1-1-2017

Health Care Providers' Knowledge of Childhood Obesity Within the Hispanic Community

Daysi Fardales
Nova Southeastern University

HEALTH CARE PROVIDERS' KNOWLEDGE OF CHILDHOOD OBESITY WITHIN THE HISPANIC COMMUNITY

Presented in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Nursing Practice

Nova Southeastern University
Health Professions Division
College of Nursing

Daysi Fardales

December 14, 2017

NOVA SOUTHEASTERN UNIVERSITY
HEALTH PROFESSIONS DIVISION
COLLEGE OF NURSING

Certification

We hereby certify that this DNP project, submitted by Daysi Fardales, conforms to acceptable standards and is fully adequate in scope and quality to fulfill the project requirement for the Doctor of Nursing Practice degree.

Approved:

Kelly Henson-Evertz, DNP, RNC-OB, CTTS — Date 3/12/18
Interim Program Director, Doctor of Nursing Practice

Marcella M Rutherford — Date 3/15/18
Marcella M. Rutherford, PhD, MBA, MSN
Dean, College of Nursing

NOVA SOUTHEASTERN UNIVERSITY
HEALTH PROFESSIONS DIVISION
COLLEGE OF NURSING

This project, written by Daysi Fardales under direction of Dr. Gitana Ng, Project Chair, and approved by members of the project committee, has been presented and accepted in partial fulfillment of requirements for the degree of

DOCTOR OF NURSING PRACTICE

PROJECT COMMITTEE

Gitana Ng — 3/12/18

Gitana Ng, DNP, ARNP, NP-C, FNP-BC
Chair of DNP Project Committee — Date

Marcella M Rutherford — 3/15/18

Project Committee Member — Date

Abstract

Background: Recent studies indicate a rise in the prevalence of obesity in children of various age groups. Obesity was officially recognized as a disease by the American Medical Association (AMA) in June 2013. It has been acknowledged as a progressive epidemic public health crisis in the United States for the past 20 years. This is a health care concern that needs examination and the development of new and more effective prevention and treatment modalities for obesity in children. Environmental, hereditary, behavioral, and socioeconomic factors play a significant role in the prevalence of obesity (Rooney, Mathiason, & Schauberger, 2011). Childhood obesity can generate serious emotional and physical consequences, thereby compromising the quality of life among children.

Purpose: The purpose of this capstone project was to assess health care providers' cultural competency by assessing the management of Hispanic parents with children diagnosed with obesity. A culturally diverse survey was developed to evaluate pediatric health care providers' daily practice and management of Hispanic parents of children with obesity.

Theoretical Framework: Madeleine Leininger's Theory of Culture Care Diversity and Universality and the Health Belief Model constitute the theoretical framework of this capstone project.

Methods: The research project gained support from the private pediatric primary care office for the completion of a questionnaire to assess health care providers' knowledge of childhood obesity.

Results: The data analysis revealed that the health care providers surveyed had at times omitted the evaluation of parameters that were vital in managing the health care of obese or overweight children. Certain parameters, such as weight, were always considered. The data analysis revealed gaps in the care of Hispanic pediatric overweight or obese patients and Hispanic caregivers. As a result of the findings, a better understanding of the importance of providing culturally competent health care was gained.

Conclusion: This survey increased health care providers' awareness of the importance of taking culture into consideration. It identified the gaps, and measures are now being evaluated to improve the quality of care provided to these children.

Acknowledgements

The completion of this project has fulfilled a desire to advance my career. I would like to extend my sincerest gratitude to all who provided support and encouragement along the way. Without the help from these people, I would not have been able to complete this capstone project.

I would like to thank Dr. Mary D. Mites Campbell. Her guidance and support, from the beginning of my journey, led me to complete this project. I would also like to thank Dr. Gitana Ng, my chair, who was always available to review, repeatedly, the changes to my project. I further thank Dr. Eglintine Rigaud, who was always available to answer questions, and also provided feedback during my proposal presentation. Dr. Henson-Hertz was inspiring during my defense presentation and provided instrumental feedback. Their expertise and guidance helped me stay focused and complete this project.

I extend a special thanks to all at the Center for Pediatric Care, for their patience during this journey.

I thank my beautiful sister, niece, and daughters for always lifting my spirits, and keeping me from giving up during my most difficult life moments. I also thank my dear friend Ellen G., who always said, "You can do this."

Thanks to all at Nova Southeastern University School of Nursing, DNP program, directly, and behind the scenes, made it all possible. I will always be grateful.

Table of Contents

List of Tables

Chapter 1

Nature of Project and Problem Identification

A steady increase in the number of obese and overweight children has been registered over the past 10 years, making obesity a significant health problem affecting children in the United States (U.S.) (CDC, 2017). Since 1980, the prevalence of obesity has tripled among children in the U.S. (Fryar, Carroll, & Ogden, 2014), with current statistics indicating that approximately 31.7% of U.S. children are obese or overweight (Fitch et al., 2013). Recent studies also indicate a rise in the obesity prevalence in children of various age groups. For instance, according to Moseley (2014), recent data show that the prevalence of obesity among children aged 6 to 11 years has increased by 19.6%. Statistics provided by the National Center for Health Statistics (2016) show that the prevalence of obesity in children is 17.4% for those aged between 6 and 11 years old, and 9.4% for those aged between 2 and 5 years old for the period between 2013 and 2014. These statistics necessitate examination and the development of new and more effective prevention and treatment modalities for obesity in children.

There are significant socioeconomic, ethnic, and racial disparities in the prevalence of obesity among children in the U.S. (Guerrero et al., 2015). According to Fitch et al. (2013), African-American and Mexican-American children aged 6 to 11 years have a higher probability of becoming obese or overweight compared to White children within the same age group. In addition, approximately 43%, 37%, and 32% of Mexican-American, African-American, and white children, respectively, are overweight or obese

(Fitch et al., 2013). Variance in the prevalence of obesity is also evident among girls and boys from various U.S. races and ethnic groups. Based on these statistics, it is apparent that culture is a significant factor in the management of childhood obesity. Culture influences the decisions people make with respect to different aspects of life such as lifestyle, treatment modalities, perceptions about physical exercise, and physical and emotional fitness (Davis, Cole, Reyes, McKenney-Shubert, & Peterson, 2015).

Childhood experiences have a substantial impact on the behavior and lifestyle of people. Environmental, genetic, behavioral, metabolic, cultural, and socioeconomic factors play a role in the prevalence of obesity (Taveras, Gillman, Kleinman, Rich-Edwards & Rifas-Shiman, 2013). The origin of most obesity cases among adults is traceable to childhood development; the majority of overweight adults were obese during adolescence, and most obese adolescents were obese during childhood (Rooney et al., 2011). Culture plays a role in many aspects of life, and the decisions adults make may be influenced by childhood experiences. Parents seem to be overly concerned with providing a good foundation, to assist children develop a career, and to become model citizens as adults. This concern does not seem to include making healthier food choices, maintaining a healthy weight or BMI, or staying active. Children who experience early adiposity rebound (before the age of 5 years) have increases in mean body mass index (BMI) from age 3 to adolescence, and those that experience late adiposity rebound have decreases in BMI from age 3 to adolescence (Rooney et al., 2011). Consequently, children and adolescents are an ideal target group in managing the ever-increasing prevalence and impact of obesity cases in the United States.

Problem Statement

Currently, pediatric health care providers in South Florida are completing the office visits of obese and overweight children ages 6 to 11 with limited nutritional and weight management guidance or clinic referrals.

Purpose Statement

The purpose of this Doctorate of Nursing Practice project was to assess health care providers' cultural competency by assessing the management of Hispanic parents with children diagnosed with oobesity. A culturally diverse survey was developed to evaluate pediatric health care providers' daily practice and management of Hispanic parents of children with obesity.

Project Objectives

The objectives of this project were to:

1. Assess and review existing guidelines for culturally diverse parents of overweight and obese children by fall 2016.
2. Obtain institutional support to evaluate health care providers' management of Hispanic overweight and obese children by fall 2016.
3. Obtain informed consent from health care providers to complete the survey on the current management of obese and overweight children by fall 2016.
4. Develop and implement pediatric health care providers' cultural competency via the survey questionnaire by spring 2017.
5. Collect data on health care providers' knowledge of childhood obesity within the Hispanic community by summer 2017.

6. Evaluate the findings and compare to the current system in place for appropriateness and future benefits when providing care to obese and overweight Hispanic children.

Theoretical Foundation

The theoretical framework selected for the capstone project is Madeleine Leininger's (2011) Theory of Culture Care Diversity and Universality and the Health Belief Model (Green & Murphy, 2014). Nursing practice is founded on a number of theories, which are important in developing and implementing health care interventions. The application of nursing theories in the development and implementation of health care intervention promotes quality of life by improving patient satisfaction and outcomes.

Culture Care Diversity and Universality Theory

The main goal of this theory is to provide culturally congruent and holistic nursing care to patients (Sagar, 2012). Leininger independently developed the theory after becoming aware of and thoroughly evaluating the dynamics of the general health care settings. Leininger's Theory of Culture Care Diversity and Universality is founded on various theoretical assumptions, the main assumptions being beneficial, healthy, and satisfying culturally competent nursing care (McFarland, & Wehbe-Alamah, 2015). The theory promotes positive outcomes because patients who receive nursing care that is not congruent with their cultures tend to show signs of noncompliance to treatment directives, stress, cultural conflicts, and ethical moral concerns. The theory is also based on other theoretical assumptions, such as that caring is essential for healing, survival, growth, and the well-being of patients facing death or illness; that culture is a broad, holistic perspective guiding nursing care practice; and that care is the fundamental and core focus of nursing practice (Leininger, 2011; Sagar, 2012).

Leininger's theory presents three action modes for providing appropriate, culturally sensitive nursing care to patients. According to McFarland and Wehbe-Alamah (2015), the three action modes presented by Leininger's theory are restructuring and patterning, negotiation and accommodation, and maintenance and preservation. The patterning and restructuring action mode promotes the provision of culturally competent nursing care by allowing a mutual decision-making process between patients and nurses with respect to treatment modalities (Leininger, 2011). On the other hand, the maintenance and preservation action mode encourages the provision of culturally competent nursing care by allowing the integration of desirable cultural values and beliefs in the nursing care and treatment plan (McFarland & Wehbe-Alamah, 2015). The negotiation and accommodation action mode ensures the provision of culturally competent nursing care by allowing nurses to adapt and provide care that is consistent with the values and beliefs of patients (Leininger, 2011).

Health Belief Model

The Health Belief Model is a commonly used theory in health promotion and education strategies. Social psychologists at the U.S. Public Health Service developed the Heath Belief Theory in the early 1950s. According to Orji, Vassileva, and Mandryk (2012), the main aim of developing this theory was to understand the reasons for the widespread failure of persons to accept screening tests and other disease prevention mechanisms used to detect asymptomatic diseases. The Health Belief Theory is based on the concept that the health behavior of an individual is mainly determined by perceptions and personal beliefs regarding the illness, and the available strategies for reducing its occurrence (Cao, Chen, & Wang, 2014). However, a number of interpersonal factors that

affect health behavior influence personal perceptions. According to Orji et al. (2012), the four core constructs of the Health Belief Model are: (a) perceived barriers; (b) perceived seriousness; (c) perceived susceptibility; and (d) perceived benefits.

Each of the perceptions can be jointly or individually applied in explaining health behaviors of people. The perceived susceptibility describes the subjective perception of various individuals with respect to the risk of contracting a given condition, while perceived seriousness involves the evaluation of both clinical and medical consequences of contracting a disease to determine its severity (Green & Murphy, 2014). By contrast, perceived benefits describe a person's perception of the efficiency or usefulness of a nursing intervention in preventing or managing a disease (Orji et al., 2012). The perceived barriers are the potential negative factors, associated with a given health action, which are likely to compromise the effective undertaking of the prescribed behavior (Green & Murphy, 2014).

The Application of the Theories

Leininger's Theory of Culture Care Diversity and Universality and the Health Belief Model apply to the capstone project in a number of ways. The Health Belief Model may be applied to childhood obesity and the perceptions of Hispanic caregivers to determine how Hispanic caregivers' health beliefs influence food choices (Prestwich et al., 2014). The Health Belief Model can also be used to increase knowledge that is required to facilitate food choice changes from childhood. Kim, Ahn, and No (2012) have found that health beliefs significantly influence behavioral intentions to perform physical exercise or eat healthy food. Their findings confirm that there is a positive correlation

between the availability of effective health knowledge and improved dietary habits among people. This will assist in developing the guidelines at discharge for nurses.

Leininger's Culture Care Diversity and Universality Theory is the most appropriate to address the Hispanic community's perception of childhood obesity. It will be a guide to increase awareness and to support nurses at the time of discharge. In addition, it will improve health care providers' cultural competency. Leininger's theory will support the findings and solutions to the understanding of health and childhood obesity within the Hispanic community. Leininger found that care is profoundly embedded in people's social structures, values, and worldviews, making it an elusive phenomenon that presents challenges for study (McFarland, Mixer, Webhe-Alamah, & Burk, 2012). The theory will provide culturally congruent care to the Hispanic population. The use of Leininger's theory is also important in creating culturally specific tools for assessing perception, and creating solutions for the Hispanic community regarding childhood obesity.

Significance to Practice

The findings of the capstone project are expected to transform practice positively. Health care providers and researchers may use the results of the capstone project to develop a culturally competent health care intervention for managing childhood obesity. The findings of the capstone project can also impact on nursing practice by proving new strategies for developing effective behavioral, lifestyle, and cultural beliefs for preventing and controlling overweight and obesity in children.

Health Care Outcomes

Apart from health care practice, the results of the project are expected to impact significantly on health care outcomes. The findings of the project will promote delivery of culturally competent nursing care to obese and overweight children, leading to improved patient outcomes as a result of reduced signs of stress, noncompliance, and conflicting cultural beliefs. The results of the project are also expected to impact on health care outcomes by creating initiatives among parents to ensure a healthy lifestyle and eating habits for their children.

Health Care Delivery

The findings of this project will impact on health care delivery by positively changing practices currently used in health care settings and at home to prevent and manage obesity and overweight in children. For instance, the project is expected to change the perceptions of parents regarding lifestyle factors affecting the management of obesity and overweight in children. This project will also change the perceptions of health care providers relating to the provision of culturally competent care to obese and overweight children.

Health Care Policy

The findings of the project have the potential to have a significant impact on the health care policies targeted at the Hispanic community. The provision of quality health care for obese and overweight children is often considered expensive, given the various diseases associated with obesity. The results of the capstone project are expected to change health care policies by providing a relatively affordable treatment modality for obese and overweight children.

Summary

Childhood obesity is a common health problem in the U.S., as a number of children are obese or overweight. However, the prevalence of obesity tends to differ significantly among different racial, ethnic, and sociocultural groups. Culture is a crucial factor affecting people's lifestyle, perception of treatment modalities, and diseases. Leininger's Theory of Culture Care Diversity and Universality and the Health Belief Model will be applied in the capstone project. The results of the project are expected to impact on health care outcomes, nursing practice, health care policies, and health care delivery. The findings of the capstone project will be used to develop effective health care policies to improve health care providers' practice and patient outcomes, and to promote quality care for obese and overweight children, particularly in the Hispanic community.

Chapter 2

Review of Literature

A systematic literature search was performed in MEDLINE, the Nursing & Allied Health Database, and professional and governmental agencies. Articles from 2011 to January 2016 were reviewed. The keywords used in the search strategy included *Hispanic children with obesity*, *increased BMI in childhood*, *obesity comorbidities*, *patient education*, *technology*, and *Internet*. The literature focuses on body mass index as a measure to determine obesity and overweight in children (Locke et al., 2015). According to the Centers for Disease Control and Prevention (CDC, 2017), overweight is defined as a BMI at or above the 85th percentile, and below the 95th percentile for children and teens of the same age and sex. Obesity is defined as a BMI at or above the 95th percentile for children and teens of the same age and sex (CDC, 2015). Poor eating behavior has been identified as one of the core contributory factors of the childhood obesity epidemic (Wilkie, Standage, Gillison, Cumming, & Katzamarzyk, 2015). The consequences of obesity are detailed and explored in the existing literature. For instance, evidence confirms that obesity is linked to the incidence of diseases such as heart disease (McCrindle, 2015), type 2 diabetes, and some cancers, as well as psychosocial problems (Pulgaron, 2013). The literature includes research and projects on specific populations, certain conditions, and how health care providers may help in the prevention of obesity.

The incidence of childhood obesity among the Hispanic population has increased rapidly in the recent past, and the prevalence of obesity is associated with several

negative health consequences (Gauthier & Gance-Cleveland, 2015). In particular, childhood obesity can cause long-term, short-term, and immediate health consequences, and it is strongly associated with numerous chronic diseases (Lobstein et al., 2015). The quality of care received, inequities in access to health care, as well as opportunities to make healthy choices regarding where individuals learn, live, play and work all contribute to the increased rates of childhood obesity among the Hispanic and Latino population, compared to the White population group (Innella, Breitenstein, Hamilton, Reed, & McNaughton, 2016). Additionally, directed marketing of less nutritious foods, limited access to safe places for playing or doing physical exercise, and higher rates of food insecurity and hunger also contribute to the higher rates of obesity among the Hispanic and Latino population groups (Profiles of Latino Health, 2014).

Benefits to the Caregivers and Pediatric Hispanic Children

The literature supports that the Hispanic population is the fastest growing population in the United States. It is estimated that approximately one in three American children will be Hispanic by 2030. Therefore, addressing health care disparities such as childhood obesity is important for the well-being of the Hispanic population to help them maintain quality of life and reduce the higher rates of childhood obesity and the resultant poor health outcomes for adults. Skinner and Skelton (2014) found that severe obesity rates are also higher among Hispanic children, with a prevalence of severe obesity at 6.6% for those between the ages of 2 and 19 years old, compared with 3.90% for White children. In addition, Skinner and Skelton (2014) report that the rates of obesity for Hispanic children are much higher, beginning at a younger age, such as for children between the ages of 2 and 5 years old. These rates of childhood obesity in the Hispanic

population are more than quadruple the rates of obesity for Whites (16.7% for the Hispanic population compared with 3.5% for the Whites) for children aged between 2 and 5 years old (Skinner & Skelton, 2014). Further, for children aged between the ages of 6 and 11 years, approximately 26.1% of Hispanic children are obese, compared with 13.10% of White children. In terms of the strengths of these studies, the researchers have attempted to highlight the prevalence of childhood obesity in the Hispanic community, but the weakness of these studies is that there are contradictions and inconsistent findings about childhood obesity in the Hispanic population.

Findings in the Body of Literature

The prevalence of childhood obesity is growing faster among Hispanic and Black children. For example, childhood obesity has increased by more than 50% in the White population but has increased by more than 120% among Hispanics and Blacks over the past decade (National Collaborative on Childhood Obesity Research, 2013). Nearly 28.0% of non-Hispanic Black adolescent girls between 2 and 19 years old, and approximately 20.0% of Mexican-American adolescent girls (ages 2 and 19 years were above or at the 95th percentile of the Body Mass Index for charts of age growth, compared with 14.50% of White, non-Hispanic teenage girls. On the contrary, Mexican-American teenage boys were considerably more likely to have a high Body Mass Index for the ages between 2 and 19 than White, non-Hispanic teenage boys. Non-Hispanic African-American boys were reported to possibly have higher BMIs for the ages between 2 and 19 at the maximum Body Mass Index for the age level (Body Mass Index for age level greater than or equal to 97th percentile) than White (non-Hispanic) teenage boys. Thus, unlike White children, Hispanic children are considerably less likely to be involved

in planned physical activities outside of school. Among children aged between 9 and 13 years, 25.90% of Hispanics and 24.10% of Blacks are involved in organized physical activity outside of school, compared to 46.60% of White children.

Ostbye et al. (2012) propose that assessment of primary caregiver or parent behavior is a significant factor of ongoing broad evaluation because the primary caregivers or parents of young children may positively influence nutrition intake, eating habits, as well as opportunities for physical exercise and activity of the children in their care. Primary caregivers and parents play a significant role in shaping children's physical activity and eating behaviors (Fitch et al., 2013). Additionally, families, primary caregivers, and parents of preschool children require education on reducing screen time, promoting healthy eating, and ensuring age-suitable levels of physical activity (Haines et al., 2013). The increased cultural competency of health care providers will provide social support and education to assist primary caregivers and parents to promote physical activity and healthy eating in children, toddlers or infants, as well as youth and adolescents. Furthermore, nurses need to collaborate with primary caregivers and parents, support staff, and educators to promote physical activity and healthy eating in all settings where children and youth frequently gather.

None of the above highlighted research studies provide a clear conclusion in discussing the importance of the perceptions and daily practice of health care providers within the pediatric Hispanic community. None of the researchers have studied perceptions of cultural competency and daily practice management of Hispanic overweight and obese children. Therefore, this study aims at filling this research gap by exploring nurses' cultural competency in terms of nutritional and weight management

discharge instructions for Hispanic caregivers of children with obesity. Caregivers of overweight and obese pediatric patients are not provided with proper instructions or guidance for further follow-up heath care. Therefore, the overweight or obese child is not being provided with the health care required for health promotion and disease prevention. The overweight and obese children are at risk of poor health outcomes and a poor quality of life. The intention of this project is to seek further care and to maintain the quality health care, which was offered in the health care facility (Goncalves-Bradley, Lannin, Clemson, Cameron, & Sheppherd, 2016). Providing health care for the complications of obesity is costly.

The knowledge obtained is based on the primary prevention concept, as this is the most effective approach, because it focuses developing a broad-based action plan that will addresses the environmental, social, and cultural factors associated with childhood obesity. The results and analysis offer a primary prevention approach that focuses on efforts, which will help most obese and overweight children not to continue being overweight or obese, but maintain a healthy weight and healthy lifestyle. Health care providers will give the caregivers of overweight and obese children specific actions that focus on the caregivers of this high-risk population by health care providers. This project will enhance health care providers' knowledge and therefore enable them to provide quality care to targeted children from various areas within the Hispanic community. Additionally, it sets effective goals for obesity prevention in the Hispanic population and contains information regarding healthy weight levels and optimum population BMI, dietary restrictions, possible effects of food intake, body size, and patterns of inactivity and physical activity (these are the main modifiable determining factors of obesity), as

well as social norms and attitudes related to eating and food, inactivity and physical exercise (WHO, 2013). For youth and children, these considerations should be framed within the context of cognitive, healthy physical and psychological development, and acknowledgement that the increased childhood obesity rate has increased the need for emphasis on dietary guidance, which aims to address patterns of physical activity, and overconsumption of energy-dense beverages and food.

Summary

Childhood obesity can cause long-term, short-term, and immediate health consequences, and it is strongly associated with numerous chronic diseases. The prevention of childhood obesity could be more multifaceted to be applied in health outcomes where the condition is both a risk factor for the health outcome itself, as well as other chronic diseases, and the childhood obesity progression is a continuum. Health care providers should identify those pediatric patients at risk for complications of obesity. Once these patients have been identified, the health care provider is able to intervene and add lifestyle modification guidance for caregivers of childhood obesity. This would be based on the primary prevention concept, as this seems to be the most effective approach.

Chapter 3

Methods

Currently, pediatric nurses at a private hospital in South Florida are providing primary care to overweight children between the ages of 6 and 11 with limited nutritional and weight management guidance, and clinic referrals. The purpose of this capstone project was to assess pediatric nurses' cultural competency with regard to nutritional and weight management instructions for Hispanic parents of obese children aged 6 to 11 years old. This section describes the methodology that was utilized for this study, including project design, setting, and inclusion criteria for participants, ethical considerations, project phases, timeline, and resources for the study. These are described in the sub-sections that follow.

Project Design

This project used a descriptive design. A survey questionnaire was provided to health care providers in a pediatric primary care setting to collect data, without actual patient interaction.

Setting

The setting for the project was a pediatric primary care office, serving the Hispanic population in Miami; the office employs physicians, an advanced registered nurse practitioner (ARNP), physician assistants (PAs), and a doctor of osteopathy. This setting was most appropriate, as the patients seek primary preventive care from the pediatric office. It was a controlled setting, and the caregivers were assessed on their ability to learn and comprehend the importance of making healthier choices to improve

health outcomes and prevent comorbidities as adults. Health care providers were recruited according to set guidelines. There were no incentives for participation in the study.

Inclusion and Exclusion Criteria

The project included health care providers, nurse practitioners, physician assistants, medical doctors, and a doctor of osteopathy caring for the obese and overweight Hispanic pediatric population only employed by the clinic. All other clinic center and organizational employees were excluded.

Ethical Considerations

Approval of the Nova Southeastern University (NSU) Institutional Review Board (IRB) was not needed for this project, since it did not directly affect human subjects, and deals with assessing the health care providers' cultural sensitivity regarding obesity. However, there were still ethical considerations. A letter of support and permission was provided to the institution administration. The information provided by the health care providers' survey results will be kept confidential. The data collected will be kept in a locked and safe file cabinet.

Project Phases/Objectives

This project was carried out in phases, in order to meet the following objectives: **Objective 1:** Assess and review the existing guidelines for culturally diverse parents of children with obesity by fall 2016. Review the literature to validate the importance of the project, and compare to existing guidelines.

Objective 2: Obtain institutional support by fall 2016. Hold meeting with stakeholders to convey the importance of the project, and the purpose of the survey to evaluate the current management.

Objective 3: Obtain informed consent from health care providers by fall 2016.

Objective 4: Assess pediatric health care providers' cultural competency via survey questionnaire by spring 2017.

Objective 5: Collect data on health care providers' knowledge of childhood obesity within the Hispanic community by summer 2017.

Objective 6: Analyze the data, and evaluate the results and how they apply to the primary care setting by summer 2017.

Timeline

Objective 1, assessing and reviewing the existing guidelines, took three weeks. Objectives 2 and 3, obtaining institutional support and consent, took 4 weeks. Objective 4, collecting the data on HCPs' cultural competency was completed in approximately 8 weeks' time. The data collection, analysis, and evaluation of Objectives 5 and 6 took approximately 4 weeks.

Resources/Budget

Costs related to the project included fuel for travel, printing, and other costs incurred, totaling approximately $500.00.

Table 1

Project Resources and Budget

Category	Item	Description	Total
Printing Material	Paper	White	$ 5.00
	Ink	Combo black/color ink cartridge	$ 90.00
Weekly Thank You for Office Staff	Edibles	Lunch	$160.00
	Appreciation token for staff	Coffee	$50.00
Travel	Fuel	Per mile	$200.00
Total Costs			**$505.00**

Outcome Measures

The outcome of this project was evaluated according to the measures listed, which are further detailed in Chapter 4.

Objective 1: Assess and review existing guidelines for culturally diverse parents of children with obesity by fall 2016.

This objective was met with the guidance of the HCP team involved. In addition, all current measures in place were reviewed.

Objective 2: Obtain institutional and Nova IRB support by fall 2016.

Obtained support from the center to approve this project. There were no human subjects as part of this project. Nova IRB exclusion was given.

Objective 3: Obtain informed consent from health care providers by fall 2016.

This objective was met with the support from the HCP team in a voluntarily and timely manner.

Objective 4: Assess pediatric health care providers' cultural competency via survey questionnaire by spring 2017.

This objective was met with the support of the HCP team included in this project. They completed the surveys voluntarily.

Objective 5: Collect data on health care providers' knowledge of childhood obesity within the Hispanic community by summer 2017.

Completed surveys were successfully collected with team support, after submission of completed surveys to assess the current daily management of overweight and obese children.

Objective 6: Analyze the data, and evaluate the results and how they apply to the primary care setting by summer 2017.

This objective was met, as the final analysis of the data collected was completed.

Summary

The purpose of this capstone project was to assess health care providers' cultural competency by assessing the management of Hispanic parents with children diagnosed with obesity. Outcomes have been measured by the evaluation of each objective. There were no ethical considerations, and the need to protect human rights was not required. The capstone project used different steps in the process of completing the objectives. The budget for the project remained low.

Chapter 4

Results and Discussion

Even though population-based childhood obesity prevention approaches can be conceptually or theoretically, the most suitable approach is used to address this concern. In the wider society, the practical challenge is to assess health care providers' current awareness of how culture impacts obesity. The result of such an assessment would determine which best interventions to adopt to attain maximal health outcomes and realize broad outreach of this population. .

A clear description of prevention objectives of childhood obesity is vital for shaping an effective program and assessing its success. Relevant and important issues for setting effective goals for obesity prevention among the Hispanic population involve concepts of healthy weight levels and optimum BMI, dietary restrictions, possible effects on food intake, body size, and patterns of inactivity and physical activity (these are the main modifiable determining factors of obesity), as well as social norms and attitudes related to eating and food, inactivity and physical exercise (WHO, 2013). For youth and children, these considerations should be framed within the context of cognitive development, physical development, and psychological development. The evidence and acknowledgement on the increased childhood obesity rate has increased awareness of the need for dietary guidance, which aims at addressing patterns of physical activity and overconsumption of energy-dense beverages and food (American Diabetes Association [ADA], 2013).

Results

This evaluation survey of health care providers' cultural sensitivity was initiated after approval from the team in July 2017. Approval from the Nova Southeastern University Institutional Review Board was not necessary, as this project did not directly impact human subjects. The survey assessed the knowledge of HCPs' management of obesity. The project objectives were completed as per set time line, and as follows:

Objective 1: Assess and review existing guidelines for culturally diverse parents of children with obesity by fall 2016.

This objective was met by obtaining authorization to review existing measures for the management of obesity. The initial meeting took place via teleconference with the MD and lead NP. After review, a meeting was set up with the director to evaluate the benefits of the project. The providers agreed and voted on developing a process to improve health outcomes and increase cultural sensitivity in health care. A plan was discussed to conduct a review of current methods in comparison to the literature review.

Objective 2: Obtain institutional support by fall 2016.

The institutional support was obtained after meeting with HCP and other stakeholders and discussing the purpose of the project. The support was obtained by submitting the project, and exclusion was provided by IRB, as this project did not directly involve human subjects.

Objective 3: Obtain informed consent from health care providers by fall 2016.

This objective was met by obtaining consent from the HCPs to voluntarily participate in completing the survey questions on the management of Hispanic

overweight and obese children. Once the consents were obtained, this objective was completed.

Objective 4: Assess pediatric health care providers' cultural competency by survey questionnaire by spring 2017.

This objective was met by requesting completed surveys regarding the current management of overweight and obese children in their daily practice for data analysis and evaluation of results.

Objective 5: Collect data on health care providers' knowledge of childhood obesity within the Hispanic community by summer 2017.

The surveys were collected and data was successfully obtained.

Objective 6: Analyze the data, and evaluate the results and how they apply to the primary health care setting by summer 2017.

This objective was met, once all the data was collected for statistical analysis. A local statistician was hired to help perform the most accurate and proper analysis of the findings. The data was reviewed for quality improvement measures to suggest for the institution's daily practice. The data was reviewed and compared by academic degree and daily practice.

Findings of the Project

Data was analyzed using the surveys provided to assess health care providers' current management of overweight and obese children in their day-to-day practice. This project followed the objectives previously mentioned. The participants were pediatric health care providers who practice daily with culturally diverse children in the Miami area. The focus, for the purpose of this project, was a survey regarding the management

of Hispanic overweight and obese children between 6 and 11 years old and their caregivers.

The findings of this project present and discuss the results of the analyses conducted for this study. The findings consist of a series of descriptive statistics, constituting frequency tables, in which the sample sizes and percentages are reported for each category of response relating to the variables of interest included in this study. Following this, a series of Spearman's correlations were conducted between all survey measures that were not found to be constant.

Descriptive Statistics

Table 2 reports the results of the descriptive statistics associated with this project. First, with regard to credentials, 20% of respondents had a DO degree, 20% had a PA degree, 30% had an MD degree, and 30% had an NP degree.

Second, all respondents replied "somewhat often" with regard to how often they saw children with obesity in their practice. Additionally, all respondents replied "often" with regard to whether they weighed every child in their practice. With respect to whether BMI was reviewed at every visit, 40% of respondents replied "often", while 60% replied "somewhat often".

Next, respondents were asked whether they documented BMIs on patients' charts. Of the sample, 70% replied "often", and 30% replied "somewhat often." With respect to the frequency with which respondents educated children on nutrition and lifestyle modifications, 45% of respondents replied "often," the same percentage replied "somewhat often," and 10% replied "never."

The following question asked respondents how often they educated caregivers on lifestyle modifications. Of this sample, 15% replied "often," 70% replied "somewhat often," and 15% replied "never." Next, with respect to how often respondents requested feedback and the patient verbalized understanding, 15% of respondents replied "often," 65% replied "somewhat often," and 20% replied "never."

With respect to how often respondents educated caregivers on nutrition, 15% replied "often," 65% replied "somewhat often," and 20% replied "never." Regarding how often respondents provided written instructions on obesity to patients and caregivers, 15% replied "often," 60% replied "somewhat often," and 25% replied "never." Finally, with regard to how often respondents requested a follow-up appointment to discuss lifestyle modification and to monitor progress, an identical pattern of response to latter respondents was found with respect to this measure.

Table 2

Descriptive Statistics: Frequencies and Percentages of Response

Credentials	Measure	*N%*
DO	4	20.0%
MD	6	30.0%
NP	6	30.0%
PA	4	20.0%
Total	20	100.0%

Table 3

Survey Responses

Question	Response	*n*	%
How often do you see children with obesity in your practice?			
	Often	20	100.0%
Do you weigh every child in your practice?			
	Often	20	100.0%
Do you review the BMI at every visit?			
	Often	8	40.0%
	Somewhat often	12	60.0%
Do you document the BMI in the patient's chart?			
	Often	14	70.0%
	Somewhat often	6	30.0%
How often do you			

educate children on nutrition and lifestyle modifications?			
	Often	9	45.0%
	Somewhat often	9	45.0%
How often do you educate the caregivers on lifestyle modifications?	Never	2	10.0%
	Often	3	15.0%
	Somewhat often	14	70.0%
	Never	3	15.0%
How often do you request feedback and the patient verbalized understanding?			
	Often	3	15.0%
	Somewhat often	13	65.0%
	Never	4	20.0%
How often do you educate the caregivers on nutrition?			
	Often	3	15.0%
	Somewhat often	13	65.0%
	Never	4	20.0%
How often do you provide written instructions on obesity to patients and caregivers?			
	Often	3	15.0%
	Somewhat often	12	60.0%
	Never	5	25.0%
How often do request a follow-up appointment to discuss lifestyle			

modification and monitor progress?			
	Often	3	15.0%
	Somewhat often	12	60.0%
	Never	5	25.0%

Correlations

A series of Spearman's correlations were also conducted between the survey items, in order to determine whether significant associations were present between them. The first two survey items, relating to obesity and weight, needed to be removed from these analyses, as they were constant, making it impossible to correlate them with any other variable. Table 4 reports the results of these analyses. As shown, strong correlations were found between the education of children and the measures of educating caregivers on lifestyle modifications, requesting feedback, educating caregivers on nutrition, providing written instructions, and requesting follow-ups. Additionally, very strong correlations were found between the following sets of items: Educating caregivers on lifestyle, requesting feedback, educating caregivers on nutrition, providing written instructions, and requesting follow-ups. All correlations cited were found to be positive, indicating a direct association between these pairs of measures.

Table 4

Correlation Results

Spearman's Correlations Measure	1	2	3	4	5	6	7
Review BMI at every visit[1]							
Document BMI[2]	.089						
Often educate children[3]	.333	.366					
Educate caregivers lifestyle[4]	.186	-.199	.569**				
Often request feedback[5]	.241	-.246	.585**	.926***			
Educate caregiver nutrition[6]	.241	-.246	.585**	.926***	1.000***		
Provide written instructions[7]	.293	-.108	.606**	.868***	.932***	.932***	
Often request follow-up	.293	-.108	.606**	.868***	.932***	.932***	1.000

Note. $*p < .05$, $**p < .01$, $***p < .001$.

Findings

As presented, a wide variety of respondents were included in this study on the basis of their credentials, with responses to all survey items primarily consisting of either "somewhat often" or "often." The items that were found to have the largest percentage of respondents replying with "never" consisted of providing written instructions to patients and caregivers on obesity, as well as requesting a follow-up appointment to discuss lifestyle modification and monitoring progress. These results indicate, overall, that these items are handled fairly frequently to frequently by respondents. Additionally, the results of the correlations conducted reveal that, with the exception of the measures relating to BMI, as well as the measures that were found to be constant within this study, strong to very strong positive associations exist between responses. This indicates that the

responses provided to this set of survey items were generally very similar among respondents.

Strengths and Limitations

Strengths of the project included the collaborative support among the health care providers. Another major strength was that the project revealed the need of increased awareness of cultural sensitivity when providing care to Hispanic obese and overweight children. Caregiver education was considered during all visits. The limitations included not having the availability or time during this project to develop a tool to implement during health care visits to guide health care providers successfully provide culturally sensitive care to this vulnerable population and age group.

Although successful, the project was only conducted as a survey for the initial phase. The project was limited due to the small group of HCPs surveyed and the limited geographical region. Lastly, the project only looked at one pediatric care clinic; perhaps recruiting HCPs at a larger organization would be a consideration.

Implications for Nursing and Health Care

The findings from this project can impact nursing practice, health care delivery, patient outcomes, and health care policy by increasing awareness about providing culturally competent care to Hispanic overweight and obese children. The project established a sense of increased cultural sensitivity when managing the care of overweight and obese Hispanic children. Health care providers changed their perception on culturally competent care regarding obese Hispanic children of all ages. As a result, health care providers will be assisting in preventing poor health outcomes and comorbidities of being overweight or obese in adulthood. In addition, the lifelong costs of

health care will be decreased, as well as the risk of comorbidities. As adults, this individual population will live a productive life, free from the complications of a preventable childhood condition.

Future Research

The pediatric primary health care setting is where health promotion and disease prevention is implemented from the beginning of human life. In every health care setting, there is always an opportunity for improving quality. A nutritional guidelines tool was developed and provided to the health care providers for further review. A discharge brochure was developed using these guidelines and provided to health care providers to consider incorporating into the discharge instructions at every visit. The future research in this project is to implement a culturally diverse tool or guide to provide to caregivers during healthcare visits. The next step for future research in this project would be the implementation of a culturally diverse tool or caregiver guide for caregivers to complete at every healthcare visit. This tool will assess and evaluate lifestyle modifications, knowledge of nutrition, and activity. In addition, as the children become adolescents, a nutritional habits questionnaire should be applied at every visit. Future research, in the implementation of this guide will improve health outcomes and quality of life. In a larger organization, further research should focus on early implementation at infancy through adulthood.

Summary

Health care providers, in all health care settings, are very influential with regard to patients and their caregivers. Ostbye et al. (2012) considered the assessment of the primary caregiver or parent behavior as a significant factor of ongoing, broad evaluation.

Primary caregivers or parents play a significant role in shaping their children's physical activity and eating behaviors (Fitch et al., 2013). Childhood obesity continues to be a serious concern in the United States; despite the stability of the statistics reported, obesity continues to place children at risk for poor health outcomes. The Centers for Disease Control and Prevention (CDC) reports obesity being higher among Hispanics (21.9%) and non-Hispanic blacks (19.5%) than among non-Hispanic whites (14.7%). The literature review confirmed that childhood obesity is more common among certain populations.

With the increased knowledge and awareness of cultural diversity, this project allowed health care providers to be able to provide culturally competent health care to obese and overweight children. The health care providers in this project will better understand the importance of using a culturally sensitive approach in managing the health care of overweight and obese children. In conclusion, Hispanic obese and overweight children will have improved outcomes as they progress into their adult years.

References

American Diabetes Association. (2013). Statistics of diabetes. Retrieved from http://www.diabetes.org/diabetes-basics/statistics/

Burgi, F., Niederer, I., Schindler, C., Bodenmann, P., Marques-Vidal, P., Kriemler, S., & Puder, J. J. (2012). Effect of a lifestyle intervention on adiposity and fitness in socially disadvantaged subgroups of preschoolers: a cluster-randomized trial (Ballabeina). *Preventive Medicine*, *54*(5), 335-340.

Canadian Nurses Association. (2013). *Registered nurses: Stepping up to transform health care.* Retrieved from http:// www.cna-aiic.ca/~/media/cna/files/en/registered_nurses_stepping_up_to_transform_health_care_e.pdf

Cao, Z. J., Chen, Y., & Wang, S. M. (2014). Health belief model based evaluation of school health education program for injury prevention among high school students in the community context. *BMC Public Health 14*(1). doi:10.1186/1471-2458-14- 26

Centers for Disease Control and Prevention (CDC). (2014). *State indicator report on physical activity, 2014.* Atlanta, GA: U.S. Department of Health and Human Services. Retrieved from http://www.cdc.gov/physicalactivitiy/resources/reports.html

Centers for Disease Control and Prevention (CDC). (2017). Childhood obesity facts. Retrieved from https://www.cdc.gov/healthyschools/obesity/facts.htm

Davis, R., Cole, S., Reyes, L., Mckenney-Shubert, S., & Peterson, K. (2015). "It hurts a Latina when they tell us anything about our children:" Implications for Mexican-origin mothers' maternal identities, aspirations, and attitudes about cultural transmission for childhood obesity prevention. *Childhood Obesity*, *11*(5), 608-615. doi:10.1089/chi.2015.001

Fitch, A., Fox, C., Bauerly, K., Gross, A., Heim, C., Judge-Dietz, J., & Larson, J. (2013). Prevention and management of obesity for children and adolescents. *Institute for Clinical Systems Improvement.* Retrieved from https://www.icsi.org/_asset/tn5cd5/ObesityChildhood.pdf

Fryar, C., Carroll, M., & Ogden, C. (2014). *Prevalence of overweight and obesity among children and adolescents: United States, 1963-1965 through 2011-2012.* Atlanta, GA: National Center for Health Statistics.

Gauthier, K., & Gance-Cleveland, B. (2015). Hispanic parental perceptions of child weight in preschool-aged children: an integrative review. *Childhood Obesity*, *11*(5), 549-559. doi:10.1089/chi.2014.0152

Geissler, M. (2015). *A comparison of nutritional health among parent-child dyads living in rural settings*. Retrieved from http://digitalcommons.brockport.edu/cgi/viewcontent.cgi?article=1096&context=honors

Goncalves-Bradley, D., Lannin, N., Clemson, L., Cameron, I., & Shepherd, S. (2016). Discharge planning from hospital. *Cochrane Database of Systematic Reviews*. doi:10.1002/14651858.CD000313.pub5

Green, E., & Murphy, E. (2014). Health belief model. *the Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society* (pp. 766-769). City, ST: John Wiley & Sons.

Guerrero, A., Mao, C., Fuller, B., Bridges, M., Franke, T., & Kuo, A. (2015). Racial and ethnic disparities in early childhood obesity: growth trajectories in body mass index. *Journal of Racial and Ethnic Health Disparities*, *3*, 129-137. doi:10.1007/s40615-015-0122-y

Haines, J., McDonald, J., O'Brien, A., Sherry, B., Bottino, C. J., Schmidt, M. E., & Taveras, E. M. (2013). Randomized trial to improve household routines for obesity prevention among preschool-aged children. *JAMA Pediatrics*, *167*(11), 1072-1079. doi:10.1001/jamapediatrics.2013.2356

Innella, N., Breitenstein, S., Hamilton, R., Reed, M., & McNaughton, D. (2016). Determinants of obesity in the Hispanic preschool population: an integrative review. *Public Health Nursing*, *33*(3), 189-99. doi:10.1111/phn.12215

Kim, H. S., Ahn, J., & No, J. K. (2012). Applying the health belief model to college students' health behavior. *Nutrition Research and Practice*, *6*(6), 551-558. doi:10.4162/nrp.2012.6.6.551

Kuo, D. Z., Houtrow, A. J., Arango, P., Kuhlthau, K. A., Simmons, J. M., & Neff, J. M. (2012). Family-centered care: Current applications and future directions in pediatric health care. *Maternal and Child Health Journal*, *16*(2), 297-305. doi:10.1007/s10995-011-0751-7

Leininger, M. (2011). Leininger's reflection on her ongoing father protective care research. *Online Journal of Cultural Competence in Nursing and Healthcare*, *1*(2), 1-13. Retrieved from http://ojccnh.org/pdf/v1n2a1.pdf

Lobstein, T., Jackson-Leach, R., Moodie, M., Hall, K., Gortmaker, S., Swinburn, B. . . . McPherson, K. (2015). Child and adolescent obesity: part of a bigger picture. *The Lancet*, *385*(9986), 20-26. doi:10.1016/S0140-6736(14)61746-3

Locke, A., Kahali, B., Berndt, S., Justice, A., Pers, T., Day, F. . . . Speliotes, E. K. (2015). Genetic studies of body mass index yield new insights of obesity biology. *Nature*, *518*(7538), 197-206. doi:10.1038/nature14177

McCrindle, B. (2015). Cardiovascular consequences of childhood obesity. *Canadian Journal of Cardiology*, *31*(2), 124-130. doi:10.1016/j.cjca.2014.08.017

McFarland, M. R., Mixer, S. J., Webhe-Alamah, H., & Burk, R. (2012). Ethnonursing: A qualitative research method for studying culturally competent care across disciplines. *International Journal of Qualitative Methods*, *11*(3), 259-279. Retrieved from http://ijq.sagepub.com/content/11/3/259.short

McFarland, M., & Wehbe-Alamah, H. (2015). The theory of culture care diversity and universality. In M. McFarland & H. Wehbe-Alamah (Eds.), *Leininger's culture care diversity & university: A worldwide nursing theory* (pp. 1-34.). Burlington, MA: Jones and Bartlett Learning.

Moseley, L. (2014*). Best practices in the management of pediatric obesity in primary care clinics* (Doctoral dissertation). Retrieved from http://scholarcommons.sc.edu/etd/2732

National Center for Health Statistics. (2016). *Health, United States 2016: With chartbook on long-term trends in health*. Retrieved from https://www.cdc.gov/nchs/data/hus/hus16.pdf#053

National Collaborative on Childhood Obesity Research. (2013). *Childhood obesity in the United States.* Retrieved from http://www.nccor.org/downloads/ChildhoodObesity_020509.pdf

Ogden, C. L., Carroll, M. D., Kit, B. K., & Flegal, K. M. (2014). Prevalence of childhood and adult obesity in the United States, 2011-2012. *JAMA Pediatrics*, *311*(8), 806-814.

Orji, R., Vassileva, J., & Mandryk, R. (2012). Towards an effective health interventions design: An extension of the health belief model. *Online Journal of Public Health Informatics*, *4*(3). doi:10.5210/ojphi.v4i3.4321

Ostbye, T., Krause, K. M., Stroo, M., Lovelady, C. A., Evenson, K. R., Peterson, B. L. . . . Zucker, N. L. (2012). Parent-focused change to prevent obesity in preschoolers: Results from the KAN-DO study. *Preventive Medicine*, *55(*3), 188-195.

Prestwich, A., Sniehotta, F., Whittington, C., Dombrowski, S., Rogers, L., & Michie, S. (2014). Does theory influence the effectiveness of health behavior interventions? Meta-analysis. *Health Psychology*, *33*(5), 465-74. doi:10.1037/a0032853

Profiles of Latino Health. (2014). A closer look at Latino child nutrition. *National Council of La Raza*. Retrieved from http://latinocenterforhealth.org/research

Pulgaron, E. (2013). Childhood obesity: A review of increased risk for physical and psychological comorbidities. *Clinical Therapeutics*, *35*(1), 18-132. doi:10.1016/j.clinthera.2012.12.014

Rooney, B. L., Mathiason, M. A., & Schauberger, C. W. (2011). Predictors of obesity in childhood, adolescence, and adulthood in a birth cohort. *Maternal and Child Health and Journal*, *15*(8), 1166-1175. Retrieved from http://link.springer.com/article/10.1007/s10995-010-0689-1#/page-1

Sagar, P. L. (2012). *Transcultural nursing theory and models: Application in nursing education, practice, and administration*. New York, NY: Springer. Retrieved from http://lghttp.48653.nexcesscdn.net/80223CF/springer-static/media/samplechapters/9780826107480/9780826107480_chapter.pdf

Skinner, A. C., & Skelton, J.(2014). Prevalence and trends in obesity and severe obesity among children in the United States, 1999-2012. *JAMA Pediatrics*, doi:10.1001/jamapediatrics.2014.21

Taveras, E., Gillman, M., Kleinman, K., Rich-Edwards, J., & Rifas-Shiman, S. (2013). Reducing racial/ethnic disparities in childhood obesity: The role of early life risk factors. *JAMA Pediatrics*, *167*(8), 731-738. doi:10.1001/jamapediatrics.2013.85

Wilkie, H., Standage, M., Gillison, F., Cumming, S., & Katzmarzyk, P. (2015). Multiple lifestyle behaviors and overweight and obesity among children aged 9-11 years: Results from the UK site of the International Study of Childhood Obesity, Lifestyle and the environment. *BMJ Open*, 1-10. doi:10.1136/bmjopen-2015-010677

World Health Organization (WHO). (2013). *Obesity and overweight.* Retrieved from http://www.who.int/ mediacentre/factsheets/fs311/en/

Appendix A

NOVA SOUTHEASTERN UNIVERSITY
Institutional Review Board

MEMORANDUM

To: Dayzi Fardales

From: Vanessa Johnson,
Center Representative, Institutional Review Board

Date: June 28, 2017

Re: IRB #: 2017-414; Title, "Health Care Providers management of Hispanic Obese and Children"

I have reviewed the above-referenced research protocol at the center level. Based on the information provided, I have determined that this study is exempt from further IRB review under **45 CFR 46.101(b) (Exempt Category 2)**. You may proceed with your study as described to the IRB. As principal investigator, you must adhere to the following requirements:

1) CONSENT: If recruitment procedures include consent forms, they must be obtained in such a manner that they are clearly understood by the subjects and the process affords subjects the opportunity to ask questions, obtain detailed answers from those directly involved in the research, and have sufficient time to consider their participation after they have been provided this information. The subjects must be given a copy of the signed consent document, and a copy must be placed in a secure file separate from de-identified participant information. Record of informed consent must be retained for a minimum of three years from the conclusion of the study.

2) ADVERSE EVENTS/UNANTICIPATED PROBLEMS: The principal investigator is required to notify the IRB chair and me (954-262-5369 and Vanessa Johnson, respectively) of any adverse reactions or unanticipated events that may develop as a result of this study. Reactions or events may include, but are not limited to, injury, depression as a result of participation in the study, life-threatening situation, death, or loss of confidentiality/anonymity of subject. Approval may be withdrawn if the problem is serious.

3) AMENDMENTS: Any changes in the study (e.g., procedures, number or types of subjects, consent forms, investigators, etc.) must be approved by the IRB prior to implementation. Please be advised that changes in a study may require further review depending on the nature of the change. Please contact me with any questions regarding amendments or changes to your study.

The NSU IRB is in compliance with the requirements for the protection of human subjects prescribed in Part 46 of Title 45 of the Code of Federal Regulations (45 CFR 46) revised June 18, 1991.

Cc: Gitana Ng
Vanessa Johnson

Appendix B

Participation Letter

Title of Study: Health Care Providers Management of Hispanic Obese and Overweight Children

Principal investigator(s)

Daysi Fardales, ARNP-C

Co-investigator(s)

Mary Mites Campbell, PhD.

Gitana Ng, DNP

Nova Southeastern Univeristy

11501 North Military Trail

Palm Beach Gardens, FL 33410

Phone #561-805-2201

Institutional Review Board

Nova Southeastern University

Office of Grants and Contracts

(954) 262-5369/Toll Free: 866-499-0790

IRB@nsu.nova.edu

Description of Study: Daysi Fardales, Student is a doctoral student at Nova Southeastern University engaged in research for the purpose of satisfying a requirement for a Doctor of Education degree. The purpose of this study is to assess the health care providers' management of Hispanic obese and overweight children. If you agree to participate, you will be asked to complete the attached questionnaire. This questionnaire will help the writer identify the gaps in practice when managing the care of obese or overweight Hispanic children. The data from this questionnaire will be used to identify those gaps in practice. The survey questionnaire will take approximately fifteen minutes to complete.

Risks/Benefits to the Participant: There is no risk involved in participating in this study. There are no direct benefits to for agreeing to be in this study. If you have any concerns about the risks/benefits of participating in this study, you can contact the

will be asked to complete the attached questionnaire. This questionnaire will help the writer identify the gaps in practice when managing the care of obese or overweight Hispanic children. The data from this questionnaire will be used to identify those gaps in practice. The survey questionnaire will take approximately fifteen minutes to complete.

Risks/Benefits to the Participant: There is no risk involved in participating in this study. There are no direct benefits to for agreeing to be in this study. If you have any concerns about the risks/benefits of participating in this study, you can contact the investigators and/or the university's human research oversight board (the Institutional Review Board or IRB) at the numbers listed above.

Cost and Payments to the Participant: There is no cost for participation in this study. Participation is completely voluntary and no payment will be provided.

Confidentiality: Information obtained in this study is strictly confidential unless disclosure is required by law. All data will be secured in a locked filing cabinet. Your name will not be used in the reporting of information in publications or conference presentations.

Participant's Right to Withdraw from the Study: You have the right to refuse to participate in this study and the right to withdraw from the study at any time without penalty.

I have read this letter and I fully understand the contents of this document and voluntarily consent to participate. All of my questions concerning this research have been answered. If I have any questions in the future about this study they will be answered by the investigator listed above or his/her staff.

I understand that the completion of this questionnaire implies my consent to participate in this study.

Participants Signature:_____

Participants Name: _____

Appendix C

Questionnaire for Health Care Providers

Health Care Providers Knowledge Assessment of Childhood Obesity within the Hispanic Community

This survey will be provided to 20 health care providers within pediatric primary care clinic center.

Respondents: Health Care Providers

Credentials: Circle one

ARNP DO PA MD

1. How often do you see children with obesity in your practice?
   (1) Often (2) Somewhat Often (3) Never
2. Do you weigh every child in your practice?
   (1) Often (2) Somewhat Often (3) Never
3. Do you review BMI at every visit?
   (1) Often (2) Somewhat Often (3) Never
4. Do you document BMI in patients chart?
   (1) Often (2) Somewhat Often (3) Never
5. How often do you educate children on nutrition and lifestyle modifications?
   (1) Often (2) Somewhat Often (3) Never
6. How often do you educate the caregivers on lifestyle modifications?
   (1) Often (2) Somewhat Often (3) Never
7. How often do you request feedback and the patient verbalized understanding?

(1) Often (2) Somewhat Often (3) Never

8. How often do you educate the caregivers on nutrition?

(1) Often (2) Somewhat Often (3) Never

9. How often do you provide written instructions to patients and caregivers on obesity?

(1) Often (2) Somewhat Often (3) Never

10. How often do request a follow up appointment to discuss lifestyle modification and monitor progress?

(1) Often (2) Somewhat Often (3) Never