CHILDHOOD OBESITY

IN

Chatham County

2014

Parent Focus Groups
Summary Report

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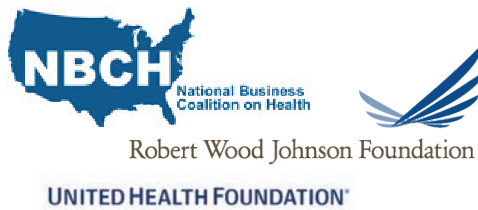

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1 EXECUTIVE SUMMARY

1.1 OVERVIEW

The Savannah Business Group (SBG) received funding from the National Business Coalition on Health (NBCH), Robert Wood Johnson Foundation (RWJF), and the United Health Foundation (UHF) to broaden the participation of parents, employers, and physicians engaged in the promotion of child wellness; specifically, to improve prevention and treatment of childhood obesity in Savannah and Chatham County, Georgia. This summary research report presents findings and recommendations to inform the parent engagement strategy: (1) design and distribution of a Chatham County Parent Resource Guide, (2) plan and host a Parent Summit for Child Wellness, and (c) engage parents in the local district-wide Parent-Teacher Association (PTA) health and wellness committee.

1.2 METHODOLOGY

Bluknowledge LLC, a research and consulting firm, managed the focus group research process. (See Appendix A | About Bluknowledge LLC for more details.) This included the design and facilitation of focus group activities; a qualitative analysis of the discussions, which were audio recorded and transcribed; and the authorship of this summary research report.

1.2.1 Participant Demographics

The research team facilitated five focus group interviews with 41 participants, mostly parents of children 5-12 years old. Women (90%) and African Americans (76%) comprised the majority of the focus groups. Approximately half (51%) of the participants reported earning a household income less than $35,000 and more than two-thirds (68%) reported to receive one or more public benefits within the past six months (e.g., Supplemental Nutrition Assistance Program [SNAP] or Women, Infants, and Children [WIC]). See Appendix B | Participant Demographics for more details.

1.2.2 Focus Group Format

Using the discussion guide, facilitators elicited insights, perceptions, knowledge, and desires among participants about

- availability, use, and accessibility of child wellness resources in the community
- school wellness, specifically physical activity and the school food environment
- comfort level and nature of relationship with child's physician
- participation in a local parent network for information sharing, advocacy, and action.

A variety of elicitation techniques were used to encourage full participation. For example, participants answered questions using stickers to the locations and reasons for specific healthcare services (e.g., child's pediatrician for well visits), annotated or marked up enlarged images of school menus, and participated in group discussion as the facilitator listed key ideas on chart paper. See Appendix C | Focus Group Discussion Guide for more details.

1.3 KEY FINDINGS

During the focus groups, participants posed critical questions about school-based polices related to physical activity and healthy eating, cited real-world challenges to promoting healthy behaviors at home, and shared relevant, healthy practices with other participants. A qualitative data analysis revealed several key findings about parents' experiences related to child wellness. This summary report presents findings across four themes: (A) The Georgia SHAPE Initiative and Physical Activity, (B) Healthy Eating and the School Nutrition Environment, (C) The Parent-Physician Relationship, and (D) Healthy Information and Resources Network.

1.3.1 The Georgia SHAPE Initiative and Physical Activity

- Overall, participants reported a lack of familiarity with the Georgia SHAPE Initiative, including the FitnessGram assessments and reports. Only two participants reported receiving a FitnessGram Report for their child.
- Participants provided valuable, concrete feedback to improve the SHAPE FitnessGram process and report, such as include pictures illustrating the exercises, add information about how to improve health, make reports age appropriate for children, and provide parent information with the student report.
- Also, participants confirmed the utility of the FitnessGram report in helping them manage their children's health. For example, several participants mentioned that the report contained good information and appreciated that it showed improvement in a child's health over multiple years. One participant remarked that it was "like a credit report on the child's health."
- Together, participants planned several child-centered "next steps" to improve children's health: (a) modify the household diet and exercise plans, (b) create opportunities for children to choose healthy eating and physical activity, and (c) incorporate language and actions that boost self-esteem.

1.3.2 Healthy Eating and the School Nutrition Environment

- Participants reported that their children usually eat (a) breakfast and dinner at home, (b) lunch at school, and (c) snacks at home and school.
- Based on the menu or what their children report to eat during the day, many participants communicated plans to supplement their child's nutrition at school by preparing meals (e.g., lunch to bring to school or dinner to eat at home) that increase *food security* (e.g., larger portions or more preferred foods), *nutritional value* (e.g., more vegetables or foods with less fat), and *variety* (e.g., different foods that what was served at school or more culturally-familiar foods).
- Participants varied in their knowledge and experiences with school nutrition policies and parent advocacy strategies. They reported a wide range of planned actions:
    - Learn about school nutrition policies and practices at their child's school by (a) asking their child what they ate during the day and (b) conducting observations

while eating lunch with their child. Spanish-speaking participants requested the school menu be made available offline and in Spanish.
    - Discuss their child's specific dietary needs with the teacher or school nutritionist with an expectation that school staff will monitor child's food intake.
    - Raise issues or provide feedback, individually or with other parents, about the school nutrition environment with staff (e.g., teacher, school nutrition managers, or principals) or groups (e.g., PTA, school wellness committee, and school board).

1.3.3 The Parent-Physician Relationship

- Mainly, participants utilized pediatricians (e.g., wellness visits, physicals, and immunizations), family practice physicians (e.g., cold or flu care and physicals), and emergency rooms (e.g., injuries, fever or cold or flu care) as their children's healthcare providers.
- Participants wanted to support their child's health; therefore they requested physicians (a) converse with them and their child about health-related behaviors at home and school, (b) allow sufficient time during visits to explain their reasoning for prescribing medicines or recommending healthy behaviors, and (c) include them and their child in planning for healthier families (e.g., goal-setting for food-related and physical activity behaviors and expectations for monitoring and follow-up).
- During physician visits, participants pay most attention to the physician's (1) communication style (e.g., Does he or she clearly explain medical terminology or demonstrate a non-judgmental stance?) and (2) methods of information sharing (e.g., Does he or she provide any take-home resources – online or handout formats or offer several options for healthy behaviors?).
- Several participants emphasized that physicians need to consider the social factors that affect families (e.g., income level, health insurance coverage, safety, and convenience) to ensure they suggest relevant and attainable healthy behaviors for parents and children.

1.3.4 Healthy Information and Resources Network

- Overall, participants reported preferences to
    - Learn about healthy information and resources via their child's school (e.g., Board of Education Office and classroom teachers), healthcare entities (e.g., physician office and community clinics), and parent organizations (PTA and Parent University)
    - Receive information via print formats (e.g., local newspapers and personalized letters) and web-based media (e.g., email and websites)
    - Share healthy information and resources with their personal networks, local groups (e.g., churches and athletic organizations), and schools (e.g., parent facilitators and front office materials)
    - Circulate potentially helpful and healthy information through web-based media (e.g., Facebook) and print channels (e.g., brochures).
- Participants placed a premium value sharing and receiving health-related information by means of word of mouth, including texting via mobile phones.

- While information overload remained a concern for a few participants, most reported that they were likely to ignore information they deemed irrelevant and share resources that may prove helpful to others.

1.4 IMPLICATIONS AND RECOMMENDATIONS

This report organizes an important body of community knowledge that offers insights into how parents care for their children. Specifically, this report makes available several examples of positive parenting practices that promote child wellness - healthy eating and physical activity behaviors and knowledge seeking and advocacy strategies. It also brings attention to the information, resources, and partnerships parents deem relevant and helpful to realizing their intentions for healthy families.

As mentioned earlier, this focus group study with parents was intended to inform a parent engagement strategy for childhood obesity prevention. The findings communicated in this summary report shaped the content of the 2014 Obesity in Chatham County Parent Resource Guide, which has been distributed to over 200 families. In addition to Let's Go 5-2-1-0 health promotion messages, the Parent Resource Guide shares information about how (a) parents can communicate more effectively with their child's physician, (b) children's body mass index (BMI) is measured and monitored using percentile charts, and (c) the Georgia SHAPE FitnessGram report informs parents about their child's health and fitness. Specific feedback about the Georgia SHAPE FitnessGram process and report was shared with the statewide SHAPE advisory committee.

The Parent Summit created the opportunity for parents and community members to participate in an engaging community health event focused on preventing childhood obesity and promoting child wellness. Participants' requests for additional information and resources defined the agenda for Parent Summit for Child Wellness, which convened a set of community-based facilitators who offered the following classes during the fall session of Parent University:

- Campaign for Healthy Kids and Families
- How do I Talk to My Child About Eating Healthy?
- Panel: How Can Parents Advocate for Healthier Schools?
- Kick Start Your Kids Into Fitness.
- Family Meals—Making Easy Choices
- Partner with Your Child's Pediatrician

The concluding section of this report proposes several recommendations that exemplify possibilities for youth-, family-, or health-centered agencies and organizations to foster nurturing relationships with families -- parents and children by (a) creating learning opportunities that position parents and children as contributors and seekers of relevant, health-related information and resources; and (b) advocating *with* parents to create and implement programs and policies that promote child wellness.

2 INTRODUCTION

In March 2013, the Savannah Business Group (SBG) received an implementation grant from the National Business Coalition on Health (NBCH), Robert Wood Johnson Foundation (RWJF), and the United Health Foundation (UHF). Building on findings from previous NBCH planning grant (2012 Childhood Obesity In Chatham County Obesity Report), this two-year implementation grant aims to broaden the participation of parents, employers, and physicians engaged in the promotion of child wellness; specifically to improve prevention and treatment of childhood obesity in Chatham County, Georgia.

To inform the parent engagement strategy, SBG commissioned bluknowledge LLC, a research and consulting firm, to conduct five focus groups with parents in Savannah and Chatham County, Georgia. (See Appendix A | About Bluknowledge LLC for more details.) The objective for these focus groups was to elicit insights, perceptions, knowledge, and desires among parents with regard to:

- availability, use, and accessibility of child wellness resources in the community
- school wellness, specifically physical activity and the school food environment
- comfort level and nature of relationship with child's physician
- participation in a local parent network for information sharing, advocacy, and action.

Findings from this formative research were initially intended to guide the (a) design and distribution of parent and physician resource guides, (b) plan and support for a local parent network, (c) design and delivery of wellness workshops for parents, and (d) potentially a parent survey to collect more data about parents' perceptions, knowledge, and desires related to child wellness.

After facilitating these parent focus groups, researchers concluded the findings from these focus groups had relevance and importance for individuals and organizations engaged in improving the health of families and communities. To this end, this summary report describes the methodology of the focus group research. Findings are presented in four sections: (a) The Georgia SHAPE Initiative and Physical Activity, (b) Healthy Eating and the School Nutrition Environment, (c) The Parent-Physician Relationship, and (d) Healthy Information and Resources Network. Finally, this summary report puts forth a set of recommendations to inform the programs and policies related to child wellness or childhood obesity.

3 METHODOLOGY

3.1 PARTICIPANTS

Forty-one parents or caregivers participated in five focus groups during the period, August - October 2013. Participants comprised a convenience sample that resulted from targeted

recruitment strategies (e.g., parents who live under-resourced communities and actively engage in parent education activities). For each focus group, the number of participants and setting varied. See Table 3.1 for more details.

Table 3.1 Summary of Focus Group Participants and Recruitment Strategy

Focus Group	Number of Participants	Setting	Target Recruitment Strategy
1	8	Local community center Weekday, mid-morning	Community members who live in under-resourced communities
2	8	Savannah Business Group (SBG) office Weekday, midday	Employees of SBG coalition business who have access to comprehensive health insurance coverage
3	2	Local Latino community Weekday, evening	Latino community members
4	18	Local school during regularly held parent education session Weekend, mid-morning	Community members who are actively engaged in parent education
5	5	Local school with active parent involvement center Weekday, mid-morning	Parent Teacher Association (PTA) members
Total	41		

3.1.1 Key Demographics

During recruitment, participants responded to the request for parents or caregivers of at least one child between 5-12 years old. Thirty-five participants (85%) met this criterion. The remaining six participants (15%) considered their participation relevant because of their previous parenting or caregiving experience with children ages 5-12 years old or their current work with youth in the community.

Women (90%) and African Americans (76%) comprised the majority of the focus groups. Approximately half (51%) of the participants reported earning a household income less than $35,000. More than two-thirds (68%) reported to receive one or more public benefits within the past six months: Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC), United States Department of Agriculture (USDA) Child Nutrition (*i.e.,* Free or Reduced Lunch), HeadStart, Temporary Assistance to Needy Families (TANF), and Temporary Emergency Foods or Commodity Foods (TEFAP). See Appendix B | Participant Demographics for more details.

3.1.2 Recruitment

Applying a targeted recruitment strategy, the research team (1) determined the desired core group of participants for each focus group, (2) leveraged existing relationships with community-based and employer organizations to help identify and recruit core participants, and (3) implemented partner organizations' suggested best practices for recruiting potential core participants (*e.g.,* face-to-face announcements and personalized invitations). For example, the research team attended a parent education session to recruit for the fourth focus group. Per the community partner's request, the team also pre-registered participants "on-the-spot", and followed up with electronic and postal invitations and reminder phone calls.

The research team also recruited "at-large" through relevant communication channels (e.g., community-based organization's contact list). To bolster these general recruitment efforts, the team located each focus group at a facility that was familiar to the core participants. See Table 3.1. For example, the third focus group (core participants: Latino) took place at the local Latino church that also serves as a community education and health promotion space. The team also conducted the sessions during regularly scheduled meeting times, such as a parent education event. Recognizing parental responsibilities (*e.g.,* work, childcare, or school), the team scheduled focus groups at different times of day (*e.g.,* morning, mid-day, and evening).

To monitor recruitment efforts, participants pre-registered via online or paper forms, telephone, or email. The team also accepted walk-ins. Finally, to incentivize participation, the team advertised plans to serve healthy light refreshments and gift fun, healthy items (e.g., water bottle, tote bag, tokens for local farmers market, balls or jump rope, and information).

***Lessons Learned*.** Overall, the research team enacted multiple strategies to successfully recruit parents and caregivers. The high-touch, customized recruitment tactics proved more effective than general email or flyers. The localized venue choices enabled the research team to "meet participants where they're at" – in their communities, and the varying scheduled times contributed provided parents and caregivers multiple options for participation. In the end, engaging community organizations as recruitment partners emerged as the most impactful recruitment strategy.

3.2 DATA COLLECTION

3.2.1 Discussion Guide

The principal at bluknowledge LLC designed the discussion guide for use during all focus groups. Each focus group session was divided into four topics: (A) The Georgia SHAPE Initiative and Physical Activity, (C) Healthy Eating and the School Nutrition Environment, (3) The Parent-Physician Relationship, (D) Healthy Information and Resources Network . Table 3.2 presents the topics, key questions, and activities. See Appendix C | Focus Group Discussion Guide for more details.

Notes on Participation Structures. Participants in focus groups one and four discussed topics A (The Georgia SHAPE Initiative and Physical Activity) and B (Healthy Eating and the School Nutrition Environment) simultaneously with participants divided in two groups. Focus group two only discussed topic A and focus group three only discussed topic B. All participants in focus group five discussed topics A and B. This alternate participation structure resulted in findings for a portion of the participants: Topic A (N=26) and Topic B (N=23). All participants discussed topics C (The Parent-Physician Relationship) and D (Healthy Information and Resources Network).

Notes on Artifacts. Participants in focus groups 1, 4, and 5 reviewed and annotated an authentic school menu of the Savannah-Chatham County School System. During focus group three, participants reviewed and annotated a comparable school menu in Spanish from the Poudre School District because the research team could not locate a local menu in the Spanish language.

During focus groups 1, 2, 4, and 5, participants watched and discussed the Children's Healthcare of Atlanta (CHOA) *Strong4 Life* video that featured conversation among a pediatrician, mother, and child about weight management and healthy behaviors for physical activity and eating. CHOA and its partners use the video to train providers (physicians, nurses, and dieticians) in motivational interviewing techniques. The research team utilized the video to provide participants with a common viewing experience for discussions. Again, the research team was challenged to find a comparable video in the Spanish language. Therefore, participants in focus group three discussed their experiences with their child's current physician.

3.2.2 Facilitation

The principal at bluknowledge LLC managed the facilitation and research process for all five focus groups. Two staff members served as facilitation assistants and led discussions for topics A and B with support from the principal. They also recorded notes during the principal's facilitation of topics C and D. The third focus group was Spanish-speaking. The principal facilitated the entire discussion, which was translated in real-time by a qualified translator. To ensure consistency, all assistant facilitators and notetakers participated in an extensive training comprised of testing and refining the discussion guide and facilitation rehearsal.

Using the discussion guide, facilitators elicited participants' ideas about their experiences, practices, suggestions, and plans related to child wellness. A variety of elicitation techniques were used to encourage full participation. For example, participants answered questions using stickers to indicate whether they have ever received their child's FitnessGram report (yes or no), the location of their child's meals (e.g., school or home), or the locations and reasons for specific healthcare services (e.g., child's pediatrician for well visits or emergency room for an injury). In addition, participants annotated or marked up enlarged images of the FitnessGram

reports (student and parent) and school menus. As participants discussed each topic, the facilitator listed key ideas on chart paper. Throughout the focus group, the facilitator checked for consensus, restated comments for clarification, and prompted participants to elaborate their responses. At the end of the end of the focus group, facilitators administered an anonymous, demographic survey.

Table 3.2 Overview of Focus Group Discussion Topics

Discussion Topic (Focus Groups)	Key Questions and Activities
A. The Georgia SHAPE Initiative and Physical Activity *(1, 2, 4, 5)*	***Answer*** *Has your child ever brought home a FitnessGram?* Review, ***annotate***, and discuss sample *FitnessGram* reports. *What do/don't you understand?* ***Discuss*** response to a scenario about a child who brings home a FitnessGram that places them outside the Healthy Zone. *If this was your child, what are your next steps?*
B. Healthy Eating and the School Nutrition Environment *(1, 3, 4, 5)*	***Answer*** *Where does your child eat breakfast, lunch, dinner, and snacks*? Review, ***annotate***, and discuss a sample school menu.[1] *What do/don't you want your child to eat?* ***Discuss*** response to a scenario that pictorially describes what a child eats throughout a normal school day. *Your child eats these meals on a typical school day. Knowing this, what do you do next?*
C. The Parent-Physician Relationship *(1, 2, 3, 4, 5)*	***Answer*** *Why do you take your child to the family practitioner, pediatrician, community clinic or center, emergency room, urgent care, or drugstore/pharmacy?* Watch and ***discuss*** observations and judgments of a video of a conversation between a parent, child, and physician.[2] ***Discuss*** *What do you want to happen at your next visit to the child's doctor? Why?*
D. Healthy Information and Resources Network *(1, 2, 3, 4, 5)*	**Discuss** *How do you want to learn about and share information about the child wellness resources?*

All focus groups lasted approximately 90 minutes and were audio recorded, with participants' verbal consent, and transcribed for content. The notetakers wrote notes during each group and typed them after each session. In addition, all artifacts (e.g., annotated, posted and charted responses) were digitized for analysis. Finally, facilitators and notetakers wrote reflections following each group to capture any immediate insights.

[1] View English and Spanish-language menus at http://tinyurl.com/sbg-schoolmenus.

[2] Video credit: Children's Healthcare of Atlanta. (2013). *Strong4Life Role Play Scenarios*. Available from Children's Healthcare of Atlanta.

Figure 3-1 Snapshots of Elicitation Techniques

A. Participants *answer* using stickers | B. Participants *annotate* school menu | C. Participants' key ideas recorded during *discussion*

Lessons Learned. Altogether, the design and facilitation of the focus groups yielded a large body of relevant data that provided valuable insights into the lives of parents and caregivers; with respect to healthy goals, decisions, and behaviors related to child wellness. The variety of discussion topics within a session sustained participants' engagement, as evidenced by the generous amount of verbal data transcribed. Participants' physical markings and discussions of artifacts, such as the FitnessGram reports and school menus allowed participants to communicate their ideas in multiple forms. The common viewing experience of the physician-visit video successfully elicited participants' ideas, experiences, and expectations about interactions with their children's physicians. The Spanish-speaking focus group would have also benefited from a comparable video. In retrospect, the discussion guide emphasized the elicitation of participants' perceptions, knowledge, and desires. Additional consensus-seeking activities might have generated data or promoted analysis that results in prioritized or ranked ideas and experiences among participants. Finally, these focus groups exemplify a well-designed interactive, multimodal process. Coupled with the targeted core group recruitment approach and advanced facilitation techniques, similar focus group designs should recruit a smaller number of participants (e.g., 4-6) for each session.

3.3 DATA ANALYSIS

The staff at bluknowledge LLC applied a systematic content analysis to the rich data elicited from focus group participants. First, staff collaborated to organize and review artifacts and transcripts. Next, they identified emergent categories, constructed coding rubrics, and established inter-rater reliability. Guided by the appropriate coding rubric (described in the *Findings* sections), staff categorized and interpreted data collected across all focus groups. Written notes and reflections were referenced to fill in missing information, inform interpretation, and provide additional context. The next sections present detailed descriptions of the relevant data analysis for each topic and key findings.

4 FINDINGS | THE GEORGIA SHAPE INITIATIVE AND PHYSICAL ACTIVITY

In 2009, Georgia legislature enacted the Student Health and Physical Education (SHAPE) Act to address childhood obesity rates in Georgia. The SHAPE Act requires (1) all Georgia public schools to assess the fitness of students in grades 1-12, and (2) the State Board of Education (SBOE) to (a) create a policy on health and physical education, and (b) report school compliance to the Governor.[3]

The Georgia Department of Education (GaDOE) Fitness Assessment Rule expands the SHAPE Act by directing local school boards to create a health and physical education program that encompasses eighteen categories, including a fitness assessment. The assessments, which began in the 2011-2012 school year, have been conducted once a year with students who are (a) in grades 1-12 and (b) enrolled in a physical education course at the time of testing.[4] School staff conducts fitness assessments with the FitnessGram, which assesses students on aerobic capacity, muscle strength, endurance, and flexibility through a variety of tests and Body Mass Index (BMI).

This rule also requires schools to send home individual FitnessGram reports to inform parents or guardians about their child with regard to (a) fitness tests performance (b) health indicators (e.g., BMI), and (c) suggestions for healthy behaviors. The report compares children's fitness performance and health indicators to children of a similar age. Parents or guardians should also receive a FitnessGram Reference Guide to help them interpret the report. These state-level policy changes informed the design of the focus group activities related to physical activity and enabled the research team to learn more about participants' (a) awareness of the SHAPE initiative, (b) understanding and feedback of the SHAPE FitnessGram report, and (c) plans for supporting their child's physical activity at home and at school.

4.1 WHAT ARE PARENTS' EXPERIENCES WITH THE GEORGIA SHAPE INITIATIVE AND SCHOOL-BASED PHYSICAL ACTIVITY?

As mentioned earlier, 26 participants across four of the focus groups completed several activities that elicited their awareness, experiences, and feedback about the FitnessGram reports and physical activity in school. The research team (1) carefully reviewed the annotations of the FitnessGram reports and the transcribed conversations during the Georgia SHAPE Initiative and Physical Activity, (2) identified 288 relevant comments, and (3) assigned each comment to an emergent category. See Table 4.1 for category descriptions and distributions.

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[3] The State of Georgia. (2009). Georgia Code OCGA 20-2-777 (SHAPE Act). *Georgia SHAPE.* Retrieved from http://www.georgiashape.org/story/georgia-code-ocga-20-2-777-shape-act

[4] Georgia Shape. (2011). DOE Fitness Assessment Rule. *Georgia SHAPE*. Retrieved from http://www.georgiashape.org/story/doe-fitness-assessment-rule

Table 4.1 Georgia SHAPE Initiative and Physical Activity | Categories: Descriptions and Distributions

Category	Description	Examples	# of Comments	% of Comments
FitnessGram Reports	Interpretation and utility of Parent Reference Guide and Student Reports	Looks like an acronym -- what does it stand for? Because it will let me know my child's body.	56	18.06%
FitnessGram Testing	Parent notification, testing procedures, and communication of findings	*Are these tests done inside or outside?* *Needs parent consent and a letter prior to evaluating student.*	54	17.42%
Knowledge-Seeking Practices	Actions that increase health-related knowledge	*Evaluate what child is doing (eating, playing, TV) at home.* *Get suggestions for better food from school*	58	18.71%
Behavior	Actions that lead to adopting healthy behaviors	*You and kids exercise together.* *Make healthy food fun, add color.*	51	16.45%
Policy and Advocacy	Policies and advocacy strategies aimed to increase physical activity at school, home, and in the community	*How are the [SHAPE] guidelines set?* *Advocate for PE in school more.*	46	14.84%
Children's Health	Additional ideas and experiences about children's health and wellness	*Everyone - no matter the age needs exercise.*	45	14.52%
Total			310	

Note: Researchers established a 95% inter-rater reliability.

4.1.1 How do Parents Evaluate the FitnessGram Report?

Participants reviewed examples of the FitnessGram Student Report and a portion of the Parent Reference Guide (one page of the seventeen page guide). See Figure 4-1A. They provided feedback by physically marking the examples and through group discussion. During this activity, participants provided suggestions that would improve the understanding and utility of the reports among students.[5]

Parent Awareness. In the Savannah-Chatham County Public School System (SCCPSS), all 30 elementary schools participated in the FitnessGram testing during the 2012-13 academic year. Despite this high level of school participation, only two participants (7.7%) reported the receipt of a FitnessGram Report for their child.

[5] The findings presented in Section 4.1.1 How do Parents Evaluate the FitnessGram Report? have also been shared with the state-level Georgia SHAPE Committee.

Parent Critique. Analysis of the annotations and transcribed group discussions revealed that the FitnessGram annotation activity elicited 56 comments about the FitnessGram reports. Twelve participant comments indicated that some parents understood the information presented in FitnessGram Reports. For example, several participants mentioned that the report contained good information and appreciated that it showed improvement in a child's health over multiple years. One participant remarked that it was "like a credit report on the child's health."

Eleven participant comments identified difficult-to-understand features of the reports. Multiple participants expressed that the reports were complicated and too wordy. Participants also specified that the following acronyms and terms used on the reports were unfamiliar or confusing:

- PACER (Progressive Aerobic Cardiovascular Endurance Run)
- Pacer lap (One of up to twenty-one 20m sprints that makes up the PACER test)
- BMI (Body Mass Index – calculated measurement of body fat using height and weight measures)
- VO2 (Maximal Oxygen Uptake, a measure of cardiovascular fitness)
- HFZ (Healthy Fitness Zone)

Also, participants expressed uncertainty about exercises being tested (i.e., What are they? and How are they performed?).

Parent Suggestions. Participants provided 22 suggestions that could increase the understanding and utility of the FitnessGram reports. See Table 4.2.

Table 4.2 Participants' Suggestions for Georgia SHAPE Fitness Gram Reports

Suggestions	Examples	# of Comments
Include pictures illustrating the exercises.	*If a picture is included with these exercises . . . we know what they are. That would be helpful.*	7
Make reports age appropriate.	*Kids should be able to read this. Students cannot understand this and make [the] corrective action.*	9
Include more information about improving health.	*Make information related to improvement more prominent.*	4
Provide parent information with the student report.	*Place parent information on back [of student report].*	2

FitnessGram Testing. Most participants were unfamiliar with the fitness assessment process. While reviewing the FitnessGram reports, participants shared 54 comments about the FitnessGram testing. They asked questions related to how the fitness tests were performed and measured and who administered the tests. A few participants requested parent notification

prior to testing or the opportunity to give consent for their child's participation in the annual fitness assessment. Several participants also raised concerns about changes in children's health status between parents' submission of health-related paperwork at the start of school and the FitnessGram testing period. In addition, participants' requested clarification about how the FitnessGram results were communicated to them and their children with regard to (a) privacy (e.g., Are the reports distributed in front of other children?, (b) method of communication (e.g., how do the reports get home? A parent would never see the report if it was sent via the "book-bag black hole."), and (c) resources (e.g.. Is a school staff member assigned to explain the report to parents? Does this report come with community resources for physical activity?).

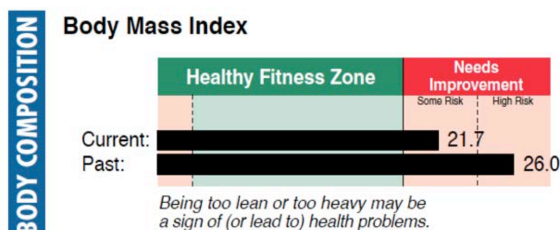
Figure 4-1 Snapshots of FitnessGram Focus Group Activities

A. Participants Annotating FitnessGram Reports

ACTION SCENARIO

Imagine Joe Jogger is your child. His FitnessGram report shows his Body Mass Index (BMI) outside the Healthy Ftness Zone.

What do you *DO* next?



B. Action Scenario

4.1.2 How Do Parents Plan to Support their Children's Healthy Behaviors?

Following the FitnessGram annotation activity, participants responded to a scenario. They reviewed a portion of an example student report that showed a student's BMI outside the *Healthy Fitness Zone*. When prompted to respond to the scenario, participants explained their planned next steps or actions. Participants' comments during these discussions were categorized as knowledge, behaviors, policy and advocacy, or children's health. See Table 4.1 for category descriptions and distributions.

Seeking Health-related Knowledge. Participants shared 58 comments that provided insights into how parents seek to increase their knowledge about their child's health. Starting with reflection, participants explained their plans to (1) observe their child's health behaviors (e.g., eating and exercise habits) and (2) talk with their child about his or her opinions of their own health. Recognizing the physician as a credible source of information, participants also expressed a desire to talk with their child's physician about additional health concerns or for

suggestions about what they could do at home to further support their child's health. Participants also discussed conducting Internet research on the health information reported in the FitnessGram (e.g., BMI) and reported plans to hold conversations with school staff (e.g., physical education teacher).

Planning Healthy Behaviors. In response to the scenario, participants shared 51 comments related to behavior. Most comments centered on modifications to exercise (e.g., create an exercise plan and ride bicycles) and diet (e.g., increase more nutritious foods, such as salads and milk and decrease sweets and fast-food meals) for the child and family members. They emphasized the importance of involving children in meal planning and preparation, and even planting and harvesting vegetables in a garden. Participants often cited words, such as "fun", "enjoyable", and "social", when describing physical activities for children and mentioned plans for their child to (a) enroll in a sports program, (b) connect with a playmate or buddy for support, and (c) participate in physical activity alongside family members. Finally, participants considered affective influences on children's behaviors, such as self-perception, as barriers to exercises, and planned to use praise and the practice of healthy behaviors to actively work toward increasing children's self-esteem.

Policy and Advocacy. Both focus group activities related to physical activity prompted policy and advocacy comments and engendered more general comments about children's health and wellness. Forty-six comments centered on SHAPE and school-based, physical activity policies. With regard to SHAPE policies, participants raised questions related to (a) implementation and compliance (e.g., Which grades participate in the FitnessGram testing? How do you test students who are not enrolled in PE due to course schedule?) and (b) follow-up (e.g., Do students have the option to retest later and compare results? and Will the school offer an intervention if many students perform poorly on the fitness assessment?). Participants also shared several comments related to school-based policies (e.g., school wellness policy). Key topics included (a) the limited amount of physical activity offered in school; (b) how the lack of physical activity affected children's behavior, academic performance, or health outcomes; and (c) participants' observations of recess being withheld as a punishment. Finally, a few participants reported the need to advocate for change within the community; increasing parental involvement in child health and offering free community exercise opportunities.

Additional Ideas about Children's Health and Wellness. Participants shared 45 comments about challenges to improving children's health, the role of physicians, current health practices, and potential and existing health resources. Several participants cited time as challenge and pitted exercise as a competing priority with homework, bedtime, and meals. They also reported that working hours contended with business hours for several community resources and personality traits, such as being a picky eater, or low self-esteem placed additional demands on parents as they seek to create a healthy environment for their children. Some participants

questioned physicians' awareness of the FitnessGram report and explained several of their pediatrician's holistic practices.

Many participants shared healthy practices: (a) limit screen time (*e.g.,* television and video games) (b) allow children to actively choose healthy food options (*e.g.,* fajita buffet), and (c) encourage children to play with pets (*e.g.,* walk the dog). They also listed several existing community resources, such NFL 60, parent centers at Title 1 schools, and community centers, and suggested desired resources, such as health education classes sponsored by the PTA and the utilization of local parks as locations for community exercise. Overall, parents accepted and welcomed their very important role in helping raise healthy children.

4.2 SUMMARY | THE GEORGIA SHAPE INITIATIVE AND PHYSICAL ACTIVITY

Key Findings

- Overall, participants reported a lack of familiarity with the Georgia SHAPE Initiative, including the FitnessGram assessments and reports.
- Even though participants provided valuable, concrete feedback to improve the FitnessGram process and report, they confirmed its utility for helping them manage their children's health.
- Eager to increase their health-related knowledge, participants identified a variety of reliable sources including their child, physicians, the Internet, and school staff.
- Together, participants planned several child-centered "next steps" to improve children's health: (a) modify the household diet and exercise plans, (b) create opportunities for children to choose healthy eating and physical activity, and (c) incorporate language and actions that boost self-esteem.
- Keen on their role in helping their children live healthfully, participants (a) posed critical questions about school-based polices related to physical activity, (b) cited real-world challenges to promoting healthy behaviors at home, and (c) shared relevant healthy practices with other participants.

5 FINDINGS | HEALTHY EATING AND THE SCHOOL NUTRITION ENVIRONMENT

The federal legislation, *The Healthy, Hunger-Free Act of 2010 (HHFKA)*, aims to improve child nutrition through the United States Department of Agriculture's (USDA) nutrition programs that include the National School Lunch Program and the School Breakfast Program. The HHFKA authorized funding to improve the nutritional value of school meals and snacks, specifically (a) decrease the fat, sodium, and added sugar in foods served and (b) increase the amount of fruits, vegetables, whole grains, and low-fat dairy served. These national-level policy changes support children's access to healthy food options in public schools.[6]

[6] USDA Food and Nutrition Services. (2014). School Meals. Retrieved from http://www.fns.usda.gov/school-meals/healthy-hunger-free-kids-act

In addition to establishing new nutritional standards for school meals, the HHFKA also requires school systems to develop and monitor a local school wellness policy that sets goals and guidelines for nutrition, nutrition education, and physical activity. The Savannah-Chatham County Public School Systems (SCCPSS) adopted a school wellness policy in 2013. This policy addresses several key areas: school meals (e.g., A minimum of 2 hours and not more than 5 hours scheduled between Breakfast and Lunch periods on full school days.), school-based activities (e.g., Students are allowed to have individual water bottles in the classroom.), and nutrition education (e.g., At a minimum, the equivalent of one hour of classroom nutrition education is provided each month for all students.).[7] These national and local level policy changes prompted the design of the school nutrition focus group activities to generate information about when and where participants' children eat and participants' (a) evaluations of their child's school nutrition environment and (b) plans to support healthy eating practices at school and home.

5.1 WHAT ARE PARENTS' EXPERIENCES WITH CHILDREN'S HEALTHY EATING BEHAVIORS AT HOME AND IN THE SCHOOL NUTRITION ENVIRONMENT?

5.1.1 Where and When Do Children Eat?

As mentioned earlier, 23 participants across four focus groups completed several activities that elicited their experiences and feedback about their children and families' nutritional environment in healthy eating practices at home and in the school. To locate where children eat most meals, participants answered the question: *Where does your child eat breakfast, lunch, dinner, and snacks?* The facilitator provided them with a set of meal stickers labeled breakfast, lunch, dinner, snack 1, and snack 2. For each meal, participants identified which locations (e.g., home, school, or afterschool program) children usually eat a particular meal. See Table 5.1 for the summary of meal-location combinations.

Table 5.1 Summary of Locations Where Children Eat Meals

	Meal				
Locations	**Breakfast**	**Lunch**	**Dinner**	**Snacks**	**All**
Home	17	4	21	21	63
School	7	19	0	16	42
Afterschool Program	0	1	0	8	9
Other: Church	0	0	0	1	1
Total	24	24	21	46	115

Participants identified home and school as the top locations where their children eat most meals. Of the 115 meal-location combinations, participants reported (a) 63 meals (55%) usually eaten at home; mainly dinner, snacks, and breakfast and (b) 43 meals (37%) at the school;

[7] SCCPSS. (2013). *Local Wellness Policy.* Retrieved from https://eboard.eboardsolutions.com/ePolicy/policy.aspx?PC=EEE-R(1)&Sch=4140&S=4140&RevNo=1.18&C=E&Z=R

mainly lunch and snacks. Other meal-location combinations included snacks at afterschool programs, breakfast at school, and lunch at home.

5.1.2 How Do Parents Evaluate the School Menu?

Participants reviewed an example of a school menu. See Figure 5-1A. They provided feedback by physically marking the menu and verbally commenting during group discussions. During this activity, participants evaluated specific breakfast and lunch items on the school menu. The research team (1) carefully reviewed the school menu annotations and the transcribed conversations, (2) identified 176 relevant comments, and (3) assigned each comment to an emergent category:

- ***Preference*** – desires based on taste, texture, or visual appeal; food allergies or intolerances; or a general like or dislike of certain foods.
- **Health** – considerations based on whether it is natural or processed, part of a healthy food group, a sufficient amount of food, or prepared in a healthy manner.
- **Familiarity** – identifications of food that have been previously eaten at home or in restaurants or considered part of one's cultural repertoire of foods.
- **Quality** –observations of how consistently and safely food is prepared and served at school.
- **Variety** – repetition of food items or the diversity of foods offered within a food group.

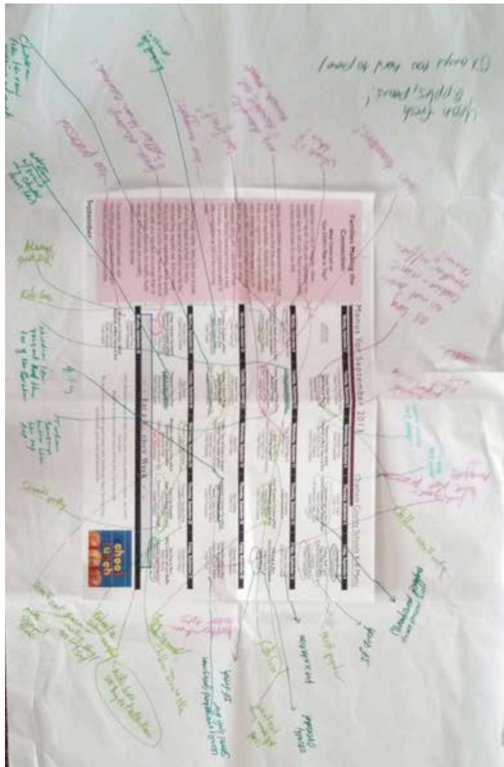
Each comment reflected a parent or child point of view. See Table 5.2 for category distributions.

Table 5.2 Healthy Eating and School Nutrition Environment | Menu Evaluation Categories and Distributions

	Comments Categorized by Criteria											
	Preference		Health		Familiarity		Quality		Variety		All	
Point of View	#	%	#	%	#	%	#	%	#	%	#	%
Parent	34	19.32%	12	6.82%	12	6.82%	14	5.11%	9	5.11%	96	54.55%
Child	64	36.36%	11	6.25%	11	6.25%	2	1.14%	2	1.14%	80	45.45%
Total	98	55.68%	23	13.07%	23	13.07%	16	9.09%	11	6.25%	176	

Preference. As participants annotated and discussed the school menu, they shared 98 *preference* comments (55.68%). A limited number of comments reflected the parent perspective, mainly indicating which menu items (e.g., vegetables or fresh foods) meet participants' approval. Sixty-four comments (36.36%) communicated participants perceived as ideas about children's preferences for (a) food items (e.g., "Every kids loves chicken nuggets." and "They don't like squash.") and (b) food preparation methods (e.g., "Children like foods they dunk or dip."). Note, these preferences varied widely and stemmed from parents' experiences with their children's food choices, medications, and food allergies or intolerances. Additionally, a few participants explained that they have observed children not eating school meals due to these preferences and suggested that these children were not eating enough throughout the school day.

Figure 5-1 Snapshots of Healthy Eating and School Nutrition Environment Focus Group Activities



A. Example of an Annotated School Menu

ACTION SCENARIO

Your child eats these meals on a typical school day.

What do you *DO* next?

Breakfast

Lunch

Afterschool Snack

B. Action Scenario

Health. Participants shared 28 comments (15.91%) related to the healthfulness of menu items; all comments except one reflected a parent perspective. Their inquiries or judgments of healthfulness considered several criteria: (1) the extent that food items are processed, (2) food preparation methods (e.g., baked or fried), (3) the food groups served (e.g., vegetables, fruit, and whole grains), (4) the amount of food (i.e., Is it filling enough?), and (5) how frequently food items are served.

Familiarity. Twenty-three participant comments (13.07%) considered the familiarity of menu items for children and themselves. Several comments expressed uncertainty about nature or preparation of the menu items. Most asserted that children usually (a) refrain from eating new foods and (b) eat foods served at home or in restaurants they frequent (e.g., tacos at Taco Bell). Participants in the Latino focus group commented on the lack of culturally familiar foods (e.g., tortillas and soups) on the school menu.

Food Service Quality. Sixteen comments (9.09%) referred to the quality of food service for school meals. With regard to preparation and presentation, participants reported observations of food items served cold, overcooked (e.g., grey-green colored vegetables), or in a visually unappealing manner. Also, participants noted the inconsistency of meal service across school

cafeterias within the district. For example, some schools served more fresh items than others or canned items were served even when listed on the menu as fresh.

Variety. Eleven participant comments (6.25%) considered the variety of foods served throughout the school nutrition program. A few comments acknowledged that alternatives have been offered to students and that some existing menu items attempt to offer "new twists on old favorites", such as breakfast pizza. The remaining comments cited too much repetition of certain menu items and little variance in the menu from month to month. Several participants requested more variety in the fruits served.

5.1.3 What are Parents' Plans to Support their Child's Healthy Eating Behaviors?

Following the school menu annotation activity, participants responded to an action scenario. They reviewed images of a set of typical school meals: breakfast, lunch, and an afterschool snack. See Figure 5-1B. When prompted to respond to the scenario, participants explained their planned next steps or actions. The research team (1) carefully reviewed the transcribed conversations, (2) identified 125 relevant comments, and (3) assigned each comment to an emergent category. See Table 5.3 for category descriptions and distributions.

Table 5.3 Healthy Eating and School Nutrition Environment | Categories: Descriptions and Distributions

Category	Description	Examples	# of Comments	% of Comments
Knowledge	Actions that increase health-related knowledge	*Talk with child about what [he or she] ate during the school day* *Inquire about the preparation method of the food*	19	15.20%
Behavior	Actions that lead to adopting healthy behaviors	*Make sure child has healthy meals and snacks at home to supplement school food*	42	33.60%
Policy and Advocacy	Policies and advocacy strategies to improve the health of the school nutrition environment	*Talk with teachers about child's dietary restrictions to make sure they are informed* *Talk with head lunchroom lady*	36	28.80%
Menu Suggestions	Suggestions specific to the meals presented in the action scenario	*Discuss substitution of menu item (e.g., a vegetable for the French fries)*	28	22.40%
Total			125	

Note: Researchers established a 95% inter-rater reliability.

Seeking Health-related Knowledge. Nineteen comments (15.20%) focused on how participants planned to learn more about the school nutrition policies or practices at their child's school or what their child eats during the school day. Some participants posed specific questions to understand their child's options for water during class and school meals, alternate food choices when unhealthy meals are served, and the preparation methods for school meals. Participants in the Spanish-speaking focus group requested access to the monthly school menu in Spanish and offline, specifically as a document sent home by their child's teacher. Finally, participants reported plans to listen to their child's descriptions of what they ate and drank at school and observe their child's school-day meals when they dine with them at school.

***Planning Healthy Behaviors*.** Participants communicated plans for healthy behaviors via forty-three comments (34.40%) that considered the questions: (1) Is my child eating enough food to fill them up?; (2) Is my child eating enough nutritious foods?; (3) Is my child eating a variety of healthy foods?; and (4) Is my child eating enough foods they prefer? Most comments discussed how participants planned to replace or supplement school meals to support their children's health. They provided several reasons for preparing lunch for their child to bring to school: (1) Their child prefers not to eat school meals. (2) Lunch from home includes healthier options than school meals. (3) It is more economical for their child to bring lunch from home since he or she throws their school meals away. (4) Their child requires particular foods due to medications or medical conditions. One participant noted that sometimes their child might buy school lunch if he or she prefers something on the menu. Another participant reported that she does not prepare lunch for her son to bring to school because he wants to eat the same foods as the children at his school.

Several participants explained that they prepare meals or snacks to supplement school meals. Some reported to (a) prepare a "large breakfast" to make sure their child is not hungry during the school day, (b) provide snacks after school because their child is often hungry at the end of the school day, or (c) prepare dinners with more food because they did not think the school meals were "filling" enough. Participants also planned to vary their child's food intake and provide different fruits or vegetables at home than what their child ate at school. Finally, participants reported plans for meals at home to include healthier options, such as more vegetables and foods with less fat. Unique to the Spanish-speaking focus group, participants shared that they would offer more soups because the school meal items seemed dry. The remaining comments exemplified how parents plan to promote healthy behaviors at home by advising children to refrain from unhealthy foods or engaging children in meal preparation activities.

Policy and Advocacy. Thirty-six comments (28.80%) described how participants planned to advocate for an improved school nutrition environment. A small subset of comments centered on participants' plans to advocate for their child with regard to their special dietary needs. Participants reported plans to inform their child's teacher or the district nutritionist prior to the start of the academic school year and provide documentation. They expected the teacher to help monitor their child's compliance with his or her special diet.

Several comments identified staff (e.g., teacher, principal, school nutrition managers, school nurse, or district nutrition director) or groups (e.g., PTA, school wellness committee, and school board) with whom participants would raise issues or provide feedback related to the quality, healthfulness, and quantity of food their children eat during the school day. For example, participants planned to request the removal or limitation of unhealthy foods or the provision of alternate healthier foods in the school nutrition environment. Note, that many participants articulated contingency plans with regard to their advocacy efforts (e.g., *talk with the principal if the school nutrition manager is not responding* or *talk with the school board if unsatisfied with school-level conversations*).

Also, some participants referred to policies that "outlaw" sugary drinks and the uneven implementation of policies that regulate school nutrition environments. Interestingly, only one participant explicitly referred to the district's school wellness policy. Participants recognized the challenges associated with enforcing policies across multiple schools.

Specific Menu Suggestions. The remaining comments focused on participants' specific recommendations to improve the meals presented in the action scenario. Based on their perceptions of foods' healthfulness, participants suggested the (a) removing or limiting of unhealthy foods, (b) serving substitute or alternate foods (e.g., vegetables instead of French fries), (c) adding of healthier foods (e.g., more complex carbohydrates), and (d) varying foods (e.g., different vegetables).

5.2 SUMMARY | HEALTHY EATING AND SCHOOL NUTRITION ENVIRONMENT

Key Findings

- Participants reported that their children usually eat (a) breakfast and dinner at home, (b) lunch at school, and (c) snacks at home and school.
- When prompted to evaluate a school menu that includes breakfast and lunch meals, participants attended to multiple criteria: (1) *preference* (e.g., What do children like to eat?), (2) *health* (e.g., Are there enough fruits and vegetables on the menu?), (3) *familiarity* (e.g., Are the foods served similar to what children usually eat at home?), (4) *quality* (e.g., Are the meals cooked safely and presented in an appealing manner?), and (5) *variety* (e.g., Are certain foods served too much?).
    - Note that participants described numerous preferences, which varied widely and stemmed from parents' experiences with their children's food choices, medications, and food allergies or intolerances.
- Participants maintain the expectation that parents and schools share responsibility for supporting children's healthy eating behaviors. Three school-home relationships emerged:
    - **Supportive**: *school meals support home meals* (e.g., students should eat more vegetables at school because these healthy foods are served at home)
    - **Complementary**: *home meals complement school meals* (e.g., students should eat vegetables at home because not enough vegetables are served at school)
    - **Influential***: school meals influence home meals* (e.g., students who eat healthy meals at schools may begin to eat healthy foods at home).
- Based on the menu or what their children report to eat during the day, many participants communicated plans to supplement their child's nutrition at school by preparing meals (e.g., lunch to bring to school or dinner to eat at home) that increase *food security* (e.g., larger portions or more preferred foods), *nutritional value* (e.g., more vegetables or foods with less fat), and *variety* (e.g., different foods that what was served at school or more culturally-familiar foods).
- Participants varied in their knowledge and experiences with school nutrition policies and parent advocacy strategies. They reported a wide range of planned actions:
    - Learn about school nutrition policies and practices at their child's school by (a) asking their child what they ate during the day and (b) conducting observations while eating lunch with their child. Spanish-speaking participants requested the school menu be made available offline and in Spanish.
    - Discuss their child's specific dietary needs with the teacher or school nutritionist with an expectation that school staff will monitor child's food intake.
    - Raise issues or provide feedback, individually or with other parents, about the school nutrition environment with staff (e.g., teacher, school nutrition managers, or principals) or groups (e.g., PTA, school wellness committee, and school board).

6 FINDINGS | THE PHYSICIAN - PARENT RELATIONSHIP

Pediatricians and family physicians play an important role in the health of children. In addition to treating short-term illness (e.g., flu or injury) or long-term health conditions (e.g., asthma or diabetes), these physicians help parents (a) anticipate the needs of children as they grow and (b) identify and role model healthy behaviors at home.[8] Their extensive training enables them to provide recommendations for the social, emotional, and physical care of children, which can range from immunizations and nutrition counseling to home safety and literacy strategies. Parents desire continuity of care with their child's physician, as they recognize their value as a resource and partner in raising healthy children.[9]

To nurture this relationship, the American Academy of Pediatrics (AAP) recommends that parents and children visit their pediatrician regularly for well-child care visits, which have been standardized by comprehensive healthcare guidelines, Bright Futures.[10] Not centered on illness, these non-emergency, scheduled visits foster dialogue between parents, physicians, and children (when appropriate). Parents can discuss immunization and growth, in addition to inquiring about developmental milestones (e.g., talking and motor skills), preventative healthcare (e.g., healthy eating and physical activity), and parenting strategies (e.g., discipline and age-appropriate independence). As well, physicians have the chance to learn more about parents, their children, and factors at work, school, and home that can influence families' health behaviors and outcomes. These conversations during well-child care visits establish trust, give rise to meaningful interactions, and build relationships necessary for the supporting children's health and wellness.[11] The import of the physician-parent relationship informed the design of relevant focus group activities and enabled the research team to learn more about participants' (a) reasons for selecting certain healthcare services or providers, (b) evaluation of physicians' communication with parents and children, and (c) desired actions and information during a visit with child's physician.

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[8] American Academy of Pediatrics. (2014). Why Choose a Pediatrician. Retrieved from http://www.healthychildren.org/English/ages-stages/prenatal/decisions-to-make/Pages/Why-Choose-a-Pediatrician.aspx

[9] Radecki, L., Olson, L. M., Frintner, M. P., Tanner, J. L., & Stein, M. T. (2009). What do families want from well-child care? Including parents in the rethinking discussion. *Pediatrics*, *124*(3), 858-865.

[10] Bright Futures. (2014). Retrieved from http://brightfutures.aap.org/

[11] American Academy of Pediatrics. (2014). Retrieved from http://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx

6.1 HOW DO PARENTS SEEK HEALTHCARE FOR THEIR CHILDREN?

To learn more about how parents access healthcare services for their children, participants answered the question: *Why do you take your child to the family doctor, pediatrician, community clinic or center, emergency room, urgent care, or drugstore/pharmacy?* The facilitator provided them with a set of stickers labeled with common reasons for seeking health care (e.g., injury, wellness visit, or fever). For each healthcare reason, participants identified which healthcare provider (e.g., pediatrician, emergency room or drugstore) they utilize most. See Table 6.1 for the tally of healthcare service-provider combinations.

Table 6.1 Summary of Healthcare Providers and Reasons for Seeking Healthcare Services

	Common Reasons for Seeking Healthcare Services						
Healthcare Providers	**Injury**	**Cold or Flu**	**Fever**	**Wellness Visit**	**Shots**	**Physicals**	**All**
Pediatrician	0	10	6	25	17	20	78
Family Doctor	9	11	4	3	8	10	45
Emergency Room	21	2	15	0	0	0	38
Community Clinic	0	1	0	3	7	3	14
Drugstore or Pharmacy	0	7	6	1	0	0	14
Urgent Care	8	0	0	0	0	0	8
Total	38	31	31	32	32	33	197

Participants identified 197 healthcare service-provider combinations. Pediatricians (78), family doctors (45), and emergency rooms (38) emerged as the most utilized healthcare providers for children. Participants reported to visit their (a) child's pediatrician for wellness visits, physicals, and shots or immunizations; (b) family doctor for cold or flu care, physicals; and (c) emergency room for injuries, fever, or cold or flu care. Community clinics, drugstores or pharmacies, and urgent care were cited less frequently and for varied reasons, such as injuries, shots or immunizations, cold or flu care, or fever.

6.2 WHAT MATTERS MOST TO PARENTS DURING A PHYSICIAN VISIT?

Participants watched a video of a conversation between a mother, school-age child, and a physician during a wellness visit. The video enabled participants to observe an example of a common healthcare experience. After viewing the video, the facilitator prompted participants to share what they observed during the video as it related to the physician, parent, or child, and elicited additional clarification or discussion, if necessary. The research team carefully (1) reviewed the observations recorded on chart paper and in the transcribed notes, (2) identified 140 relevant comments, and (3) assigned each comment to an emergent category. See Table 6.2 for a category descriptions and distributions. Participant comments that described their observations and perceptions of the video indicate key elements about the interactions between physicians, parents, and children.

Table 6.2 Relationships Between Physicians and Parents | Categories: Descriptions and Distributions (Observations)

Category	Description	Examples	# of Comments	% of Comments
Physician	Observations or perceptions about the physician's actions or intentions	*Dr. gave mom ideas or suggestions. Dr. seemed less personable; robotic.*	79	56.4%
Mother	Observations or perceptions about the mother's actions or intentions	*Mom justified fast food w/ 2 jobs. Saw mom being open to what the Dr. was saying.*	37	26.4%
Child	Observations or perceptions about the child's actions or intentions	*No one asked about [the child's] opinion about [his] health. Child was not engaged.*	24	17.1%
Total			140	

Note: Researchers established a 90% inter-rater reliability.

6.2.1 Key Observations of a Physician Visit

Observations of the Physician. Of the 140 comments, 79 (56.4%) centered on the physician's' actions and possible intentions. Many participants perceived the physician in a positive manner because they observed him (a) highlighting what the mother was doing well with respect to her son's health, (b) providing the opportunity for the mother to explain what happens in their home lives, and (c) asking the mother questions that will shape her decision-making about her child's health.

With regard to the physician's communication style and practices, participants varied in their observations and perceptions. Some observed him explaining medical terms (e.g., BMI) clearly and others expressed concerns that he (a) presumed the mother's knowledge of the medical terminology and (b) struggled to communicate the purpose and outcomes of his suggested behavior changes. Also, a few participants reported that he used fearful language when discussing the risks related to obesity-related diseases (e.g., diabetes); and some participants perceived him finding a balance between using direct language and being too polite. While some participants described the physicians' communications as impersonal and robotic, most agreed that he did not seem judgmental.

Participants also reported different observations about how the physician shared health-promotion resources with the mother. Several observed that physician focused his recommendation on one significant behavior change and attempted to build upon the mother's current lifestyle. For example, the physician (a) shared several suggestions to help the mother engage her child in healthier behaviors at home (e.g., more physical activity, less sweet drinks), (b) provided a web site with additional information, and (c) wrote a "prescription" for healthy behaviors, which some participants perceived as reinforcement for the mother. A few shared

that the physician did not offer enough take-home information or alternatives for the prescribed healthy behaviors.

Observations of the Mother. Thirty-seven comments (26.4%) focused on how the mother participated in the conversation with the physician about her son's health. Many participants reported negative observations and perceptions about the mother: mainly she seemed in denial or unconcerned about her child's health after the physician explained her son's high Body Mass Index (BMI). Participants observed that the mom (a) justified eating fast food because she worked two jobs and (b) considered it an opportunity for she and her son to eat together given her time restrictions. Some participants noted that her lack of concern might have result from a limited understanding of the implications for high BMI.

Later in the video, the physician explains to the mother that her son can develop diabetes or hypertension. Participants noted that after this key event, the mother reflects on her family history (e.g., her father has diabetes) and shifts her demeanor. Comments indicated that participants perceived her as more open to the physician's explanation of her child's health and receptive to his suggestions for implementing healthier behaviors for her family.

Observations of the Child. Participants reported 24 comments (17.1%) about the child. A few participants shared observations related to the child's health (e.g., he needs to lose weight, he drinks sugary beverages, and he doesn't look like he needs to lose weight). Most comments attended to the fact that the physician and mother did not consult with the child about his health. Many participants contended that the child is old enough to be a part of the conversation and answer any questions the physician asks him. A few participants expressed concerns: (a) the child should not have been in the room and (b) the physician and mother used language that might have hurt the child's feelings.

Reflections on Physician Visits during Spanish-speaking Focus Group. In lieu of the video, the participants in the Spanish-speaking focus group responded to questions about their experiences with their child's current physician. Many comments resonated with other focus group discussions. Participants explained that although their children's physicians communicated with them in Spanish, they did not always understand the medical terminology or explanations. Also, participants reported that they (a) feel comfortable asking their child's physician questions, (b) are sometimes challenged to ask questions because the physician dominates the conversation, (c) do not always feel that the physician fully answered their questions, and (d) sometimes forgets to ask all the questions they planned prior to the physician visit. Finally, participants explained that their child's physician provides recommendations for how to keep their child healthy, but does not offer alternatives for prescribed medicine, even when requested.

6.2.2 What Do Parents Want to Happen During a Physician Visit?

After viewing and discussing participants' observations of the physician-visit video, the facilitator asked participants to discuss what they want to happen on the next visit to their child's physician. The research team carefully (1) reviewed the observations recorded on chart paper and in transcribed notes, (2) identified 82 relevant comments, and (3) assigned each comment to an emergent category. See Table 6.3 for a category descriptions and distributions.

Table 6.3 *Relationships Between Physicians and Parents* | Categories: Descriptions and Distributions (Next Visit)

Category	Description	Examples	# of Comments	% of Comments
Parent - Physician Communication	Communication preferences between parents and physician	*[Physician to] listen to parent concerns* or *explain what will happen on the next visit*	16	19.5%
Child - Physician Communication	Communication preferences between children and physician	*[Physician to] involve the child in the conversation*	17	20.7%
Resources and Services	Resources or services to support physician care or healthy practices at home	*[Physician to] provide referrals* or *suggest lifestyle changes prior to medication*	34	41.5%
Time and Access	Time with and access to physicians	*Would like Dr. to be more patient and attentive* or *be available 7 days a week*	15	18.3%
Total			82	

Physician Communication with Parent and Child. Participants focused 33 comments (40.2%) on communication practices between the physician and either the parent or child. With regard to parent-physician communication, participants reported that they want physicians to acknowledge what parents are doing well with regard their child's health outcomes (e.g., healthy weight) or efforts toward adopting healthy behaviors. They also expressed the need for two-way communication where physicians listen to parents' as "experts" on their children and ask parents questions about the child and their behavior at school and home. Also, parents want the opportunity to ask questions about their child and for physicians to explain (a) medical conditions and related terminology in easy-to-understand language, (b) their reasoning for prescribing medications or recommending healthy behaviors, and (c) expectations for the next visit.

Most comments related to the physician-child communication requested that the physician involve the child in the conversation during the visit. Specific suggestions included (a) elicit child's input about physician's concerns or recommendations and (b) engage the child in planning for healthy behaviors (e.g., ask child what he or she can do to be healthy?). Depending

on the child's age, physicians can talk with them along with their parent or one-on-one after the exam. Similarly to physician-parent communication, participants reported that physicians should explain things so that children understand the health information conveyed and buy-in to the recommended healthy behaviors.

Provision of Resources and Services. Participants articulated 34 comments (41.5%) that mentioned a wide-range of resources and services the child's physician could offer to families. For example, many participants requested their child's physicians provide referrals earlier for repeated, common conditions (e.g., strep throat or ear infection) and avoid offering "band-aids", such prescriptions for medicines that only treat symptoms. In addition, they desired that their child's physician (a) review family history more closely for preventable diseases (e.g., diabetes, kidney and heart disease) because it may play an important role in their child's health and (b) explore lifestyle changes before prescribing medicines. A few participants discussed the opportunity to "try out" different medical practices to inform their physician's recommendations and receive samples of prescription medicines their child may need.

The comments related to resources asked physicians to share local resources for physical activity and healthy foods in a variety of formats (e.g., prescriptions for healthy behaviors, relevant pamphlets, or calendars) that communicate multiple healthy opportunities and are hard to misplace. Participants wanted these resources to provide health information that addresses common misconceptions and concrete examples of healthy behaviors (e.g., substitute fruit juice for sweet drinks). Some participants emphasized that the physicians need to consider the social factors that affect families: single parenthood, low income, lack of health insurance and therefore limited access to quality healthcare, and few options for healthy-food retailers. Given this, participants expressed the need for physicians to suggest low-cost, or free activities and creative, healthy activities that can be done inside the home, if the child (a) cannot play outside safely, (b) lacks adult supervision due to parents' work schedules, or (c) has limited transportation options. Finally, participants wanted to learn which questions to ask physicians (e.g., options for testing or key topics based on child's age) during appointments.

Time and Access. Fifteen comments (18.3%) centered on participants' desire to spend more time with their child's physician, especially when their child is ill. Several participants asserted that more time would enable the physician to perform a thorough assessment of their child's health and provide parents enough time to comprehend the information discussed, which is often plentiful and complex, and ask sufficient questions for clarification. Also, participants requested their child's physician demonstrate more patience and attentiveness so parents do not feel rushed. Several participants commented they spend more time in the waiting room than in the exam room or physician's office. A few comments described preferences for more general access to healthcare, such as the medical practice being open seven days a week or

removal of penalties (e.g., fees or being "kicked out the practice) for late or missed appointments.

6.3 SUMMARY | THE RELATIONSHIP BETWEEN PARENTS AND PHYSCIANS

Key Findings

- Mainly, participants utilized pediatricians (e.g., wellness visits, physicals, and immunizations), family practice physicians (e.g., cold or flu care and physicals), and emergency rooms (e.g., injuries, fever or cold or flu care) as their children's healthcare providers.
- During physician visits, participants pay most attention to the physician's (1) communication style (e.g., Does he or she clearly explain medical terminology or demonstrate a non-judgmental stance?) and (2) methods of information sharing (e.g., Does he or she provide any take-home resources – online or handout formats or offer several options for healthy behaviors?).
- Participants wanted to support their child's health; therefore they requested that physicians (a) converse with them and their child about health-related behaviors at home and school, (b) allow sufficient time during visits to explain their reasoning for prescribing medicines or recommending healthy behaviors, and (c) include them and their child in planning for healthier families (e.g., goal-setting for food-related and physical activity behaviors and expectations for monitoring and follow-up).
- Several participants emphasized that physicians need to consider the social factors that affect families (e.g., income level, health insurance coverage, and safety and convenience) to ensure they suggest relevant and attainable healthy behaviors for parents and children.
- Participants communicated a variety of expectations, mentioned above, about physician care for their children. This may have been influenced by their cultural backgrounds or previous experiences with physicians.

7 FINDINGS | HEALTHY INFORMATION AND RESOURCES NETWORK

At the end of each focus group, the facilitator elicited participants' preferences for sharing and receiving health-related information and resources. The research team carefully (1) reviewed the transcribed notes for the Healthy Information and Resources Network portion of all five focus groups, (2) identified 157 comments related to the receipt and sharing of information about health-related resources and events, and (3) assigned each comment to a communication-system category. See Table 7.1 for a category descriptions and distributions.

Most participants described their preferences for the receipt of health-related information with 61.7 percent of comments related to communication sources and channels. One third of the comments (33.8%) explained with whom participants plan to share health-related information (receivers) and which communication channels they prefer to use.

Table 7.1 Healthy Information and Resources Network | Categories: Descriptions and Distributions

Category	Description	Examples	# of Comments	% of Comments
Sources	A person or organization that has information to share	Doctor's office, school, or parent organizations	39	24.8%
Channels (Sources)	The medium or method for sharing information	Bulletin board, web sites, or flyers	58	36.9%
Receivers	A person with whom the information is shared	Friends and family or community organizations	24	15.3%
Channels (Receivers)	The medium of or method for receiving information	Text messages, Facebook, or word of mouth	29	18.5%
Frequency	How often information is received or shared	Daily (because health is such an important issue)	7	4.5%
Total			157	

7.1 HOW DO PARENTS WISH TO RECEIVE HEALTHY INFORMATION?

7.1.1 Preferred Sources for Healthy Information

Of the 39 communication sources mentioned, ten comments pertained to school. Participants expected to hear about relevant information from multiple levels of the school system, including the Board of Education, school-level administration, and teachers. They also emphasized that all schools should communicate this important information. Participants highlighted the significant role of parent engagement facilitators, staff that coordinates the parent centers at many Title 1 schools. These key school staff members have multiple opportunities to share health-related information with parents who visit the parent centers for use of computers, education sessions, or to pick up resources, such as school supplies or food.

Participants also cited eight health-related entities, such as physicians, hospitals, and health clinics (e.g., St. Joseph's/Candler Good Samaritan and the Chatham County Health Department) as desired sources for learning about how to support the health and wellness of their children. Most reported expectations that their child's physician would share relevant resources during the appointment or make available health promotion materials in reception areas.

Six comments named parent groups and organizations as sources for communicating about healthy opportunities for children and families. For example, Parent-Teacher Association (PTA) and Parent University boast a significant base of involved parents and serve as organic sources for sharing information about children's wellness. Also, local websites, such as Southern Mamas -- a one-stop web-based resource for parents, were viewed as valuable sources for disseminating health-promoting information.

Participants also referenced government entities (three comments), such as the City of Savannah and Chatham County, and community centers (three comments) as sources for sharing healthy information. Other mentioned sources included grocery stores, Public Broadcasting Service (PBS), social workers, faith-based organizations, fitness centers, and employers.

7.1.2 Preferred Channels to Receive Healthy Information

The facilitator prompted participants to explain how their preferred sources should communicate health-related information. Of the 58 comments related to communication channels, 20 comments indicated many participants preferred to receive information in print formats. Local newspapers, magazines, and billboards can provide the space to advertise or promote healthy ideas and events. Additional print formats included flyers, mailings -- personalized letters and colorful postcards, and postings on bulletin boards in clinics and schools. Participants also reported expectations to receive health-related information from their child's teachers via the communication folder that is sent home regularly.

Sixteen comments indicated participants desire web-based resources: Internet, email, and social media. Mainly, participants expected the aforementioned sources to provide health-related information via their web sites. As well, a couple of participants explained how they preferred to increase their awareness of healthy events and information via Facebook pages from within their personal networks and from trusted organizations.

Seven comments suggested the use of radio and television (e.g., commercials or community bulletin shows) as relevant communication channels. Also, seven additional comments identified events or meetings, such as a back-to-school expo, guest speakers at community centers, or athletics competitions, as promising channels. The group discussion also yielded three stated preferences for telephone communication -- "robo" calls, voice conversations, and text messages. Several participants reported how they expected to learn about healthy opportunities via word of mouth.

7.2 HOW DO PARENTS WISH TO SHARE HEALTHY INFORMATION?

7.2.1 Preferred Persons or Organizations with Whom to Share Healthy Information

Participants' comments represented a collective, strategic approach to sharing information. Of the 24 receiver comments, ten named participants' personal network, which included friends, family members, and neighbors. Nine comments explained they would share with athletic, home-school, faith-based, and parent organizations who were likely to share health-related information with their members. Also, two participant comments recognized the reach of key school-staff positions, such as parent facilitators and counselors. A participant also suggested sharing with community leaders who could disseminate to their constituents.

7.2.2 Preferred Channels to Share Healthy Information

Participants reported multiple methods for sharing health-related information with their diverse set of recipients. Ten comments indicated participants preferred to share via web-based applications: email, and social media platforms – Facebook, Twitter, and Instagram. A few participants explained how they already use Facebook to share information among their friends, who are parents. Given the visible nature of Facebook posts, many people can see and easily share information with their personal networks.

Seven comments related to participants' print formats: flyers, brochures, letters, and notes. Participants who worked as school staff suggested sending these print materials home with students or displaying in the front office in schools. All focus group discussions underscored the importance of word of mouth communications. Five comments explained how this informal, yet effective method of dialogue might happen more directly through conversations within their personal networks or during casual encounters when attending events at school or in community centers. Two of the three comments related to telephone-use described sending text messages as an effective way to share health-related information.

7.3 HOW OFTEN DO PARENTS WISH TO SHARE AND RECEIVE INFORMATION?

Seven participant comments indicated desires to receive or share health-related information when it seemed relevant and reasonable. Their preferred frequency ranged from once a month to daily. Some participants raised the notion of oversaturation or a person becoming overwhelmed with too much or too frequent information. While some participants acknowledged this concern, many shared the sentiment that one could turn off the information when they wanted to or simply pass on information they cannot use to others.

7.4 SUMMARY | HEALTHY INFORMATION AND RESOURCES NETWORK

Key Findings

- Overall, participants reported preferences to
  - Learn about healthy information and resources via their child's school (e.g., Board of Education Office and classroom teachers), healthcare entities (e.g., physician office and community clinics), and parent organizations (PTA and Parent University)
  - Receive information via print formats (e.g., local newspapers and personalized letters) and web-based media (e.g., email and websites)
  - Share healthy information and resources with their personal networks, local groups (e.g., churches and athletic organizations), and schools (e.g., parent facilitators and front office materials)
  - Circulate potentially helpful and healthy information through web-based media (e.g., Facebook) and print channels (e.g., brochures); participants placed a premium value sharing by means of word of mouth, including texting via mobile phones.
- While information overload remained a concern for a few participants, most reported that they were likely to ignore information they deemed irrelevant and share resources that may prove helpful to others.

8 KEY RECOMMENDATIONS

The findings presented in the summary report represent the perceptions, knowledge, experiences, and desires of 41 participants in the Savannah-Chatham County community. While focus group methodology may limit the generalizability of this local study, this report organizes an important body of community knowledge that offers insights into how parents care for their children. Specifically, this report makes available several examples of positive parenting practices that promote child wellness - healthy eating and physical activity behaviors and knowledge seeking and advocacy strategies. It also brings attention to the information, resources, and partnerships parents deem relevant and helpful to realizing their intentions for healthy families. Reflection on these noteworthy findings reveal possibilities for youth-, family-, or health-centered agencies and organizations to foster nurturing relationships with families -- parents and children by (1) creating learning opportunities that position parents and children as contributors and seekers of relevant, health-related information and resources; and (2) advocating *with* parents to create and implement programs and policies that promote child wellness. This report concludes with several recommendations that exemplify possibilities to further engage parents in improving child wellness in their communities.

8.1 CREATE LEARNING OPPORTUNITIES THAT POSITION PARENTS AND CHILDREN AS CONTRIBUTORS AND SEEKERS OF HEALTH-RELATED INFORMATION AND RESOURCES

The ubiquitous nature of learning affords unlimited opportunities to educate children, parents, and community members about health outcomes and behaviors related to child wellness. For example, the content and layout of individualized fitness reports, school menus, and health promotion materials, can raise awareness about important health information and prompt action with strategies for adopting healthy behaviors. Physician visits or school-wide lessons also provide a forum for children and parents to (a) reflect on their existing health-related knowledge and practices and (b) discover, adapt, and integrate new strategies for healthy eating and physical activity into their day-to-day family life. Recognizing these materials and interactions as learning tools and experiences expands the opportunities for health education by and for communities.

8.1.1 ReSHAPE FitnessGram Reports into Accessible Tools for Parents and Children

Individualized health tools, such as the SHAPE FitnessGram report communicate an individual child's health outcomes (e.g., BMI, Healthy Fitness Zone) and suggest a set of actions to help families adopt healthy behaviors related to physical activity and eating. Participants' critiques of the SHAPE FitnessGram reports called for modifications that more clearly illustrate the exercises performed during the fitness assessment and explain the connection between fitness performance and children's health. Additionally, participants suggested language revisions (e.g., reading level and style) to improve comprehension among children and adults. A more accessible FitnessGram report will increase its utility as a family learning tool and resource for healthful planning at home.

8.1.2 Connect Home and School with a School Menu that Informs Healthy Eating

The school menu can connect healthy eating at home and in school. The focus group findings revealed participants' attention to this health tool. They expected access the school menu on a monthly basis, either online or a paper-version sent home by their child's teacher. Most parents reported using the menu to stay informed about what their children eat at school. Some used it to plan their children's meals at school (i.e., prepare lunch to send to school) and home. Per participants' feedback, the school nutrition should consider revising the menu. All school menu items should (a) feature descriptive titles that name key ingredients (e.g., Pizza with tomato sauce, grilled chicken, and low-fat cheese), (b) identify the preparation method (e.g., Baked French fries), and (c) list key nutritional information (e.g., calories, fat, carbohydrates, or protein). These added details enhance the school menu as a tool to (a) educate parents and children about what constitutes a healthy, well-balanced meal and (b) enables parents to make informed decisions about what their children eat at school and home.

Each month, the local school menu includes a “Families Making the Connection” section that shares health-related information about school nutrition programs, such as *Eat a Rainbow Week*. To engage more families, the school nutrition program should consider adding more activity-oriented content. For example, present a recipe for a school menu item, explain why it is healthy, and encourage families to try it at home and share their experiences on Facebook or Twitter. The school nutrition program might also consider changing the format of their online menu from PDF file format to a more interactive, web-based version. Parents or children can click links to access more detailed nutritional information or view pictures of the menu items. As well, parents can interact with information that changes more frequently than once a month, such as special events (e.g., Farm-to-School Week), healthy recipes, and blogs written by staff, health professionals in the community, teacher, parents, and even students.

8.1.3 Reimagine the “Doctor’s Appointment” as a Collaborative Learning Experience

When discussing parent-physician relationships, participants’ reported observations and expectations suggested they perceived the “doctor’s appointment” as more than a medical experience. Their desires to discuss their child’s health in detail and to learn how to best teach and support healthy behaviors at home and in school upholds this notion of parents as learners. As well, participants’ requisite specifications of a “doctor’s appointment” broadens the physician’s role beyond a medical expert who disseminates information to (a) coach who engages parent and child in the planning and monitoring of healthy behaviors and (b) learner who seeks to understand the resources, culture, and values of patients. These reimagined roles set the stage for collaborative learning among physicians, parents, and children.

To optimize the “doctor’s appointment”, parents should spend time preparing for visits with their child’s physician. Parents should write down (a) health concerns (e.g., symptoms or observed changes in physical or emotional behavior), (b) questions they want to ask, and (c) health-related goals for their child or family. These notes, along with individualized health tools like the FitnessGram report, should be reviewed with the physician during the visit. When possible, physicians should validate and build upon positive caretaking experiences to engage parents (and children when appropriate) in the planning and monitoring of healthy behaviors. Note, that due to physicians’ limited time, parents and children can interact with health promotion messages and materials outside the exam room. For example, posters on waiting room walls can visually communicate healthy messages, and nurses or other medical staff can review health promotion materials with families. Finally, physicians should offer resources that take into consideration families’ lived experiences (e.g., parents’ work schedules, neighborhood safety, and proximity to healthy food retailers) and recommend multiple pathways toward healthy goals.

8.1.4 Design Lifelong Learning Experiences that Support Healthy Eating

Participants' review of typical school meals uncovered a wide variety of food preferences among participants and their children. While the school nutrition program must adhere to USDA nutrition guidelines and accommodate students' medical needs, it is unreasonable to expect the program to appease all taste preferences. Instead, school nutrition staff, along with teachers, youth-serving community organizations, and parents or caregivers, should engage children in academic experiences that increase familiarity with more foods, broaden food preferences (e.g., taste, texture, or preparation methods), and deepen knowledge of human health and food-related diseases (e.g., obesity, diabetes). Three examples:

1. Teachers collaborate with the school nutrition staff to design science inquiry activities where students investigate and compare different characteristics of school menu items (e.g., taste, texture, nutrition, health benefits, etc.).
2. In Language Arts, students design and evaluate a marketing campaign for the school nutrition program, including conducting polls with local families and testing marketing messages for children and parents.
3. School gardens offer students and staff the opportunity to learn while growing vegetables, which can lead to increased knowledge of, and enthusiasm for healthy foods.

These lifelong learning experiences satisfy the nutrition education requirement for SCCPSS wellness policy and offer children and their families strategies for adopting healthy eating behaviors across school, home, and community settings.

8.2 ADVOCATE *WITH* PARENTS TO CREATE AND IMPLEMENT POLICIES THAT PROMOTE CHILD WELLNESS

The health topics investigated in this report relate to the federal, state, and school-level policies: USDA Healthy and Hunger-Free Kids Act, Georgia SHAPE Act, and the SCCPSS Wellness Policy. During discussions, participants rarely referenced these policies, suggesting limited awareness of these child wellness policies and the impact on their child's school or home life. Focus group findings also indicated that participants varied in their knowledge and experience advocating for the health of their child or other children at school throughout the community. Organizations seeking to promote or implement health-related policies should invest time and resources to (a) raise awareness about the new or existing policies, (b) educate parents about how this policy translates into action that benefit their children, and (c) create multiple opportunities for parents to advocate or support these policies (e.g., observations, audits, mobilization).

8.2.1 Share Relevant, Credible Information to Establish Relationships with Parents

In response to parents' reported preferences for communication, school, healthcare agencies, and parent organizations should coordinate online, web-based, and word-of-mouth

strategies to raise awareness about these child-wellness policies. These entities should also consider creating promotional or educational materials that are easy for parents to share with their personal network in-person or via web-based channels.

These communications must extend beyond descriptions of the policies and intended purposes to specific examples of policy actions. This will help parents recognize the relevance of these policies as pertinent to their lives. For example, promotional materials about Georgia's SHAPE Act should position this legislation as a set of obesity-prevention or child wellness strategies. In addition, key messages should highlight examples of the policy in action: School-level activities, such as the annual FitnessGram assessment and report that feature their child's fitness performance and health outcomes. When appropriate, these organizations should share policy-related data, such as aggregate, school-level FitnessGram data and include a call to action to either improve or maintain the impact of child wellness policies.

8.2.2 Engage Parents in the Advocacy and Monitoring of Policies in Action

This focus group research yielded a preponderance of evidence that participants care tremendously about the health and wellness of their children. During discussions, they shared several strategies for how parents and children can develop healthier behaviors for eating and physical activity. As well, participants presented several examples of how parents can more broadly contribute to improved child wellness on school and community levels through policy action. Leveraging this commitment, organizations should mobilize parents as advocates.

To supplement awareness campaigns, as described above, parents can advocate via word of mouth to other parents in their personal (e.g., friends and families), organizational (e.g., Parent Centers at Title 1 schools or PTA), or community (e.g., church and community centers) networks. In addition, parents can assist with data collection and monitoring of policy compliance. For example, the SCCPSS Wellness Policy mandates several healthy actions, such as specific time minimums between breakfast and lunch, vending of healthy snacks, and prohibiting food as rewards or missed physical activity as consequences. School wellness committees can engage parent leaders to conduct walk-throughs where they observe and document schools' compliance with these policy actions. In the end, engaging parents in the policy communication and compliance, increases their stake in promoting child wellness and empowers them as advocates for healthier homes, schools, and communities.

9 APPENDIX

9.1 APPENDIX A | ABOUT BLUKNOWLEDGE LLC

Bluknowledge LLC is a research and consulting firm resolved to end health and scientific inequities through empowering community education, research, and advocacy. Through a diverse portfolio of projects, bluknowledge envisions empowered communities that thrive in education, health and wellness, and economic sustainability. Recent community research projects include:

- focus group research for Savannah Economic Development Agency's (SEDA) Workforce Development study
- planning consultation for Step Up Savannah and Chatham County Safety Net Planning Council, including design and facilitation of community stakeholder workshops, focus group research, and proposal writing for the Mayor's Campaign for Healthy Children and Families – a National League of City initiative
- community engagement for the Coastal Health District, including the design and facilitation of the community stakeholder workshops -- Let's Eat Healthy, Play Often, and Create Community
- community education - design and facilitation of community health and wellness sessions at Parent University and Early Learning College.

Visit www.bluknowledge.com for more information.

The principal researcher, Erika Tate, PhD, is the Founder and Chief Executive Officer of bluknowledge LLC, which fuses her social justice orientation, expertise in inquiry-based science and health education, community-centered design and research philosophy, and demonstrated aptitude for fostering creativity and collaboration. Since the inception of bluknowledge LLC in 2012, she has collaborated with partners on local and national education and public health projects to support healthy, sustainable, and just communities. Dr. Tate earned her PhD in Education in Mathematics, Science, and Technology, from the University of California, Berkeley.

Acknowledgement: Jacelyn Lane, MPH, Garth Marchant, and Shinal Patel participated on the parent focus group research team during their practicum studies. They assisted with facilitation, data collection and analysis, and data summarization.

9.2 APPENDIX B | PARTICIPANT DEMOGRAPHICS

Table 9.1 Summary of Demographic Information for Focus Group Participants

Demographic Category		Number of Participants (Percentage)
N (Total Focus Group Participants)		41
GENDER		
Male		4 (10%)
Female		37 (90%)
RACE/ETHNICITY		
African-American		31 (76%)
White		5 (12%)
Hispanic		3 (7%)
Asian		1 (2%)
Not Reported		1 (2%)
ANNUAL INCOME	# Children <18 years old in Household	
<$34,999	1-5	21 (51%)
$35,000-$49,999	1-6	6 (15%)
$50,000-$74,999	2-4	6 (15%)
> $75,000	2-5	5 (12%)
Not Reported		2 (5%)
Receive Public Assistance (*e.g.,* SNAP, Free or Reduced Lunch)		28 (68%)

9.3 APPENDIX C | FOCUS GROUP DISCUSSION GUIDE

Table 9.2 Detailed Discussion Guide for the Facilitation of Focus Groups

Agenda and Notes	Facilitator Notes	Materials
Registration and Light Refreshments Welcome and Overview Topics 1-4 Close: Demographic Survey and Incentives *Notes:* The activities have been designed to be highly interactive and use a variety of artifacts to support the elicitation and sharing of participant ideas about each topic. • Topics 1 and 2| Parents split into two groups and participate in 1 “station” - Physical Activity & Healthy Eating. • Topics 3 and 4 | Parents participate as a whole group.	• 1 Lead Facilitator manages the entire focus group. • 2 Assistant Facilitators ○ Facilitate topics 1 and 2 while Lead Facilitator floats between “stations” • 1-3 Notetakers record written notes. Recorders capture what parents are saying throughout the focus groups. If time, open up for additional questions or comments from parents)	Sign-in sheet Nametags Pens Slides Surveys Gift Bags
Topic 1: The Georgia SHAPE Initiative and Physical Activity		
Answer | Has your child ever brought home a FitnessGram? (Answers: Yes or No)	Parents place a dot next to their answer choice.	Laminated Signs (question and answers)
Annotate | Parents review examples FitnessGram report and parent reference guide and annotate: • Circle what you understand. • Write an “X” by what you don’t understand. • Write other notes, questions, etc.	Parents write on and around the FitnessGram reports. Facilitator prompts parents for explanations of circles, “X”’s, and notes. Recorder captures the “why’s.”	Dot stickers Tape Large FitnessGram reports placed on chart paper Laminated instructions Markers
Discuss | Parents read or listen to scenario about a child who brings home a FitnessGram that places them outside the Healthy Zone. *Imagine Joe Jogger is your child. His FitnessGram report shows his Body Mass Index (BMI) outside the Healthy Fitness Zone. What do you do next?*	Facilitator prompts for action steps and lists actions on large chart paper. Recorder captures the “why’s.”	Chart Paper
Topic 2: Healthy Eating and the School Food Environment		
Answer| Where does your child eat? (Answers: home, school, afterschool program, church, other)	Parents place meal labels in by placing a dot next to the appropriate location.	Laminated Signs (question and answers)
Annotate | Parents review school menu and annotate: • Circle what you want your child to eat. • Write an “X” by what you don’t want your child to eat. • Write other notes, questions, etc.	Parents write on and around the school menu reports. Facilitator prompts parents for explanations of circles, “X”’s, and notes. Recorder captures the “why’s.”	Labels (meals) Tape Large school menu placed on chart paper Laminated instructions
Discuss| Parents read or listen to a scenario that visualizes and describes what a child eats	Facilitator prompts for action steps and lists actions on large chart paper.	Markers

Agenda and Notes	Facilitator Notes	Materials
throughout a normal school day. *(Images (tray w/ food) of breakfast, lunch, and snack are displayed) Your child eats these meals on a typical school day. What do you do next?*	Recorder captures the "why's."	Chart Paper
Topic 3: Parent-Physician relationship		
Answer | Why do you take your child to the family practitioner, pediatrician, community clinic or center, emergency room, urgent care, drugstore or pharmacy? (Answers: cold/flu, shots, physicals, wellness visits, injury, fever)	Parents place labels next to the appropriate provider.	Laminated Signs (question and answers) Labels (visit reasons) Tape
Discuss | Parents watch a video of a conversation between parent, child, and physician and discuss: • What did you see or hear in the video? • What was the [parent, child, or physician] saying or doing? • What do you like about it? Why? • What do you dislike about it? Why?	Facilitator lists observations on large chart paper. Recorder captures the "why's." Facilitator marks whether participants like or dislike observations on large chart paper. Recorder captures the "why's."	Video Chart Paper Markers
Discuss | What do you want to happen at your next visit to the child's doctor? Why?	Facilitator lists responses on large chart paper. Recorder captures the "why's."	
Topic 4: Parent Network		
Discuss | How do you want to learn about this [*child wellness*] resource? • Who do you want it learn about it from? • In what form do you want to receive it? • How often do you want to learn about it or receive it?	Facilitator selects one resource: Low cost after school program where kids are active for at least 30 minutes a day OR Local farmers market doubles SNAP or WIC dollars OR Food Education program for families.	Chart Paper Markers
Discuss | How do you want to share information about [*child wellness*] resource? • How do you want to share it? • In what form do you want to share it? • How often do you want to learn about it or receive it?	Notes are captured on large chart paper by facilitator. Recorders capture the "why's."	