A CLINICAL PATHWAY FOR THE EVALUATION AND MANAGEMENT OF CHILDHOOD OBESITY

NORMAL WEIGHT (BMI ≥5th to 84th %ile)

1. MD gives 5-2-1-0

2. MD highlights SHA areas for

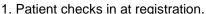
handout and no follow-up visit.

3. No diagnosis given, no

4. BMI is rechecked at next

messages.

improvement.



AT WELL CHILD VISITS:

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.

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).
- **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 g 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.
- INCENTIVE DISTRIBUTION. Cookbook and Gym Pass (1st FU), Exercise Bands (2nd FU), Salsa Video (3rd

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.