

Table 4: Evidence for Follow-up Visits for Children Who Are Overweight

Type of Evidence	Key Findings	Level of Evidence (USPSTF Ranking*)	Citations
Expert recommendation	The complexity of treating a chronic problem such as obesity and the need for patient education about self-management can overwhelm patients and clinicians during an office visit. A model for chronic care envisions a structure that integrates health care, patient self-management, and community resources to provide more comprehensive and useful care. (p. s170) The committee proposes staged treatment for overweight or obese children, beginning with an office-based intervention for the greatest number of overweight or obese children and then a systematic intensification of effort tailored to the capacity of the clinical office, the motivation of the family, and the degree of obesity. The most aggressive treatment would be considered for patients who have not responded to other interventions. The four stages are 1) Prevention Plus, 2) Structured Weight Management, 3) Comprehensive Multidisciplinary Intervention, and 4) Tertiary Care Intervention. (p. s182)	III	Barlow SE. Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. <i>Pediatrics</i> 2007; 120(Suppl 4):S164-S192
Consensus statement	The vulnerability of the obese child to serious complications makes the case for prevention and treatment irrefutable; overweight children are also at increased risk. (p. 1879) Most of the metabolic complications of childhood obesity emerge in adolescence and young adulthood but evidence suggests intervention is warranted in children. (p. 1880) Children with BMI $\geq 85^{\text{th}}$ percentile should receive regular lifestyle counseling addressing diet and exercise. Children with a BMI above the 95 th percentile require specialist pediatric care, and those with comorbidities or severe obesity should receive care in a multidisciplinary specialist service. (p. 1884)	III	Speiser PW, Rudolf MC, Anhalt H, et al. Childhood obesity. <i>J Clin Endocrinol Metab</i> 2005; 90(3):1871-1887
Scientific statement	Clinicians should assess obesity risk in all children, integrating information about the patient's BMI, medical risk, and current eating and physical activity behaviors and attitudes. This assessment should guide initiation of prevention or treatment strategies. (p. 2115)	III	Daniels SR, Jacobson MS, McCrindle BW, Eckel RH, McHugh Sanner B. American Heart Association Childhood Obesity Research Summit: Executive Summary. <i>Circulation</i> 2009; 119:2114-2123

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Task force recommendation	The USPSTF found adequate evidence that multicomponent, moderate- to high-intensity behavioral interventions for obese children and adolescents aged 6 years and older can effectively yield short-term (up to 12 months) improvements in weight status. Inadequate evidence was found regarding the effectiveness of low-intensity interventions. There is adequate evidence that the harms of behavioral interventions are no greater than small. (pp. 362-364)	III	US Preventive Services Task Force. Screening for obesity in children and adolescents: US Preventive Services Task Force recommendation statement. <i>Pediatrics</i> 2010; 125(2):361-367
HHS recommendation	Improving access to obesity-related services is a priority for the federal government. The increasing prevalence of obesity among children makes it important that attention be given to assure that screening and services are provided to children when medically necessary. CMS guidance will encourage States to remind providers to include diet and exercise advice in the comprehensive well-child examinations. The Affordable Care Act includes a range of provisions that will help promote obesity-related preventive efforts and coverage. (pp. 8-10)	III	Department of Health and Human Services. Preventive and Obesity-Related Services Available to Medicaid Enrollees. Washington, DC 2010

Note: USPSTF criteria for assessing evidence at the individual study level are as follows: I) Properly powered and conducted randomized controlled trial (RCT); well-conducted systematic review or meta-analysis of homogeneous RCTs. II) Well-designed cohort or case-control analytic study. III) Opinions of respected authorities, based on clinical experience; descriptive studies or case reports; reports of expert committees.