

Food Working Group Speaker Series Session #2

March 26th, 2014 @3:00pm

Speaker: Sarah Armstrong, Director of the Duke Healthy Lifestyles Program

Topic: “Status Report from the Front Lines” – Childhood Obesity

The focus today is a neglected sub-population: childhood obesity treatment.

Children are growing, so there is no cut-off point for what is a healthy body mass index. 5 year old could have a BMI of 16. Too little for an adult, obviously.

The “obese” child is unique in medical literature. The phrase is derogatory and hurtful to use their weight category to define them. We don’t talk about the “cancer” child. Also incorrect as it is based on populations, not individuals.

For those overweight at a young age, diabetes seems reversible, but the risk for heart attacks persists into adulthood. They are more likely to be obese later. School treatment programs are not working.

There is a spike in risk factors for children very suddenly when you reach the 99th percentile of BMI.

“cardiovascular risk factor” sounds mild, but it means hypertension, cholesterol. These are not risks, but things that are happening now.

All children are quite different, so you need different treatment strategies.

For kids: no meal replacements! But we consider most of the other approaches for adults. A lot of the focus is on behavioral change.

USPSTF Guidelines in 2005 were very vague, non-specific.

Very few insurance recognitions for obesity treatment – only recently being seen by them as a disease as opposed to a cosmetic concern. A BCBS insurance policy was developed but not advertised

Audience Q: why is the 11% of pediatrician use of BMI so slow?

Sarah A: the pediatricians needed to use a BMI calculator, but weren’t taking the next step to plug the weight/height into a calculator.

Audience Q: is obesity a disease?

Sarah A: people fall on both sides of the argument. Is it a disease, or is it happening to them? One professional described it as “drowning” on the part of the children- can’t get out of it due to other circumstances. More concerned with the treatment than the labeling. For parents not labeling it a disease, they felt less stress about treating their children. If we call it a disease, some fear people will want a magic pill and the pharmaceutical companies will step in more.

How much would an obese child have to lose in a year to have a change in a health metric? We don’t understand what our targets should be still.

“motivational interviewing”

-the kids like the Healthy Lifestyle program the most because they can go there to work out with kids “to work out with kids who look like me”

People are very confused about what a healthy carbohydrate looks like, whereas most people have a good idea of healthy fats/unhealthy fats.

Audience Q: do you provide food to the participants?

Sarah A: It is a real world setting so we can't. And there is no funding for this.

Audience Q: Is it more expensive to be on a healthier diet?

Sarah A: we haven't had much of a concern from our families. But there has been a lot of concern from Hispanic families because their typical cultural foods are more carb-heavy. Some of them feel the diet is too expensive then.

Audience Q: what are the causes of obesity you see?

Sarah A: it's our activity, time in front of computers, cheap carbs in the diet, infant weight gain (mom's BMI before the child is born is predictive), calorie-dense food. But what can we change now? Sugary beverage consumption. Can we apply the public-health smoking intervention to food? We can't ban it, we need to eat. But for sodas, we could ban it- there are some extremely unhealthy foods that we could target.

None of the studies they have done have worked on familial-based behavioral interventions. It's typically just kids, or just adults. When the parents are more engaged, the kids do better....except for the teenagers.

Targeting parents with text- messages based on motivational interviewing.

“motivational interviewing”- Put them the patient in the driver seat of what the patient wants to do. User-generated approach. Uses open-ended questions. Motivation has to come from inside the patient, not outside. Need intrinsic motivation.

Barriers to kids being more active- live in dangerous situations sometimes and don't want to be outside.

[BREAK FOR RECEPTION]

[DISCUSSION]

Q: Do you do outreach to restaurants to see if they could help with some of your programs? Could you get partners to put a logo on their menu near a healthy item?

Sarah A: we could survey patients to see where they go. Good idea.

Funding from Bull City Fit comes from Kolh's Department Store. Ask for 30% to be paid to media for the program.

May get some luck from chain restaurant. Put them on tray liners.

Q: For schools, give you are targeting areas, have you have had success getting people into the program?

Sarah A: Public schools are already pretty overtaxed dealing with their own programmatic requirements.

Additional Commentary:

Holton Parks and Rec Center currently underutilized. Parks and Rec runs lots of low-cost programs but they are not getting them out there.

In the US, obese individuals are from higher socioeconomic classes (with the exception of some Caucasian boys), whereas this can be reversed in other parts of the world.

Most extremely obese kids Sarah A sees have extremely obese parents. Thinks you probably don't get so obese without a kind of mental trauma.

FWG Feedback:

Is there a way that people who can't physically get here can be involved? Discussion forum?

Possibly alternate the time to be different days.

Parking is difficult on Duke's campus (perhaps reserve 10 spots in Bryan Center).

Could host the meetings at different locations. For example, host a meeting at the Diet and Fitness Center. Or different research entities can host tours. Diet and Fitness is happy to do this. A summer time would work well for visits.

Lunch time may be an option to get people to attend. Or 4pm at the end of the day may work better for those with clinics.

Perhaps have community speakers come in to share their work in the future (Veggie Van).

[Session ended at 5pm]

Next Speaker Series Session on April 2nd with speaker Kelly Brownell, Dean of the Sanford School of Public Policy.