Evidence-based Childhood Obesity Treatment Services: Applying Recommendations from the AAP/AHRQ Obesity Treatment & Reimbursement Conference Webinar

Prologue

The following Frequently Asked Questions (FAQs) stem from the January 2017 webinar: Evidence-based Childhood Obesity Treatment Services: Applying Recommendations from the AAP/AHRQ Obesity Treatment & Reimbursement Conference. These FAQs represent an aggregate of the most frequent questions received during and after the webinar, organized by topic.

We invite you to read the full conference consensus report (referred to hereafter as Consensus Statement): Improving access and systems of care for evidence-based childhood obesity treatment: Conference key findings and next steps published in Obesity 2017. This report includes all supplemental materials developed from the conference, e.g. stakeholder pre-conference survey, etc.

Additionally, AAP hosted a second webinar on this topic that focused on payment models for childhood obesity treatment services as well as advocacy strategies; go to aap.org/AHRQConf to access the payment webinar.

Throughout these FAQs, we refer to the USPSTF “Obesity in Children and Adolescents: Screening” draft recommendation statement, research plan, and evidence review. These documents are available here: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryDraft/obesity-in-children-and-adolescents-screening1

Frequently Asked Questions

Patient/Family Engagement

The 25-hour minimum recommendation over a 6 month period requires a significant investment on the part of the family. What strategies have worked to promote sustained engagement, acceptability, and satisfaction?

One key theme that has emerged to support patient engagement in childhood obesity treatment programs has been to increase family involvement (vs. the child being the primary target). In fact, parents of children in behavioral weight management programs have stated they strongly prefer interventions that address behavioral modification through collaborative goals and family support.

More detail on the strategies used to increase children’s and parents’ acceptability and satisfaction with behavior-based weight management interventions are detailed in Appendix E in the draft evidence review report by the USPSTF. Please follow this link for a brief literature review and relevant references: https://www.uspreventiveservicestaskforce.org/Page/Document/draft-evidence-review156/obesity-in-children-and-adolescents-screening1.
Payment/Reimbursement for Treatment
How are families paying for participation in these high intensity programs?
As described in the Consensus Statement, reimbursement for evidence-based childhood obesity treatment is inconsistent and often insufficient. Please refer to aap.org/AHRQConf to access the webinar and additional FAQs on payment models, care delivery systems, and advocacy for payment that may be more conducive to supporting evidence-based childhood obesity treatment.

Expanding on Treatment and Team Roles
With respect to the treatment team, how important do you consider the role of the behavioral interventionist?
The conference stakeholders identified the behavioral interventionist as a key member of the core team tasked with delivering the family-based behavioral treatment program. Suggested types of providers who can fill the behavioral interventionist role include: Behavioral/mental health specialist (e.g. psychologist, social worker, Master’s level counselor), registered dietitian, exercise physiologist, or a health coach/educator. Please see Table 2 of the Consensus Statement for the complete listing of team roles.

Do you have any recommendations for training models for health care professionals that may not already have specialized training in pediatric obesity treatment?
The American Academy of Pediatrics (AAP) Institute for Healthy Childhood Weight developed many resources to aide providers in addressing the issue of childhood obesity including webinars, Maintenance of Certification, etc. Please visit aap.org/COPC to see the complete selection of resources.

While not a component of the AAP, the following institutions have developed trainings on the topic area of obesity management; please visit their sites for more information:

- The Commission on Dietetic Registration (https://crdnet.org) as the credentialing agency for the Academy of Nutrition and Dietetics offers a Certificate of Training in Childhood and Adolescent Weight Management and an Interdisciplinary Certification in Weight Management.

- Center for Healthy Weight & Wellness, Washington University in St. Louis, provides training in family-based behavioral treatment (FBT) for childhood obesity. For more information, please contact: Denise Wilfley, PhD at wilfleyd@wustl.edu.

What is the format for the time spent with families (i.e. individual, group, in-person, etc.)?
Conference consensus was reached on the need to take an individualized approach to care that allows for the tailoring of treatment to patient or family needs and preferences. Individual family or mixed-format approaches (i.e., some time with individual families and some group time) produce better treatment outcomes than group-only approaches (see section on “Treatment Format” in the Consensus Statement).
What are the goals with obesity treatment for children?
Conference attendees recommended that a menu of evidence-based individual and system-level measures be considered for tracking goal-achievement and treatment success, with the treatment team choosing the best measures based on the individualized plan for the patient. The primary indicator of success should be stabilization or reduction of relative weight (e.g., body mass index [BMI], BMI z-score, % weight above the 95th percentile), depending on the child’s age and obesity status, with a focus on achieving clinically significant weight changes. Weight goals are detailed in the Expert Committee Recommendations by age and BMI category. Cut-offs for clinically significant changes have been proposed (e.g., 0.25 or 0.5 BMI z-score decrease) because weight changes of this magnitude have been associated with improvements in indicators of cardiometabolic functioning such as blood pressure, cholesterol levels, and HbA1c values, and improved psychosocial health. Early intervention is important because less weight change is needed at younger ages to achieve a healthy weight compared with the amount of weight loss necessary at older ages. In addition, you may wish to access POWER (Pediatric Obesity Weight Evaluation Registry study) which is tracking the clinical data from national comprehensive pediatric weight management programs in the US for overweight and obese children.

Additional measures of importance to the patient and the parent may include assessments of psychosocial functioning (e.g., quality of life, body image), biomedical outcomes (e.g. change in lipids), behavior change (e.g., change in dietary intake and physical activity), and family engagement and retention in the program. See Table 1 in the Consensus Statement for examples of outcome measures.


After achieving a healthy body composition, what is a maintenance program for this chronic disease?
Long-term maintenance of weight loss is one of the big issues still faced by obesity researchers. While the long-term effects of family-based behavioral treatment have been documented in studies looking at 10 year outcomes, some families still experience weight re-gain. The social facilitation maintenance (SFM) treatment has shown promise in enhancing weight maintenance following FBT. SFM is built on a social-ecological model and encourages children and parents to develop peer and community networks that support healthy eating and physical activity in order to support long-term practice of healthy energy-balance behaviors. The SFM approach also targets peer and self-perceptual factors identified as barriers to eating and activity. In the 2007 study, children in SFM were better able to maintain weight losses at two-year follow-up than a usual care condition.

When should a patient move to adding on advanced tools such as weight loss medications, weight loss devices, and bariatric surgery?
The first line of treatment for children with obesity is family-based, multicomponent behavioral treatment. Only two medications have been approved for use with children, Metformin and Orlistat. It is important to note that the USPSTF draft report found that the evidence regarding the effectiveness of Metformin and Orlistat is inadequate. Metformin received FDA approval in 2000 for children 10 years and older with primary use for type 2 diabetes. While it has been shown to have a small but statistically significant weight reduction effect, it has not been approved for treatment of obesity. The second medication, Orlistat, has had FDA approval since 2003 for children 12 years and older.

Adolescents with severe obesity can be considered candidates for weight loss surgery, and weight loss surgery can be effective at treating obesity among this population. However, in order to maximize effectiveness, weight loss surgery should be used in combination with evidence-based behavioral weight loss treatment. See the following references for additional information and guidance:

- Algorithm for the Assessment and Management of Childhood Obesity in Patients 2 Years and Older. AAP Institute for Healthy Childhood Weight. (2015).

Is there evidence of long-term benefit?
Yes, see the following references that reported long-term benefits of sustained weight loss following behavior-based weight loss intervention:

- USPSTF draft evidence review (see Appendix A Table 1)
**Is the effect of working with the parent and child together the same as working with the child alone?**

Conference attendees reached consensus that the child cannot be the agent of change and that the intervention should not be child-focused, but rather family-focused.

Programs such as family-based therapy (FBT) in which parents are active participants in the intervention result in superior child weight outcomes compared with interventions in which the parent is not encouraged to make their own behavioral changes. FBT results in improvements in both child and parent weight status. Parental weight loss is a robust predictor of child success in FBT, with evidence suggesting that parental influences on child weight outcomes occur through parental modeling of healthy behaviors and changes to the home environment. Furthermore, FBT is cost effective in comparison to treating children with obesity and parents with obesity separately.

For additional reading, please see the [Consensus Statement](#) as well as:


**Are there specific age groups that the consensus recommendations apply to?**

The conference consensus accepted the USPSTF Screening for Obesity in Children and Adolescents as the framework; these recommendations begin with children age 6 years and older.

Promising work is being done with children <6 years old for specifics, please see: