

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.

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 as 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 policies 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>

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

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

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).

6.2.2 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	<i>[Physician to] listen to parent concerns or explain what will happen on the next visit</i>	16	19.5%
Child - Physician Communication	Communication preferences between children and physician	<i>[Physician to] involve the child in the conversation</i>	17	20.7%
Resources and Services	Resources or services to support physician care or healthy practices at home	<i>[Physician to] provide referrals or suggest lifestyle changes prior to medication</i>	34	41.5%
Time and Access	Time with and access to physicians	<i>Would like Dr. to be more patient and attentive or be available 7 days a week</i>	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