Weight Co-Management Guidelines

Lifestyle Medicine Collaborative (LMC) Program (Hepatology, Gastroenterology, Endocrinology, Cardiology and Clinical Nutrition)

These guidelines support referring patients with obesity. Guidelines include criteria for referral to Lifestyle Medicine Collaborative, NEW Kids, Endocrinology and Healthy Hearts programs. To support collaborative care, we have developed guidelines for our community providers to utilize when referring to, and managing patients with, the pediatric specialists at Children's Wisconsin. These guidelines provide protocols for jointly managing patient cases between community providers and our pediatric specialists.

Diagnosis/symptom:	Referring provider's initial evaluation and management:	When to initiate referral/ consider refer to Lifestyle Medicine Clinic (LMC):	What can referring provider send to Lifestyle Medicine Collaborative?	Specialist's workup after referral to LMC will likely include:

Signs and symptoms
Child age 2-18 years with BMI ≥ 85%
AND
• Serum ALT ≥40 or known NAFLD
AND
• Pre-diabetes or diabetes (non insulin-dependent)
OR
• Hyperlipidemia:
  • LDL >190 or LDL persistently >160 with lifestyle changes
  • TG >500
OR
• Hypertension
	Diagnosis and Treatment
	Diagnosis is based on history, physical and additional testing, which may include but not limited to: height, weight, blood pressure, BMI, BMI%, BMI z-score, lab work, including: lipid panel, ALT, glucose, hemoglobin A1c, LDL.
	Treatment can be based on underlying cause, severity of obesity, age and sex. Can include, but not limited to:
	• Lifestyle changes
	• Referral to additional sub-specialists at Children's
	• Referral to Behavioral/ Counseling
	• Medication
	• Liver FibroScan
	• Referral to Froedtert's Adolescent Bariatric Surgery
		Child age 2-18* years with BMI ≥ 85%
		≥ 2 comorbidities:
		WITH:
		• Serum ALT ≥40 or known NAFLD
		AND EITHER
		• Pre-diabetes or diabetes (non insulin-dependent)
		OR
		• Hyperlipidemia:
		  • LDL >190 or LDL persistently >160 with lifestyle changes
		  • TG >500
		OR
		• Hypertension
		**Any child with obesity before or by age 5, provider should consider a genetic referral.*
			In order to help triage our patients and maximize the visit, please include:
			• Growth charts
			• Chief complaint, onset, frequency
			• Recent progress notes
			• Urgency of the referral
			• Labs and imaging results
			• Other diagnoses
			• Office notes with medications tried/ failed in the past and any lab work that may have been obtained regarding this patient's problems
				• Parents will be called for an appointment.
				• Clinic is held twice per month.
				• Patients will meet with a PNP in GI, Hepatologist, Endocrinology PNP/ MD or Cardiologist MD, and registered dietitian for the first visit
				• RD and GI PNP for the second visit or Endocrinology PNP
				• Additional visit with full team (GI PNP, Endocrinology/Cardiology, Hepatologist, RD) 6 mos. after initial visit
				• A liver FibroScan (measures fat/ fibrosis) will be performed biannually.
				• Labs will be rechecked 1-6 months after initial visit
				• The patient may be referred to additional specialists if needed.
				• Information about the Lifestyle Medicine Collaborative Program: childrenswi.org/lifestyle-medicine-collaborative-clinic

Send referrals to Children's LMC.

- **Internal referral via Children's Epic**
  Send an ambulatory referral to *Lifestyle Medicine Clinic*. OR to *Weight Management*.
- **External referral via Epic**
  Send to CHW GASTROENTEROLOGY CLINICS. Add Lifestyle Medicine Collaborative in the notes/comments.
- **Via fax**
  (414) 607-5288
- **Via phone**
  (414) 266-2420

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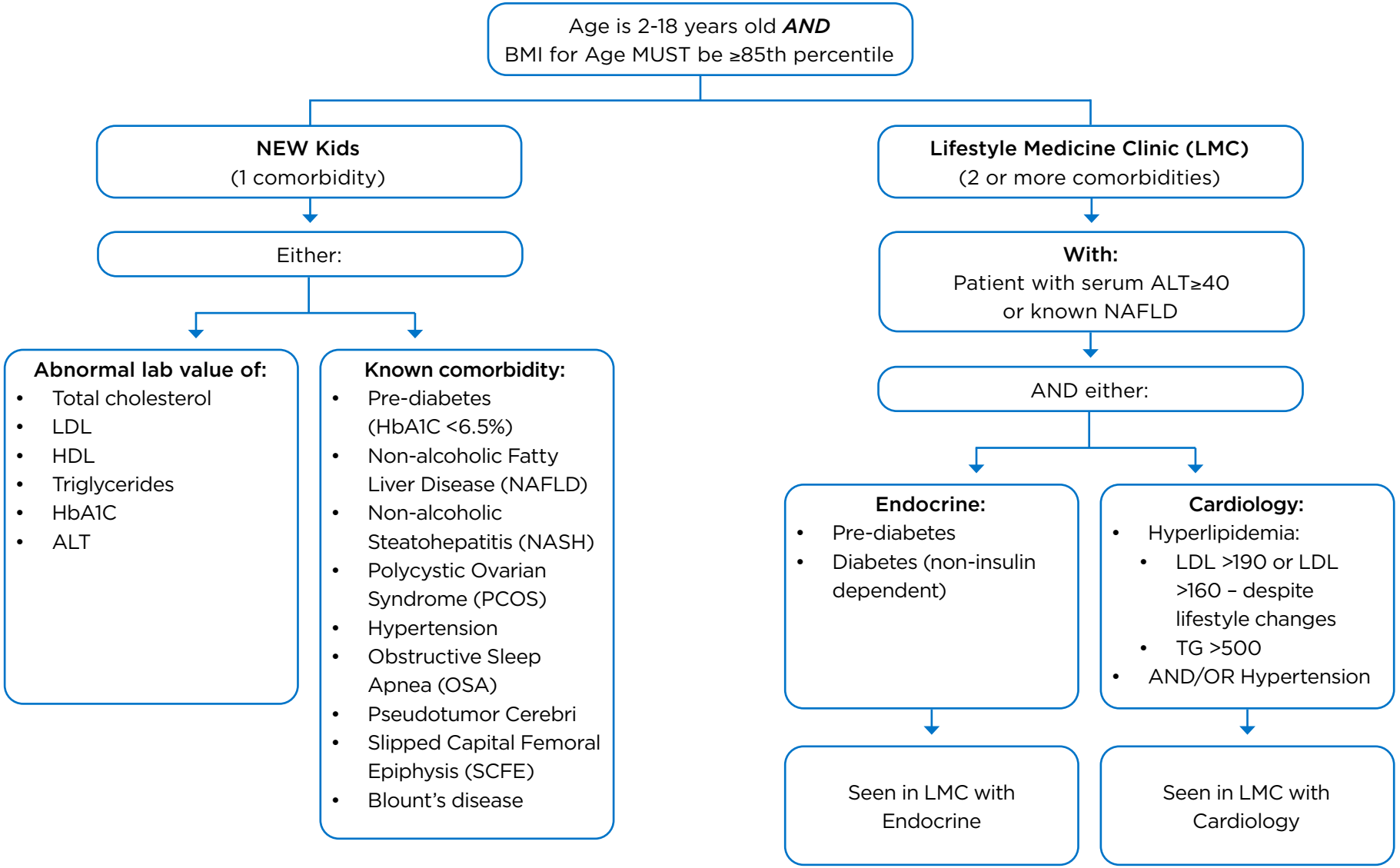
Kids deserve the best.



For questions concerning this work, contact mdconnect@childrenswi.org

Updated: 6/2024, Cara Mack, MD

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