FOCUS ON A Fitter Future

A SURVIVAL GUIDE
Planning, Building and Sustaining a Pediatric Obesity Program

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FOCUS ON A FITTER FUTURE
CHILDHOOD OBESITY FOCUS GROUP
NACHRI

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Dear Colleagues,

The obesity and weight management programs represented by the 15 members of FOCUS on a Fitter Future did not develop and evolve using identical visions, strategies or tactics. Similarly, the survivability of all 15 programs is not yet assured. The following recommendations have been gleaned from the experiences of the group and are meant to assist new programs with the planning phases and existing programs with growth spurts. While these recommendations may seem straightforward in many ways, it is critical to recognize that each institution, department and locale will take different approaches to the related issues, have varying support systems available and respond to challenges in its own unique way.

Flexibility and persistence are the critical characteristics on which to build a successful obesity and weight management program. Remember that life rarely goes exactly as planned, and this effort is unlikely to be different. Your hospital environment and leadership will change; some staff will be more easily brought on board than others; turnover will be inevitable; competing interests for institutional support will have claims on your resources; everyone will want your physical space; research funding opportunities will come and go; and community relationships will wax and wane. Be understanding of these inevitabilities and work diligently to diminish their effects. Keep your missions, goals and visions in view at all times, and you will make a difference.

Good luck!
FOCUS on a Fitter Future is a National Association of Children’s Hospitals and Related Institutions (NACHRI) FOCUS Group addressing the role of children’s hospitals in combating the epidemic of pediatric obesity. This multidisciplinary group began in 2008 with support from Mattel Children’s Foundation and participation from 15 NACHRI institutions. Unique to this group is its inclusion of physicians, dieticians, exercise specialists, psychologists, researchers and executive sponsors from participating hospitals. The goal of the members of FOCUS on a Fitter Future is to deliver quality, cost effective care and improve service for children and families in the prevention and treatment of pediatric obesity.

Over an 18-month period, the teams shared common experiences and challenges related to building and sustaining a thriving childhood obesity clinic or program. Seven subcommittees were formed to tackle the most pressing issues.

Subcommittee topics were:
- Assessment tools and formation of a national registry
- Bariatric surgery
- Creating a healthy hospital environment
- Long-term patient care and family engagement
- Outreach to primary care providers
- Program sustainability
- Reimbursement and payment

For many children’s hospitals, childhood obesity treatment and weight management services are relatively new subspecialty offerings. The purpose of Planning, Building and Sustaining a Pediatric Obesity Program: A Survival Guide is to share the practical strategies and tactics that have proven successful across the country with institutions that want to start, grow or sustain an obesity program or clinic. The Survival Guide is the culminating work of the program sustainability subcommittee with substantial contributions from the other six subcommittees.

The authors garnered additional information for the Survival Guide through (i) structured interviews with the 15 children’s hospital programs in the FOCUS Group about their experiences of setting up and sustaining a pediatric obesity clinic and/or program, and (ii) Perspectives on Obesity Programs at Children’s Hospitals Survey, administered to senior level administrators at 49 hospitals with pediatric obesity programs.

Also referenced are other important resources in the field of pediatric obesity, including additional works developed by the FOCUS on a Fitter Future subcommittees. These resources will be available on the NACHRI website at: www.childrenshospitals.net/obesity.
The vision for a strong obesity program begins with the passion of those who believe in it. Many physicians and specialists feel passionate about the topic of childhood obesity. Through this strong desire to help obese patients, they may become vocal advocates for establishment of a childhood obesity program in the hospital. The success of a hospital-based obesity program often relies on the influence of these program champions.

The program champion is the primary supporter of a hospital-based obesity program and will work with hospital administration to define the importance and magnitude of the childhood obesity epidemic and the role of the hospital. Ideally, the champion should be part of a “champion team” — a multidisciplinary group of individuals who advocate for the program. This is especially important in larger organizations where executives view collaborative teams as a strength. Collaboration helps assure them that efforts are not competing with one another.
**Identify a Champion**

Characteristics of a good program champion include: enthusiasm for addressing childhood obesity, experience in the treatment of overweight children, influential personality and position, ability to take risks, in-depth knowledge of the institution, commitment to remaining in the institution and some understanding of development of new programs. A clinical or population-based research background is advantageous because it is critical that the champion be knowledgeable of the vast amounts of obesity-related literature to avoid approaches proven ineffective decades ago.

While administrative experience is not necessary, the program champion must quickly develop a strong appreciation for the financial implications of running a clinic or program. It is crucial for a program champion to align with a mid-level program administrator at the inception of the program. Considerable debate continues on whether the program champion should be a physician or an allied health provider, e.g., a dietitian, physical therapist or psychologist.

Occasionally programs evolve from a research or program startup grant. If this is the case, those involved should ideally create a partnership to ensure that the scope of the proposed program or clinic will extend beyond the grant. The champion characteristics described above are much more relevant than area of clinical expertise. That means the original principal investigator of the grant may not necessarily be the ideal program champion.

The initial tasks of the program champion often include (i) creating a strategic plan to guide program development, (ii) garnering institutional acceptance by advocating to hospital administration and boards, (iii) building a team (iv) collaborating with physician specialists and (v) writing grants or business plans to fund the program.

In summary, program champions are vital to the successful development and sustainability of a program.
Work Within the Continuum of Obesity Care

The role of children’s hospitals in tackling the obesity epidemic varies across institutions. Ideally, children’s hospitals are best suited to provide broad-based continuum of obesity care, extending from health promotion by prevention, early intervention, and treatment of obesity and related co-morbidities, to the provision of bariatric surgery.

For clinical services, the continuum is reflected in the recent guidelines for managing the overweight child. In October 2007, the American Academy of Pediatrics (AAP) released the *Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Child and Adolescent Overweight and Obesity* (Barlow, 2007). These recommendations outline four stages of obesity management and treatment.

Stage 1:
Primary care providers serve as the frontline and advise obese patients and families on healthy lifestyle eating and habits. Improvement of body mass index (BMI) scores rather than maintenance of healthy BMI scores is the goal. Patients are monitored on a monthly basis during this stage.

Stage 2:
Structured weight management is the second level of obesity treatment. Utilizing the services of an allied health care provider, such as a dietitian, this level provides frequent and structured support to the child and family to encourage healthy eating and behaviors. Monthly office visits to the primary care provider are recommended for children in this stage. This stage is recommended for patients who have attempted the prevention plus model (Stage 1) for at least three to six months.
**Stage 3:**
Comprehensive, multidisciplinary intervention increases the intensity of behavior change; the involvement of multiple care providers, including a physician; and the frequency of visits. This stage is recommended for patients who have been unsuccessful with the structured weight management program (Stage 2). Most primary care offices do not have the capacity to handle this level of treatment. Therefore, patients at this level should be referred to specialists or a comprehensive weight management center.

**Stage 4:**
Tertiary care intervention is the final category of treatment to be offered to severely obese youth. Patients in this stage have attempted weight control in the comprehensive multidisciplinary model (Stage 3) and have been unsuccessful. Treatment options include bariatric surgery, very low calorie diets and medications. Implementation of these tertiary care interventions should only occur in pediatric weight management centers.

The role of a children’s hospital can span all four stages with varying levels of involvement and personnel. For instance, a children’s hospital with an extensive, vibrant primary care network or well-established relationships with community-based organizations can focus on Stages 1 and 2. However, given their expertise, the expectation for most children’s hospitals is the provision of comprehensive services and interventions (Stages 3 and 4) that are often too specialized to be offered in the primary care setting.
A hospital may start with services in its greatest area of community need or its greatest strength. Both approaches can be successful if the clinical and financial implications have been carefully considered. The key is to determine the most effective way to serve the community (patients, families, health care providers) and maximize visibility from the onset. For example, some hospitals have determined that while they cannot start a medical or surgical program for obesity, they would like to play a role in community, regional or national advocacy. Regardless of how the program begins, over time all programs develop in complexity and incorporate other aspects of the continuum from prevention through treatment to tertiary care services.

**FIGURE 1 | CONTINUUM OF CARE FOR CHILDHOOD OBESITY**

- Community environmental supports and policies for healthy lifestyles
- Community services for at-risk and overweight children
- Primary care and early ID and management of at-risk and less complex cases
- Medical management of complicated patients
- Specialty diagnosis services including surgery

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**Community-Based Services**  
**Weight Management Clinic, Specialty Services**  
**Primary Care Practices**
Determining what aspects of an obesity program or service your organization and community need can be a complex process. To help answer that question, the program team should address these key questions:

Definition of services:
• What services will you provide (Stages 1, 2, 3 and/or 4)? Location, personnel, physical plant and institutional investments will vary widely depending on the services provided.
• Will you start with a small, single-stage program with plans to grow? Or do you have the resources to start with a comprehensive center?
• If starting small and growing is your plan, over what period do you expect to grow? Into which form? Institutions will often grant startup options for new ideas, but may not welcome later requests for additional startup. Be clear from the beginning about plans for change, growth and future support.

Program prototypes around the country include:
☐ Community-based prevention or awareness programs
☐ Limited medical clinic within another specialty office
☐ Freestanding obesity clinical service
  • with or without physical activity component
  • with or without bariatric surgery
  • with or without research focus
☐ Physical activity and/or nutrition program without clinical service
☐ Primary care or medical resident and student training component (either freestanding or part of another clinical service)

Exploring the websites of participating FOCUS on a Fitter Future hospitals can provide valuable information on program structure. In addition, there are examples of program and obesity center prototypes at children’s hospitals in Appendix A.
Conduct a Needs Assessment

Support from institutional leaders, regional primary care providers and the community at large is vital to the success of the program, and a consensus of need should be developed prior to detailed planning.

A thorough needs assessment of the community and surrounding areas should be completed before beginning the program. The need for a pediatric obesity program or clinic in the community is often obvious, but a careful evaluation will reveal information vital to the development and sustainability of the program. The community constituency includes primary care physicians who may feel there are no existing places to refer obese patients. However, some local physicians may be providing these services without the children’s hospitals’ knowledge. By looking at other area practices, hospitals and community organizations, the existing gaps and bridges in services will be noticeable.

Long-term program sustainability depends on a needs assessment being carried out in a forthright manner. Thus, it is critical that the group conducting the program needs assessment not be dominated by the program’s champion or the team’s passion for the program. An unbiased evaluation of resources, needs and political issues will result in the best outcome.

The program team needs to consider these key questions:

Needs:

- Will this program provide access to patient services for unmet clinical needs in the community? (i.e., after careful evaluation, is this program really needed?)
- Will this program provide a resource to local medical providers and programs or will it be seen as competition?
- Will this program provide additional referrals to the institution, and will these referrals be welcomed or problematic?
- Can this program provide significant focus for institutional wellness initiatives, philanthropy opportunities, research plans, advocacy/policy objectives, community education needs or institutional public relations desires?
Goals:

☐ What short-term and long-term visions and goals do you and your institution have for this program?

☐ How do these visions and goals link to (or conflict with) the institution’s strategic goals and plans?

☐ What are the risks and benefits of this program, how will they be managed and by whom (SWOT analysis)?

SWOT (strengths, weaknesses, opportunities and threats) analysis of the current environment may also be helpful in assessing current strengths. This information would be beneficial to include in a business plan to show administration that the clinic planners have looked at all angles of the program (see Appendix B).

Researching services provided by other area hospitals and community organizations provides a larger understanding of what the geographic region has available, such as state initiatives, public health programs and other nonprofit agencies working specifically on childhood obesity. Duplication of services in a fragile market with insufficient demand will lead to difficulty for a program.

Other organization types involved in obesity include:

- Schools and after school programs
- Head Start
- Local and state departments of health
- Universities and extension offices
- Hospitals
- YMCAs
- Parks and recreation departments
- AAP chapters
- Medical schools/residency programs
- Religious organizations
Articulate Rationale for the Obesity Program

Given the high prevalence rates and seriousness of co-morbid conditions of obesity, treatment should not be presented as a choice, but rather as an integral part of services expected from a children’s hospital.

The motivations of each hospital system are unique. However, properly phrased rationale should spur the administration into action and demonstrate the impact of inaction. Obesity is the most prevalent chronic problem among children and has been called, by some, the greatest health threat of this generation. A clear argument in support of your future program is obesity’s impact on co-morbidities and, in turn, obesity’s impact on your institution’s subspecialty care provision.
Increased patient weight compromises and complicates the treatment of other conditions ranging from cardiac to sleep apnea. Yet, these subspecialists are not treating obesity to help the co-morbidities. Obesity needs to be treated in order for the other specialists to be able to do their jobs. By underscoring the importance of hospital-based weight management programs to subspecialty care, obesity is framed as a core service in pediatrics deserving institutional support and sustainability.

Other rationales have also proven powerful for members of FOCUS on a Fitter Future:

**Severity of the problem**

Obesity can cause significant medical complications in children, including obstructive sleep apnea, asthma, dyslipidemia, slipped capital femoral epiphysis, Blount’s disease, glucose intolerance, Type 2 diabetes and psychological conditions such as depression and low self-esteem. The combined effect of these conditions dramatically increases health care utilization. According to MarketScan estimates from Thomson Healthcare, the annual incremental expense per patient for total health care expenditures is $3,731 more for obese children compared to non-obese children (Thomson Healthcare & Child Health Corporation of America, 2007).

According to an article by Wang and Dietz in Pediatrics, May 2002, obesity-associated annual hospital costs (based on 2001 constant U.S. dollar value) increased more than threefold — from $35 million (0.43 percent of total hospital costs) during 1979-1981 to $127 million (1.70 percent of total hospital costs) during 1997-1999.

Where possible, data relevant to the local population (prevalence of obesity, patient volumes, need from health care community) should be included.
Clinical outcomes

Results from recently published studies on pediatric obesity programs have shown significant positive outcomes. Significant decreases in anthropometric measures and improvements in dietary and physical activity knowledge, alignment of attitudes and behaviors, and decreases in comorbid conditions (insulin resistance, dyslipidemia and hypertension) have all been reported (Savoye, Shaw, & Dziura, 2007; Young, 2007; Reinehr, Temmesfeld, Kersting, de Sousa, & Toschke, 2007; Southern, Schumacher, von Almen, Carlisle, & Udall, 2002).

The number needed to treat (NNT) in a 12-month multidisciplinary obesity program to resolve insulin resistance in one participant is 4.8, while seven participants are needed to be treated to prevent insulin resistance (Young, 2007). For one overweight child, the NNT to decrease the BMI below the 95th percentile is 13, but for a reduction in BMI below the 97th percentile, the NNT is only seven participants (Young, 2007).

Patient referrals

One way to gain the support of your institution for an obesity program is to determine the impact obese patients have on subspecialty practices throughout the hospital. Often, obese patients are referred to subspecialists who do not have the expertise to treat obesity. The increase in patient load due to inappropriate referrals may decrease the efficacy of the clinic.

Community benefit

Eighty-five percent of responders to the Perspectives of Obesity Programs at Children’s Hospitals Survey that have obesity clinics said that “value to the community” is the reason why their hospital supports the obesity program. The clinic not only increases a hospital’s visibility in the community, but it meets the needs of the patients, families and health care providers. Referring providers often look to the children’s hospital to provide leadership on obesity treatment and can become great partners in this work.
Necessary service
Approximately half of all children’s hospitals in the United States have some type of obesity program (Hanson & Hinton, 2008). To assess the comprehensiveness of children’s hospital services, even the U.S. News Best Children’s Hospitals survey now asks if the hospital has a multidisciplinary weight management and/or obesity program. While obesity care may not have been a core competency of a children’s hospital 25 years ago, it is quickly gaining attention from both the community and clinical providers as a necessary component of services offered.

Create Institutional Involvement
While community leaders, faculty members, hospital administrators or engaged support personnel are all valid leaders for new programs, only faculty members and administrators are likely to have the institutional clout necessary to develop, build and sustain a new program. Hopefully, these leaders will be brought on board during the initial conceptualization phase, but they should definitely be intimately involved with the administrative and financial planning of the program.

There are four dynamic steps in creating institutional buy-in.
1. Inform: All identified stakeholders must be informed about the decision and plan for a program. The discussion should involve general and specific information as well as context and expectation. To communicate program intentions, create a short concept paper describing need for the program, initial thoughts on program design and anticipated outcomes.
2. Involve: Address what stakeholders will gain from the program both personally and altruistically. Tailor emphasis to the experience and expectations of individuals or groups.
3. Invite: Be specific about your invitation to participate. For example, “Can I count on your division to provide backup consults for morbidly obese children?”
4. Ignite: The program leaders have to apprise institutional key players of program successes as well as the overarching rationale to support the program. In a sense, this stage is internal marketing of the program. If marketing is not targeted to hospital administration, it can be detrimental to the sustainability of the program. This last step must continue as long as the program exists.
Identify Internal Business and Administrative Partners

A passionate physician leader rarely can get the institutional support needed to launch a comprehensive program without a business plan that encompasses the estimated costs of operating the program, the potential revenue streams and the overall impact to the hospital system. Hence, it is important to identify early internal partners who are knowledgeable in the way business is done in your hospital. The administrative partner can prepare other key hospital executives through the program development process, present the importance of the program to the organization’s strategic plan and mission, and can be a well-versed spokesperson for the program in front of influential audiences.

A strong administrative partner aids process, including:

- Presentation of program concept to key stakeholders
- Presentation to a strategic growth committee
- Application for philanthropic support
- Board presentation for approval

Gather Support From Medical Staff

Survival of an obesity program depends on support from the hospital and community medical staff. To gain this support, discuss the program’s goals with the medical team. An individual meeting with key doctors will help them understand the program objectives and help them feel involved in the business plan and programming. Often, obese patients are referred to subspecialists without the capacity — or the desire — to treat obesity. The increase in patient load from inappropriate referrals may negatively affect their operations, and linking with an obesity program may directly benefit the subspecialty practice. Alternatively, some subspecialty practices may welcome obese patients and their management and could see a new program as competition. As previously mentioned, candid evaluation of the landscape is vital to success.

Ideally, a physician champion is the best person to have conversations with colleagues regarding the current medical needs of their clients, ideal protocols for obese patients and potential impacts on other departments. By involving physicians and medical staff from various departments and including them in important program decisions, the obesity program is more likely to have their support in the future.
If the conceptualization phase described in Section I meets with optimism, it is time to organize your team’s ideas on how a weight management program can fit within the institution in a formal plan that can be further assessed by internal leaders. This collaborative planning will involve departmental or divisional leadership, hospital officials and business administrators. Together, you can thoroughly assess and tailor ideas to maximize success.
Begin With Administrative Planning

The placement of the obesity program within the hospital varies significantly from program to program. Departments that supervise obesity programs include general pediatrics, general ambulatory services, clinical nutrition, endocrinology and gastroenterology. Some programs were created by program champions but not strategically positioned in a specific area of the hospital. Independent placement is often helpful for financial tracking purposes. The programs participating in FOCUS on a Fitter Future are located in different administrative departments in the hospital (Figure 2).

FIGURE 2 | DEPARTMENT OVERSEEING OBESITY PROGRAM

Source: Perspectives on Obesity Programs at Children’s Hospitals Survey
Many programs were initially placed in the administrative homes of their champions, some in the general pediatrics division, some in nutrition, some in subspecialties and some as administrative programs. Separate financial tracking processes are highly recommended to avoid losing outcomes within the financials of a larger division. If your program appears best placed within an existing division, the support of that division leadership must be assured in advance of further planning and sustainability.

During administrative planning, the program team needs to answer these key questions:

☐ Where do you belong in terms of administrative structure?
☐ What will your relationship be to primary care and subspecialty colleagues?
☐ Are you offering a service to these colleagues by providing a medical home for obese patients or will you be seen as competition for patient volume?
☐ What role will the program play relative to referring practices and subspecialty collaborators?
☐ What is the role and expectation for each team member?
☐ What are the program outcomes? What is a realistic reporting timeline for the outcomes?
☐ What are your space and building needs? How do they fit into current and future hospital facilities plans?

Link to Your Institution’s Strategic Plan

A true sign that the obesity program is gaining prominence among competing initiatives of a busy hospital is inclusion in the organization’s strategic plan. Typically, getting the program included in the plan is the result of sustained efforts of the program champion, key physicians and a strong administrative partner.
Two key steps are important to linking the program to your hospital’s strategic plan. The first step is to understand the plan and study the successful programs within that plan. The second is to identify the section in the plan that underscores your obesity program goals. For example, if the primary focus of your program will be on community and advocacy activities around obesity, the link to the strategic plan may reside in the community vision section. This decision should then be communicated at every meeting or presentation that involves hospital staff. Occasionally, a program may need to shift its goals to better align with the strategic plan. While this may be less than ideal, it may be politically necessary to ensure survival of the program.

**Understand Personnel Needs**

The personnel needed for the obesity team varies with type of program. Only very careful consideration of options will allow the construction of an effective, committed and successful team. Cobbling together a group of unprepared individuals without true enthusiasm for the cause is likely to result in frustration, high turnover and failure.

**Necessary team members**

Professionals from specific disciplines are often included in the treatment of obese children and teens. These include one or more pediatricians (one of whom may function as medical director), nurse practitioners, pediatric psychologists, exercise specialists (exercise physiologists), physical therapists and registered dietitians. A clinic or program coordinator is an essential staff member. Although it is ideal to have a research assistant/data coordinator, hospital administrators may balk at the cost. This position has to be well justified in a business plan for it to be sustainable. A more practical initial approach is to hire or identify a clerical staff member with strong data management skills and seek a collaborative research partnership with a colleague to help with analysis.
For youth with medical co-morbidities, identified colleagues within several pediatric subspecialties are essential for conferring and referral. A licensed clinical social worker strengthens the weight management team. A pediatric nurse and medical assistant support clinic-based treatment teams, especially for programs providing Stage 3 and 4 services.

Another key operational partner is the business manager/administrator. While dedicated business administrative support is rare in current programs, guaranteed access to such support is highly recommended. A community liaison, i.e., someone to maintain current partnerships and explore new ones, also proves a helpful addition. This role can also be carried out by your program coordinator or perhaps by collaboration with your hospital community relations officer. Clinical care providers are rarely trained in administrative aspects of program management or financial evaluation, and their time is better spent in other arenas. The guidance of an experienced business manager greatly facilitates timely and accurate reporting and planning.

Addressing your team’s knowledge gaps and needs prior to program initiation will maximize your financial outcomes and endear your program to your business administrator. Consider your needs for the following areas:

• IT equipment and technical support
• Referrals and scheduling
• Coding training and audits
• Billing
• Charting/documentation
• Dealing with insurance providers
• Marketing
Recommended team members are:

- Physician/physician assistant/nurse practitioner
- Nutrition support (registered dietician)
- Physical activity support (Physical therapy, exercise physiology, etc.)
- Psychological/psychiatric support
- Behavior modification professional (either psychologist, social worker or other clinician)
- Social worker
- Clerical/administrative support for referrals, scheduling, charting, insurance, phone management, etc.
- Data management for tracking, reporting and outcomes research
- Research staff
- Bariatric Surgeon

**Essential characteristics of team members**

The staff of a multidisciplinary pediatric weight management program must have a passion for working with obese youth and their families. They need an understanding of the chronic nature of obesity and the ability to connect with families without bias, accepting them where they are. These few characteristics should be common to all members of the team. Because the treatment is multidisciplinary by necessity, excellent teamwork and communication skills are also necessary. In addition, because the treatment is often extended in duration, patience during multiple visits (with families and among staff), enthusiasm and hopefulness are three additional essential traits. Several surveys conducted by weight management programs found that many families arrive hopeless and that the ability of the team to instill hope in the family is crucial to a family’s success.

Obesity programs in FOCUS on a Fitter Future repeatedly referred to the benefits of a multidisciplinary approach to the care of obese youth and their families. One program reported that having multiple team members afforded patients a greater likelihood of making a connection that led to a therapeutic relationship with at least one team member. At times, the removal of even one team member can affect the patient’s entire care.
Training the team members

Specific training strengthens the pediatric weight management treatment team. A desire to learn more is essential to keep up with best practices in this rapidly growing field. All team members will benefit from instruction in: social cognitive theory, motivational interviewing, transtheoretical models, self-determination theory, and behavioral economic theory with empirical support in obesity treatment. The American Dietetic Association Certificate of Training in Childhood and Adolescent Weight Management is a helpful adjunct for registered dietitians. Experience in cognitive behavioral therapy and in working with patients with chronic illnesses aids psychologists.

For any team member, prior experience in working with obese youth and families is helpful. However, experience is not essential as long as the willingness to learn is present and more experienced mentors are available to provide training. Perhaps the best and sometimes least expensive training comes from observing an existing program. Interacting with staff from successful programs may allow you to establish professional mentors for your program.

Build Bridges With Primary Care Practices

Gaining the support of community physicians in the development of a childhood obesity program often serves as a significant source of referred participants to the program. By interviewing or surveying potential referring physicians, hospitals gain an understanding of the desires and needs of the local community. This also encourages providers to express their opinions and concerns, which may influence the development and design of the clinic or program. The experience of many hospital-based programs indicates that referring providers are thrilled to have a tertiary program where referrals can be sent. An important aspect to consider is how to ensure that the referrals received for the clinic or program are the most appropriate.
Most typically, hospitals link with primary care physicians through educational forums, such as formal continuing medical education (CME) workshops or trainings. They may also interact with primary care practices in year-long quality improvement collaboratives to enhance the system-wide approach to obesity identification/management (Pomietto, et al., 2009). These forums offer networking and the sharing of best practices and lessons learned.

Additionally, obesity programs can engage providers and help them gain a broader understanding of obesity as a health issue. Some develop a subspecialist relationship with primary care physicians with ongoing discussion of patients and coordination of care. Most programs require physician referral. If the patient is self-referred, the primary care physician is notified. Programs also forge relationships with subspecialists, particularly in endocrinology and cardiology, who may refer patients to the obesity clinics.
Develop and Manage a Bariatric Surgery Program

According to the 2007 AAP Expert Committee recommendations, bariatric surgery is categorized as a Stage 4 treatment option. Bariatric surgery is recommended for the severely obese adolescent (BMI >40), with/without weight-related comorbidity. (Barlow, 2007; Inge, et. al., 2004).

Pediatric obesity centers perform three standard procedures: gastric bypass surgery, laparoscopic band (lap-band) surgery and sleeve gastrectomy. Gastric bypass involves creating a thumb-sized pouch for the stomach and reconfiguring the alignment of the small intestine to decrease available absorptive surfaces. The lap-band procedure involves encircling the stomach with an inflatable silicon ring to reduce its size. This procedure is yet to be approved by the Food and Drug Administration (FDA) for patients younger than 18 years. However, results from a five-year, multi-center, industry-funded study using the lap-band device for adolescents 14-17 years is expected soon. Most providers anticipate the FDA will approve the lap-band procedure for children in the near future. The sleeve gastrectomy, the newest procedure, reduces the size of the stomach to a narrow tubular structure after surgical excision of the large portion of the stomach including the fundus (the bottom or base of the organ).

For a successful outcome, bariatric surgery represents a unique constellation of services and personnel. The bariatric surgery subcommittee of the FOCUS Group established consensus criteria and recommendations on bariatric surgical procedures. These recommendations will be released in 2011 in an anticipated supplement to Pediatrics titled “Pediatric Obesity: Practical Applications and Strategies from Primary to Tertiary Care.”
Recommended members of the bariatric surgery team include:

- A general or pediatric surgeon
- A pediatrician/subspecialist who will oversee programmatic needs in the clinic and in the operating room
- A bariatric coordinator to supervise day-to-day activities of the program and its patients
- A child and adolescent psychologist/psychiatrist who is behaviorally trained and interested in individual and family centered treatment of adolescents (including eating disorders)
- A registered dietitian with certification in childhood and adolescent weight management and interest/experience in the nutritional management of various bariatric procedures of obese adolescents
- An exercise physiologist/physical therapist with experience in the treatment of morbidly obese adolescents
- A social worker
- A nurse practitioner or physician's assistant, as needed

From the program’s onset, a multidisciplinary patient selection oversight committee should be assembled. The committee should ensure that patients are appropriately chosen and properly prepared. Preoperative, perioperative and postoperative protocols should be developed and periodically evaluated to ensure excellent quality patient care and outcomes. Appropriate equipment and furniture, such as bariatric scales, exam tables, chairs and blood pressure cuffs, must be available. Because morbidly obese youth typically have obese family members, standard-sized exam rooms may become cramped during long visits. Some programs have designed larger exam rooms to address this concern.

To remain sustainable, a bariatric surgery program should determine a benchmark for surgeries performed annually that will offset the overhead costs for the program. For some centers, that benchmark is 25 surgeries per year. In addition, it is critical that the program develop a relationship with each insurer to maximize reimbursements for services.
Connect With Community Organizations

Patient access to community resources can be optimized by connecting with organizations/agencies that offer healthy lifestyle or physical activity programming or healthy food/nutrition. This prevents duplicative services, supports families in the neighborhoods where they live, responds to common access barriers such as transportation, may enhance retention and promotes consistency of messages.

Listening to the community is a key strategy for hospital programs working with outside groups. It is important to avoid an expert stance and look to all organizations as equal contributors. Seattle Children’s partners on community-based initiatives and collaborative studies with 22 community organizations. The hospital’s program serves as a repository of community benefits reports. It is important to look at shared goals, missions and leadership when working with outside organizations. For more information, contact Mo Pomietto, MN, RN, at mo.pomietto@seattlechildrens.org.
Networking/linking with community organizations has also resulted in innovative and collaborative programming. For example, several FOCUS on a Fitter Future hospitals established partnerships with their local YMCAs. Mt. Washington Pediatric Hospital, Inc. partners with the YMCA to offer patients a one-month YMCA membership or participation in a two-week summer camp. Seattle Children’s and YMCA of Greater Seattle work together to provide formal 18-week healthy lifestyle programs for overweight youth ages 8–14 — a program that has expanded to 11 branches. Linking with community organizations puts resources in place when hospital-based programs may not have the capacity (space/FTE/funding) to have a physical activity component as a part of their weight management programs.

However, working with community organizations can have some hazards. For example, intellectual property issues have come up regarding design of competing programs; discussions regarding these issues should take place prior to program onset and publication of research. On the other hand, funders often look for programs with community partners. Several obesity programs discovered the advantage of a staff person dedicated to community collaborations because face-to-face contact cements partnerships. A forum to evaluate progress and outcomes with partners is essential.

Provide Outreach Activities
Many programs have early desires to extend their services into environments outside their home institutions and communities. In some states, the AAP chapter has been a strong community partner for obesity programs. Building partnerships might include provision of standard medical services in outlying underserved communities or the development and mentorship of “locally owned and operated” programs to provide ongoing services outside the auspices of the home institution. Programs are advised to consider these opportunities carefully to avoid potential staffing and time conflicts with the home program. Community collaborators and local champions are mandatory for the success of these operations and require time and care to develop effectively. Program leaders should consider issues and needs of outreach programs as diligently as they would their core operations.
That being said, obesity programs that educate children and families through school-based programs or community collaborations provide an opportunity to decrease lifestyle risk factors for obesity. Positive community feedback ensures increased visibility for the children’s hospital within the community.

Leading, building or partaking in effective community networks can be a complex process. Several papers offer helpful insights and tools to build sustainable community networks. *Building Smart Communities through Network Weaving* (Krebs & Holley, 2002) offers ways to learn and evaluate the progress of networks. Additional emphasis is placed on “knitting the network” together to enhance the cohesiveness and effectiveness of the group.

Network MAP can be a valuable tool to visually identify links between partnering agencies and to show relationships, flows and transactions (Cohen & Swift, 1999; Cohen, Baer, & Satterwhite, 2002). This mechanism can be used to improve dialogue about potential collaborative efforts and to track partnerships or integration between partners over the life of a network. The Spectrum of Prevention, used nationally in prevention initiatives, such as injury and violence prevention, is a systematic tool that promotes a range of activities for effective prevention ([www.preventioninstitute.org](http://www.preventioninstitute.org)).

Challenges should be anticipated. With artful communication, challenges can be openly discussed. Establishing common goals, brainstorming or negotiating potential solutions for collective implementation and evaluation can be helpful steps toward strengthened partnerships. Occasionally, there may be more people/efforts for potential involvement than feasible. In that case, the program must be judicious in selecting its partnerships.

Lessons learned from established hospital-based obesity programs with first-hand experience in collaborating with networks/coalitions can also be useful. The FOCUS on a Fitter Future hospitals identified guiding principles helpful when working with organizations, networks or coalitions to promote success, effectiveness and sustainability.
Guiding principles:

- Start with what exists and learn from families and their concerns.
- Become a member of a community-based collaborative/coalition to assess what other community agencies are doing and what their needs are. Children’s hospitals need to figure out what they can add to other agencies.
- Find organizations with similar missions and, from there, develop a variety of different and responsive programs.
- Provide the medical and scientific expertise that is often lacking in many of the agencies.
- Communicate — communication is the key.

**Building clinical or community networks**

Obesity centers at pediatric hospitals can build or actively engage in established clinical and community networks to increase their ability to address the complexities of childhood obesity. Broader goals can be achieved more efficiently and effectively by convening or participating with individuals, groups, agencies or coalitions to work on issues of common interest. For example, members of the Childrens Hospital Los Angeles obesity program found that by working in schools and parks and training other sites to deliver its program, the number of children served increased. Retention and satisfaction were also improved when programs were offered near the home of participants.

Before forming or joining a network, keep in mind that the contributing factors to obesity are multifaceted and part of a much larger social context that influences behavior. To tackle such a complex issue, the U.S. Institute of Medicine Preventing Childhood Obesity report (Institute of Medicine, 2005) emphasizes the importance of organizations (federal, national, state and local) taking action to address the complex interactions across social, environmental and policy contexts that influence childhood obesity. Specifically, the Local Government Action to Prevention Childhood Obesity report “echoes the need for broad community engagement” (Parker, Burns & Sanchez, 2009).
With this framework, providers of obesity services, researchers, primary care providers and residents can best provide community obesity solutions by joining with local governmental agencies, including public health, schools and community organizations. Such a community-oriented approach by providers, who are often isolated from the broader community context, has resulted in collaborative programs of intervention, prevention and service delivery not always achieved individually (Longlett, Kruse, & Wesley, 2001; Mullen & Epstein, 2002). Providers contribute to community-based efforts and results are enhanced through the contributions of community partners. Such community partnerships also support the AAP’s call for “synthesis of clinical practice and public health principles to promote the health of all children within the context of family, schools and communities” (Haggerty, 1968).

Other key players at children’s hospitals, such as advocacy committee members, can play an integral role in such collaborations. Experience and skills used in existing community-based advocacy efforts (e.g., child abuse and drowning prevention) and in legislative efforts can be readily applied to obesity prevention and management.
During challenging economic times, hospital administrators may need to be reminded of the value of such networks and the designated staff time required to maintain relationships at the community level. Highlight the link between the hospital’s mission and refresher courses. Note how hospital staff involvement will improve and assure a coordinated health care strategy incorporating obesity prevention, policy change and early intervention. Such strategies can improve outcomes and reduce costs.

**Potential opportunities for networking**

Collaborating with state and national advocacy groups provides multiple avenues to maximize an obesity program’s impact. For example, an institution can collaborate with state AAP chapters to plan CME offerings pertaining to management of pediatric obesity or advocacy issues. In addition to enhancing provider competence and comfort in working with overweight youth and their families, such CME offerings can serve as a forum to strengthen clinical networks, including connecting providers with healthy lifestyle community organizations. Youth moving among neighborhood clinics, community-based organizations and obesity center – and back again – ultimately benefit from strong and integrated clinical systems.

Advocacy for improved reimbursement for obesity services, at both the primary and tertiary care levels, is another area of collaboration for existing and new networks. The Alliance for a Healthier Generation has linked with employers, insurers and consumers in a program supporting primary care providers and registered dieticians in efforts to promote healthy eating and fitness. AAP councils can also bring issues of payment and service to the attention of insurers.
Community engagement with grassroots efforts and coalitions

In high-risk populations, effective coalitions and programs for community-wide interventions can be developed through community engagement and grassroots efforts. Targeting policy work and sustainable system change becomes more doable when working together across sectors of the community. Children’s hospitals and obesity programs can play leadership roles by actively participating with local agencies, community organizations, networks and coalitions to address obesity prevention and management. Synergistic collaborations fueled by the passionate work of many leads to resilient communities, healthy lifestyle promotion and a greater impact on obesity prevention and management.

Through participation in Steps to Health King County, Seattle Children’s collaborated with local and state workgroups advocating for improved nutrition as well as physical activity and obesity prevention and management. Action for Healthy Kids and the King County Food and Fitness Initiative, funded by the Kellogg Foundation, are working to improve access to healthy foods and activities. Seattle Children’s also collaborated on broader health and safety promotion efforts with Harborview Medical Center and Public Health - Seattle & King County for a variety of active living initiatives (walking school bus project, safe playgrounds, bike helmet use). For more information, contact Mo Pomietto, MN, RN, Seattle Children’s, at mo.pomietto@seattlechildrens.org.

Build a Research Base

Many long-standing obesity programs have also established clinical research components. In those programs, these components play an important role in sustainability. A strong data collection program can provide the opportunity to partner with local experts as well as the ability to develop needed expertise. Programs can provide a patient base for interested research parties, such as local university programs, on medicine, dietetics, psychology or physical science. Research grant funding can help enhance programs or initiate new programs. The results of studies can help shape treatment techniques for future programs and guide development of universal recommendations.
The program team needs to examine these key areas:

- **Institutional expectations**: Does your institution expect research productivity as a component of your program? If so, what benchmarks are expected within what time frame? Are there local sources of research startup funds or private foundations that will support outcomes or community-based research?

- **Investigators**:
  - Who will they be? Look broadly to link effectively with the multidisciplinary nature of obesity-related science.
  - Who will control access to patients and patient data?
  - Who is responsible for grant submissions, and what are the institution’s expectations in this regard?
  - Are the interests of the investigators in line with the interests and expectations of the program staff?

- **Space**: Be cognizant that NIH-sponsored institutions have highly defined and complex rules for designation of research space as opposed to clinical care space.

- **Databases**: Outcome measurements require timely, robust and accurate data management. As electronic medical records develop and evolve, this arena is likely to change rapidly. Program leaders are advised to discuss expected needs with institutional IT staff well in advance of program initiation.

- **Institutional links and support personnel**:
  - Institutional review board liaisons and clinical research coordinators provide unique skills and are valuable members of an effective research team.
  - Financial grants administrators are often necessary to manage the documentation and legal needs of contract negotiations and financial management.
Provide Educational Opportunities

The advances of obesity-related services and the need for better community and medical understanding of their complexities make educational activities a core part of the mission for most programs.

Collectively, U.S. pediatric obesity programs can treat thousands. However, the obesity crisis has enveloped millions of children (Ogden et. al., 2006; Ogden, Flegal, Carroll, & Johnson, 2002; Troiano, Flegal, Kuczmarski, Campbell, & Johnson, 1995). In the NACHRI tool “Survey of U.S. Pediatric Obesity Programs at Children’s Hospitals,” programs reported a median of 110 patients seen per year — hardly sufficient to address a problem that already affects one-third of the nation’s children (Hanson & Hinton, 2008). Thus, interventions delivered by primary care physicians toward obesity prevention and early treatment offer the most promise. More importantly, families look to their health care providers as a significant resource to address weight concerns for their children (Eneli, Kalogiros, McDonald, & Todem, 2007).

As outlined in the recommendations of the 2007 AAP Expert Committee on obesity, the primary care physician will need to assume responsibility for prevention messages, tracking of BMI, early identification of weight problems, initial workup, counseling and motivation with appropriate referrals to dietitians, fitness professionals and subspecialists (Barlow, 2007). Thus, obesity programs within children’s hospitals have a responsibility to drive best practices for childhood obesity prevention and treatment through education, training and support for providers within academic medical centers as well as community providers.

A key aspect of most hospital-based programs is the development of models to educate pediatricians and family practices to better deal with children before obesity becomes severe.
For planning, consider the following:

- What collaborative teaching model can the program provide depending on your resources? What educational format (e.g., webinars, grand rounds, conferences) will provide easy accessibility for busy practitioners?
- What type of learning opportunities can the program provide for other individuals, such as: medical students, residents, fellows, nursing students and advanced nursing trainees, nutrition interns, social workers, physical therapists/exercise physiologists, community groups, university undergraduate and graduate students, patients and families?
- What teaching loads can the program realistically accommodate while providing seamless service?
- What oversight and evaluation processes will be required of your staff?
- Can these education activities be managed effectively within the clinical or research space and time under consideration? Do you require large spaces for group activities?
Know the Mechanics of the Business Plan

Building a strong foundation for your program requires a well-thought business plan. Remember that you will not always have 100 percent of the answers before the program launches.

Financial decisions

Understanding how the hospital makes financial decisions is essential in gaining administration support. This process is not always evident to physician leaders or program champions. Sometimes called an “executive sponsor,” a senior administrator or department chair is likely the person to best advise you on the approval process for your institution.

Most of the FOCUS on a Fitter Future programs were started or evolved without an official business plan, a fact that many program directors subsequently regretted. With the probable exception of boutique operations and bariatric surgery programs, weight management and obesity treatment programs usually do not make money. Even a bariatric program will generate a profit only at a certain threshold number of surgeries per year. Although the number varies, 25 surgeries per year has been suggested and is significantly higher than what most programs will perform, particularly during their early years. However, many pediatric outpatient subspecialties share this economic reality, and the non-financial gains to the institution can significantly offset the financial concerns. Most pediatric hospitals now recognize that the care of the obese child and adolescent is a core responsibility similar to the care and management of other chronic diseases. Program champions should acknowledge these issues up front and honestly, and present strategies to their institutions to maximize revenues, minimize costs and highlight the indirect and non-financial benefits to the community and the institution.

The financial planning aspects of program development are likely the most unsettling for most clinical champions because they usually have minimal experience in this arena. Therefore, it is advisable to consult with the experts. Departmental or institutional business administrators are sources for much of the necessary information needed and are excellent strategists on institutional politics and processes. Use them!
Funding sources

Nearly all the FOCUS on a Fitter Future programs describe a mixed process of revenue streams inclusive of clinical income, philanthropy, research grants and institutional support (Figure 3). The contributions of each of these sources vary among programs, all with concerns about long-term sustainability.

FIGURE 3 | REVENUE STREAMS FOR WEIGHT MANAGEMENT PROGRAMS

Source: Perspectives on Obesity Programs at Children’s Hospitals Survey
Clinical income streams:

- Physician/physician’s assistant/nurse practitioner billing revenues (driven by CPT codes and provider regulations)
- Other staff revenues (nutrition, physical therapy; allowances vary by state)
- Radiology revenues (usually directed outside the program but within the institution)
- Laboratory revenues (usually directed outside the program but within the institution)
- Consult revenues (psychology, subspecialty; usually directed outside the program but within the institution)
- Surgical revenues (driven by CPT and DRG codes and provider regulations; may be directed outside the program)

Most programs bill for individual service by the primary medical provider alone. A few programs, utilizing their institutional contracting operations and the voices of champions, have been successful in establishing bundled reimbursements for their programs — but usually not with significant increases in income over the standard processes. Advocacy efforts with federal and state policymakers and third-party payers continue to encourage payment for obesity-related services using disease management strategies.

Investigating reimbursement rates by payer mix is advisable in your institution to estimate returns. Investigation of obesity treatment reimbursement allowances by plans with large numbers of local covered lives can reveal particularly helpful or problematic insurers. This investigation is not meant to ration access, but instead to find out up front if payment for services will be frequently denied so that alternative funding can be identified. To ensure patient satisfaction and better reimbursement for your program, have the clinic staff pre-certify every patient for all possible visits within the center. (See Appendix C for payment template and sample prior authorization form.) The billing and collections operations have a cost as well. Take those taxes and any other corrections your institution expects into account during the planning phase.
Consider these revenue sources:

**Philanthropy:** Most FOCUS on a Fitter Future programs have utilized philanthropic gifts for operating support. Many national, state and local nonprofit organizations now support strategies to promote wellness and attack the obesity crisis. Collaborations with these entities can provide funding and enhanced community awareness, both critically important to new programs. Program directors are encouraged to use institutional development personnel and continuously monitor the environment for potential benefactors. Many large gifts result from interactions that begin small, and even small gifts can make a big difference to a new operation. Cultivation of ongoing relationships is crucial. Program directors are also encouraged to think beyond money when looking at philanthropy. Space, advertising, equipment, supplies, volunteers and brainpower are vital gifts that allow dollars to be spent in other ways. One note of caution: several FOCUS on a Fitter Future programs have noted difficulties in maintaining philanthropic support over time. Many organizations prefer to sponsor new or splashy opportunities and may target their giving broadly. Think creatively to keep these donors engaged.

**Research:** While many of the FOCUS on Fitter Future programs are beginning research activities, most do not yet have significant independent grant funding. The development of collaborations with successful investigators not directly involved with the obesity program can result in unique opportunities and experience in grant writing. Many basic science investigators need access to patient data and samples, and the creative program director may be able to fund partial staff support to facilitate that process. For example, to evaluate the effects of dietary changes on human leptin levels, funding for support of a nutritionist to develop and monitor the diet may be available. While research dollars cannot be used to fund clinical care, it can help the program cover the costs of crucial auxiliary staff for program evaluation.
Institutional support:
Most FOCUS on a Fitter Future programs depend to some degree on ongoing institutional support for operating expenses, administrative support and space. It is imperative to set the expectation from the start that the program will require a long-term commitment from the institution. The generation and maintenance of these funds requires careful and ongoing discussions with institutional leaders. If critical care and surgical revenues support child abuse programs and adolescent health, they can support your weight management program, too. Hospital leaders search for mechanisms to improve patient safety and reduce complications and their exorbitant costs, many of which are minimally reimbursed. If your team can help solve those problems by decreasing the severity of obesity and improving the quality of care delivered to obese patients, your hospital is likely to support your efforts. Most importantly, maintain regular communications with administrators on your program outcomes. Program leaders are again reminded to stay connected to the institution’s strategic plans and goals. If your institutional leadership sees your program as beneficial to the achievement of those goals, support is likely to be maintained.

Expenses
Estimating expenses is another difficult challenge for most program champions, but the hard work is already done. By this point, your list of expected personnel, equipment and space are complete, and your collegial business administrator has access to the costs and taxes that can be expected from each of those sources. (See Section 1)

When estimating expenses, be sure to:
☐ Evaluate the salary and benefits cost of each team member including bonuses and continuing education. Take into account expected increases over time.
☐ Evaluate the reimbursement capabilities of each team member.
  • The FOCUS on a Fitter Future programs noted extreme variation in the ability of team members to bill independently. The reimbursement success also varied widely. It is vital to understand your local rules as the team is assembled.
  • Consider reimbursement issues up front when developing your team.
Billable services vary by state and by insurer. In the “Survey of U.S. Pediatric Obesity Programs at Children’s Hospitals,” the following team members bill for their services: pediatrician, advanced practice nurse, physician assistant, pediatric psychologist and physical therapist. In certain states, registered dietitians and social workers also bill for their services.

**Writing a business plan for a hospital-based program**

Writing a business plan for the childhood obesity program is an important step in the development process. Including people from a range of backgrounds will help to strengthen the business plan. It may be helpful to model the obesity program business plan after a similar clinic or program in your hospital. Some clinics or other childhood obesity programs will share business plans with interested parties to use as road maps to design programs to fit the community’s needs. Depending on the expectations of your institution’s leadership, you may be asked to write a formal business plan. Inquire if your institution has an expected format or list of requirements. A sample is provided in Appendix D.
Business plan formats vary by organization, but typically:

**Include financial pro forma** — Commonly defined as a financial statement that reflects the effects of potential activity, a financial pro forma is often the least understood by staff with less financial background. It is highly recommended that you engage a business manager/finance manager early in the process to ensure that the pro forma follows the required form used at your organization and that you can include institutional assumptions, such as payer mix, lease costs, etc.

**Involve marketing and communications** — For the sustainability of any program, ongoing marketing and communications to consumers and referring physicians is necessary for appropriate patient recruitment, sustained institutional support and overall community awareness. Marketing strategies vary for each program depending on patient volume, criteria, target population, internal support, established relationships, finances and interest of each individual community in childhood obesity. Differences may exist when marketing the prevention, treatment and surgical components of one program.

Marketing activities to consumers, patient families, referring physicians and internal audiences could include:
- Web presence (Internet and intranet)
- Handouts
- Fact sheets
- Brochures
- Posters
- Advertising (print, radio, TV and Web)
- Direct mail
- Health fairs and conferences
- Success stories in video and print
- Informal informational sessions
- Physician practice visits by liaisons and program leader(s)
- Media relations (proactive and reactive)
- Relationships with key health community groups
Working with a contact in the hospital media relations department will help identify opportunities and enhance marketing efforts.

**Branding**

A SWOT (strengths, weaknesses, opportunities and threats) analysis is key to defining and understanding your product (see Appendix B). Familiarize yourself with names of other programs at your institution to identify a unique name linking to the main institution. Acronyms are overused and rarely memorable to the community. Usually the marketing department in your hospital can assist with the development of a name and logo. These pieces can be used on incentives, displays, handouts, giveaways, brochures and posters to increase marketing value. All of the materials need to be sensitive to the bias of obesity.

**Internal audience**

The first step in marketing is to focus on your internal environment. If feasible, identify marketing and website representatives as permanent members of your team. Also identify a contact from your hospital foundation to market the program to potential donors.

The main source of referrals will initially come from primary care and subspecialty clinics in your institution. Reach these clinics by conducting brown bag lunch and learn sessions and presenting at department staff meetings, management meetings and grand rounds. Hospital physician liaisons can be valuable in reaching the private practice environment. They already have established a network and a steady stream of communication. Beware of offering services that cannot be delivered. Many FOCUS on a Fitter Future programs have retracted their initial marketing efforts due to inability to meet community demand.

**Measure results of marketing efforts**

Marketing efforts can be measured by tracking number of calls or Web visits after a marketing effort; overall Web traffic, especially pages with the most traffic; number of sustained or new referrals based on physician outreach; and number of new assessments and patients based on consumer outreach. Most importantly, to define a successful campaign, identify the expected tangible outcomes prior to a marketing initiative.
“SUSTAINABILITY IS THE CAPACITY TO MAINTAIN SERVICE COVERAGE AT A LEVEL THAT WILL PROVIDE CONTINUING CONTROL OF A HEALTH PROBLEM.”

-Claquin, 1989

The Survival Guide provides a framework for building a successful pediatric obesity program that can adequately tackle the most common chronic health condition in childhood. Given the chronic nature of childhood obesity, scarce health care resources, high overhead costs to develop and maintain a program, and the long-term benefit of decreasing obesity-related co-morbid conditions and health care costs, pediatric obesity programs must remain sustainable.
Understand Conceptual and Operational Sustainability

Moving sustainability from a latent goal to a planned approach requires conducting a program needs assessment, formulating objectives, and developing and implementing strategies specifically to foster sustainability. Each strategy has to be continuously monitored and revised in response to patients’ needs, shifts in personnel and the overall strategic vision of the hospital. Figure 4 illustrates the three pillars of sustainability for a pediatric obesity program: social responsibility, environmental stewardship and economic strength.

FIGURE 4 | THREE PILLARS OF SUSTAINABILITY
THE PEDIATRIC OBESITY PROGRAM
Follow General Strategies for Sustainability

The program champion must:

☐ Institute a continual evaluation process that responds to the changing needs of the patients, families and communities

☐ Garner a visible acknowledgement of institutional support to the program, e.g., linking the obesity program to the hospital’s mission or a component of the strategic plan

☐ Identify key outcome measures or benchmarks to monitor trends and to present a consistent case for continual support from the hospital

☐ Actively seek and embrace opportunities that enhance and diversify the program

☐ Understand and plan to tackle the financial risks inherent in operating a program in a resource-scarce and competitive environment

☐ Build a network of stakeholders that includes health care providers, administrators and patient advocates

☐ Create three-year strategic and business plans to guide the program

☐ Continually emphasize the negative impact on community support and trust if the program is inappropriately terminated

☐ Be alert to attempts from administration to downsize a program to a token program without the resources to provide significant clinical impact

Measure Outcomes

At the development of the program, key outcome measures must be identified, tracked and reported to your program administrator at least every three months regardless of whether this information is expected. This helps the program team maintain an open and active discussion with relevant administrators to minimize unpleasant surprises. In the survey “Perspectives on Obesity Programs at Children’s Hospitals,” demonstrating program effectiveness was the most frequently cited outcome measure to ensure sustainability (Figure 5).
Outcome measures include:

- Administrative: wait time, attrition rate, patient volume, satisfaction rates, net margin loss or gain, generation of downstream revenue
- Clinical: decrease in anthropometric measures, improvement in laboratory studies, physical fitness, dietary intake and quality of life
- Programmatic: partnerships established in the community, visibility in the community, media releases
- Research: number of publications, grant submissions and funding

**FIGURE 5 | OUTCOMES THAT DEMONSTRATE SUSTAINABILITY TO ADMINISTRATORS**

Source: Perspectives on Obesity Programs at Children’s Hospitals Survey
Define Programmatic and Operating Outcomes

Programmatic and operating outcomes relate to the day-to-day activities supporting the obesity program. Although monitoring these outcomes is typically tedious and time consuming, it is necessary because they create the framework for a successful and sustainable program. Largely, the success of these outcomes will be directly related to the competency of your program manager, the maintenance of open communication and the cohesiveness of program leadership.

Program Infrastructure:

- Hire a competent business manager familiar with the clinical and financial implications of running a program. Build on excellent communication and professional respect to create a strong relationship with your business manager.
- Learn appropriate coding to get optimal reimbursement from your payers. After the first three months, ask the billing department to audit your coding/billing to see what you have done right or wrong and what changes should be made to ensure that all services are covered optimally.
- Consider access issues for your staff and your target population. Extremely overweight patients require easy access to parking. Consider access to public transportation, if appropriate.
- Remember that teens and tweens, especially those with body image concerns, may be hesitant to be seen in standard pediatric medical environments.
- Do not forget education space for patients and trainees.
- Find and maintain the appropriate physical space for your program. Address the need early in the process and re-evaluate during the hospital’s capital budget process. Be sure to make a clear case for the type of space necessary to operate the program successfully.
- Activity suites may be part of your facility design. To cut costs and save space, consider making these available for other institutional programs. If exercise space is not available, look for partnership opportunities with local fitness clubs or YMCA locations.
Practice Management

- Plan and control the number of referrals in the early phases. Many new programs have found themselves understaffed, underequipped and rapidly frustrated due to large numbers of referrals. Plan and communicate your growth plans with your referring colleagues.
- Conduct periodic patient satisfaction surveys and encourage your patients to share, in writing, positive testimonials about their care.
- FOCUS on a Fitter Future members note long total clinic times (two hours for initial visits) due to the multidisciplinary nature of obesity. Visualize the use of your personnel, equipment and space to ensure sufficient and optimal use of facilities. Collaborate with an operational expert to conduct a capacity analysis of your proposed staffing and space.
- Consider visits where the patient is seen only by a physician to help improve your patient volume and revenue generation.
- If your space is shared by other programs, learn the successes and challenges of their clinic workflow. Strategize ways to make the addition of your program as seamless and trouble-free as possible.
- Conduct periodic surveys or structured interviews with your referring base at least once a year, either through feedback at grand rounds or through your hospital physician liaison officers, to remain responsive to its needs. Find innovative ways to collaborate with them on caring for the patients, e.g., promoting evening educational sessions on diet and activity for their practices.
- Actively participate in quality improvement projects and research protocols that will benefit your patients and your clinic, e.g., improving patient outcomes and generating positive publicity.
Highlight Benefits to the Institution

Most children’s hospital administrators are vested in increasing the visibility and reputation of their hospitals locally, regionally and nationally. A strategy for your program should be to align with such institutional goals.

Consider these tips:

- Identify how best to contribute to increasing hospital visibility. For instance, if the hospital has a strong emphasis on research, the program may seek to focus on obtaining grants. If the emphasis is on community relations and service, then highlight your activities in this area or seek opportunities to collaborate with the hospital on these initiatives.

- Maintain an active strategic outreach plan that involves media. Activities that increase visibility for the hospital both locally and nationally are usually viewed positively by the hospital.

- Have a visible and integral role in your hospital’s wellness policy, usually a sustainable hospital initiative important to senior level administrators because it decreases health care costs for the organization.

- Obesity program staff can help the institution ensure patient safety, a key objective for Joint Commission accreditation, by training staff on the care of the obese patient, appropriate equipment, instruments, clothing and facilities needed in clinics, operating rooms, diagnostic imaging suites and inpatient rooms.

- Sensitivity to the prevalent bias and stigma encountered by morbidly obese children and their families should be addressed through educational presentations and newsletters to ensure a safe environment for optimal care.

Sustainability of a pediatric obesity program should be guided by the three pillars: social responsibility, environmental stewardship and economic strength. Thus, each program needs to devise a strategic plan that develops and enhances each pillar in stepwise fashion starting with either an area of strength or greatest area of community need. A program that has successfully met most of its objectives and demonstrated growth within two three-year cycles of a strategic and business plan has the strongest probability of remaining sustainable.
REFERENCES


Sustainability
1. The capacity to maintain service coverage that will provide continuing control of a health problem. Service coverage will need to be benchmarked against the patient and family needs as the epidemic progresses.
2. The long term viability of a new program within an organization
3. Organizational change which supports the service coverage in an optimal manner including support of personnel, evaluation and patient services.
4. To develop the health promotion capacity of community health educators and to increase community capacity for obesity prevention and treatment.

Clinic — an office or clinical setting where patients are evaluated by a medical doctor or mid-level provider. Most pediatric obesity clinics are made up of a multidisciplinary team of providers that may include a nutritionist, physical activity specialist, social worker, psychologist or behaviorist. Many clinics also incorporate the expertise of sub-specialists as well. Services typically occur within a hospital-based setting and are billed to insurance.

Program — in this guide the term Program is intended to encompass a wide variety of types of programs including medically supervised weight loss programs, community-based prevention and intervention program and in some cases the overall work of a division or department of weight management. A program is a behavior-based series of visits for education and often physical activity, which may occur within the hospital setting or offsite. These visits may occur in a group format over a number of weeks or months and often involve parent/caregiver.

Weight Management Service — May be a combination of individualized clinic-based service delivery with group-based programmatic support.
SECTION 1
STARTING WITH A VISION

Identify a Program Champion:
This person must have a passion for addressing childhood obesity and have the administrative skills to be involved in program development. The tasks of the program champion at inception often include:

☐ Creating a strategic plan to guide program development
☐ Garnering institutional buy-in by advocating to hospital administration and boards
☐ Building a team
☐ Organizing collaborations with physician specialists
☐ Writing grants or business plans to fund the program

Determine where your program will be on the continuum of obesity care
Examine these key questions:

☐ What services will you provide?
☐ Will you start with a small, single-stage program with plans to grow, or do you have the resources to start with a bang?
☐ If starting small and growing is your plan, over what time frame do you expect to grow into what form?

Conduct an initial needs assessment
☐ Will this program provide access to services for currently unmet clinical needs for patients in the community?
☐ Will this program provide a resource to local medical providers and programs or will it be seen as competition?
☐ Will this program provide additional referrals to the institution, and will these additional referrals be welcomed or problematic?
☐ Can this program provide significant focus for institutional needs?
Develop a rationale for the obesity services you intend to provide
Craft this rationale to:
☐ Speak to the unique motivations of the hospital system
☐ Acknowledge that children’s hospitals have an important role in leading efforts to address the issue of childhood obesity

Develop institutional buy-in for your program
☐ Inform all identified stakeholders or groups
☐ Involve stakeholder individuals or groups
☐ Invite groups to participate in specific ways
☐ Ignite the institutional key players by keeping them apprised of program successes as well as the overarching rationale to support the program

Identify internal business support and an administrative partner
☐ Foster relationships with an individual in the organization who can help lead the program champion through the business side of development efforts.
☐ Identify a member of the administrative team who can sponsor the movement forward of the program development.

Gather support from medical staff
Ideally, the physician champion will meet personally with subspecialists who will be valuable resources in treating patients. Initial work in this area can garner support and teamwork for the program. Face-to-face communications can help to build teamwork among the physician champion and the hospital’s subspecialists. Consider collaboration with:
☐ Endocrinology
☐ Cardiology
☐ Nephrology
☐ Pulmonary/sleep clinic
☐ Orthopedics
☐ Other specialties that deal with a high volume of obese patients
SECTION 2
BUILDING THE PROGRAM

Administrative Planning
- Determine where your program will be housed within the hospital.
- Consider what department will house the program, but also how the program’s staff will relate to primary care and subspecialties and whether your program will be a medical home for obese patients.
- Clearly define roles and boundaries for staff and write explicit job descriptions.
  - Develop realistic reporting lines.
- Determine your space and building needs.

Link to the Institution’s Strategic Plan
Become familiar with the organization’s strategic plan and identify where your program’s goals align with the institution’s goals.

Personnel
- Build a multidisciplinary team to meet the diverse needs of the pediatric obese population.
- Hire personnel with the appropriate skills and passion for treating obese children.
- Develop a comprehensive training program for those staff.
- Provide for business and administrative support.

Building the Bridges with Primary Care Practices
- Plan for collaborating with community PCPs, other allied professionals and subspecialists.
- Develop specific referral criteria
- Communicate effectively with these community partners how and when to refer a patient
Connecting with Community Organizations
Locate organizations within the community that can enhance your patients’ success by providing services you cannot. Approach these organizations with partnership ideas, being careful to consider intellectual property and staff time dedicated to the partnership.

Outreach activities
Consider ways that your program can extend its reach through outreach efforts, i.e., training community partners or providing services in a satellite location.

Physical space
Consider the following space considerations:
- Location
- Amount of space needed
- Specialized equipment and rooms needed

Financial Planning
Begin with a business plan that addresses:
- Funding sources
- Income streams
- Program expenses

Marketing and Communications
Plan for:
- Program branding
- Internal marketing
- External marketing
- Measurement of marketing efforts
Advocacy: Building Clinical or Community Networks/Coalitions
Contributing factors to obesity are multifaceted and are part of a much larger social context that influence behavior, so become involved in a variety of arenas including:
- Local governmental agencies
- State and national advocacy groups
- Community engagement with grassroots efforts and coalitions

Research and Education
Research considerations:
- Institutional expectations
- Identify investigators and outline roles and responsibilities of program staff
- Space requirements for research
- Data storage and retrieval systems
- Institutional links and support personnel, including IRB contacts and grant administrators

For planning educational activities, consider:
- Student types
- Volume of students your program can accommodate
- Evaluation and oversight
- Space

SECTION 3
ADDING SUSTAINABLE VALUE TO YOUR INSTITUTION AND COMMUNITY

Sustainability of a pediatric obesity program should be guided by three pillars; social responsibility, environmental stewardship, and economic strength. Thus, each program needs to devise a strategic plan that develops and enhances each pillar in a stepwise fashion starting with its identified area of strength. A program that has successfully met most of its program objectives and demonstrated growth within two three-year cycles of a strategic and business plan has the strongest probability of remaining sustainable within its institution.
Social Responsibility
☐ Facilitating and contributing to community outreach through network building
☐ Committing to meeting the need for quality health care for obese children

Environmental Stewardship
☐ Program structure: Rather than a single specialty program, a diverse team of medical stakeholders is more likely to be viewed favorably and garner support necessary for long-term sustainability.
☐ Education: Free nutrition and physical activity seminars can be offered, teaching medical, dietetics, physiology, nursing, kinesiology, and therapeutic recreational students in your program, providing a visible and often appreciated service to your community.
☐ Benefit to the Institution: creation of a hospital-based wellness policy, training staff on the care of the obese patient, contributing to the visibility of their hospital locally, regionally and nationally.

Economic Strength
☐ Identify sources of funding for the program (internal, external or both) along with local community resources that may provide adjunct funding.
☐ Implement strategies to facilitate gradual financial self-sufficiency from the outset.
☐ Report key outcome measures to program administrator, regardless of explicit expectation, to keep communication open.
☐ Avoid focus on short term ROI in preventing or treating childhood overweight; rather value should be based on ability to control weight efficiently and improve the quality/length of life for target children.
APPENDICES

Appendix A: Examples of Weight Management Treatment Programs and Program Structures

Appendix B: SWOT Analysis from Helen DeVos Children’s Hospital’s Healthy Weight Center

Appendix C: Payment Template and Sample Prior Authorization Form

Appendix D: Sample Business Plan

Appendix E: Joint Commission certification for disease-specific care
ABOUT US

The National Association of Children’s Hospitals and Related Institutions is a not-for-profit membership organization of more than 200 children’s hospitals. The Association and its members are driven by a vision of a society in which all the nation’s children achieve their health potential. NACHRI promotes the health and well-being of children and their families through support of children’s hospitals and health systems that are committed to excellence in providing health care to children. It does so through advocacy, education, research and health promotion.

The American Academy of Pediatrics and its member pediatricians dedicate their efforts and resources to the health, safety and well-being of infants, children, adolescents and young adults. The AAP has approximately 60,000 members in the United States, Canada, Mexico, and many other countries. Members include pediatricians, pediatric medical subspecialists and pediatric surgical specialists. More than 34,000 members are board-certified and called Fellows of the American Academy of Pediatrics.

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