

Evaluation and Treatment of Children and Adolescents with Obesity

An AAP Clinical Practice Guideline



Learning Objectives

- Review the Key Elements of the 2023 AAP CPG on Obesity
- Discuss how the guidelines can be implemented in the primary care setting
- Review the comorbidities of obesity
- Discuss treatment approaches for obesity, with a lens inclusive of treating obesity comorbidities

Obesity is a complex chronic disease

- Obesity is often an indicator of structural inequities like unjust food systems, health inequities and environmental & community factors
- Genetics, obesity-promoting environments, life experiences combined with inequities and structural barriers to healthy living all contribute to overweight and obesity

Social and Environmental Risk – Context for Comorbidity Risk

We now recognize that race is not a biological construct.

So the association between:

- ethnicity,
- race,
- obesity, and
- comorbidities

most likely reflects the impact of epigenetic, social, and environmental factors, such as SDoHs (i.e. limited food access, low SES, exposure to structural racism, neighborhood deprivation, etc.)



Methodology – Scope of the Review

Key Question 1

What are clinic-based, effective treatments for obesity?

Key Question 2

What is the risk of comorbidities among children with obesity?

Original search period ended April 6, 2018.
An additional search was conducted covering the time period April 7, 2018 - February 15, 2020.

- 15 988 Articles screened
- 1642 Full text articles reviewed
- 382 Studies included

CPG By the Numbers

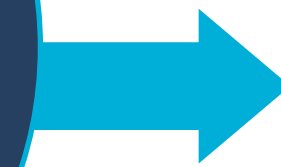
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Years Since Last
Comprehensive
Guidance

**16K Abstracts
Reviewed**



1642
Full Text
Articles



382
Studies
Included



13

CPG Key Action
Statements



11

CPG Consensus
Recommendations



2

Technical
Reports

New from previous recommendations



NEW

- Offer treatment early and immediately – **there is no benefit to watchful waiting**
- Treat obesity and comorbid conditions **concurrently**
- There are **multiple evidence-based strategies** that can be used collectively to deliver intensive & tailored obesity treatment
- **Structured, supervised** weight management interventions **decrease current & future eating disorder symptoms**

Obesity Bias

- Bias is prevalent in the setting of healthcare and can be unconscious
- Individuals who have obesity have suffered years of bias/stigma in healthcare settings, school, and in home environments
- You can take an on-line test to help you understand your own bias

[Take a Test \(harvard.edu\)](https://www.harvard.edu/obesity-bias-test)

- Internalized weight bias should be recognized and is treatable

Communication of Weight Status – this can be hard and charged

A couple key things to keep in mind.....

- It can be very helpful to ask permission to discuss growth concerns
- Using extended growth curves and discussion of health risk can help switch the conversation from weight to health
- Using person first language is important - describing a patient as having obesity, not being obese
- Your choice of words is critical - and having phrases on hand might be helpful
 - “your weight might be putting you at risk for health concerns”,
 - “it looks like you might be gaining weight faster than you are growing tall”

Allowing the family to have a safe space to understand and process the complexity of obesity and its chronicity *requires tact, empathy, and humility*. Achieving this goal enables the patient and family to gain the knowledge and understanding needed to recognize risk factors in their environment and behaviors, to honor cultural preferences, and to institute changes independently as well as under the guidance of a trusted and well-trained advocate—such as pediatricians and other PHCPs

- AAP Clinical Practice Guideline



CPG

Evaluation & Treatment
of Pediatric Obesity

Evaluation

Recommendations

Assessment & Evaluation KAS Topics



BMI Measurement



Comprehensive Evaluation
(PE, ROS, Hx, etc)



Risk Assessment
(Whole child)

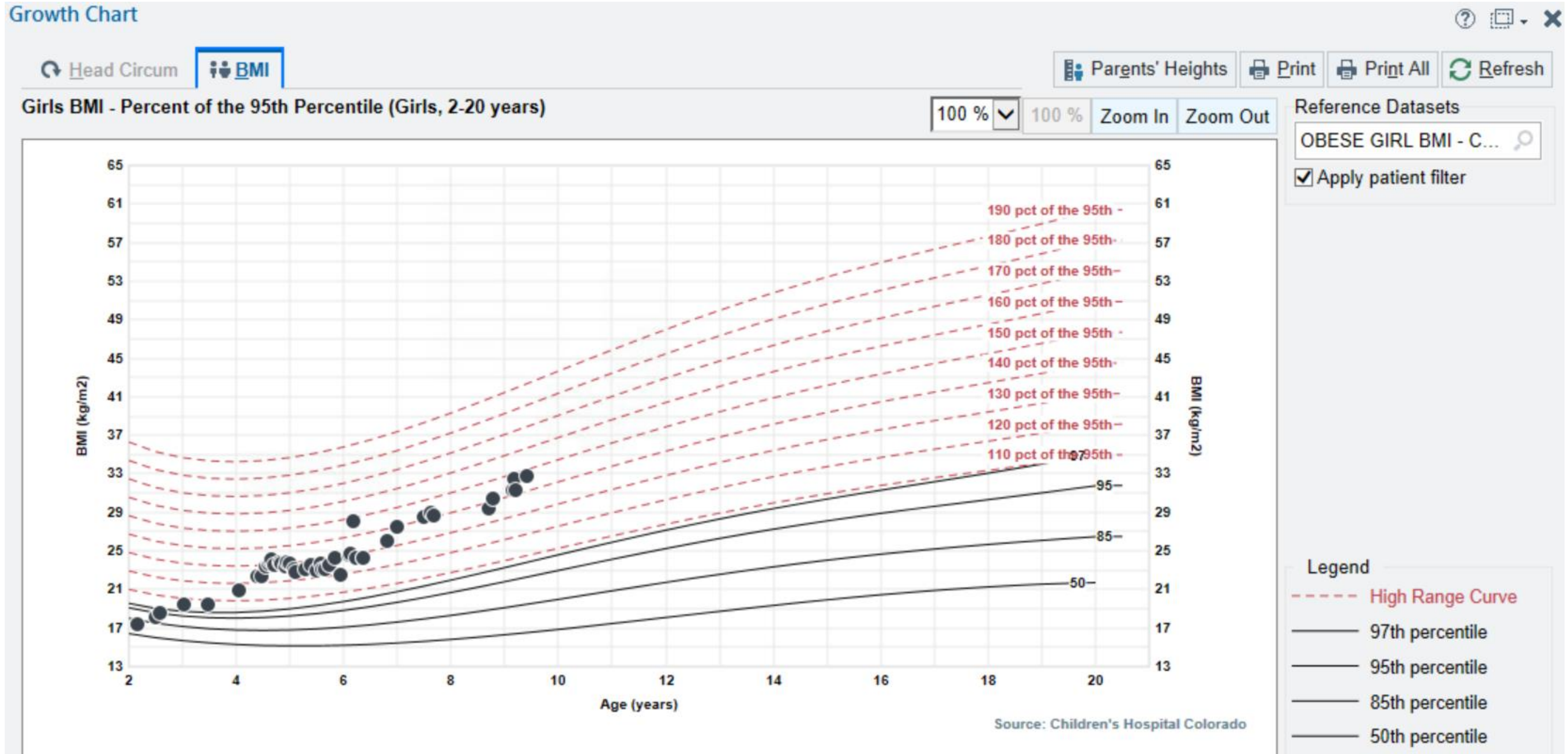


Comorbidity Evaluation
(labs, tests)

BMI Measurement

KAS 1. Pediatricians and other PHCPs **should measure height and wt, calculate BMI, and assess BMI percentile using age- and sex-specific CDC growth charts** or growth charts for children with severe obesity at least annually **for all children 2 to 18 y of age** to screen for overweight (BMI \geq 85th percentile to $<$ 95th percentile), obesity (BMI \geq 95th percentile), and severe obesity (BMI \geq 120% of the 95th percentile for age and sex).

Tracking BMI with extended growth charts



Evaluate for Comorbid Conditions

KAS 2. Pediatricians and other PHCPs should evaluate children 2 to 18 y of age with overweight (BMI \geq 85th percentile to $<$ 95th percentile) and obesity (BMI \geq 95th percentile) for obesity-related comorbidities by using a comprehensive patient history, mental and behavioral health screening, SDoH evaluation, physical examination, and diagnostic studies.

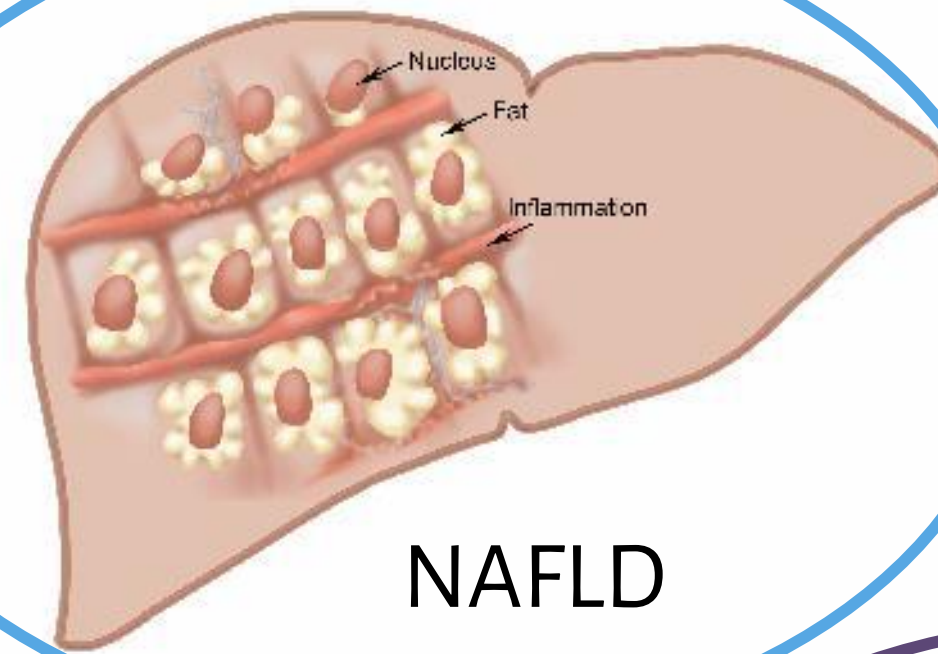
Additional evaluation considerations

- Social history
- Nutrition and PA history
- Assessment of disordered eating and behavioral and mental health
- Physical Examination
- Assessment of Readiness to change

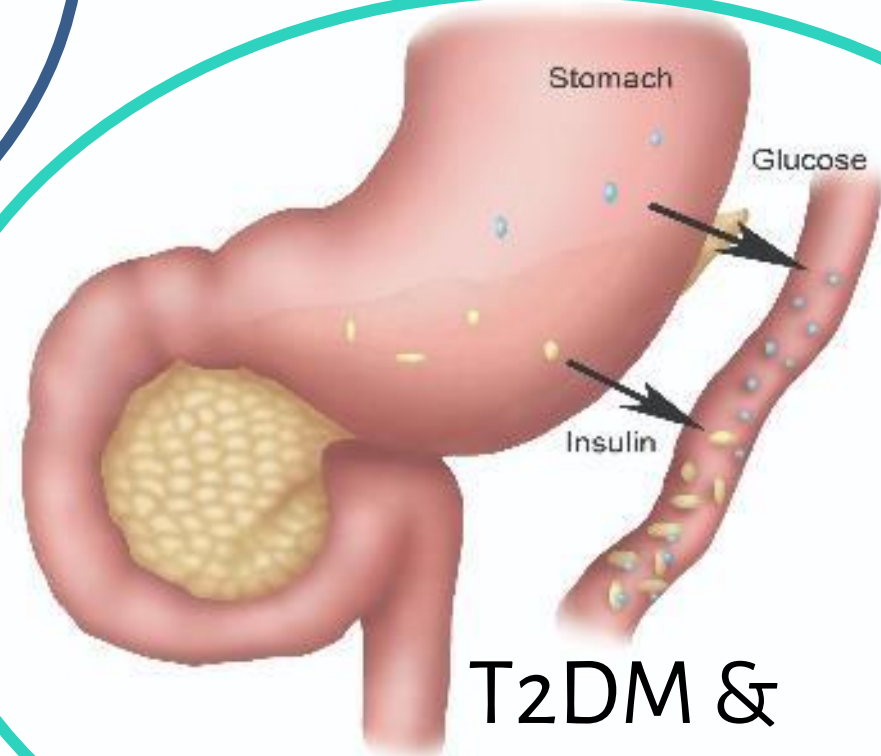
Comorbidities Addressed Include



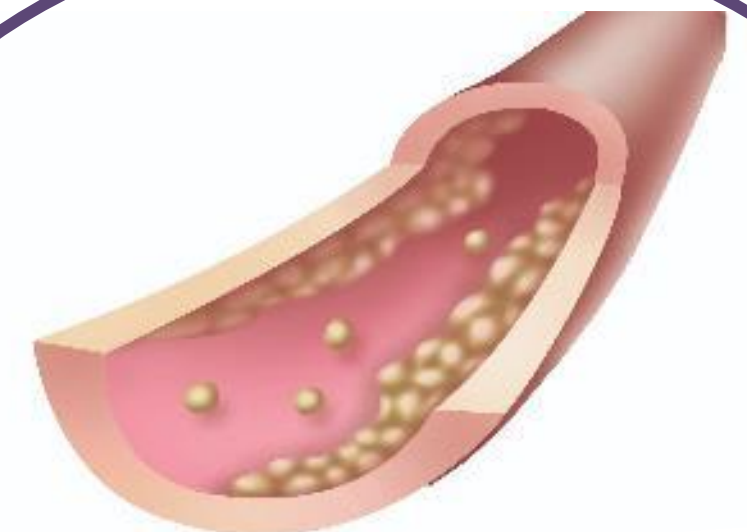
Hypertension



NAFLD



T2DM &
Prediabetes



Dyslipidemia

Lab Evaluation

KAS 3. In children 10 y and older, pediatricians and other PHCPs should **evaluate for lipid abnormalities, abnormal glucose metabolism, and abnormal liver function** in children and adolescents **with obesity** (BMI \geq 95th percentile) and for **lipid abnormalities in children and adolescents with overweight** (BMI \geq 85th percentile to <95th percentile).

KAS 3.1. In children 10 y and older with overweight (BMI \geq 85th percentile to <95th percentile), pediatricians and other PHCPs may evaluate for **abnormal glucose metabolism and liver function** in the presence of risk factors for T2DM or NAFLD. In children 2 to 9 y of age with obesity (BMI \geq 95th percentile), pediatricians and other PHCPs may evaluate for lipid abnormalities.

Concurrent Treatment KAS

KAS 4: Pediatricians and other PHCPs should treat children and adolescents for overweight (BMI \geq 85th percentile to <95th percentile) or obesity (BMI \geq 95th percentile) and comorbidities concurrently.

Laboratory and Diagnostic Screening KAS

Dyslipidemia

KAS 5. Pediatricians and other PHCPs should evaluate for dyslipidemia by obtaining a fasting lipid panel in children 10 y and older with overweight (BMI \geq 85th percentile to $<$ 95th percentile) and obesity (BMI \geq 95th percentile) and may evaluate for dyslipidemia in children 2 through 9 y of age with obesity.

Laboratory and Diagnostic Screening KAS

Prediabetes and Diabetes Mellitus

KAS 6. Pediatricians and other PHCPs **should evaluate for prediabetes and/or diabetes mellitus** with fasting plasma glucose, 2-h plasma glucose after 75-g oral glucose tolerance test (OGTT), or glycosylated hemoglobin (HbA1c)

Laboratory and Diagnostic Screening KAS

NAFLD

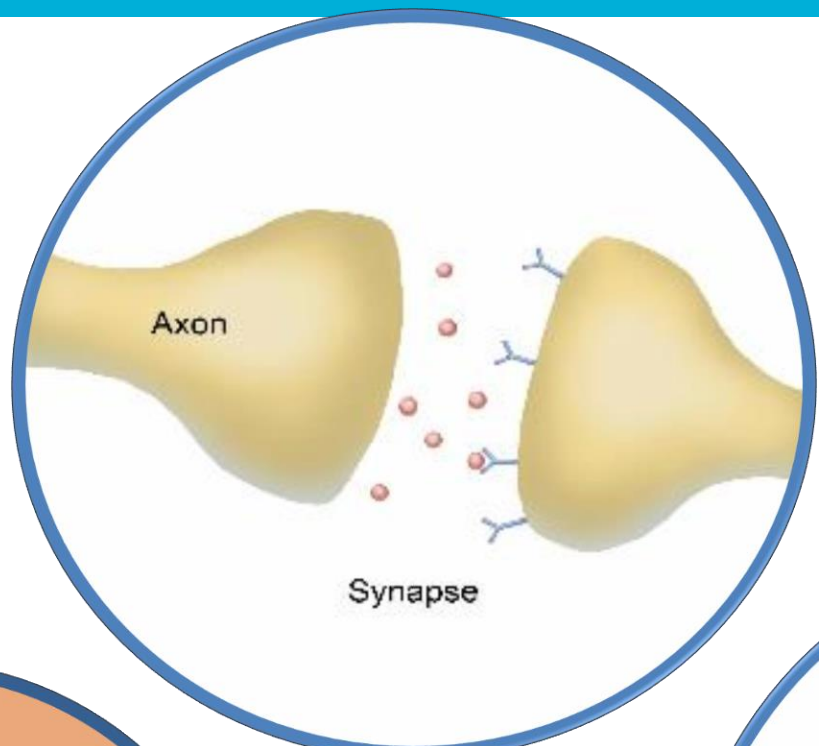
KAS 7. Pediatricians and other PHCPs should evaluate for NAFLD by obtaining an alanine transaminase (ALT) test.

Laboratory and Diagnostic Screening KAS

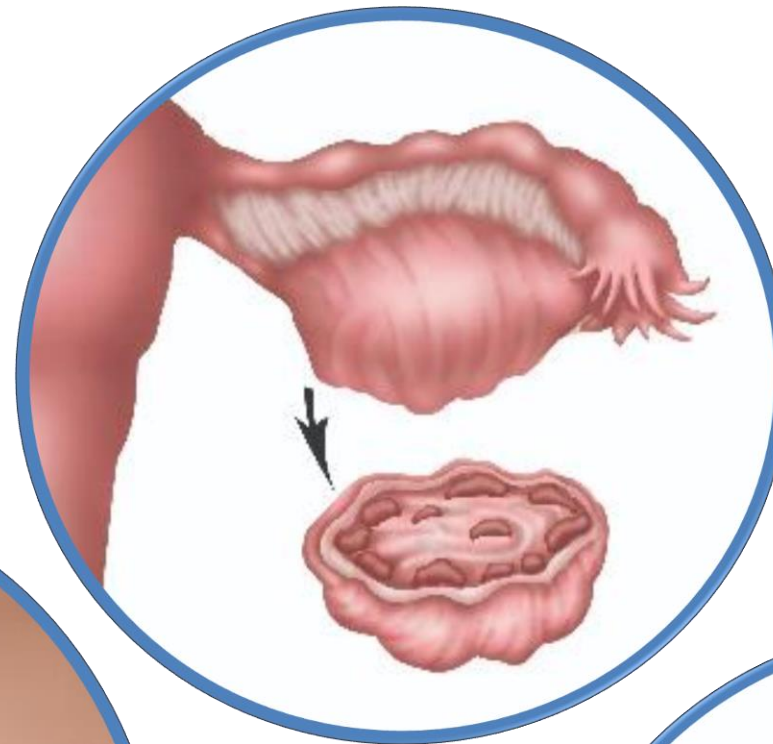
Hypertension

KAS 8. Pediatricians and other PHCPs should evaluate for hypertension by measuring blood pressure at every visit starting at 3 y of age in children and adolescents with overweight (BMI ≥ 85 to < 95 th percentile) and obesity (BMI ≥ 95 th percentile).

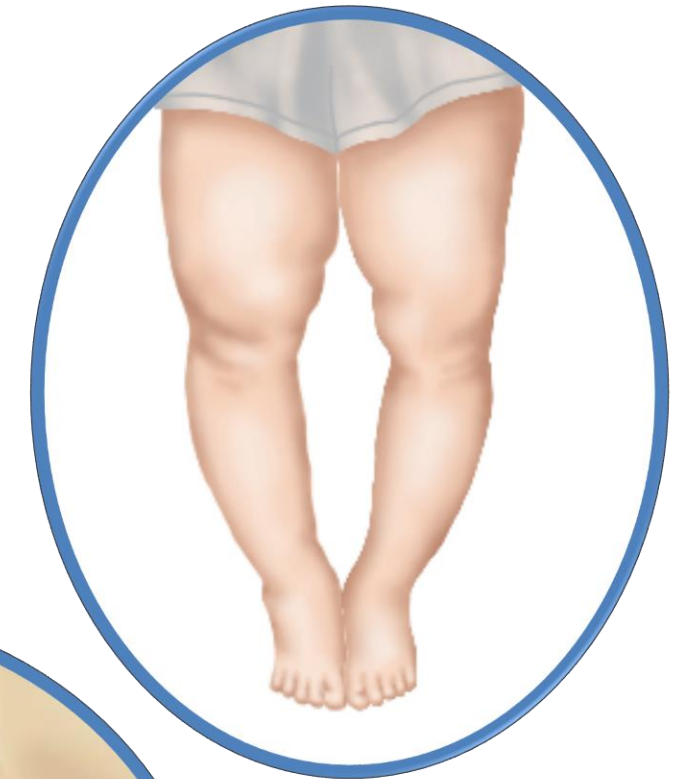
Comorbidities Addressed Include



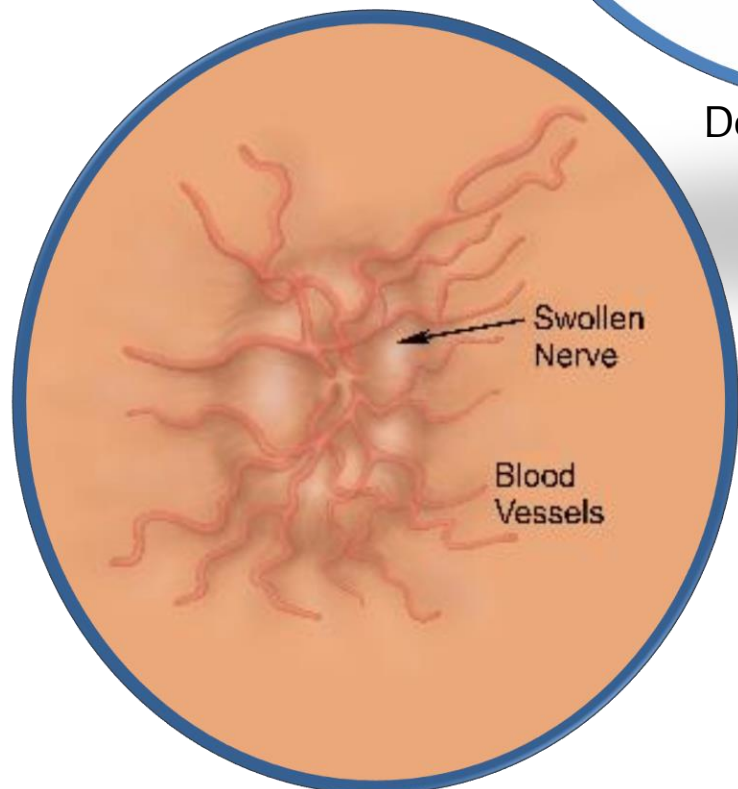
Depression



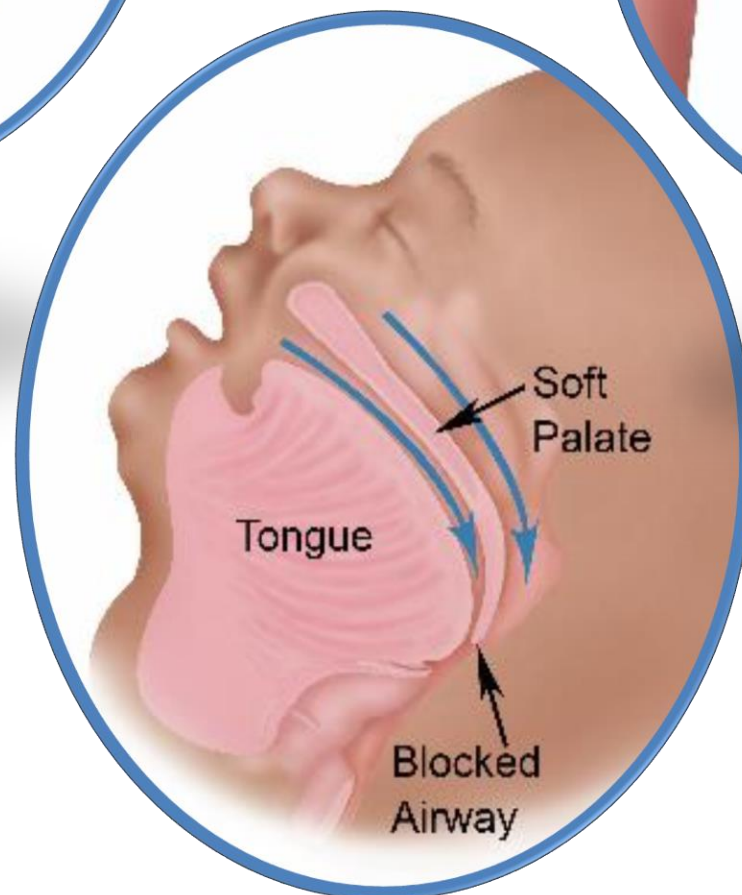
PCOS



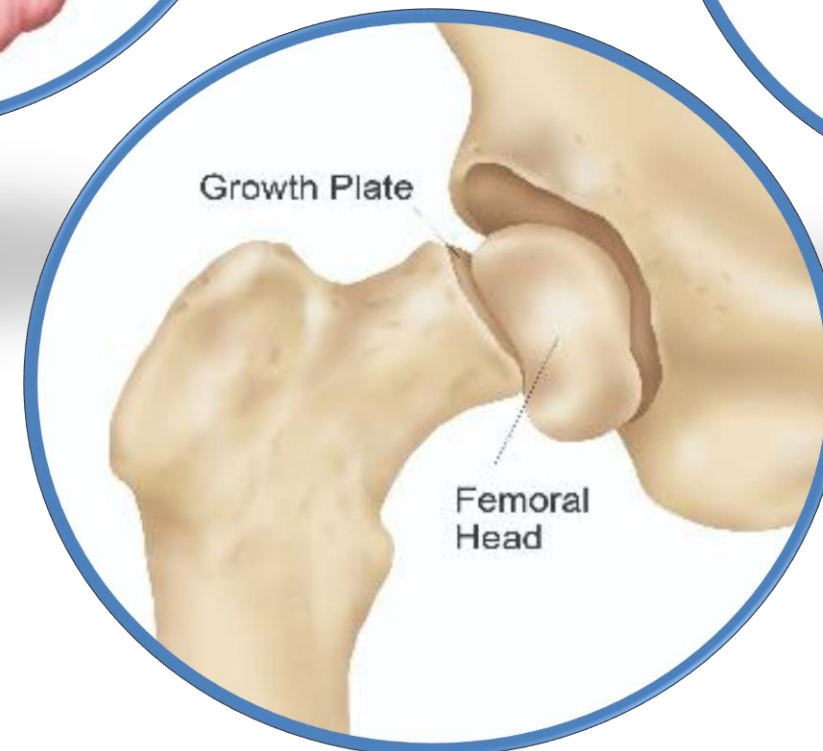
Blount disease



Idiopathic Intracranial Hypertension



Obstructive Sleep Apnea



SCFE

Consensus Recommendations for Other Comorbid Conditions

Comorbid Condition	Consensus Recommendation
OSA	<ul style="list-style-type: none">• Obtain a sleep history, including symptoms of snoring, daytime somnolence, nocturnal enuresis, morning headaches, and inattention, among children and adolescents with obesity to evaluate for OSA.• Obtain a polysomnogram for children and adolescents with obesity and at least one symptom of disordered breathing.
PCOS	<ul style="list-style-type: none">• Evaluate for menstrual irregularities and signs of hyperandrogenism (ie, hirsutism, acne) among female adolescents with obesity to assess risk for PCOS.
Depression	<ul style="list-style-type: none">• Monitor for symptoms of depression in children and adolescents with obesity and conduct annual evaluation for depression for adolescents 12 years and older with a formal self-report tool.
Blount	<ul style="list-style-type: none">• Perform a musculoskeletal review of systems and physical examination (eg, internal hip rotation in growing child, gait) as part of their evaluation for obesity.
SCFE	<ul style="list-style-type: none">• Recommend immediate and complete activity restriction, non–weight-bearing with use of crutches, and refer to an orthopedic surgeon for emergent evaluation, if SCFE is suspected. PHCPs may consider sending the child to an emergency department if an orthopedic surgeon is not available.
IIH	<ul style="list-style-type: none">• Maintain a high index of suspicion for IIH with new-onset or progressive headaches in the context of significant weight gain, especially for females.



CPG

Evaluation & Treatment
of Pediatric Obesity

Treatment

Recommendations

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While representing such a broad spectrum of perspectives, **the members of this committee are all keenly aware of the multitude of barriers to treatment that patients and their families face. These barriers impact not only their access to treatment, but their ability to follow prescribed treatment plans. While some patients are able to adopt the lifestyle changes and habitualize elements of their prescribed treatment plans, so many others struggle to do so for a wide variety of reasons.** The members of the Subcommittee understand all of this. To assist with overcoming these barriers, guidance on a number of factors related to barriers to treatment, such as health [in]equity and multilevel risk factors, have been included in these guidelines.

- Doug Lunsford, Family Representative CPG Subcommittee

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Comprehensive Obesity Treatment KAS

KAS 9. Pediatricians and other PHCPs **should treat overweight** (BMI \geq 85th percentile to <95th percentile) and **obesity** (BMI \geq 95th percentile) in children and adolescents, following the principles of the **medical home** and the **chronic care model**, using a **family-centered** and **non-stigmatizing** approach that acknowledges **obesity's biologic, social, and structural drivers**.

Provide the most intensive longitudinal treatment in the medical home....



Provide or ensure ongoing medical evaluation & monitoring
What is happening with this patient and family physically, emotionally, and socially?



Develop & implement an individualized comprehensive treatment plan, using evidence-based strategies
What can help the patients & family develop & reach treatment goals and treat comorbidities?



Tailor treatment as needed
What else is needed to support the patient & family's immediate needs & longitudinal treatment progress?



Serve as medical home
What care coordination and/or advocacy does this patient/family need?



PCP & PHCP Evidence-Based Toolbox



Motivational Interviewing



Intensive Health Behavior & Lifestyle Treatment



Pharmacotherapy

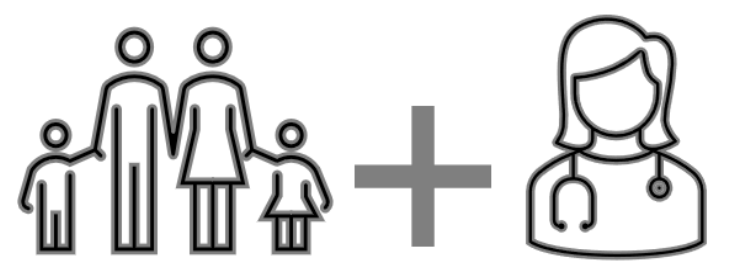


Surgery

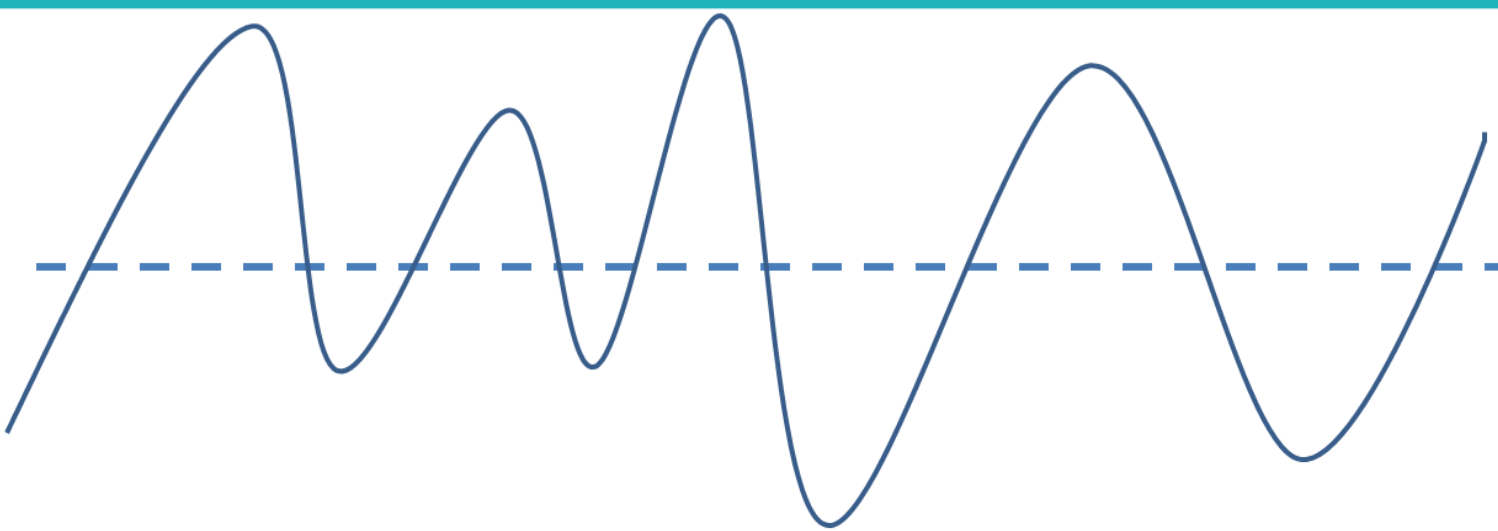
Treatment Experience of Obesity as a Chronic Disease

Longitudinal Non-Stigmatizing Care Coordinated Patient-Centered Treatment Across Lifespan

- Shared decision making with patient & family
- Culturally competent care
- Treatment coordinated in the medical home
- Transition planning



Patient & Family & PCP/PHCP Partnership



Treatment intensity & support vary to address relapsing & remitting nature of obesity as a chronic disease

Structural and Contextual Factors

- Access to Care
 - Weight Bias and Stigma
 - Obesogenic Environments
 - Adverse Child Experiences
 - Racism
 - Health Inequities
- That Impede & Influence Health & Treatment

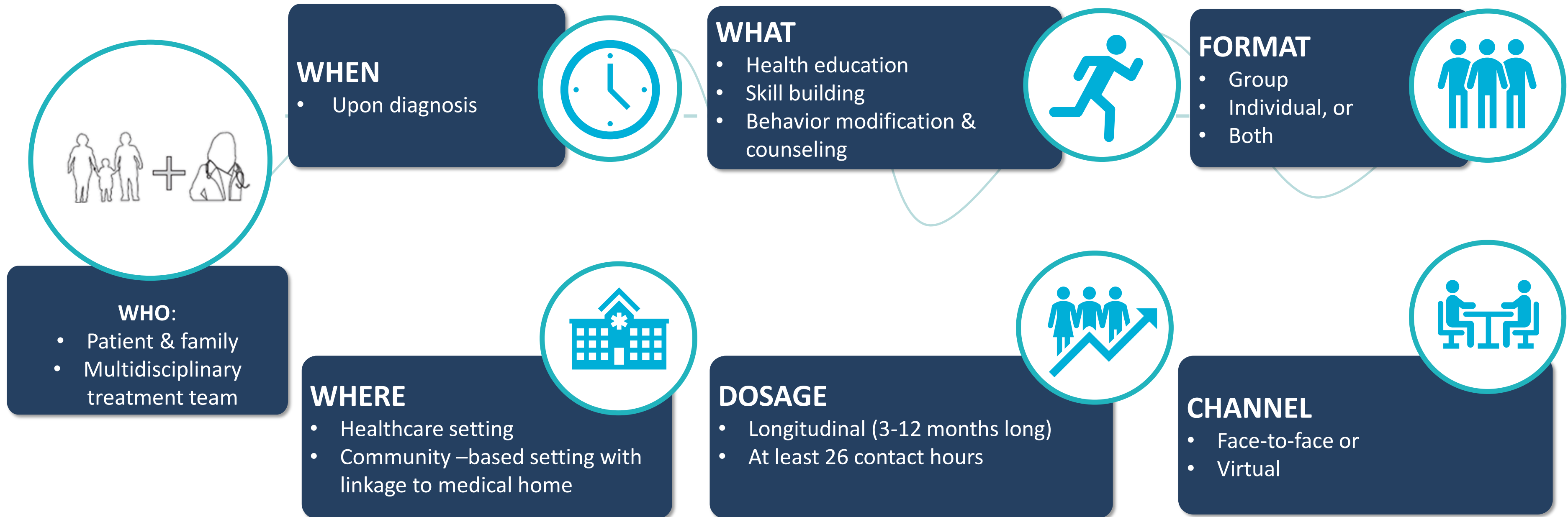
Motivational Interviewing KAS

KAS 10. Pediatricians and other PHCPs **should use motivational interviewing** (MI) to engage patients and families in treating overweight (BMI \geq 85th percentile to <95th percentile) and obesity (BMI \geq 95th percentile).

Intensive Health Behavior and Lifestyle Treatment KAS

KAS 11. Pediatricians and other PHCPs should provide or refer children 6 y and older (Grade B) and may provide or refer children 2 through 5 y of age (Grade C) with overweight (BMI \geq 85th percentile to $<$ 95th percentile) and obesity (BMI \geq 95th percentile) to intensive health behavior and lifestyle treatment. Health behavior and lifestyle treatment is more effective with greater contact hours; the most effective treatment includes 26 or more hours of face-to-face, family-based, multicomponent treatment over a 3- to 12-mo period

More about IHBLT



When IHBLT is not available

Deliver the best available intensive treatment to all children with overweight and obesity.

Build collaborations with other specialists and programs in their communities.

Pharmacotherapy

KAS 12. Pediatricians and other PHCPs **should offer adolescents 12 y and older with obesity** (BMI \geq 95th percentile) wt loss **pharmacotherapy**, according to medication indications, risks, and benefits, as an **adjunct to health behavior and lifestyle treatment**.

Consensus Recommendation: PHCPs may offer children ages 8 through 11 y of age with obesity wt loss pharmacotherapy, according to medication indications, risks, and benefits, as an adjunct to health behavior and lifestyle treatment.

Prescriber Qualifications

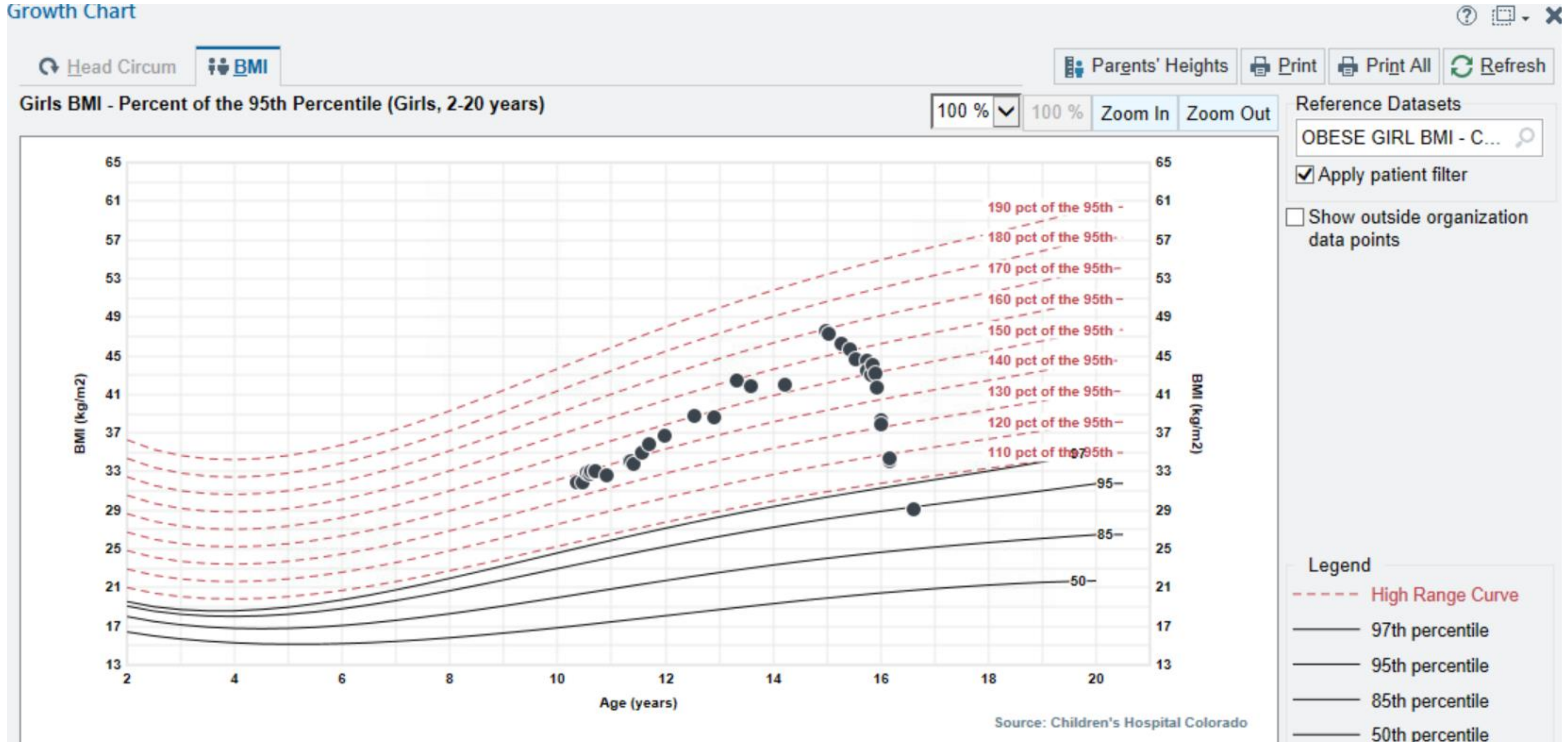
Pediatricians and other PHCPs who prescribe weight loss medications should have knowledge of:

- the patient selection criteria,
- medication efficacy,
- adverse effects, and
- follow-up monitoring guidelines
- injectable medications may require additional teaching for families that is not available in all primary care offices

Metabolic and Bariatric Surgery

KAS 13: Pediatricians and other PHCPs should offer referral for adolescents 13 y and older with severe obesity (BMI \geq 120% of the 95th percentile for age and sex) for evaluation for metabolic and bariatric surgery to local or regional comprehensive multidisciplinary pediatric metabolic and bariatric surgery centers.

Extended Growth Chart after MBS



Criteria for Pediatric Metabolic & Bariatric Surgery

TABLE 20

Criteria for Pediatric Metabolic and Bariatric Surgery⁷³³

Weight Criteria	Criteria for Comorbid Conditions
Class 2 obesity, BMI \geq 35 kg/m ² or 120% of the 95th percentile for age and sex, whichever is lower	Clinically significant disease; examples include but are not limited to T2DM, IIH, NASH, Blount disease, SCFE, GERD, obstructive sleep apnea (AHI >5), cardiovascular disease risks (HTN, hyperlipidemia, insulin resistance), depressed health-related quality of life.
Class 3 obesity, BMI \geq 40 kg/m ² or 140% of the 95th percentile for age and sex, whichever is lower	Not required but commonly present.

AHI, apnea-hypopnea index.

“

Start treatment immediately
and deliver it intensively.

- Sandra Hassink, MD, FAAP

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Putting It All Together

The Continuum of Obesity Care and the Role of PCP/PHCP

FOCUS	ROLE OF THE PEDIATRICIAN/PHCP
Diagnosis and Measurement	<ul style="list-style-type: none"> ✓ Measure height and weight ✓ Calculate BMI and assess BMI Percentile ✓ Communicate BMI and weight status to patient and family
Risk Factors	<ul style="list-style-type: none"> ✓ Assess individual, structural and contextual risk factors
Evaluation	<ul style="list-style-type: none"> ✓ Perform comprehensive patient history ✓ Conduct physical exam ✓ Evaluate for comorbidities ✓ Order relevant diagnostic studies and labs ✓ Assess readiness to change
Treat Comorbidities	<ul style="list-style-type: none"> ✓ Treat obesity and comorbidities concurrently
Treat Obesity	<ul style="list-style-type: none"> ✓ Manage children with overweight & obesity following principles of chronic care model & medical home ✓ Deliver non-stigmatizing care ✓ Use MI to engage patient and families in addressing overweight and obesity, set goals and promote participation or utilization of local resources or programs ✓ Promptly engage and refer children to intensive HBLT treatment, if available. If intensive HBLT treatment is not available in your area, deliver highest intensity HBLT treatment possible. ✓ Foster self-management strategies ✓ Refer to subspecialists if needed ✓ Serve as medical home, coordinate care, advocate for family, & support transition to adult care. ✓ Offer weight loss pharmacotherapy, to eligible patients, according to medication indications, risks, and benefits, as an adjunct to HBLT. ✓ For eligible patients with severe obesity, offer referral to a local or regional comprehensive multidisciplinary pediatric metabolic and bariatric surgery center for surgical evaluation.

Barriers to Implementation/Adoption of Clinical Practice Guidelines

Personal Factors

- Physician Knowledge (Awareness & familiarity)
- Physician Attitudes (Efficacy, skills, motivation, etc.)

Guideline-related Factors

- Complexity, plausibility, etc.
- Lack of evidence or clarity
- Poor layout and lack of applicability

External Factors

- Organizational constraints (standards, protocols, quality)
- Lack of collaboration (multi-professional cross collaboration)
- Social & clinical norms (consensus)

Advocacy Recommendations

- Promote supportive payment and public health policies that cover comprehensive obesity prevention, evaluation, and treatment
- Public health agencies, community organizations, health care systems, health care providers, and community members need to partner with each other to expand access to evidence-based pediatric obesity treatment programs
- Supportive payment and public health policies and partnerships between healthcare providers and key stakeholders are critical to expand access to evidence based care
- Improved Education and Training for medical learners and practitioner



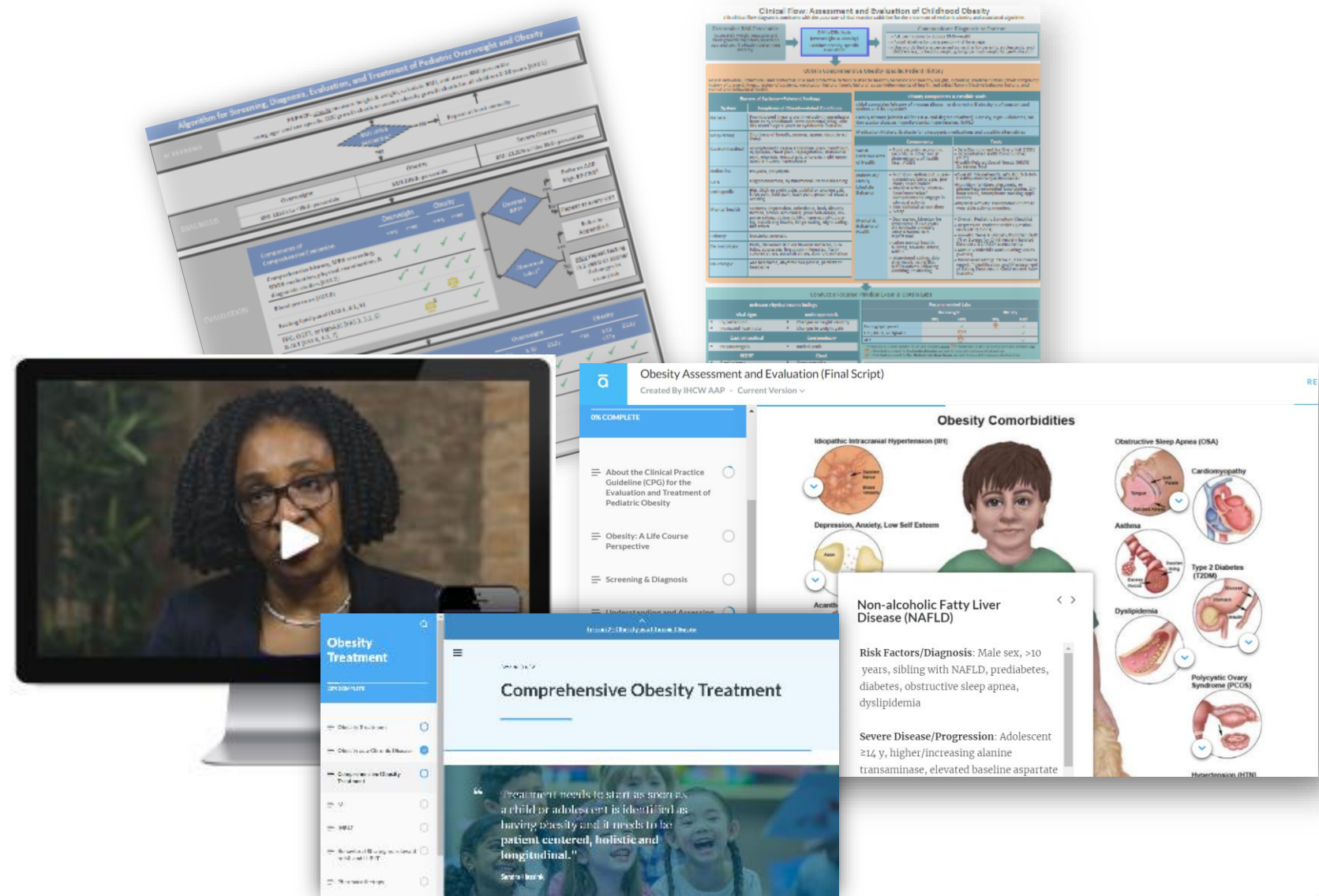
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Evaluation & Treatment
of Pediatric Obesity

**AAP Clinical
Implementation
Resources**

AAP Resources & Website

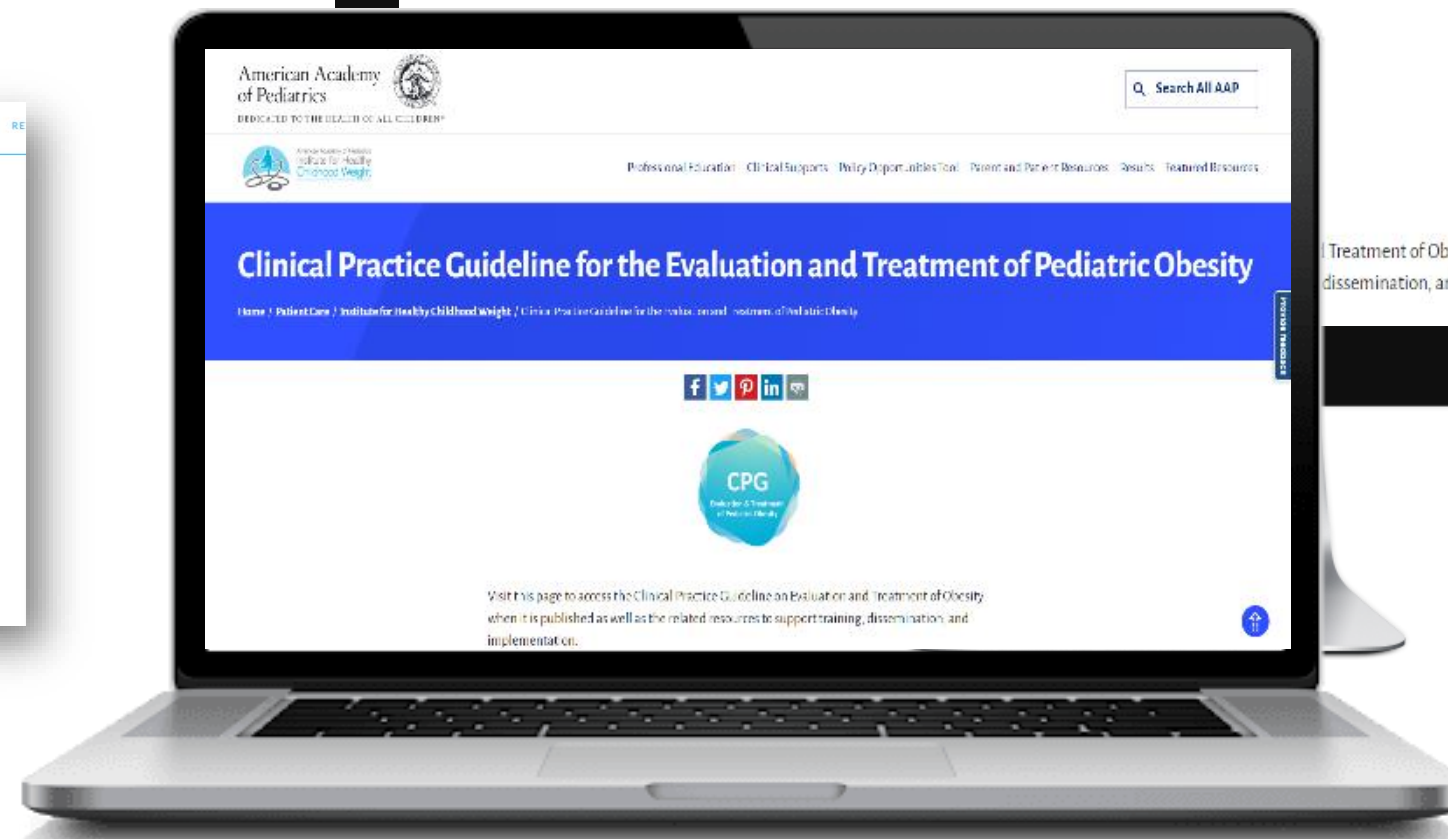
www.aap.org/obesitycpg 



This collage displays various AAP resources for pediatric obesity. It includes a flowchart titled "Algorithm for Screening, Diagnosis, Evaluation, and Treatment of Pediatric Overweight and Obesity" with decision points for BMI percentiles and comorbidity screening. A video player shows a woman speaking. A "Comprehensive Obesity Treatment" page features a quote: "Treatment needs to start as soon as a child or adolescent is identified as having obesity and it needs to be patient centered, holistic and longitudinal." Another page titled "Obesity Assessment and Evaluation (Final Script)" lists "Obesity Comorbidities" such as Idiopathic Intracranial Hypertension (IIH), Depression, Anxiety, Low Self-Esteem, Non-alcoholic Fatty Liver Disease (NAFLD), Obstructive Sleep Apnea (OSA), Cardiovascular, Asthma, Type 2 Diabetes (T2DM), Dyslipidemia, and Polycystic Ovary Syndrome (PCOS). The NAFLD section lists risk factors and diagnosis criteria: "Risk Factors/Diagnosis: Male sex, >10 years, sibling with NAFLD, prediabetes, diabetes, obstructive sleep apnea, dyslipidemia" and "Severe Disease/Progression: Adolescent ≥14 y, higher/increasing alanine transaminase, elevated baseline aspartate".



The desktop view of the AAP website features the header "American Academy of Pediatrics" with the tagline "DEDICATED TO THE HEALTH OF ALL CHILDREN®". A search bar is located in the top right. The main navigation menu includes "Professional Education", "Clinical Supports", "Policy Opportunities Tool", "Parent and Patient Resources", "Results", and "Featured Resources". The central banner reads "Clinical Practice Guideline for the Evaluation and Treatment of Pediatric Obesity" with a breadcrumb trail: "Home / Patient Care / Institute for Healthy Childhood Weight / Clinical Practice Guideline for the Evaluation and Treatment of Pediatric Obesity". Social media icons for Facebook, Twitter, Pinterest, LinkedIn, and YouTube are visible at the bottom of the banner.



The laptop view of the AAP website displays the same header and navigation as the desktop version. The main banner is identical, but the text below the banner is partially obscured by a large, semi-transparent "CPG" logo. Below the logo, there is a call to action: "Visit this page to access the Clinical Practice Guideline on Evaluation and Treatment of Obesity when it is published as well as the related resources to support training, dissemination, and implementation."

Treatment of Obesity dissemination, and



The mobile view of the AAP website shows the header and navigation menu. The main banner is visible, and the "CPG" logo is prominent. Below the logo, the text "Visit this page to access the Clinical Practice Guideline on Evaluation and Treatment of Obesity when it is published as well as the related resources to support training, dissemination, and implementation." is displayed. The page is formatted for a vertical screen.

Weight and Wellness Resources

TALKING WITH PATIENTS AND FAMILIES/CAREGIVERS

Speaking with your child about health when they have extra weight



How do you talk with your child to encourage a healthy relationship with food and a positive self-image? The first thing is to leave out any focus on their weight. Here are some tips for having a helpful conversation.

Talk about how making a healthy choice may prevent disease and keep them healthy. Give your child an idea of a healthy choice like drinking less soda. Don't talk about how it could end up in weight loss. Discuss how things like soda can be bad for your health by zapping your energy, giving you a stomach ache, or stopping you from keeping up with friends on a hike. This way of talking with your child works better than saying how drinking soda can make you gain weight.

Work as a team! Children are more likely to make changes if the whole family is working together to get healthier. Include all family members regardless of their weight. Singling out a child to move more or eat differently because they carry more weight than other family members can lead to poor self-image. Many people learn by example. So, join together for the benefit of the whole family.

Avoid fad diets. Some people may lose weight for a short period of time on these types of diets, but the changes in eating patterns will not result in weight loss that sticks or better health. These diet patterns also set your child up for a less healthy relationship with food in the future. It is much better to shift to healthier, balanced meals as a long term way to achieve weight loss goals.

Try not to use words that sound hurtful when talking about yourself, your child or anyone else's body. The words we use to describe our own body, our child's body or another person's body can have a lasting impact. If our children hear us calling ourselves fat, they are more likely to call themselves fat. Words like "overweight" or "carrying extra weight" are better choices than fat, chubby, and obese.

If you catch yourself saying something negative about your own body, correct yourself out loud. Tell your child that you are working on being kinder to yourself and on noticing when you say something hurtful. Work together to think about something you could say instead.

Build your child's self-esteem! When a child carries extra weight, they are at higher risk for having low self-esteem. Self-esteem can be built up in many ways. In your home, talk about the strengths of your child's personality, character, artistic, academic, athletic, or musical talents. Sometimes when we carry extra weight, we judge ourselves. Not only can this put us in a bad mood, but can also make it harder to make healthier choices and reach health goals.

Download additional tools and resources at letsgo.org/pedclinicaltools

Speaking with Your Child About Health when they Have Extra Weight

TALKING WITH PATIENTS AND FAMILIES/CAREGIVERS

How to respond if your child uses negative language about their body like "I am fat."



Questions to ask to talk about self-esteem

- Do you like about your body?
- Something great that your body can do?
- Something you might like to do with your body now?


Questions to ask about language that is used about your child

- Have you heard someone say something about your weight or body?
- How do you feel when you hear it? Remind your child that it is never okay for someone to say those things to them.
- What would you like to do if it happens again? Talk with your child about which adults they can go to if someone is using unkind words. If your child is old enough, make a spoken or written action plan and talk with the adults that are included in the plan.

letsgo.org/pedclinicaltools

TALKING WITH PATIENTS AND FAMILIES/CAREGIVERS

Why Consider Bariatric Surgery for Adolescents?



There is a lot of misunderstanding about the benefits and risks of bariatric surgery, how it works, and when to consider it. Before you decide if bariatric surgery is or isn't the right thing for your child, know the facts!

- It is safe, it works and it is approved by the American Academy of Pediatrics.** Bariatric surgery is very safe. It is similar in safety risk to minor surgery. Sometimes it can cause some vitamins in the body to be too low, but vitamins are given to all patients after surgery and levels are monitored by a dietitian, so that it's not a problem.
- Adolescents who have bariatric surgery can keep the weight off that they have lost.** Studies have shown that weight loss can last 10 years after surgery.
- The surgery changes hormones that control weight.** The surgery works because it helps a body that carries extra weight accept weight loss by changing calorie burning and hunger hormones.
- It can treat diabetes.** If a person has Type II Diabetes and has not started insulin yet, bariatric surgery allows most people to stop taking medicine for diabetes.
- It can help with other medical conditions that are connected with obesity.** This surgery has been shown to help improve mood and quality of life and most of the illnesses that people with obesity have including sleep apnea, fatty liver disease, heartburn and reflux, and high blood pressure.
- Help and support are part of the surgery plan.** The surgery is covered by most major insurances. The plan for surgery is supported with a medical and surgical physician, a dietitian and counselors. Your child will have ongoing support through the Maine Medical Center Weight & Wellness Program before, during and after surgery.
- Sooner may be better than later.** Bariatric surgery helps people lose a great deal of their extra body weight if it is done soon enough. An adolescent could lose up to 100 pounds after surgery. Having surgery before the body stores too many fat cells can help bring the body to the healthiest place. Don't delay!
- Bariatric surgery needs regular follow up.** After surgery, your child will have regular follow up visits. You and your child will learn a great deal about healthy eating, physical activity, mental health and more. Your child will need to make some changes in how they eat, but surgery can be life-changing for those that are interested and able to follow the plan.

Download additional tools and resources at letsgo.org/pedclinicaltools

Why Consider Bariatric Surgery for Adolescents?



Save the Date

September 21 & 22, 2023 | zoom

Improving Your Patients' Health: Understanding the Underutilized Tool of Bariatric Surgery in Adolescents and Adults

Conference Objectives:

- Increase knowledge in understanding the physiology, benefits, and efficacy of bariatric surgery
- Understand which patients will benefit from bariatric surgery, the requirements and risks
- Increase confidence to initiate early conversations with patients about bariatric surgery
- Understand support needed to help ensure long-term patient success including integrating other treatments for the chronic disease of obesity

For more details: www.mhesevents.org/LetsGo2023

Thank You

carrie.gordon@mainehealth.org

obesity@aap.org

<https://ihcw.aap.org>

www.aap.org/obesitycpg

Twitter: [@AAPHealthyWT](https://twitter.com/AAPHealthyWT)



American Academy of Pediatrics
Institute for Healthy
Childhood Weight