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Primary-Care Weight-Management Strategies: Parental Priorities and Preferences

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Abstract

Objective—Examine parental perspectives/rankings of the most important weight-management clinical practices; and, determine whether preferences/rankings differ when parents disagree that their child is overweight.

Methods—Mixed-methods analysis of a 32-question survey of parents of 2-18 year-old overweight children assessing parental agreement that their child is overweight, the single most important thing providers can do to improve weight status, ranking AAP-recommended clinical practices, and preferred follow-up interval. Four independent reviewers analyzed open-response data to identify qualitative themes/subthemes. Multivariable analyses examined parental rankings, preferred follow-up interval, and differences by agreement with their child's overweight assessment.

Results—Thirty-six percent of 219 children were overweight, 42% were obese, and 22% severely obese; 16% of parents disagreed with their child's overweight assessment. Qualitative analysis of the most important practice to help overweight children yielded 10 themes; unique to parents disagreeing with their children's overweight assessments was, “change weight-status assessments.” After adjustment, the three highest-ranked clinical practices included, “check for weight-related problems,” “review growth chart,” and “recommend general dietary changes” (all

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$P < .01$);” parents disagreeing with their children’s overweight assessments ranked “review growth chart” as less important, and “reducing screen time” and “general activity changes” as more important. The mean preferred weight-management follow-up interval (10-12 weeks) did not differ by agreement with children’s overweight assessments.

Conclusions—Parents prefer weight-management strategies that prioritize evaluating weight-related problems, growth-chart review, and regular follow-up. Parents who disagree that their child is overweight want changes in how overweight is assessed. Using parent-preferred weight-management strategies may prove useful in improving child weight status.

Keywords

childhood obesity; primary care; weight management; parents

INTRODUCTION

Primary-care visits for overweight children are important opportunities to assess and treat overweight/obesity, but strategies are needed to help providers maximize the effectiveness of these opportunities. AAP recommendations for the assessment/treatment of childhood overweight/obesity include identifying a child’s weight status, assessing medical/behavioral risk factors, and preventing/treating obesity using parent/family counseling, a stepwise treatment approach, and longitudinal follow-up.¹

Parental input is needed regarding primary-care weight-management strategies preferred by parents. Research suggests that interventions that include parents and incorporate preferences of target populations are more effective than those that do not.² Prior qualitative research conducted by our team indicates that parents have specific preferences regarding weight-management strategies; however, many preferences appear to be discordant.³ For example, parents’ recommendations on the primary-care provider’s role in weight management included both discussing weight-related health risks and not using health risks as scare tactics.³ Parents also recommended de-emphasizing weight and specifying whether a child needs to maintain or lose weight, and how much weight the child should lose.³ Parents also differed in their agreement that their child was overweight. Notably, studies document that many parents of overweight children do not perceive their child to be overweight⁴⁻⁵; and parents who do not perceive that their child is overweight are less likely to be concerned about their child’s weight status.⁶ Therefore, a follow-up mixed-methods study was conducted in a larger sample of parents of children from a wider age-range (2-18 year-olds). The study aims were to examine parental perspectives regarding the single-most important thing providers can do to improve an overweight child’s weight status, parental rankings of specific AAP-recommended weight-management clinical practices, and whether preferences/rankings differ when parents disagree with children’s overweight assessments.

METHODS

Study Design

In this mixed-methods analysis of a cross-sectional survey, a consecutive series of parents/guardians (hereafter referred to as “parents”) was recruited from an academic primary-care

clinic at Children's Medical Center (CMC) and administered a 32-question survey. CMC is the seventh largest pediatric hospital in the US. Over 12,000 school-age children are followed in its affiliated primary-care clinics, including 4,100 who are cared for at the academic primary-care teaching clinic and 8,000 at satellite community clinics. Data document that 60% are Latino, 25-30% are African American, and almost all are publicly insured.⁷ Eligibility criteria were parent/legal guardian of a 2-18 year-old overweight (body-mass-index [BMI] 85th percentile calculated directly using measured weight/height⁸) child, and parental English or Spanish proficiency. The reason for including parents of overweight (vs. obese) children is that, compared to healthy-weight children, children with BMIs-for-age 85th-<95th percentile have poorer health status⁹; higher cholesterol and blood pressure¹⁰; and the same Expert-Committee-recommended prevention/treatment strategies for those with risk factors (including concerning family histories, high blood pressure/cholesterol, or large changes in BMI).¹ Eligible parents were identified by reviewing medical records of patients scheduled for a visit between June-September 2013. Upon completion of recruitment, 34 parents who disagreed that their child was overweight had been enrolled; for quantitative analyses by parental agreement, this sample size allowed detection of a 30% difference in mean clinical-practice rank with 90% power.

Prior to survey administration, parents were informed by their child's provider that they were eligible for the study because their child's weight-for-height/BMI was consistent with overweight. Surveys were orally administered by trained staff to avoid literacy issues. Questions assessed socio-demographic characteristics of the parent (including self-reported weight/height) and child; parental agreement with the provider's assessment of their child's weight status, the single-most important thing a provider can do to help improve their child's weight status (open response), ranking AAP-recommended clinical practices, and preferred frequency of weight-management follow-up. All parents provided written informed consent. The study was approved by the UT Southwestern IRB.

Main Outcome Measures

Parents were asked, "What is the single-most important thing your child's pediatrician can do to improve his/her weight status?" Open-response answers were written down verbatim by trained staff, then reviewed with parents for accuracy/completeness. Spanish responses were reviewed and transcribed into English by a bilingual medical student and bilingual pediatrics fellow trained in medical Spanish.

Next, parents ranked the importance of 13 recommended weight-management clinical practices that were selected and adapted from strategies in the Expert Committee Recommendations (Appendix 1).¹ The list was read to the parent by trained staff who also provided a written copy; parents ranked the importance of each item from 1-13, where "1" indicated the single-most important practice to "13," the least important. Clinical practices included: "review your child's growth chart," "check for weight-related problems (for example, diabetes)," "recommend general dietary changes," "recommend a specific diet," "recommend general activity changes," "recommend specific activity changes (for example, get one hour of exercise/day)," "recommend reducing screen time," "recommend parental role-modeling of a healthy diet/exercise plan," "tell you how much child's overweight," "tell

you how many pounds child needs to lose by next visit” (which parents were told included 0 pounds for growing children who need to maintain their weight¹), “refer to a nutritionist,” “refer to a weight-management program,” and “follow-up more frequently.” Staff confirmed that each rank was used only once and parents had no further edits to rankings.

Parents were asked to specify their preferred frequency of weight-management follow-up. Response options included: every week, every two weeks, every three weeks, every month, every two months, every three months, every four months, every six months, every year, or never. For analyses, responses were transformed into a continuous variable, preferred follow-up in weeks, from 0 (never) to 48 weeks (every year).

Independent Variables

Independent variables included child weight status (overweight [BMI% 85-<95th], obesity [BMI% 95-<99th], or severe obesity [BMI% 99th]), age (2-5, 6-11, or 12-18 years old), and race/ethnicity (African American, Latino, non-Latino white, or other); parent’s highest educational attainment, age, and weight status; mean annual household income; and parental agreement with the provider’s assessment that their child was overweight (using a 5-point Likert scale ranging from strongly agree to strongly disagree). For analyses, parental agreement with providers’ assessments of children’s overweight was dichotomized as strongly disagree/disagree vs. strongly agree/agree/neither agree nor disagree.

Analysis

Parental responses regarding “the single-most important thing your child’s pediatrician can do to improve his/her weight status” were analyzed using margin coding and grounded theory.¹¹ Thematic coding and the constant-comparison method were used to identify response themes and subthemes within and between parental responses.¹¹ Four trained coders independently reviewed parental responses, identifying qualitative themes/subthemes and illustrative quotes. To validate thematic coding for the sample overall and by parental agreement with children’s overweight assessments, coders met to compare results, finalize a taxonomy of themes/subthemes, and resolve disagreements through consensus.

Bivariate and multivariable analyses examined associations of parental disagreement with ranking of the most important clinical practices providers can use to improve their child’s weight status and preferred follow-up interval. In multivariable analyses, the dependent variable was clinical-practice rank or follow-up frequency. All covariates (child weight status, race/ethnicity, age, and gender; parental educational attainment, age, BMI, and annual household income) were entered into models and selected with backward-stepwise regression and an alpha-to-stay <.15. Variables with a *P*-value <.05 were considered significant. Analyses were performed using SAS version 9.2.

RESULTS

Of 244 children (242 parents) screened in clinic, 221 (91%) were enrolled in the study (219 parents—two parents completed surveys on separate days for siblings). Compared to parents who enrolled, those who did not enroll were more likely to be parents of African-American and 6-11 year-old children. The most common reasons cited for not enrolling were time

limitations and lack of interest. Of those enrolled, data from two surveys were censored from analyses (one child received nutrition through a gastrostomy tube and another survey was terminated due to time limitations).

Of 219 children, 33% were 2-5 years old, 38%, 6-11 years old, and 28%, 12-18 years old; 43% were female; 36% overweight, 42% obese, and 22% severely obese; 60% were Latino, 34% African-American, 1% non-Latino white, and 5% more than one/other race/ethnicity (Appendix 2). For parents ($N=217$), the mean age was 34 years old; 46% were obese; 19% had less than a high-school degree; 34% had a high-school degree/equivalent; the median annual household income was \$24,000; and regarding agreement that their child was overweight, 68% strongly agreed/agreed, 16% neither agreed nor disagreed, and 16% strongly disagreed or disagreed with the provider's assessment that their child was overweight.

Characteristics significantly associated with parental disagreement with children's overweight assessment included child overweight (vs. obesity/severe obesity), lower household income, African-American race/ethnicity, and having attained a technical degree/some college (Table 1). No other factors were significantly associated with parental disagreement.

Qualitative analysis of the most important thing a provider can do to help an overweight child improve his/her weight status yielded 10 themes (Table 2), 10 subthemes, and unique and overlapping themes/subthemes by parental agreement with children's overweight assessments. Major themes included change the weight-status assessment; provide parenting advice/partner with parents; dietary, activity, general, and weight advice; educational materials; risk factors/consequences; communication; refer to specialist; follow-up; and nothing/unsure. Unique to parents who disagreed that their child was overweight was the theme, change the weight-status assessment, including "*Have a BMI scale specific for ethnicity.*" Unique to parents who agreed that their child was overweight was partner with parents/provide parenting advice.

Remaining themes/subthemes were common to all parents. Five subthemes emerged under the theme "advice," including dietary, activity, diet and activity, general, and weight. An illustrative quote from a parent wanting dietary advice was, "Provide healthy food choices, particularly at fast-food places." A parent who wanted activity advice said, "*Give us a list of fun ways to exercise.*" Other parents wanted both diet and activity advice. One parent stated, "Talk to her about what she should or shouldn't eat and to exercise more." A parent wanting weight advice stated, "*Tell me if he really is overweight*"; another parent said, "*Give information on why they think he's overweight.*" Educational materials also were cited as helpful. One parent said, "Give me resources besides nutrition referrals—some kid activities outside the home, [a] printout with specific schedules [for] exercise and a meal plan."

In terms of the most important thing providers can do to help their child improve his/her weight status, discussion of risk factors and consequences of being overweight was cited. Another theme was communication; subthemes were communication with the parent/family and communication with the child. One parent said, "*Give advice about parenting.*" Another

remarked, “Talk to [the child] one-on-one, so they understand.” The importance of referrals to specialists was another theme. An illustrative quote was, “I’d like information from a nutritionist with specific diet recommendations.” Other parents cited follow-up as most important. One parent said, “Check weight at every visit and put pressure on me to address weight.” Among parents who stated that providers could do nothing to help their child improve their weight status, subthemes included general issues, the child’s responsibility, and the parent’s responsibility. A parent who noted that providers could do nothing in general to help their child stated, “We are doing exercises and watching what she eats already.” Exemplifying the subtheme, child’s responsibility, one parent stated, “It’s up to [your child], between parents and [the child].” And regarding the responsibility being the parent’s, an illustrative quote was, “*I have to change habits.*”

In the parental ranking of importance of specific clinical practices providers should use to help an overweight child, the number one most important thing parents said that providers can do is to check for weight-related problems, ranked #1 by 47% of parents who disagree and 33% of parents who agree that their child is overweight (Table 3). The second most important thing parents cited was review the growth chart, which was ranked #1 by 32% of parents who disagree and 33% of parents who agree. In the unadjusted analysis of the association of parental agreement that the child was overweight and specific clinical-practice rank, parents who disagree ranked state how much the child is overweight as less important, and recommend reducing screen time as more important compared to parents who agree (data not shown).

In the multivariable analysis, the top three highest-ranked clinical practices remained unchanged after adjustment, and included, check for weight-related problems, review the growth chart, and recommend general dietary changes (Table 3). Of the remaining 10 clinical practices, parents ranked as next important, recommend reducing screen time, refer child to nutritionist, recommend specific activity changes, state how much child is overweight, and recommend specific dietary changes. Parents ranked as least important, recommend parental role modeling, state how many pounds your child needs to lose by the next visit, recommend general activity changes, refer child to intensive weight-management program, and follow-up with child to monitor weight and goals more frequently. In the adjusted analysis of the association of parental agreement with children’s overweight assessments and specific clinical-practice rank, parents who disagree were significantly more likely to assign a lower rank for review growth chart ($\beta = -2.3$, $P = .02$) and higher ranks for recommend reducing screen time ($\beta = 1.7$, $P = .02$) and recommend general activity changes ($\beta = 1.4$, $P = .02$) (data not shown).

In bivariate analysis, the mean preferred frequency of follow-up to address weight management among parents who agreed that their child was overweight was 10 weeks, vs. 12 weeks among parents who disagreed. After adjustment, the preferred follow-up frequency did not differ by parental agreement with children’s overweight assessments, and was approximately 10 weeks ($P > .05$, data not shown).

DISCUSSION

This study provides new information regarding parental preferences and rankings of weight-management clinical practices recommended by the Expert Committee, including preferences of parents who disagree with the provider's assessment that their child is overweight. A novel study finding is that parents rank checking for weight-related problems as the single-most important thing providers can do to help an overweight child improve his/her weight status. Childhood obesity is strongly associated with multiple comorbid problems, such as high blood pressure, hyperlipidemia, dysglycemia, poor health status, and emotional/behavioral problems^{9-10,12}; however, rates of risk-factor screening and communication appear to be suboptimal, according to data from a cross-sectional study of video-recorded provider-patient communication regarding weight-management: providers discussed family history in 35% of visits, communicated abnormal physical-exam findings in 42% of visits, and recommended obesity-related laboratory studies in 62% of visits.¹³ The study findings suggest that performing risk-factor screening and result communication may help providers partner with parents and overweight children on weight management.

Parents cite reviewing their child's growth chart as the second-most important thing providers can do to help an overweight child improve his/her weight status, even among parents who disagree that their child is overweight. This finding complements data from a nationally-representative study in which two-thirds of parents stated that it was important to be shown their child's growth chart; however, in the same study, almost 80% of parents interpreted their child's growth chart incorrectly.¹⁴ Perhaps parents rank growth-chart review so highly because they want to better understand the information conveyed by the growth chart. Providers might have the greatest impact by using the growth chart as a useful tool both at well-child visits and for weight management; and, providers might couple practical information regarding what the BMI-percentile cutoffs mean for health, by pointing to the 85th BMI-percentile line and indicating that above that line, children are more likely to have at least one risk factor for heart disease, and that children with a BMI-percentile above the 95th percentile line are more likely to have two or more risk factors for heart disease,¹⁵ even among children as young as 1-5 years old.¹⁶ The provider then could use the growth chart as a springboard for a dialogue with the parent and child about how best to tailor the weight-management plan.

Parents who disagree that their child is overweight want changes in how overweight is assessed, and rank growth-chart review lower and recommending physical activity and reducing screen time higher than parents who agree. Although it is unclear why parents who disagree with their child's overweight assessment prefer recommendations for activity and reduced screen time, the qualitative data suggest that parents who disagree want the weight-status assessment changed, such as using ethnicity-specific growth charts. This is an interesting point, given that race/ethnicity-specific differences do exist in the relationship between BMI-percentile and adiposity. For example, compared with white children with the same BMI-percentile, African-Americans have less fat mass.¹⁷ Early prevention/treatment of childhood obesity, however, is especially important for African-American children. Compared with overweight white children, overweight African-American children are at far greater risk of having their high BMI persist into adulthood, developing more severe obesity-

related health complications, and suffering higher morbidity and premature death from cardiovascular disease, diabetes, and stroke.¹⁸⁻¹⁹ For now, providers might acknowledge limitations to the way weight-status currently is assessed, and focus on the critical importance of establishing healthy habits early, to prevent long-term obesity and its related health consequences.

Certain study limitations should be noted. The sample was recruited from an academic primary-care clinic, and there were few parents of non-Latino white children, with college or professional degrees, or annual household incomes above the federal poverty level. Study results, therefore, may not generalize to children followed at community or private practices, who are white, or have parents with higher educational attainment or income levels. Also, parents were asked to rank the same weight-management strategies and goals despite having children of varying ages and BMI-percentiles. Because weight-management goals differ for children by age and BMI-percentile,²⁰ some parents were asked to rank weight-management strategies (for example, a goal to lose or maintain weight) that were not indicated for their child.

The study has some notable strengths. It is the first study, to our knowledge, to identify how parents prioritize the importance of specific clinical practices recommended by the AAP. Research suggests that interventions that include parents and incorporate the preferences of the target population are more effective than those that do not.² The study findings have important implications for clinical practice—for example, providers might ask parents about their assessment of their child's weight status before reviewing the growth chart; with parents of minority children who disagree with their child's overweight assessment, providers might acknowledge racial/ethnic differences in growth and focus on preventing long-term obesity and its related health consequences; and with all parents, providers might highlight the need for and results of weight-related comorbidity assessments. Another strength is the sample's excellent representation of parents of children from broad age ranges; overweight, obese, and severely obese children; and low-income and minority children. Studies of childhood obesity need greater inclusion of parents of minority, low-income children, because these children have significantly higher rates of overweight/obesity.²¹ The study also included a significant number of Latino parents with limited English proficiency, and a population disproportionately underrepresented in research.²²

CONCLUSION

Parents prefer primary-care weight-management strategies that prioritize evaluating weight-related problems, sharing the growth chart with parents, and regular follow-up, approximately every two months. Parents who disagree that their child is overweight want changes in how overweight is assessed, and prefer advice regarding limiting screen time and increasing physical activity. These findings suggest that using parent-preferred primary-care weight-management strategies and tailoring these strategies to parental agreement with the provider's weight-status assessment may prove useful in improving child weight status.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Carla Upperman assisted with designing the study and data-collection instruments, assisted with analyses and interpretation of data, contributed to drafting the manuscript, and approved the final manuscript, as submitted.

Zahra Merchant assisted with analyses and interpretation of data, contributed to drafting the manuscript, and approved the final manuscript, as submitted.

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Glenn Flores oversaw the study design and development of data-collection instruments, analyses, and interpretation of data; critically revised the manuscript; and approved the final manuscript, as submitted.

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Appendix 1: Survey questions

Survey question ranking the adapted Expert Committee Recommendations for primary-care weight management

Please rank the following in order from 1-13, using each number only once, where -1- is the SINGLE MOST IMPORTANT thing and -13-, the LEAST IMPORTANT thing, your pediatrician can do to help your child lose weight.

-
- ☐ Review your child's growth chart
 - ☐ Check for weight-related problems, including high blood pressure and diabetes
 - ☐ Recommend general dietary changes (for example, cut out soda and juice)
 - ☐ Recommend a specific diet (for example, a low-fat or low-carbohydrate diet)
 - ☐ Recommend general activity changes (for example, aim for one hour of exercise/day)
 - ☐ Recommend specific activity changes (for example, walk for one hour/day)
 - ☐ Recommend reducing "screen time" (TV/computer/video-game/cell phone use)
 - ☐ Recommend parental role-modeling of a specific diet and exercise plan
 - ☐ Tell you how much your child is overweight
 - ☐ Tell you how many pounds your child needs to lose by the next visit, including 0 pounds for growing children who need to maintain their weight
 - ☐ Refer child to a nutritionist
 - ☐ Refer child to an intensive weight-management program
 - ☐ Follow up with child to monitor weight and goals more frequently
-

Survey question regarding preferred follow-up frequency

How frequently should YOUR CHILD's pediatrician schedule a follow-up visit to address his/her weight? Every week

-
- ☐ Every two weeks
☐ Every three weeks
☐ Every month
☐ Every two months
☐ Every three months
☐ Every four months
☐ Every six months
☐ Every year
☐ Never
-

Appendix 2: Participant Characteristics

Characteristic		<i>n (%) or mean (SD)</i>
Child Characteristics		(N = 219)
Child age, in years	2 – 5	72 (33%)
	6 – 11	83 (38%)
	12 – 18	61 (28%)
Female gender	Female	94 (43%)
BMI-percentile category	Overweight	79 (36%)
	Obesity	92 (42%)
	Severe obesity	48 (22%)
Race/ethnicity	Latino	131 (60%)
	African-American, non-Latino	75 (34%)
	White, non-Latino	2 (1%)
	More than one or other	11 (5%)
Parent Characteristics		(n = 217)
Age	Mean age, in years (SD)	34 (9.1)
Weight status	Overweight, BMI 25 - <30 kg/m ²	56 (26%)
	Obesity, BMI ≥ 30 kg/m ²	100 (46%)
Educational attainment	Less than high-school degree	42 (19%)
	High-school degree/GED	74 (34%)
	Technical school/some college	74 (34%)
	College/professional degree	27 (13%)

Characteristic		<i>n (%) or mean (SD)</i>
<i>Child Characteristics</i>		<i>(N = 219)</i>
Income	Median annual household income, \$ (IPR)	\$24,000 (16,800-34,000)
Agreement that child is overweight	Strongly agree/agree	147 (68%)
	Neither agree nor disagree	34 (16%)
	Strongly disagree/disagree	34 (16%)

Abbreviations: SD, standard deviation; GED, general educational development; IPR, interpercentile range

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WHAT'S NEW

Preferred weight-management strategies identified by parents include checking for weight-related comorbidities, reviewing the growth chart, and regular follow-up. Parents who disagree that their child is overweight want weight-status assessments changed and strategies that include increasing activity and reducing screen time.

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Table 1

Participant Characteristics by Parental Agreement with Child's Overweight Assessment

Characteristic		Parental Agreement with Child's Overweight Assessment		<i>P</i>
		Strongly Disagree/ Disagree	Strongly Agree/ Agree/Neutral	
		<i>n</i> =34 (16%)	<i>n</i> =185 (84%)	
Characteristic		%	%	
Child BMI% category	Overweight	68	30	<.001
	Obesity	29	44	
	Severe obesity	3	25	
Annual household income, mean (SD)		\$22,400 (12,000)	\$28,800 (30,000)	<.001
Child race/ethnicity	African-American	56	30	.02
	Latino	38	64	
	White	0	1	
	More than one or other	6	5	
Educational attainment	Less than high-school degree	15	20	.09
	High-school degree/GED	21	37	
	Technical school/some college	53	31	
	College/professional degree	12	13	
Parent weight status	Obesity, BMI ≥ 30 kg/m ²	32	48	.09
Parental age	Mean age, in years (SD)	33 (11)	35 (9)	.11
Child age, in years	2 – 5	47	31	.16
	6 – 11	26	41	
	12 – 18	26	29	
Child gender	Female	32	45	.19

Abbreviations: GED, general educational development

Table 2

Illustrative Quotes Regarding the Most Important Thing a Provider Can Do to Help an Overweight Child Improve Their Weight Status

Theme	Illustrative Quote
Change weight-status assessment	<ul style="list-style-type: none"> “ <i>I disagree with measuring weight and height</i>” “ <i>Have [a] BMI scale specific for his ethnicity</i>”
Provide parenting advice/partner with parents	<ul style="list-style-type: none"> “ <i>Reinforce the things mom states, including limiting sugar-sweetened drinks and sugar; address [the] role of father in providing unhealthy foods</i>” “ <i>Help me find healthier eating habits, partner with me on managing her weight</i>”
Advice: Dietary	<ul style="list-style-type: none"> “ <i>Check up on [us], make sure we are doing the right thing to change her diet</i>”
Activity	<ul style="list-style-type: none"> “ <i>Give advice and tips on ways to keep my child fit</i>”
Diet and Activity	<ul style="list-style-type: none"> “ <i>Give tips on how to get him to exercise. Give recipes of healthy foods</i>”
General	<ul style="list-style-type: none"> “ <i>Counsel on ideas we can practice</i>”
Weight	<ul style="list-style-type: none"> “ <i>Stress importance of weight loss, relate to her the damage being overweight can cause to her body and mental state</i>”
Educational materials	<ul style="list-style-type: none"> “ <i>Give me resources besides nutrition referrals—some kid activities outside of the home, [or a] print-out with specific schedules [for] exercise and a meal plan</i>”
Risk factors/consequences	<ul style="list-style-type: none"> “ <i>Talk to [the] child about being overweight, including risks of being overweight</i>”
Communicate: With parent	<ul style="list-style-type: none"> “ <i>Talk to me directly, be completely honest about how serious his case may be</i>”
With child	<ul style="list-style-type: none"> “ <i>Talk to [the child] one-on-one so they understand</i>”
Refer to specialist	<ul style="list-style-type: none"> “ <i>Refer me to a nutritionist or a diet specialist</i>”
Follow-up	<ul style="list-style-type: none"> “ <i>Have more appointments to motivate him</i>”
Nothing: In general	<ul style="list-style-type: none"> “ <i>Nothing</i>”
Child's responsibility	<ul style="list-style-type: none"> “ <i>Nobody can do anything about it unless she wants to</i>”
Parent's responsibility	<ul style="list-style-type: none"> “ <i>I don't think there's anything I'm doing that I need to change</i>”
Unsure	<ul style="list-style-type: none"> “ <i>I don't know—I cook—I'm not a McDonald's parent</i>”

Parental Ranking of the Importance of Specific Clinical Practices Providers Can Use to Help an Overweight Child Improve His/Her Weight Status

Table 3

Specific Clinical Practice	Median Unadjusted Rank	Adjusted Rank (95% CI)
Check for weight-related problems	2	3.3 (2.8 – 3.8)
Review growth chart	3	5.0 (3.8 – 6.2)
Recommend general dietary changes	5	5.4 (4.9 – 5.8)
Recommend specific dietary changes	6	8.2 (6.3 – 10.0)
Recommend general activity changes	7	9.3 (7.1 – 11.6)
Recommend specific activity changes	7	7.6 (7.2 – 8.0)
State how much child is overweight	7	7.7 (4.4 – 10.9)
Follow up with child to monitor weight and goals more frequently	8	10.7 (8.6 – 12.8)
Recommend parental role modeling of a diet and exercise plan	8	8.2 (7.6 – 8.7)
Recommend reducing screen time	8.5	5.9 (3.5 – 8.3)
Refer child to nutritionist	9	6.7 (5.0 – 8.4)
State how many pounds your child needs to lose (or maintain weight) by the next visit	9	8.8 (5.4 – 12.2)
Refer child to intensive weight-management program	11	10.0 (7.8 – 12.3)