

Attachment 1: Focus Group Protocol

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[NOTE: The focus group discussions will use the following protocol as a general guide. However, as is typical with focus groups, the moderator will allow the discussion to proceed naturally, and therefore the protocol may not be administered either completely or chronologically.]

1. Introduction

Welcome. My name is _____. Before we start, I want to make sure that you understand who we are and why you're here. We are the Collaborating Center for Questionnaire Design and Evaluation Research in the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) and our expertise is the design, refinement and testing of surveys.

2. Overview and Group Rules

Before we continue, I'd like to go over some general information, establish some ground rules for our focus group, and tell you about the confidentiality procedures we have in place.

I would like you to know that in our focus group today, you don't have to reveal anything that you are not comfortable revealing.

For purposes of the group discussion, we'd like you to pick a name that you would like to be called— a first name is fine, it doesn't even have to be your real name. [ASK THEM TO FILL OUT NAME CARDS.]

The consent form you just signed assures you that we will keep your information confidential. We would also like to ask everyone to treat this focus group as confidential. That is, if you learn anything private about another member of the group, we ask that you do not share this information with anyone outside of this room. Although we are required by federal law to keep information private, we cannot guarantee that everyone else will honor your privacy. All we can do is ask that people please agree to that. And again, you should never feel obligated to share any information that you are not comfortable sharing.

We are planning to [video/audio] record this focus group. This is for note-taking purposes in case we miss anything that was said. We will use the recording to double-check our notes and make sure they are complete. Only the Collaborating Center for Questionnaire Design and Evaluation Research staff and the Division of Health and Nutrition Examinations Survey's staff who are working on the project will have access to the recordings.

One of the great things about this discussion is the "group dynamic" – ideas that one person raises will remind someone else of a related issue. That's great, feel free to speak up. But please don't interrupt each other. We ask that there be only one speaker at a time so that responses can be accurately recorded. You may have more or less to say about some topics than others, and that's OK too.

Don't feel like you have to agree or disagree with anyone in this room. We want to hear about your personal experiences and thoughts and it's OK to disagree with someone else. But please be respectful of the opinions or experiences of others in the room.

Sometimes groups start talking about subjects that are off the main topic. That's natural; but please don't be offended if we steer the conversation back to the material we need to cover.

As a courtesy to everyone, please turn off cell phones. The focus group will last no longer than 90 minutes. We will not have breaks built into it, but should you need to go to the restroom during the focus group, please feel free to leave. However, I would appreciate it if you would go one at a time.

Does anyone have any questions before we get started?

[Note to reviewers—as is custom for CCQDER focus group projects, the focus groups will be iterative, with the content of each helping to refine and expand the protocols of future discussions. As such, this protocol includes a list of topics the facilitators intend to cover during the discussion, and not a detailed list of questions.]

3. Typical Use of Growth Charts in Clinical Interactions

- a. How pediatricians use growth charts during clinical interactions
 - i. Any use of paper charts, or all/mostly EHR-based?
 - ii. Gendered differences—do pediatricians find the color-coding of the charts (i.e. blue for males, pink for females) to be useful? If so, how and why?
 - iii. Do or would pediatricians use color-coded growth charts by weight category (e.g., green for healthy weight, yellow for overweight, red for obesity, darker red for extreme BMI)
- b. The language they use to describe various levels on the growth charts
- c. Any special language they use to describe “extreme BMIs,” “severe obesity,” or BMIs above the level of obesity (95th percentile).
- d. How do they use the charts to frame care plans or ongoing clinical interactions.
 - i. For instance, how do they use the growth charts to track progress over time, and how do they relate this progress to their patients/patients’ families?
 - ii. Which terms do they use to convey clinical progress and goals to patients and families?
- e. Which guidelines or recommendations, if any, inform how they assess weight status at extreme BMI. Or, Recommendations from which organization would they find most credible?
- f. How do they document the patient’s weight status in the medical record.

4. Proposed NCHS/CDC Growth Chart Extension

[At this point in the discussion, participants will be shown both the current and extended growth charts, and the reasoning behind the additions will be described. Facilitators will explain that the extended lines are based on z-scores and give an overview of the statistical process by which they were developed. Please note that the final versions of the growth charts are not yet complete.]

- a. Initial reactions to having more accurate growth curves above the 95th percentile.
 - i. What information could be provided by CDC to increase clinicians’ adoption of extended growth charts?
 - ii. What terminology would you expect to see in electronic health records for children with BMI values far above the 97th percentile?
- b. How they might use these extended lines both during clinical interactions and in developing care plans
- c. The language that would be helpful in facilitating these clinical interactions and developing the care plans—i.e. using 99.99 percentile vs some qualitative or descriptive label. That is, would it help to have labels attached to the z-score lines? Or is having the 95th percentile as a clinical target sufficient?

5. Wrap-Up

OK. We are pretty much out of time. Does anyone have any last thoughts or questions?

I want to thank all of you for coming today and sharing your opinions. The information you’ve shared today will be very useful in determining what guidance we release alongside these expanded growth charts.