

# Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report

<b>(1) Overview material</b>	<i>Provide a structured abstract that includes the guideline's release date, status (original, revised, updated), and print and electronic sources.</i>
<i>Release Date</i>	December 2007
<i>Status</i>	Empty
<i>Available in Electronic Format</i>	Empty
<i>Available in Print Format</i>	Empty
<i>Bibliographic citation</i>	Empty
<i>Contact Information</i>	Empty
<i>Adapted From Another Guideline</i>	Empty
<b>(2) Focus</b>	<i>Describe the primary disease/condition and intervention/ service/ technology that the guideline addresses. Indicate any alternative preventive, diagnostic or therapeutic interventions that were considered during development.</i>
<i>Primary disease or condition</i>	3 areas of focus: prevention, assessment, and treatment of childhood overweight and obesity.
<i>Alternative Strategies Available</i>	Empty
<i>Comparable Guideline</i>	Empty
<b>(3) Goal</b>	<i>Describe the goal that following the guideline is expected to achieve, including the rationale for development of a guideline on this topic.</i>
<i>Goal</i>	These new recommendations use current, evidence-based data, as well as clinical experience when evidence does not exist, to provide updated practical guidance to practitioners
<i>Rationale</i>	IN 1997, when the Department of Health and Human Services Health Resources and Service Administration convened the first expert committee to develop recommendations on the evaluation and treatment of child and youth obesity, few studies of this problem had been conducted to provide evidence for the recommendations. Since then, increasing scientific attention has resulted in an expanded body of literature on the causes, comorbidities, and treatment of this problem. The condition remains frustrating and difficult to treat but, with more-current scientific information available, in 2005 the American Medical Association, in collaboration with the Health Resources and Service Administration and the Centers for Disease Control and Prevention (CDC), convened a new expert committee that was charged with providing revised recommendations.
<i>Outcomes or Performance Measures Considered</i>	Empty
<b>(4) Users/Setting</b>	<i>Describe the intended users of the guideline (e.g., provider types, patients) and the settings in which the guideline is intended to be used.</i>
<i>Users</i>	Empty
<i>Care Setting</i>	Empty
<b>(5) Target population</b>	<i>Describe the patient population eligible for guideline recommendations and list any exclusion criteria.</i>
<i>Population Target</i>	Empty
<i>Eligibility</i>	Empty
<i>Inclusion criteria</i>	Empty
<i>Exclusion criteria</i>	Empty
<b>(6) Developer</b>	<i>Identify the organization(s) responsible for guideline development and the names/credentials/potential conflicts of interest of individuals involved in the guideline's development.</i>
<i>Name of Developer</i>	American Medical Association, in collaboration with the Health Resources and Service Administration and the Centers for Disease Control and Prevention (CDC)
<i>Name of Committee</i>	Representatives from 15 national health care organizations formed the expert committee The steering committee, composed of representatives from the American Medical Association, the Health Resources and Service Administration, and the CDC, invited these member organizations because they serve children at high risk of obesity, they represent experts in obesity-related conditions, or they represent experts in aspects of obesity treatment. Special care was taken both to ensure that a broad range of disciplines, including medicine, nutrition, nursing, psychology, and epidemiology, was represented and to capture the interests of diverse cultural groups.
<i>Committee Expertise</i>	The steering committee, composed of representatives from the American Medical Association, the Health Resources and Service Administration, and the CDC, invited these member organizations because they serve children at high risk of obesity, they represent experts in obesity-related conditions, or they represent experts in aspects of obesity treatment. Special care was taken both to ensure that a broad range of disciplines, including medicine, nutrition, nursing, psychology, and epidemiology, was represented and to capture the interests of diverse cultural groups.

<b>(7) Funding source/sponsor</b>	<i>Identify the funding source/sponsor and describe its role in developing, and/or reporting the guideline. Disclose potential conflict of interest.</i>
<i>Source of Funding</i>	Empty
<i>Name of Developer</i>	American Medical Association, in collaboration with the Health Resources and Service Administration and the Centers for Disease Control and Prevention (CDC)
<i>Role Of Sponsor</i>	Empty
<i>Conflict Of Interest</i>	The author has indicated she has no financial relationships relevant to this article to disclose.
<b>(8) Evidence collection</b>	<i>Describe the methods used to search the scientific literature, including the range of dates and databases searched, and criteria applied to filter the retrieved evidence.</i>
<i>Description of Evidence Collection</i>	Empty
<i>Number of Source Documents</i>	Empty
<i>Evidence Time Period</i>	Empty
<i>Criteria for Selecting Evidence</i>	Empty
<b>(9) Recommendation grading criteria</b>	<i>Describe the criteria used to rate the quality of evidence that supports the recommendations and the system for describing the strength of the recommendations. Recommendation strength communicates the importance of adherence to a recommendation and is based on both the quality of the evidence and the magnitude of anticipated benefits or harms.</i>
<i>Recommendation Grading Criteria</i>	Empty
<i>Evidence Quality Rating Scheme</i>	he writing groups provided a broad rating of the evidence, so that readers can appreciate the limitations of these recommendations and watch for new studies that will refine them. The rating categories were as follows: recommends with consistent evidence (CE), that is, multiple studies generally show a consistent association between the recommended behavior and either obesity risk or energy balance; recommends with mixed evidence (ME), that is, some studies demonstrated evidence for weight or energy balance benefit but others did not show significant associations, or studies were few in number or small in sample size; suggests, that is, studies have not examined the association of the recommendation with weight or energy balance, or studies are few, small in number, and/or without clear findings; however, the expert committee thinks that these recommendations could support the achievement of healthy weight and, if future studies disprove such an effect, then these recommendations are likely to have other benefits and are unlikely to cause harm.
<i>Recommendation Strength Rating Scheme</i>	Empty
<b>(10) Method for synthesizing evidence</b>	<i>Describe how evidence was used to create recommendations, e.g., evidence tables, meta-analysis, decision analysis.</i>
<i>Description of Evidence Combination</i>	Each multidisciplinary writing group reviewed the current literature to develop the recommendations. Because the science continues to lag behind the obesity epidemic, many gaps in evidence-based recommendations remain. With few exceptions, randomized, controlled, intervention trials have not been performed to prove or to disprove the effect of a particular behavior on weight control in obese children. The available studies often examine associations between health behaviors and weight or between health behaviors and energy balance. Even less evidence exists about the process of addressing obesity in a primary care setting. The purpose of the expert committee was to offer practical guidance to clinicians by providing recommendations in all areas of obesity care, including those that lack the best possible evidence. When evidence of an effect on obesity was not available, the writing groups considered the literature, clinical experience, the likelihood of other health benefits, the possible harm, and the feasibility of implementing a particular strategy before including it. When evidence of an effect on obesity was not available, the writing groups considered the literature, clinical experience, the likelihood of other health benefits, the possible harm, and the feasibility of implementing a particular strategy before including it.
<i>Methods To Reach Judgment</i>	Empty
<b>(11) Pre-release review</b>	<i>Describe how the guideline developer reviewed and/or tested the guidelines prior to release.</i>
<i>External Review</i>	The writing groups presented their recommendations to the expert committee for discussion and revision in May 2006. Once consensus was reached, the committee members then presented the recommendations to their member organizations for endorsement (see "Acknowledgments" for expert committee and writing group participants).
<i>Pilot testing</i>	Empty
<i>Formal Appraisal</i>	Empty
<b>(12) Update plan</b>	<i>State whether or not there is a plan to update the guideline and, if applicable, an expiration date for this version of the guideline.</i>
<i>Expiration</i>	Empty
<i>Scheduled Review</i>	Empty
<b>(13) Definitions</b>	<i>Define unfamiliar terms and those critical to correct application of the guideline that might be subject to misinterpretation.</i>
<i>Definitions</i>	Empty

<i>Term - Meaning</i>	
<b>(14) Recommendations and rationale</b>	<i>State the recommended action precisely and the specific circumstances under which to perform it. Justify each recommendation by describing the linkage between the recommendation and its supporting evidence. Indicate the quality of evidence and the recommendation strength, based on the criteria described in 9.</i>
<i>Recommendation</i>	The Role of the Provider's Office - <i>Imperative</i> - The expert committee endorses the following office practices. routine documentation of BMI.
<i>Action</i>	Document BMI routinely
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	The Role of the Provider's Office - <i>Imperative</i> - The expert committee endorses the following office practice establishment of procedures to deliver obesity prevention messages to all children. When the patient's individual risk of obesity is low, these messages can promote appropriate general health or wellness, rather than weight control.
<i>Action</i>	establish procedures to deliver obesity prevention messages
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - The BMI percentile, although imperfect, is the recommended screen for body fat in routine office practice.
<i>Action</i>	Use BMI percentile to screen for body fat
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - Skinfold thickness measurements are not recommended.
<i>Action</i>	Do not perform Skinfold thickness measurements
<i>Reference</i>	Empty
<i>Reason</i>	they are difficult to perform accurately without careful training and experience and reference data are not readily available.
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - waist circumference measurements are not recommended currently.
<i>Action</i>	Do not measure waist circumference
<i>Reference</i>	Empty
<i>Reason</i>	reference values for children that identify risk over and above the risk from BMI category are not available
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - Parental obesity is a strong risk factor for a child's obesity persisting into adulthood, especially for young children.
<i>Action</i>	Empty
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - Offices should review and regularly update the family history regarding first-and second-degree relatives
<i>Action</i>	review and regularly update the family history
<i>Reference</i>	Empty
<i>Reason</i>	several obesity-related medical conditions are familial. Family history predicts type 2 diabetes mellitus or insulin resistance, and the prevalence of childhood diabetes is especially high among several ethnic and racial backgrounds common in the United States, including Hispanic, black, and North American Indian. <sup>53</sup> Cardiovascular disease and cardiovascular disease risk factors (hyperlipidemia and hypertension) are also more common when family history is positive. <sup>5</sup>
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - A review of systems and a physical examination represent an inexpensive way to screen for many of these conditions, although some conditions are without symptoms or signs.
<i>Action</i>	Empty
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - Blood pressure should be assessed at all health supervision visits, and offices should have large cuffs, including thigh cuffs, which allow accurate assessment of blood pressure for severely obese youths.
<i>Action</i>	Assess blood pressure at all health supervision visits
<i>Reference</i>	Empty
<i>Reason</i>	Approximately 13% of overweight children have elevated systolic blood pressure, and 9% have elevated diastolic blood pressure.
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - the expert committee recommends a focused assessment of behaviors that have the strongest evidence for association with energy balance and that are modifiable.
<i>Action</i>	asses behaviors that have the strongest evidence for association with energy balance and that are modifiable.

<i>Reference</i>	Empty
<i>Reason</i>	Because comprehensive dietary and physical activity assessments, such as diet or physical activity diaries, are impractical in a typical office setting
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - For eating behavior assessment, the following behaviors should be addressed frequency of eating food prepared outside the home, including food in restaurants, school and work cafeterias, and fast food establishments and food purchased for "take out"; • ounces, cups, or cans of sugar-sweetened beverages consumed each day; portions that are large for age (qualitative assessment); • ounces or cups of 100% fruit juice consumed each day; frequency and quality of breakfast; consumption of foods that are high in energy density, such as high-fat foods; number of fruit and vegetable servings consumed each day; and number of meals and snacks consumed each day and quality of snacks.
<i>Action</i>	Address frequency of eating food prepared outside the home,
<i>Action</i>	Address ounces, cups, or cans of sugar-sweetened beverages consumed each day
<i>Action</i>	Address portion size
<i>Action</i>	Address ounces or cups of 100% fruit juice consumed each day;
<i>Action</i>	Address frequency and quality of breakfast
<i>Action</i>	Address consumption of foods that are high in energy density, such as high-fat foods;
<i>Action</i>	Address number of fruit and vegetable servings consumed each day
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Medical Assessment - <i>Imperative</i> - For physical activity assessment, the following behaviors should be addressed: time spent in moderate physical activity each day (including organized physical activity and unstructured activity, including play), to estimate whether the goal of 60 minutes of moderately vigorous activity each day is achieved; routine activity patterns, such as walking to school or performing yard work; sedentary behavior, including hours of television, videotape/DVD, and video game viewing and computer use to determine whether viewing is andgt;2 hours per day.
<i>Action</i>	Address time spent in moderate physical activity each day
<i>Action</i>	Address routine activity patterns
<i>Action</i>	Address sedentary behavior
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Prevention Plus - <i>Imperative</i> - involve the whole family in lifestyle changes
<i>Action</i>	involve the whole family in lifestyle changes
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	(CE)
<i>Recommendation</i>	Prevention Plus - <i>Imperative</i> - help families tailor behavior recommendations to their cultural values
<i>Action</i>	help families tailor behavior recommendations to their cultural values
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Assessment Recommendations - <i>Conditional</i> - the expert committee recommends that individuals 2 to 18 years of age with BMI of 95th percentile for age and gender or BMI of 30 (whichever is smaller) should be considered obese and individuals with BMI of 85th percentile but 95th percentile for age and gender should be considered overweight; this term replaces "at risk of overweight."
<i>Decision Variable</i>	2 to 18 years of age
<i>Decision Variable</i>	BMI of 95th percentile for age and gender
<i>Decision Variable</i>	BMI of 30
<i>Action</i>	consider obese
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Strength of Recommendation</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Assessment Recommendations - <i>Conditional</i> - the expert committee recommends individuals with BMI of 85th percentile but 95th percentile for age and gender should be considered overweight; this term replaces "at risk of overweight."
<i>Decision Variable</i>	BMI of 85th percentile
<i>Decision Variable</i>	95th percentile for age and gender
<i>Action</i>	consider overweight; this term replaces "at risk of overweight."
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Strength of Recommendation</i>	Empty
<i>Quality of Evidence</i>	Empty
	Assessment Recommendations - <i>Conditional</i> - The expert committee recommends that a thorough physical examination be performed and

<b>Recommendation</b>	that, for a child identified as overweight or obese, the following measurements be included, in addition to the aforementioned recommendations on BMI: (a) pulse, measured in the standard pediatric manner; (b) blood pressure, measured with a cuff large enough that 80% of the arm is covered by the bladder of the cuff; and (c) signs associated with comorbidities of overweight and obesity (see the assessment report). <sup>2</sup> Waist circumference is not recommended for routine use. Although high waist circumference can indicate insulin resistance and other comorbidities of obesity and may be useful to characterize risks for obese children, measurement is difficult and appropriate cutoff values are uncertain.
<b>Decision Variable</b>	identified as overweight or obese
<b>Action</b>	Measure pulse
<b>Action</b>	Blood pressure
<b>Action</b>	signs associated with comorbidities of overweight and obesity
<b>Reference</b>	Empty
<b>Reason</b>	Empty
<b>Strength of Recommendation</b>	Empty
<b>Quality of Evidence</b>	Empty
<b>Recommendation</b>	Assessment Recommendations - <i>Conditional</i> - If the BMI is 85th to 94th percentile for age and gender with no risk factors, then a fasting lipid profile should be obtained.
<b>Decision Variable</b>	BMI is 85th to 94th percentile for age and gender
<b>Decision Variable</b>	no risk factors
<b>Action</b>	Obtain a fasting lipid profile
<b>Reference</b>	Empty
<b>Reason</b>	Empty
<b>Strength of Recommendation</b>	Empty
<b>Quality of Evidence</b>	Empty
<b>Recommendation</b>	Assessment Recommendations - <i>Conditional</i> - If the BMI is 85th to 94th percentile for age and gender with risk factors in the history or physical examination, then AST, ALT, and fasting glucose levels should also be measured.
<b>Decision Variable</b>	BMI is 85th to 94th percentile for age and gender
<b>Decision Variable</b>	risk factors in the history or physical examination
<b>Action</b>	Measure fasting lipid profile, AST, ALT, and fasting glucose levels
<b>Reference</b>	Empty
<b>Reason</b>	Empty
<b>Strength of Recommendation</b>	Empty
<b>Quality of Evidence</b>	Empty
<b>Recommendation</b>	Assessment Recommendations - <i>Conditional</i> - If the BMI is andgt;95th percentile for age and gender, even in the absence of risk factors, then all of the tests listed for 85th to 94th percentile BMI with risk factors should be performed.
<b>Decision Variable</b>	BMI is andgt;95th percentile for age and gender
<b>Action</b>	Measure fasting lipid profile, AST, ALT, and fasting glucose levels
<b>Reference</b>	Empty
<b>Reason</b>	Empty
<b>Strength of Recommendation</b>	Empty
<b>Quality of Evidence</b>	Empty
<b>Recommendation</b>	Assessment Recommendations - <i>Imperative</i> - The expert committee recommends that physicians and allied health care providers perform, at a minimum, a yearly assessment of weight status for all children and that this assessment include calculation of height, weight (measured appropriately), and BMI for age and plotting of those measures on standard growth charts.
<b>Action</b>	Assess at a minimum yearly height, weight and BMI for age
<b>Action</b>	Plot those measures on standard growth charts
<b>Reference</b>	Empty
<b>Reason</b>	Empty
<b>Quality of Evidence</b>	Empty
<b>Recommendation</b>	Assessment Recommendations - <i>Imperative</i> - the expert committee recommends that individuals 2 to 18 years of age with BMI of 95th percentile for age and gender or BMI of 30 (whichever is smaller) should be considered obese and individuals with BMI of 85th percentile but 95th percentile for age and gender should be considered overweight; this term replaces "at risk of overweight."
<b>Action</b>	Empty
<b>Reference</b>	Empty
<b>Reason</b>	Empty
<b>Quality of Evidence</b>	Empty
<b>Recommendation</b>	Assessment Recommendations - <i>Imperative</i> - The expert committee recommends the use of 99th percentile BMI values for age as cutoff points (indicated by using a table with cutoff points for the 99th percentile BMI according to age and gender), to allow for improved accessibility of the data in the clinical setting and for additional study.
<b>Action</b>	use 99th percentile BMI values for age as cutoff points to allow for improved accessibility of the data in the clinical setting and for additional study
<b>Reference</b>	Empty

<i>Reason</i>	use of 99th percentile BMI values for age as cutoff points (indicated by using a table with cutoff points for the 99th percentile BMI according to age and gender), to allow for improved accessibility of the data in the clinical setting and for additional study
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Assessment Recommendations - <i>Imperative</i> - The expert committee recommends that qualitative assessment of dietary patterns for all pediatric patients be conducted at each well child visit for anticipatory guidance and readiness to change and identification of the following specific dietary practices, which may be targets for change: frequency of eating outside the home, excessive consumption of sweetened beverages, consumption of excessive portion sizes for age
<i>Action</i>	qualitatively assess dietary patterns at a minimum, at each well-child visit for anticipatory guidance
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	Assessment Recommendations - <i>Imperative</i> - The expert committee recommends that physicians and allied health care providers obtain a focused family history for obesity, type 2 diabetes mellitus, cardiovascular disease (particularly hypertension), and early deaths resulting from heart disease or stroke, to assess the risks of current or future comorbidities associated with a child's overweight or obese status.
<i>Action</i>	obtain a focused family history for obesity, type 2 diabetes mellitus, cardiovascular disease (particularly hypertension), and early deaths resulting from heart disease or stroke
<i>Reference</i>	Empty
<i>Reason</i>	to assess the risks of current or future comorbidities associated with a child's overweight or obese status
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	RECOMMENDATIONS FOR PREVENTION OF CHILDHOOD OBESITY: Patient-Level Interventions - <i>Conditonal</i> - 1. The expert committee recommends that physicians and allied health care providers counsel the following for children 2 to 18 years of age whose BMI is 5th to 84th percentile: (a) limiting consumption of sugar-sweetened beverages (consistent evidence); (b) encouraging diets with recommended quantities of fruits and vegetables (mixed evidence); (c) limiting television and other screen time by allowing no more than 2 hours per day, as advised by the American Academy of Pediatrics (consistent evidence), and removing television and computer screens from children's primary sleeping areas (consistent evidence);
<i>Decision Variable</i>	2 to 18 years of age
<i>Decision Variable</i>	BMI is 5th to 84th percentile
<i>Action</i>	Counsel: limiting consumption of sugar-sweetened beverages (consistent evidence)
<i>Action</i>	Counsel: encouraging diets with recommended quantities of fruits and vegetables (mixed evidence)
<i>Action</i>	Counsel: limiting television and other screen time by allowing no more than 2 hours per day
<i>Action</i>	Counsel: removing television and computer screens from children's primary sleeping areas (consistent evidence)
<i>Action</i>	Counsel: eating breakfast daily (consistent evidence)
<i>Action</i>	Counsel: limiting eating at restaurants, particularly fast food restaurants (consistent evidence)
<i>Action</i>	Counsel: encouraging family meals in which parents and children eat together (consistent evidence)
<i>Action</i>	Counsel: limiting portion sizes (consistent evidence)
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Strength of Recommendation</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	RECOMMENDATIONS FOR PREVENTION OF CHILDHOOD OBESITY: Patient-Level Interventions - <i>Imperative</i> - 2. The expert committee also suggests that providers counsel families to engage in the following behaviors: (a) eating a diet rich in calcium; (b) eating a diet high in fiber; (c) eating a diet with balanced macronutrients (energy from fat, carbohydrates, and protein in proportions appropriate for age, as recommended by Dietary Reference Intakes); (d) initiating and maintaining breastfeeding; (e) participating in 60 minutes of moderate to vigorous physical activity per day for children of healthy weight (the 60 minutes can be accumulated throughout the day, rather than in single or long bouts; ideally, such activity should be enjoyable to the child); and (f) limiting consumption of energy-dense foods.
<i>Action</i>	Counsel: eating a diet rich in calcium
<i>Action</i>	Counsel: eating a diet high in fiber
<i>Action</i>	Counsel: eating a diet with balanced macronutrients
<i>Action</i>	Counsel: initiating and maintaining breastfeeding
<i>Action</i>	Counsel: participating in 60 minutes of moderate to vigorous physical activity per day
<i>Action</i>	Counsel: limiting consumption of energy-dense foods.
<i>Reference</i>	Empty
<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	RECOMMENDATIONS FOR PREVENTION OF CHILDHOOD OBESITY: Practice-and Community-Level Interventions - <i>Imperative</i> - 1. The expert committee recommends that physicians, allied health care professionals, and professional organizations (a) advocate for the federal government to increase physical activity at schools through intervention programs from grade 1 through the end of high school and college and through the creation of school environments that support physical activity in general and (b) support efforts to preserve and to enhance parks as areas for physical activity, inform local development initiatives regarding the inclusion of walking and bicycle paths, and promote families' use of local physical options by making information and suggestions about physical activity alternatives available in doctors' offices.
<i>Action</i>	advocate for the federal government to increase physical activity at school
<i>Action</i>	support efforts to preserve and to enhance parks as areas for physical activity, inform local development initiatives regarding the inclusion of walking and bicycle paths, and promote families' use of local physical options by making information and suggestions about physical activity alternatives available in doctors' offices
<i>Reference</i>	Empty

<i>Reason</i>	Empty
<i>Quality of Evidence</i>	Empty
<i>Recommendation</i>	RECOMMENDATIONS FOR PREVENTION OF CHILDHOOD OBESITY: Practice-and Community-Level Interventions - <i>Imperative</i> - 2. The expert committee recommends the use of the following techniques to aid physicians and allied health care providers who may wish to support obesity prevention in clinical, school, and community settings: (a) actively engaging families with parental obesity or maternal diabetes, because these children are at increased risk for developing obesity even if they currently have normal BMI; (b) encouraging an authoritative parenting style (authoritative parents are both demanding and responsive) in support of increased physical activity and reduced sedentary behavior, providing tangible and motivational support for children; (c) discouraging a restrictive parenting style (restrictive parenting involves heavy monitoring and controlling of a child's behavior) regarding child eating; (d) encouraging parents to model healthy diets and portions sizes, physical activity, and limited television time; and (e) promoting physical activity at school and in child care settings (including after-school programs) by asking children and parents about activity in these settings during routine office visits.
<i>Action</i>	actively engaging families with parental obesity or maternal diabetes,
<i>Action</i>	encouraging an authoritative parenting style
<i>Action</i>	discouraging a restrictive parenting style regarding child eating
<i>Action</i>	encouraging parents to model healthy diets and portions sizes, physical activity, and limited television time;
<i>Action</i>	promoting physical activity at school and in child care settings
<i>Reference</i>	Empty
<i>Reason</i>	because these children are at increased risk for developing obesity even if they currently have normal BMI;
<i>Quality of Evidence</i>	Empty
<b>(15) Potential benefits and harms</b>	<i>Describe anticipated benefits and potential risks associated with implementation of guideline recommendations.</i>
<i>Health Outcomes</i>	Empty
<i>Cost Analysis</i>	Empty
<i>Description of Harms and Benefits</i>	Empty
<i>Quantification of Harms and Benefits</i>	Empty
<i>Alternative Practices Risks</i>	Empty
<b>(16) Patient preferences</b>	<i>Describe the role of patient preferences when a recommendation involves a substantial element of personal choice or values.</i>
<i>Role of Patient Preferences</i>	Empty
<b>(17) Algorithm</b>	<i>Provide (when appropriate) a graphical description of the stages, and decisions in clinical care described by the guideline.</i>
<i>Algorithm</i>	Empty
<i>Action Steps</i>	Empty
<i>Conditional Steps</i>	Empty
<i>Alternative Steps</i>	Empty
<i>Synchronization Step</i>	Empty
<b>(18) Implementation considerations</b>	<i>Describe anticipated barriers to application of the recommendations. Provide reference to any auxiliary documents for providers or patients that are intended to facilitate implementation. Suggest review criteria for measuring changes in care when the guideline is implemented.</i>
<i>Implementation Plan</i>	Empty
<i>Implementation Strategy</i>	Empty
<i>Supporting Documents</i>	Empty
<i>Patient Resources</i>	Empty
<i>Anticipated Enabler</i>	Empty
<i>Anticipated Barrier</i>	Empty
<i>Quick Reference Guide</i>	Empty
<i>Technical Report</i>	Empty