A CLINICAL PATHWAY FOR THE EVALUATION AND MANAGEMENT OF CHILDHOOD OBESITY

AT WELL CHILD VISITS:
1. Patient checks in at registration.
2. MA records vitals & distributes Staying Healthy Assessment (SHA). If follow-up visit, MA will distribute Healthy Habits Questionnaire.
3. SHA completed in exam room by patient/family.
4. MD reviews BMI percentile and SHA.

NORMAL WEIGHT
(BMI ≥5th to 84th %ile)

1. MD gives 5-2-1-0 messages.
2. MD highlights SHA areas for improvement.
3. No diagnosis given, no handout and no follow-up visit.
4. BMI is rechecked at next

OVERWEIGHT OR OBESE
(BMI ≥85th%ile or higher)

1. Document new diagnosis of overweight and obesity using ICD-9 code.
2. MD gives 5-2-1-0 messages.
3. MD highlights SHA areas for improvement and sets goals.
4. MD documents goals set with patient into EMR.
5. MA will provide patient with Patient Satisfaction Survey and collect prior to scheduling follow-up appointment.
6. Schedule follow-up visit within 2 months **(depending on BMI)** to complete evaluation for overweight or obesity.

AT FOLLOW-UP VISIT:

1. **REASSESS**. Repeat WCC visits steps 1-4 (listed above).
2. **COMPLETE EVAULATION**. MD takes thorough obesity-related history and physical exam, particularly:
   - Family history: obesity, diabetes, HTN, cholesterol, early (<50yrs) death from stroke/heart disease;
   - Social History;
   - Review of systems for obesity-related conditions;
   - Physical exam, noting signs of obesity-related conditions (including HTN).
3. **LABORATORY EVAULATION**: Ordered per MD Recommendations:
   - Cholesterol: >95th%ile 2 fasting lipid profiles 2 weeks apart (within 3 months), > 85th %ile only if high risk family history or other medical condition **(as clinically indicated)**;
   - Fatty Liver: ALT/AST **(as clinically indicated)**;
   - Diabetes: fasting glucose q 2yrs at 10yrs or puberty with 2 risk factors (race, ethnicity, family history, and signs or conditions associated with insulin resistance);
   - Other tests as indicated by health risks.
4. **COUNSEL.** MD reinforces 5-2-1-0 messages.
5. **SET GOALS.** Healthy Weight Rx distributed, with goals developed using motivational interviewing techniques.
6. **COMMUNITY REFERRALS.** Community Rx distributed, referring to nutrition and physical activity resources.
7. **MEDICAL REFERRALS.** If labs are abnormal, treat or refer as appropriate.
8. **INCENTIVE DISTRIBUTION.** Cookbook and Gym Pass (1st FU), Exercise Bands (2nd FU), Salsa Video (3rd FU)

Goal Setting and Weight Management Follow-Up Calls

6 MONTH INTERVENTION (Stage 1: Prevention Plus)

- >95th%ile: Follow-Up visits q 1 month x6months.
- >85th%ile: Follow-Up visits q 2-3 month x6months.

1. **REASSESS**. Repeat WCC visits steps 1-4 (listed above).
2. **LABORATORY EVAULATION**: MD addresses laboratory results.
3. **COUNSEL.** MD reinforces 5-2-1-0 messages.
4. **ADDRESS GOALS.** Healthy Weight Rx distributed, with revised goals.
5. **REFERRALS.** MD addresses compliance with both community and medical referral.