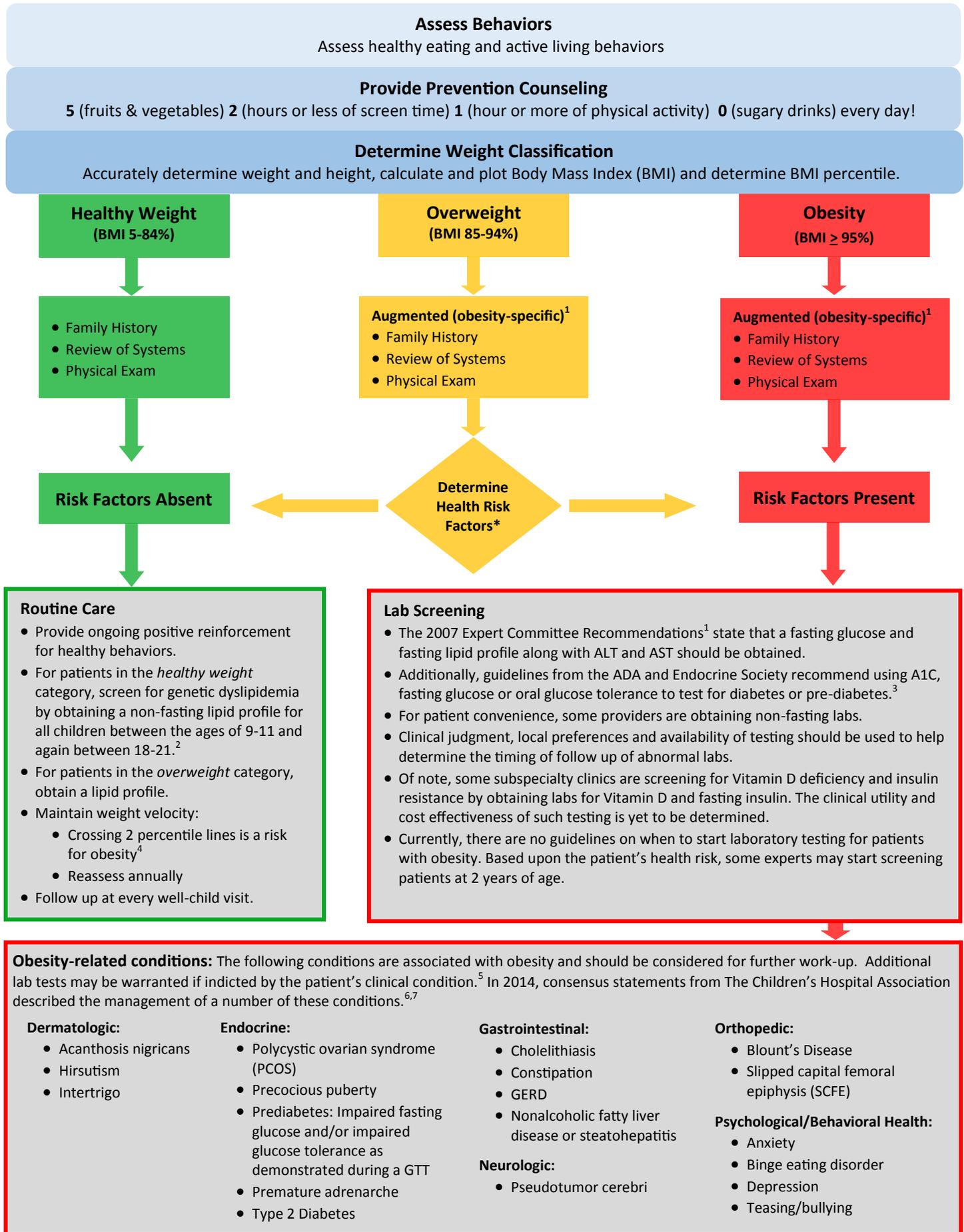


Algorithm for the Assessment and Management of Childhood Obesity in Patients 2 Years and Older

This algorithm is based on the 2007 Expert Committee Recommendations,¹ new evidence and promising practices.



*Based on behaviors, family history, review of systems, and physical exam, in addition to weight classification.

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. 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.

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 \geq 95% and significant comorbidities if unsuccessful with Stages 1 - 3. Also recommended for children $>$ 99% 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

1. Barlow S, Expert Committee. Expert committee recommendations regarding prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. *Pediatrics*. 2007;120(4):S164-S192.
2. US Department of Health and Human Services. Expert panel on integrated guidelines for cardiovascular health and risk reduction in children and adolescents: Full report. 2012.
3. American Diabetes Association. Classification and diagnosis of diabetes. Sec.2. In Standards of Medical Care in Diabetes – 2015. *Diabetes Care* 2015;38(Suppl.1):S8-S16.
4. Taveras EM, Rifas-Shiman SL, Sherry B, et al. Crossing growth percentiles in infancy and risk of obesity in childhood. *Arch Pediatr Adolesc Med*. 2011;165(11):993-998.
5. Copeland K, Silverstein J, Moore K, et al. Management of newly diagnosed type 2 Diabetes Mellitus (T2DM) in children and adolescents. *Pediatrics*. 2013;131(2):364-382.
6. Estrada E, Eneli I, Hampl S, et al. Children's Hospital Association consensus statements for comorbidities of childhood obesity. *Child Obes*. 2014;10(4):304-317.
7. Haemer MA, Grow HM, Fernandez C, et al. Addressing prediabetes in childhood obesity treatment programs: Support from research and current practice. *Child Obes*. 2014;10(4):292-303.
8. Preventing weight bias: Helping without harming in clinical practice. Rudd Center for Food Policy and Obesity website. <http://biastoolkit.uconnruddcenter.org/>.
9. Resnicow K, McMaster F, Bocian A, et al. Motivational interviewing and dietary counseling for obesity in primary care: An RCT. *Pediatrics*. 2015;134(4): 649-657.