

# American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



## *Council on Community Pediatrics Rural Health Special Interest Group July 2007*

### ***Fresh Start for Kids – An Obesity Clinic in Rural Michigan*** by Sarah Campbell, MD, FAAP

As a pediatrician, we are all aware of the epidemic of childhood obesity. It is estimated that the prevalence of obesity is almost 16%, a rate which has more than quadrupled in the last 30 years. We encounter it daily in our practices, from toddlers to teenagers - with the rising costs of food, busy lifestyles, and limited resources available to families, our rural community in the western part of the Upper Peninsula of Michigan is no exception.

In October of 2005, the Portage Health Medical Group in Hancock, Michigan, started **Fresh Start for Kids**, a monthly obesity clinic, funded in part by an AAP Catch Grant. The families meet individually with a registered dietician, an exercise physiologist, a social worker, and a pediatrician. We focus on lifestyle changes – nutrition, exercise, screening for depression/social concerns, and the medical complications of obesity. The goal of the clinic is to make long term patient change – from initial weight stability, to the ultimate reduction in Body Mass Index (BMI)/weight. The catch grant was beneficial in helping support our exercise physiologist, nutritionist, and program materials during the first few months of implementing the clinic. Now we rely primarily on reimbursement for the physician component of the monthly clinic to help cover the fees for the nutritionist and exercise physiologist. Needless to say, creative coding does come into play.

Our patients are mostly self-referrals, responding to newspaper advertisements, as well as referrals from area physicians. The majority of our patients have BMI > 95% for age; most have had a long standing weight problem; many have family histories of obesity, diabetes, and/or early heart disease. Every patient is screened for complications from obesity, we have diagnosed dyslipidemia, elevated cholesterol, insulin resistance, depression and exercise induced asthma.

Over the first 18<sup>th</sup> months of our clinic, we unfortunately have seen many families come and go. Many families were looking for quick fixes, easy solutions, and were resistant to acknowledge problems with the family's approach to food. We currently have approximately 10 families who have spent over six months in the clinic. No patient has been placed on a meal plan; rather we are focusing on the patient and the family's approach to food, and suggest making small changes monthly. While patients struggle with not being able to see immediate major results, we are beginning to see positive changes in the approach the families and patients have with food. They are learning to recognize the smaller, but equally important incremental successes along the way, which hopefully will carry over a lifetime. Many patients actually had an initial increase in their weight and BMI, but now in subsequent months are achieving stabilization in their weight, along with either a decrease or stabilization in their BMI.

Although many aspects of the monthly clinics are challenging, it has been rewarding to begin to see positive changes in the patients and families. We have discovered that a team approach, consistent follow-up, and allowing patients to make slow, steady lifestyle changes, we appear to be making small, but significant improvements in our battle against childhood obesity. In a rural



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environment with limited resources, we are finding that ½ to one day a month is feasible for our staff to make the commitment to the clinic.

The biggest hurdle has been for families to make the lifestyle changes, especially with both financial and physical limitations. How do you have a child who gets federal subsidized breakfast and lunches work at choosing a salad bar (if available) over pizza day after day. How do you have a child go to the YMCA after school to play rather than watch TV/videos/etc, when there is no YMCA. How do you teach Mom and Dad the idea that they decide what and when the family eats (limit setting), and the child determines how much. How do you get families to change what they eat when fast food is cheaper than cooking on a limited budget? These are some of our ongoing problems, some unique to rural areas, others more universal problems we all face.

***Questions To Think About:***

1. What is the role of the physician regarding the health of our children in the school setting – gym class, recess, school lunch programs? Has the federal mandate for Wellness Policies for schools getting subsidized meals made a difference? (i.e. vending machines out of schools, certain nutritional standards etc).
2. Media – At a recent talk on obesity I attend ended, it is estimated that during 4 hours of Saturday morning cartoons, there are 202 ads aired for ‘junk-food’. Marketing is focused on the ‘purposeful’ nagging strategy which is harder for parents to resist. Marketing is also trying to get brand loyalty at young ages (i.e. if you drink X-brand soda in school from the vending machine, likely to drink X-brand soda over a lifetime). How do we combat this as clinicians and parents? How do parents combat this – besides the obvious – turning off the TV? How do we cover this in a 15 minute WCC block?
3. In the adult world, there is a growing belief that surgery can ‘cure’ morbid obesity and its complications. Most patients have resolution of their Type 2 DM, Dyslipidemia, HTN. Most pediatric bariatric surgery centers have strict criteria to be eligible for adolescent surgery (banding and gastric-bi-pass) including BMI > 50 with severe or less severe co-morbidity or greater than 40 with severe co-morbidities (Type 2 DM, Obstructive sleep apnea, pseudotumor cerebri, Metabolic Syndrome, Weight related arthropathies which impair physical activity), and have failed 6-12 months of intensive, multi-disciplinary, physician supervised weight management program. In rural areas, if we have children who meet these criteria and are in fact going to have worsening severe complications from their obesity and become greater surgical risks as they age, should we be referring them to centers for surgical evaluation, and if so, are we prepared for the close-post-op monitoring while under our care (a life time of monitoring).
4. In rural areas, typical gyms (i.e. YMCA, Boys & Girls Clubs) may not be available for our patients to go to. What strategies can we give families on staying fit and active, especially for our single-parent, impoverished families?
5. WIC – in many rural areas, a large percentage of our patients qualify for WIC and the services they provide. Do you find that your families are less likely to breast feed (economic and beneficial for infants with potential to decrease obesity) because they are

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offered free formula? What about all the juice that is provided, are families teaching kids to drink sugary beverages from the start, thinking it is 'healthy' because they are offered it?