians can take steps to improve their patients' health not only at the individual level, but by advocating for healthier communities. More than 95% of 6,950 healthcare providers surveyed by Medscape feel a responsibility to make an impact on obesity-related public policy. [Medscape Education Survey 2010]

PROGRAM CONTEXT

In partnership with The California Endowment, Medscape developed a four-part continuing education curriculum for physicians and nurses (Table 1) that outlined the epidemiology of pediatric overweight and obesity nationally and in California, clinical and lifestyle interventions for patients and families, and steps clinicians can take to become advocates for obesity prevention. These programs launched in the summer of 2013 and, in the first six months, attracted more than 6,000 clinician learners within California and more than 61,000 nationwide.

TABLE 1 — Continuing Education Programs on Pediatric Overweight and Obesity

Title	Launch Date	CA Participants	Overall Participants
A Focus on Childhood Obesity in California	6/28/2013	2,082	18,651
Become a Child Health Advocate for Obesity Prevention in California	6/28/2013	1,253	9,582
Preventing Childhood Obesity: School Food and Physical Activity	7/31/2013	1,647	20,518
Best Practices in Preventing Childhood Obesity: Advocating for Health Communities	8/29/2013	1,049	12,450
TOTAL		6,031	61,201

EVALUATION METHODS AND RESULTS

Learners who participated in two activities were asked to complete a Planned Change Assessment survey indicating what professional changes they planned to initiate as a result of having participated in the activities. Respondents included 406 clinicians from California and 2,405 from other states. Characteristics of participants (by percentage) are summarized in Table 2.

TABLE 2 — Planned Change Assessment - All Participants*

	California (%) (n=406)	Non-California (%) (n=2,405)
Profession		
MD/DO	66	47
NP/RN	30	50
PA	4	3
Specialty		
Primary Care	37	41
Pediatrics	63	59
Practice setting		
Rural	14	26
Suburban	42	43
Urban	44	31
Estimated income level of patient population		
Poverty level (<$24,000)	21	21
Low income ($24,000 to $37,000)	35	38
Middle income ($37,000 to $75,000)	36	35
Upper income ($76,000+)	8	5
Racial/ethnic demographics of patients		
>50% African American, Latino, Asian, Pacific Islander	60	39
>50% White	32	52
Other	9	9

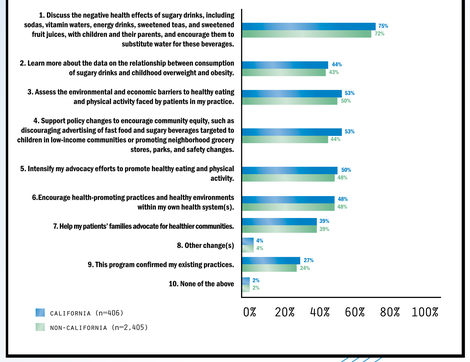
*Numbers may not equal 100 because of rounding.

Among 2,811 respondents of the Planned Change Assessment survey (Table 3):

- 75% of California clinicians and 72% of non-California clinicians indicated they intend to discuss negative effects of sugary drinks with children and their parents.
- 53% of California clinicians and 44% of non-California clinicians indicated they would support policy changes that encourage community equity, such as discouraging advertising of fast food to children in low-income communities.
- 53% of California clinicians and 50% of non-California clinicians indicated they would assess their patients' environmental and economic barriers to healthy eating and physical activity.
- 48% overall indicated they planned to encourage health-promotion practices within their healthcare systems.
- When the percentage of changes intended was analyzed by clinician practice location, California practitioners in urban settings indicated the most changes, while non-Californians in suburban settings indicated the most changes.
- When intended changes are measured by patient income level, most changes were intended by those treating low- to middle-income patients; however, 19% of intended changes by Californians were among those whose patients are in the poverty level of income, an income level very likely to be impacted by obesity.

TABLE 3 — Intended Changes

"As a result of participating in this activity, I intend to..." (Select all that apply.)



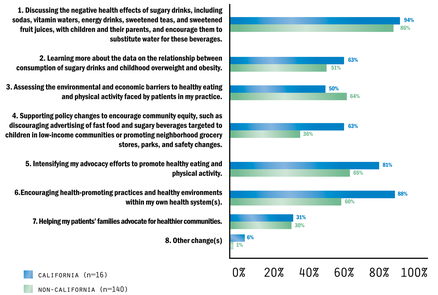
Of the 165 learners who completed a follow-up survey approximately eight weeks after completion of the activities (California, n=17; non-California, n=148), 156 (95%) reported that they had made a change in clinical practice as a result of their participation in the activities. A total of 626 changes were selected. Many respondents to the follow-up survey indicated that they already performed a number of these behaviors, while others reported engaging in them more consistently. On average, learners selected 3.6 planned changes to undertake and averaged 4 completed changes.

Among the learners who completed the follow-up survey (Table 4):

- 94% of California clinicians and 86% of non-California clinicians indicated that they now discuss negative effects of sugary drinks with children and their parents.
- 50% of California clinicians and 64% of non-California clinicians assess their patients' environmental and economic barriers to healthy eating and physical activity.
- 63% of California clinicians and 36% of non-California clinicians who made changes in practice support policy changes that encourage community equity, such as discouraging advertising of fast food to children in low-income communities.
- 88% of California clinicians and 60% of non-California clinicians reported that they now encourage health-promotion practices within their health systems.

TABLE 4 — Implemented Changes

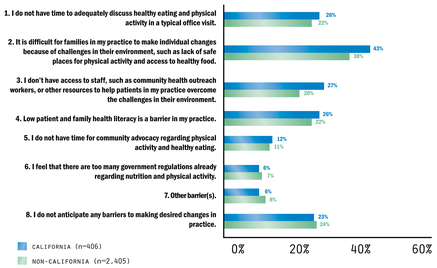
Please indicate what you are doing differently as a result of participating in this program. (Select all that apply.)



Respondents were asked to indicate barriers to that may prevent changes in practice. They were able to select as many of the barriers as applied to them. The most common barriers selected included environmental factors (lack of safe places for physical activity or access to healthy food), lack of access to community outreach staff, and low patient and family health literacy. (Table 5)

TABLE 5 — Barriers to Change in Practice

Please indicate any barriers that may prevent you from making any changes in practice. (Select all that apply.)



CONCLUSIONS

This curriculum, which blended epidemiology, clinical, and policy-related learning objectives, was most effective in prompting physicians to discuss the effects of sugary beverages with their patients, encourage healthy practices within their own health system, and intensify the role of clinicians as advocates for healthy eating and physical activity. Based on self-reported data from follow-up survey completers, the activities encouraged clinicians to take on new approaches to preventing obesity or to follow best practices more consistently.

IMPLICATIONS FOR RESEARCH AND/OR PRACTICE

Future investigation options include attempting to reproduce these findings with similar curricula built for specific regions with large youth populations, focusing on local policy environments and cultural makeup.

References

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