

Effort Trains Doctors to Counsel Overweight Kids

BY CHRISTINE KILGORE

Contributing Writer

As Paul L. Rowland III, M.D., now sees it, physicians can talk to parents and their overweight children about diet and physical activity, or they can really *counsel*—that is, ask, listen, listen some more, and talk.

It's only through real counseling, he said, that doctors can hope to prevent and treat obesity and overweight—and all the morbidities that accompany it. "I've learned how to approach this in a positive way, how not to alienate [the families]."

Dr. Rowland is 1 of 20 pediatricians in the Pittsburgh area who participated in a two-pronged practice-based pilot project in which they changed and intensified their counseling—and implemented behavioral treatment programs in their two practices for overweight 8- to 12-year-old children and their families.

The short-term results have encouraged Dr. Rowland and his colleagues to continue. Thirty-seven children who were counseled during well-child visits and subsequently completed the 5-month-long intervention had a mean weight loss of 4 pounds. Seventeen of these children, who were followed for 6 months or more, had a mean decrease in BMI of 2 absolute units, or approximately 7% of their baseline BMI.

Perhaps more importantly, the children made dietary changes and changes in their activity levels that Dr. Rowland and his colleagues believe will have a long-lasting impact.

"We didn't see great weight loss. But these children are at an age where they're expected to gain weight and height, so any weight loss is fabulous," said Ellen Wald, M.D., who codirected the project.

The call for physicians to incorporate weight management into their practices is intensifying. Numerous bodies have recommended that childhood obesity be prevented and treated in the primary care setting, and both the American Academy of Pediatrics (AAP) and the American Medical Association soon plan to issue clinical



Through this program, "I realized what a huge issue these lifestyle changes are," said Dr. Paul L. Rowland III.

guidelines for weight management in children.

Surveys have repeatedly revealed what holds back primary care physicians: a lack of training and perceived competence, a lack of time, parent unwillingness to become involved, few available treatment options, and a lack of third-party reimbursement.

Dr. Rowland said he "didn't need any prompting" when asked to participate in the project almost 2 years ago. He and the five other full-time pediatricians in his ethnically and economically diverse practice, Pittsburgh Pediatric Associates, had only recently begun measuring BMI in some patients. Still, he said, overweight "was a concern that [had been] weighing on our minds for a long time."

Dr. Rowland also is a member of a 3-year-old practice-based research network—Pediatric PitNet—comprising physicians in practices that are partially owned by Children's Hospital of Pittsburgh. The network had been awarded a \$125,000 grant through the Robert Wood Johnson Foundation's "Prescription for Health" program—an initiative that funds practice-based pilot projects aimed at combating unhealthy behaviors in primary care.

For their part, he and the other physician participants completed a 60-minute self-study packet that included 7-year-old recommendations on obesity management from the federal Maternal and Child Health Bureau, the AAP's 2003 policy statement on pediatric overweight and obesity, and reports by Leonard H. Epstein, Ph.D., on his successes with behavioral family-based treatment.

(In 1994, Dr. Epstein and his colleagues reported 10-year outcomes showing that significant numbers of children who lost weight through family-based behavioral treatment maintained that weight loss, or lost more, through adolescence and into adulthood.)

They then attended a 90-minute session—led by health psychologists from the Western Psychiatric Institute and Clinic—in which they revamped their approach to talking during well-child visits about weight and BMI, nutrition, and physical activity.

"The important thing is not to come off sounding judgmental, but to solicit and tease out their concerns a little bit better," said Dr. Rowland. "I learned to see where

the family's coming from—to ask open-ended questions and restate what they're saying—before I start sharing my opinions."

He said he was surprised by how many parents are concerned about their child's excess weight, but just need to be prompted to talk about it. When parents don't voluntarily express concern, "I show them the [BMI] curve and see how they respond. I might ask, are you concerned? Many will say 'Yes, I didn't bring it up before, but yes.'"

"We almost always end up talking about activity or snacking. Parents will sometimes say, 'He's eating a lot of healthy foods' but when I restated their thoughts, they'd start talking about portion size, how 'He eats seconds or thirds.'"

Per the study protocol, Dr. Rowland encouraged children with a BMI at the 85th percentile or higher, whenever possible, to participate with their parents in a behavioral treatment program. Each run of the program consisted of eight weekly group sessions and three individual follow-up sessions held right in his practice. (See box below at right.)

On his own initiative, Dr. Rowland went further. He attended many of the sessions, sitting in with the kids and keeping his own food and activity logs.

"I don't have any weight issues, and I am physically fit, but I really wanted to learn what these kids were thinking. And I started thinking, maybe I could also do better. I realized what a huge issue these lifestyle changes are," Dr. Rowland said. "That's

why the whole family has to be on board—one member can't make [the] change if other members aren't trying, too."

Of 73 families who enrolled in the program, 37 completed it. (Families were "completers" if they attended six of the eight group sessions and one of the three follow-up sessions.)

In addition to the mean drop in weight and BMI, the 37 children decreased their consumption of high-fat, low-nutrient foods by half or more. Twenty-one of these children who used pedometers throughout the intervention period also saw a 50% increase in steps per day. (All children started the intervention using pedometers, but many discontinued using the pedometers after the first few weeks.)

Interviews with parents showed that the physicians used what they'd been taught, said Linda Ewing, Ph.D., a codirector of the project who presented some of the findings at the annual meeting of the Pediatric Academic Societies.

Twenty-seven randomly selected parents were interviewed before and after the program. Prior to the training, 37% reported that their child's doctor had discussed physical activity during their well-child visit; after training, this jumped to 89%.

The percentage of parents who reported that the doctor had discussed their child's eating habits jumped from 37% before training to 82% afterward, she said.

"We've shown that it's feasible—that pediatricians will [adopt new skills] and address issues of weight more confidently, and that parents will come to an evidence-based intervention in the office," said Dr. Ewing of the University of Pittsburgh. "It's the first step, but by no means the last." ■

From Weigh-Ins to Group Sessions: What Behavioral Treatment Entails

Children who attended the behavioral treatment program at Dr. Rowland's practice started each of the eight weekly sessions with a "weigh-in" and an individual family "coaching" session.

The children then met in a group with a clinical psychologist from outside the practice while the parents met primarily with the pediatric office's nurse-practitioner, M. Kathleen Kelly.

"The kids are very honest, and they're encouraged by small changes," said Dr. Rowland, who attended many of the children's group sessions. "They would readily answer to 'What was difficult for you?' and 'What can you do for next week?'"

Sessions for both parents and children focused on self-monitoring of diet and activity, stimulus control, goal setting, positive reinforcement, social assertion, and relapse prevention.

The goals were to decrease intake of high-fat, low-nutrient foods; to increase intake of low-fat, high-nutrient

foods; to decrease sedentary behaviors; and to increase activity and exercise.

Many of the children already had received a small BMI chart color-coded into red, yellow, and green zones to indicate overweight, at-risk, and healthy ranges of BMI. The colors correspond to the red, yellow, and green categories of food in the "stop-light diet"—a concept that the project directors incorporated into the nutritional counseling element of the project. They had the chart designed as an educational tool.

Of 73 children who enrolled, only 4 had a BMI between the 85th and 94th percentiles; the rest of the children were heavier.

Each run of the program in each of the two participating practices—Pittsburgh Pediatric Associates, Dr. Rowland's practice, and Children's Community Care, a rural practice right outside Pittsburgh—consisted of fairly even numbers of boys and girls, with a mean age of 10 years.

Clinical Growth Charts 'To Go'

If your practice is already working on weight management or getting ready to work with the upcoming clinical guidelines on weight management, the Centers for Disease Control and Prevention's National Center for Health Statistics can help with the record keeping. Copyright-free, customizable PowerPoint charts for tracking boys' and girls' stature-for-age, weight-for-age, and BMI-for-age are available online (www.cdc.gov/nchs/about/major/nhanes/growthcharts/Powerpt.htm). There are instructions on adding your own text or logos to the "slides" to use in electronic patient records or to reproduce.