Childhood Obesity in Primary Care
Attendees: Prior to the start of the activity, please review the below information to ensure successful participation in this Enduring Activity

Accreditation and Designation Statements

• The American Academy of Pediatrics (AAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

• The AAP designates this enduring material for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

• This activity is acceptable for a maximum of 1.0 AAP credits. These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Members of the American Academy of Pediatrics.

• The American Academy of Physician Assistants (AAPA) accepts certificates of participation for educational activities certified for AMA PRA Category 1 Credit™ from organizations accredited by ACCME. Physician assistants may receive a maximum of 1.0 hours of Category 1 credit for completing this program.

• This program is accredited for 1.0 NAPNAP CE contact hours of which 0 contain pharmacology (Rx), (0 related to psychopharmacology) (0 related to controlled substances), content per the National Association of Pediatric Nurse Practitioners (NAPNAP) Continuing Education Guidelines.
Purpose of Course
The Childhood Obesity in Primary Care Modules are designed to provide evidence-based practice for obesity prevention and treatment and use of effective strategies with families. The modules also aim to create healthcare systems that better supports evidence-based practice, increasing the likelihood of effective and sustainable changes in practice. In addition, the modules also enhance collaboration of providers with other healthcare professional and with broader community initiatives.

Learning Objectives
Upon completion of this activity, participants will be able to:
- Describe the components of a supportive office environment
- Explain patient-first language
- Describe specific strategies for management of obesity in the primary care office (Stages 1 and 2)
Disclosure of Commercial Support for AAP CME Activities
The AAP gratefully acknowledges support for Childhood Obesity in Primary Care: Module 4 in the form of educational support from Nestlé Nutrition.

Disclosure of Financial Relationships and Resolution of Conflicts of Interest for AAP CME Activities Grid
The AAP CME/CPD program develops, maintains, and improves the competence, skills, and professional performance of pediatricians and pediatric healthcare professionals by providing quality, relevant, accessible, and effective educational experiences that address gaps in professional practice. The AAP CME/CPD program strives to meet the educational needs of pediatricians and pediatric healthcare professionals and support their lifelong learning with a goal of improving care for children and families. (AAP CME/CPD Program Mission Statement, May 2015)

The AAP recognizes that there are a variety of financial relationships between individuals and commercial interests that require review to identify possible conflicts of interest in a CME activity. The "AAP Policy on Disclosure of Financial Relationships and Resolution of Conflicts of Interest for AAP CME Activities" is designed to ensure quality, objective, balanced, and scientifically rigorous AAP CME activities by identifying and resolving all potential conflicts of interest prior to the confirmation of service of those in a position to influence and/or control CME content. The AAP has taken steps to resolve any potential conflicts of interest.

All AAP CME activities will strictly adhere to the Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support: Standards to Ensure the Independence of CME Activities. In accordance with these Standards, the following decisions will be made free of the control of a commercial interest: identification of CME needs, determination of educational objectives, selection and presentation of content, selection of all persons and organizations that will be in a position to control the content, selection of educational methods, and evaluation of the CME activity.

The purpose of this policy is to ensure all potential conflicts of interest are identified and mechanisms to resolve them prior to the CME activity are implemented in ways that are consistent with the public good. The AAP is committed to providing learners with commercially unbiased CME activities.

Activity Title: Childhood Obesity in Primary Care Module 4: Childhood Obesity and the Primary Care Practice: Setting up your office for success and a practical approach to starting treatment in your PCP office
Activity Location: Online/Enduring Material
Activity Date: November 1, 2015 - November 1, 2018

DISCLOSURE OF FINANCIAL RELATIONSHIPS
All individuals in a position to influence and/or control the content of AAP CME activities are required to disclose to the AAP and subsequently to learners that the individual either has no relevant financial relationship or any financial relationship with the manufacturer(s) of any commercial products and/or providers of commercial services discussed in CME activities. Listed below are the disclosures provided by individuals in a position to influence and/or control CME activity content:

* A commercial interest is defined as any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or related to, patients.

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<th>Role</th>
<th>Relevant Financial Relationship (Please indicate Yes or No)</th>
<th>Name of Commercial Interest(s)*</th>
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<tbody>
<tr>
<td>Christopher Bolling, MD, FAAP</td>
<td>Faculty</td>
<td>No</td>
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<tr>
<td>Victoria Rogers, MD, FAAP</td>
<td>Planning Committee</td>
<td>No</td>
<td>None</td>
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<tr>
<td>Janine Liebhart, MS</td>
<td>Planning Committee</td>
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Disclosure of Off-Label (Unapproved)/Investigational Uses of Products
AAP CME Faculty are required to disclose to the AAP and to learners when they plan to discuss or demonstrate pharmaceuticals and/or medical devices that are not approved by the FDA and/or medical or surgical procedures that involve an unapproved or “off-label” use of an approved device or pharmaceutical.

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**DISCLOSURE OF FINANCIAL RELATIONSHIPS**

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* A commercial interest is defined as any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.

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<tr>
<td>Corrie Pierce</td>
<td>Disclosure Admin</td>
<td>No</td>
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<td>Do not intend to discuss</td>
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<tr>
<td>D. Michael Foulds, MD</td>
<td>AAP Reviewer</td>
<td>No</td>
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<tr>
<td>Zoey Goore, MD</td>
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<tr>
<td>Ivor Hill, MD</td>
<td>AAP Reviewer</td>
<td>Yes</td>
<td>I have a paid Consultant</td>
<td>Do not intend to discuss</td>
<td>(Consultant with Abbvie Inc.)</td>
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<tr>
<td>Robert Wiebe, MD</td>
<td>AAP Reviewer</td>
<td>No</td>
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<tr>
<td>Rickey Williams, MD</td>
<td>AAP Reviewer</td>
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<tr>
<td>D. Corey Lachman, MD,</td>
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<td>No</td>
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<td>Do not intend to discuss</td>
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AAP gratefully acknowledges support for its Childhood Obesity in Primary Care Modules in the form of an educational grant provided by Nestlé.

Product-Specific Advertising / Links to Product Websites
No product-specific advertising of any type appears in this activity. No links to product websites appear in this activity.

List of Principal Faculty and Credentials
• Christopher Bolling, MD, FAAP

Method of Participation
Participants will participate in the module online. Upon completion of the webinar, participants will complete an assessment in order to receive CME credit.

Minimum Performance Level
Per the 2010 revision of the American Medical Association (AMA) Physician’s Recognition Award (PRA) and credit system, a minimum performance level must be established on enduring material and journal-based CME activities that are certified for AMA PRA Category 1 Credit™. In order to successfully complete this Ambulance Safety for the 21st Century Webinar CME activity for AMA PRA Category 1 Credit™, learners must demonstrate a minimum performance level of 70% or higher on the post-activity assessment, which measures achievement of the educational purpose and objectives of the activity.
Medium or Combination of Media Used
Enduring Material

List of hardware/software requirements
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Provider Contact Information
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Privacy and Confidentiality Statement
Childhood Obesity in Primary Care
Childhood Obesity and the Primary Care Practice Team:
Setting your office up for success and a practical approach to
starting treatment in your PCP office

Chris Bolling, MD, FAAP
Disclosure Statement

Christopher Bolling, MD, FAAP

✓ I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this CME activity.

✓ I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
About Chris

- Full-time general pediatrician at Pediatric Associates, PSC in Crestview Hills, KY (suburban Cincinnati)
- Chair, AAP Section on Obesity
- KY-AAP Obesity Task Force chair
- Special interests: preschoolers, severe obesity and motivational interviewing
- Cheerleader-in-chief, Institute for Healthy Childhood Weight
What is your quest?

To help my fellow pediatricians manage pediatric obesity in their office and not lose their minds or their shirts in the process.
Learning Objectives

- Describe the components of a supportive office environment
- Explain patient-first language
- Describe specific strategies for management of obesity in the primary care office (Stages 1 and 2)
Setting up Your Office: Systems that can support your follow-up care
Components of a Supportive Office Environment

- The office environment should be comfortable and have positive health messages
- An informed, understanding and respectful staff is critical
- Role modeling is important
- It should be a bias/stigma-free zone
- Engaging all staff in a team approach is essential
Your Environment: The physical place

What does your office say about you?

- Do you have posters of healthy eating and active living?
- Do you give out candy as a reward?
- Do you have a TV in the waiting room?
- Do you have furniture and exam equipment that is appropriate for obese patients and parents?
- Is your weight/height area private, or are staff trained to be discreet with regard to weighing and measuring patients?
Checklist for Assessing the Office Environment

From the Rudd Center for Food Policy and Obesity
Starting the Contact...
In the Exam Room...
Weight Bias

Before you begin integrating comprehensive obesity assessment into your office there are some key foundational elements to consider.
Weight Bias and Its Connection to Motivational Interviewing

- Patient centeredness
- Doesn’t assume anything
- Meeting patients where they are
- Avoids confrontation
- Improves collaboration
What Can You Do?

Strategies for providers to reduce bias

- Recognize the complex etiology of obesity and its multiple contributors, including genetics, biology, sociocultural influences, the environment, and individual behavior
- Recognize that many obese patients have tried to lose weight repeatedly
- Consider that patients may have had negative experiences with health professionals, and approach patients with sensitivity and empathy
- Explore all causes of presenting problems, in addition to body weight
- Emphasize the importance of behavior changes rather than just weight
- Acknowledge the difficulty of achieving sustainable and significant weight loss
- Recognize that small weight losses can result in meaningful health gains
Typical Image from The Rudd Center...
The Staff: Your words

Does the staff understand the complex nature of obesity and the cultural aspects that may come into play with your patient population?

Attitudes and Beliefs

• Does anybody on the staff have weight bias?
• Does anybody struggle with weight?

What language do you want to use to describe weight? Some examples:

• “Obesity?”
• “Carrying extra weight?”
• “Gaining weight more quickly than growing tall.”
Patient-first Language

Respects that the patient is not the disease

Try this:

• “A patient with obesity......”

Instead of this:

• “An obese patient......”

Studies have shown that this really matters to patients and families
The Staff : Your actions

Role modeling
- Healthy beverages
- Pedometers
- Walking meetings
Team Approach

- Everybody has a role
- Consistent language and approach is essential
- Scheduling is key for planned follow up appointment
A Golden Opportunity...

- You can use patient-centered medical home training to help you with this transformation
- This is a chronic disease measure
- There are plenty of places to demonstrate improvement
- It can energize your staff
## Self-Management and Communication: The keys to clinical effectiveness

### Objectives
- Define self-management and describe in what types of patients and encounters it is most important.
- List the 5 A's of self-management.
- Explain how motivational interviewing (MI) fits into a self-management approach to patients.
- Demonstrate the use of reflective statement and elicit-provide-elicit in clinical settings.

### PART 1
**Self-management and the Basics of Effective Communication with Patients and Families**

### Self-Management, Defined
“Learning and practicing the skills necessary to carry on an active and emotionally satisfying life in the face of a chronic condition. (Furthermore, self-management) is aimed at helping the participant become an active, not adversarial, partner with healthcare providers.”

-K. Lorig, RN, DrPH

### What does self-management look like at Pediatric Associates?
- What we are already doing...
  - Any ideas?
  - Diane ES pre-visit planning
  - She assesses resources, discusses challenges, identifies strengths and weaknesses, communicates all this to the providers, reviews with the patient, documents in permanent record

### What does self-management look like at Pediatric Associates?
- What we are already doing...
  - Any ideas?
  - Our ADHD start up and follow-up visits
  - Lots of education, resource provision, opportunities for questions, use of decision aids, arranged follow-up, monitoring of outcomes, assessment

---

*Pediatric Associates, PSC*
What does self-management look like at Pediatric Associates?

- What we are already doing...
- Where we want to go...
  - PCMH
- Where else might we go in the future...
  - The sky's the limit!

The Socio-Ecological Model

The Expanded Chronic Care Model: Integrating Population Health Promotion

The 5 A's of Self-Management

The Virtuous Cycle

Identifying Specific Behaviors
- Self-Management Skills
- Goal Setting

Stimulus Control
- Positive Reinforcement
- Self-Monitoring

Change!
Integrating Treatment into Your Office
Management and Treatment Stages for Patients with Overweight or Obesity

- Patients should start at the least intensive stage and advance through the stages based on the response to treatment, age, BMI, health risks, and motivation.
- An empathetic and empowering counseling style, such as motivational interviewing, should be employed to support patient and family behavior change.
- Children aged 2–5 should lose more than 1 pound/month; older children and adolescents with obesity should lose no more than an average of 2 pounds/week.

**Stage 1: Prevention Plus**

**Where/By Whom:** Primary Care Office/Primary Care Provider

What: Planned follow-up themed visits (15–20 min) focusing on behaviors that resonate with the patient, family, and provider.

Consider partnering with dietician, social worker, athletic trainer or physical therapist for added support and counselling.

Goals: Positive behavior change regardless of change in BMI. Weight maintenance or a decrease in BMI velocity.

Follow-up: Tailor to the patient and family motivation. Many experts recommend at least monthly follow-up visits. After 3–6 months, if the BMI/weight status has not improved consider advancing to Stage 2.

**Stage 2: Structured Weight Management**

**Where/By Whom:** Primary Care Office/Primary Care Provider with appropriate training

What: Same intervention as Stage 1 where including basic behavioral techniques to achieve healthy behavior change.

Goals: Positive behavior change. Weight maintenance or a decrease in BMI velocity.

Follow-up: Every 2–4 weeks as determined by the patient, family, and physician. After 3–6 months, if the BMI/weight status has not improved consider advancing to Stage 3.

**Stage 3: Comprehensive Multi-disciplinary Intervention**

**Where/By Whom:** Pediatric Weight Management Clinic/Multi-disciplinary Team

What: Increased intensity of behavior changes, frequency of visits, and specialists involved. Structured behavioral modification program, including food and activity monitoring, and development of short-term diet and physical activity goals.

Goals: Positive behavior change. Weight maintenance or a decrease in BMI velocity.

Follow-up: Weekly or at least every 2–4 weeks as determined by the patient, family, and physician. After 3–6 months, if the BMI/weight status has not improved consider advancing to Stage 4.

**Stage 4: Tertiary Care Intervention**

**Where/By Whom:** Pediatric Weight Management Center/Providers with expertise in treating childhood obesity

What: Recommended for children with BMI ≥ 95% and significant comorbidities if unsuccessful with Stages 2–3. Also recommended for children >95% who have shown no improvement under Stage 3. Intensive diet and activity counseling with consideration of the use of medications and surgery.

Goals: Positive behavior change. Decrease in BMI.

Follow-up: Determine based upon patient’s motivation and medical status.

References

Management and Treatment Stages for Patients with Overweight or Obesity

- Patients should start at the least intensive stage and advance through the stages based upon the response to treatment, age, BMI, health risks and motivation.

- An empathetic and empowering counseling style, such as motivational interviewing, should be employed to support patient and family behavior change. 8,9

- Children age 2 – 5 who have obesity should not lose more than 1 pound/month; older children and adolescents with obesity should not lose more than an average of 2 pounds/week.

Stage 1 Prevention Plus

Where/By Whom: Primary Care Office/Primary Care Provider

What: Planned follow-up themed visits (15–20 min) focusing on behaviors that resonate with the patient, family and provider.

Goals: Positive behavior change regardless of change in BMI. Weight maintenance or a decrease in BMI velocity. 4

Stage 2 Counseling

What: Counseling to address obesity – 2 should be conducted by the patient, family, and health care provider. 3

Goals: BMI/weight status has not improved consider advancing to Stage 4.

Stage 4 Tertiary Care Intervention

Where/By Whom: Pediatric Weight Management Center/Providers with expertise in treating childhood obesity

What: Recommended for children with BMI ≥ 95% and significant comorbidities if unsuccessful with Stages 1 – 3. Also recommended for children > 95% who have shown no improvement under Stage 3. Intensive diet and activity counseling with consideration of the use of medications and surgery.

Goals: Positive behavior change. Decrease in BMI.

Follow-up: Determine based upon patient’s motivation and medical status.

References:

Updated 08/19/15
Stage 1 Prevention Plus

Where/By Whom: Primary Care Office/Primary Care Provider

What: Planned follow-up themed visits (15-20 min) focusing on behaviors that resonate with the patient, family and provider. Consider partnering with dietician, social worker, athletic trainer or physical therapist for added support and counseling.

Goals: Positive behavior change regardless of change in BMI. Weight maintenance or a decrease in BMI velocity.4

Follow-up: Tailor to the patient and family motivation. Many experts recommend at least monthly follow-up visits. After 3 – 6 months, if the BMI/weight status has not improved consider advancing to Stage 2.
Stage 2 Structured Weight Management

Where/By Whom: Primary Care Office/Primary Care Provider with appropriate training

What: Same intervention as Stage 1 while including more intense support and structure to achieve healthy behavior change.

Goals: Positive behavior change. Weight maintenance or a decrease in BMI velocity.

Follow-up: Every 2 - 4 weeks as determined by the patient, family and physician. After 3 – 6 months, if the BMI/weight status has not improved consider advancing to Stage 3.
 Operationalizing Stages 1 and 2 in Primary Care

- Patient-centered: Let the patient and family be the guide
- Goals should be around behaviors, not necessarily weight
- Set realistic expectations
- Use planned follow-up visits
- Follow-up every 2 - 4 weeks is recommended; patient and family ultimately decide
- The follow-up can take different forms: in-person, phone calls, emails, texts
- Consider using partners to help with ongoing care and management
Innovations in Treatment

- Registered Dietician co-location in primary care provider office
- Group visits
- Telemedicine
- Use of technology: Fitbit®, etc.
- Co-managing patients with allied health professionals:
  - Social worker
  - Physical therapist
  - Registered Dietician
A Possible Path For Follow-Up

- Themed Visits:
  - Work best for engaged and committed patients
  - Provide format and content for visits focused on health
  - Provide structure for long term continuity
- Use motivational interviewing techniques
- Give your program a name!

MOST IMPORTANT:
Family chooses the theme and drives the process
Name Your Program!

- Ours may sound a little more hardcore than you might choose!
Practitioner Strategies that Improve Patient Outcomes

- Develop Relationships
- Encourage Small Steps
- Use Motivational Interviewing
- Focus on Countable Goals
- Use Community Resources
Practitioner Strategies that Improve Patient Outcomes, cont.

- Get commitment from patients and families
- Anticipate Relapses
- Innovate around the type and frequency of visits
- Adapt the themes and strategies to the patient’s culture
- Celebrate early wins
- Think about Maintenance
A Framework for Each Visit

Motivational interviewing can be very helpful to engage patients in making change:

- Identify an MI champion
- Ask permission
- Set the agenda
- Assess motivation and confidence: consider using the importance and confidence ruler
- Summarize and probe regarding possible changes
- Schedule follow-up
How to Integrate a Theme into a Visit

20 MINUTE VISIT

Wt/Check In
BMI %ile

Barriers

PE

Theme

Follow Up

5

5

1

5

4
Possible Themes

A
- Understanding Your Health

B
- Understanding Healthy Food
- Home Environment
- Eating and Your Emotions
- Portion Sizes
- Healthy Drinks
- Parenting

C
- Physical activity
- Feeling Good About Yourself
- Reading Food Labels
- Screen Time and Sleep
- Meal Patterns and Snacks
- Eating Away From Home
- Holidays and Special Occasions
- Healthy Family
- Community
- Bullying and Teasing
- Unintentional Disruptions

*Drawn from Next Steps*
### How to Choose a Theme

- Use themes with greater pay off first
- Consider:
  - Provider’s expertise and knowledge base
  - Patient’s age, readiness to change, habits, or BMI
  - Patient’s/family’s culture
MULTIPLE COMPLEX PROBLEMS IDENTIFIED

- BMI > 99th %
- Drinks 1 Liter Soda/Day
- Very Sedentary
- 5 hours screen time/Day
- Never reads Food Labels
- Large Portion Sizes
- Grandparent not helping

Next Steps

Themes For Today:
- Portion Size

Themes For Future Visits:
- Healthy Drinks
- Exercise
- Screen Time/Sleep
- Food Labels
- Family

Addressing One Thing at a Time
Who has the Conversation with the Patient/Family?

<table>
<thead>
<tr>
<th>MEDICAL PROVIDER VISITS (NP, PA, MD, DO, RN)</th>
<th>DIETITIAN VISITS (RD, Nutritionist, Health Educator)</th>
<th>PHYSICAL THERAPIST VISITS (OT, PT, CPT, AT, PhysEd)</th>
<th>PSYCHOLOGIST OR SOCIAL WORKER VISITS (PhD, LCSW, LCPC,)</th>
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<tr>
<td>•Purpose of Visits</td>
<td>•Understanding Healthy Food</td>
<td>•Physical Activity</td>
<td>•Behavioral and Emotional Eating</td>
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<td>•Physical Activity</td>
<td>•Portion Sizes</td>
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<td>•Television</td>
<td>•Label Reading</td>
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<tr>
<td>•Breastfeeding</td>
<td>•Snacks</td>
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<tr>
<td></td>
<td>•Meal Patterns</td>
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<td></td>
<td>•Calorie Balance</td>
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Knowing When and Where to Refer

- Know your own referral network
- Use local resources
- Establish a connection with your local center
- Develop a strategy for severe obesity
- Be as prepared as possible but remain flexible
Your Local Referral Center: Questions to ask

- What kind of treatment does your center provide?
- How does your center handle co-morbidities?
- What studies are your patients able to access at this point?
- How do patients access bariatric options from your center?
Setting Realistic Expectations
Aligning Expectations

- Goals should be focused on small behavior steps set by patient
- Weight, BMI, BMI z-score are important but should not be the focus

So, what is the focus?
- Health
- Patient and Family Priorities
BMI and Setting Goals

- First goal: Stabilize BMI
- Stable BMI = lower BMI percentile
- “A stable BMI is like a grownup losing weight.”
- “I, of course, want to see BMI stabilize or improve, but I’m more interested in what you’re doing to be healthy.”
# Weight Loss Targets

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<tr>
<th>Age (years)</th>
<th>85&lt;sup&gt;th&lt;/sup&gt;-94&lt;sup&gt;th&lt;/sup&gt; Percentile No health risks</th>
<th>85&lt;sup&gt;th&lt;/sup&gt;-94&lt;sup&gt;th&lt;/sup&gt; Percentile With health risk(s)</th>
<th>BMI ≥95&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
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<tr>
<td>2-5</td>
<td>Maintain weight velocity</td>
<td>Maintain weight or gain weight more slowly</td>
<td>Maintain weight; if BMI &gt;21 or 22 kg/m&lt;sup&gt;2&lt;/sup&gt;, lose up to 1 lb./mo.</td>
</tr>
<tr>
<td>6-11</td>
<td>Maintain weight velocity</td>
<td>Maintain weight</td>
<td>Lose weight gradually (1lb./month); if &gt;99&lt;sup&gt;th&lt;/sup&gt; BMI percentile, lose up to 2 lb./week</td>
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<tr>
<td>12-18</td>
<td>Maintain weight velocity; after linear growth, maintain weight</td>
<td>Maintain weight or lose weight gradually</td>
<td>Lose up to 2lb./week</td>
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2007 Expert Panel Recommendations
Bringing it All Together for Marco: Initial assessments

- Marco is a 12 year old boy who was seen at well visit
- Weight and height put him in the >95\textsuperscript{th} BMI percentile (obese category)
- He drinks 3-4 sodas a day, skips breakfast, eats out with the family a lot and routinely has no real physical activity
- The mom and dad both are struggling with weight-related illness
During physical exam, you noticed a few signs and symptoms of obesity-related comorbidities:

- Snoring
- Shortness of breath when running hard
- Elevated blood pressure
- Acanthosis nigricans
Bringing it all together for Marco: The conversation

- You asked permission to talk about weight and Marco and his Dad said okay
- You mentioned that you are concerned about a few things on his physical and would like to get some lab work
- You also asked if the family is concerned – they say “yes” and the conversation begins (2-3 mins)
- You start using snippets of MI and realize that Marco and his dad would be good candidates to come back for a follow-up visit
Bringing it all together for Marco: Follow-up

- They come back in 2 weeks. You discuss that his labs all look okay and that you think with some small changes the things you were concerned about may go away, and they are relieved.
- You use the Next Steps framework and MI and see them on a regular basis for the next 3-6 months.
- Marco begins to make small changes and his BMI drops to the 85th-94th percentile range. He is feeling much better, his snoring has gone away, and his exercise tolerance has increased.
In Closing

- Assessing and managing patients with overweight and obesity can seem daunting in a busy primary care practice.
- A supportive, comfortable office environment is essential
- A supportive staff is critical:
  - Consistent message and approach
  - Patient-first language
  - Bias-free zone
The Right Tools

Help guide the management and treatment of patients in your practice:

- New algorithm
- Next Steps guide
- Motivational interviewing
For More Information

www.aap.org/healthyweight

www.aap.org/soob

Bolling.cf@gmail.com

Thank you!