



REPLY TO  
ATTENTION OF

DEPARTMENT OF THE ARMY  
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND  
2748 WORTH ROAD  
FORT SAM HOUSTON, TEXAS 78234-6000

MCCG

09 MAR 2012

MEMORANDUM FOR Commanders, MEDCOM Regional Medical Commands

SUBJECT: Screening and Prevention of Childhood Obesity

1. Although lower than the national average, childhood obesity is still a problem with our military children. The 2010-2011 clinical body mass index (BMI) data of children ages 2-18 years of age show that nearly one-third of Army children are either overweight (15 percent) or obese (13 percent). These children represent the future of the nation's workforce including the armed forces, and it is critical that we address obesity now to ensure optimal health for this generation.
2. In order to address the obesity epidemic, we must engage parents in the discussion on how they can help their children achieve and maintain a healthy weight. Primary care providers have critical opportunities to document and address the issue of healthy weight with parents and children.
3. Therefore, I direct all MTF Commanders to have their primary care teams perform the following actions to improve the documentation, diagnosis, treatment and prevention of overweight and obesity in military children:
  - a. Objectively measure a child's height/length and weight at each visit and enter data into the vital signs section of AHLTA. AHLTA will automatically calculate the BMI in both the vital signs and clinical encounter notes section.
  - b. Plot and assess child's weight and BMI status and determine if the child is overweight or obese using the U.S. Centers for Disease Control and Prevention's (CDC) clinical growth charts for boys or girls. Find the growth charts on the CDC's website: [http://www.cdc.gov/growthcharts/clinical\\_charts.htm](http://www.cdc.gov/growthcharts/clinical_charts.htm).
    - (1) For infants and children 0-2 years of age, assess gender specific weight-for-length percentile.
    - (2) For children and teens 2-18 years of age, assess gender specific BMI-for-age percentiles. A healthy BMI-for-age percentile range is between the 5<sup>th</sup> and 85<sup>th</sup> percentile; a range between the 85<sup>th</sup> and 95<sup>th</sup> is classified as overweight; and anything equal to or greater than the 95<sup>th</sup> percentile is defined as obese.
  - c. Enter the appropriate diagnosis into the child's problem list.

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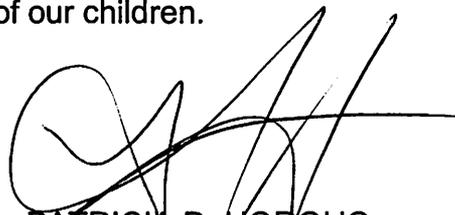
SUBJECT: Screening and Prevention of Childhood Obesity

d. Address weight status and provide age-appropriate education on the prevention and treatment of overweight or obesity, at least annually. Discuss with children and their parents the actions they can take to prevent becoming overweight or obese; these include healthy eating habits, increased physical activity, and decreased time using electronic devices for entertainment (television, video games, etc). Provide referrals as appropriate.

e. Follow nationally recognized guidelines for the treatment and prevention of childhood obesity, "Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity – 2007," [http://pediatrics.aappublications.org/cgi/reprint/120/Supplement\\_4/S164](http://pediatrics.aappublications.org/cgi/reprint/120/Supplement_4/S164).

4. Additionally, all MTFs should be aware of the benefits of breastfeeding and take recommended actions to promote breastfeeding at all MTFs and clinics.

5. Actively addressing childhood weight and obesity not only supports MEDCOM's transition from a healthcare system to a system of health, but sets the child on a healthier path in life. I appreciate your support with incorporating these guidelines into your practice to improve the quality of life of our children.



PATRICIA D. MOROHO  
Lieutenant General  
The Surgeon General and  
Commanding General, USAMEDCOM

Encl  
HA Memo (Child), 17 Oct 11



## THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

17 Oct 2011

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)  
ASSISTANT SECRETARY OF THE NAVY (M&RA)  
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)  
COMMANDER, JOINT TASK FORCE, NATIONAL CAPITAL  
REGION MEDICAL  
DIRECTOR, TRICARE MANAGEMENT ACTIVITY

SUBJECT: Guidelines for Management and Prevention of Adult Obesity

Adult obesity rates in the United States have reached epidemic proportions. Nationally, 33.8 percent of adults are obese and 68 percent are either overweight or obese. Based upon 2010 data, 26 percent of adults enrolled to Military Treatment Facilities (MTF) in the Military Health System (MHS) were considered obese, and 66 percent of adults were either overweight or obese, which is comparable to national rates. Obesity is a serious concern in the MHS, and work remains on this critical issue as it does impact military readiness.

To decrease rates of overweight and obesity in MHS adults, I am requesting that the Surgeons General direct all primary care providers to:

- Objectively measure a patient's height and weight at each visit, assess the patient's Body Mass Index (BMI) using Centers for Disease Control and Prevention (CDC) guidelines to determine if the patient is overweight or obese, and enter the appropriate diagnosis into the patient's problem list (if applicable).
- Provide all patients with appropriate education and counseling on the prevention and treatment of being overweight or obese, at least once yearly, regardless of risk.
- Discuss with patients the actions they can take personally and within their family to help prevent overweight and obesity. Address healthy eating habits, increased physical activity, and decreased time using electronic devices for entertainment (screen time).
- Follow the Veterans Health Affairs/DoD Clinical Practice Guideline for the Screening and Treatment of Overweight and Obesity in their practices

To decrease the rate of overweight and obesity in adults receiving care in the purchased care sector, TRICARE Management Activity (TMA) will develop and implement a communication plan to encourage network primary care providers to accomplish these same measurement, diagnosis, documentation, treatment, and prevention efforts whenever a TRICARE beneficiary is seen by them.

In order to assess compliance with these guidelines in MTFs, TMA is developing measures to follow the prevalence of overweight and obese beneficiaries in the direct care system, as well as documentation of the appropriate diagnosis on a patient's problem list when his/her BMI meets the CDC definition for overweight or obese.

WA  
10/24/11

A referenced guidance document providing more detailed information on the background and reasons for these directives can be found in attachment 1. Additionally, attachment 2 contains a list of resources to aid providers as they implement this policy in their practice.

Updates to these guidelines will be published as required to reflect significant advances from ongoing research in the field of adult obesity management. Questions may be directed to John P. Kugler, M.D., MPH, Deputy Chief Medical Officer, Office of the Chief Medical Officer, TMA, Falls Church, Virginia, (703) 681-0064.

A handwritten signature in black ink, appearing to read "Jonathan Woodson". The signature is fluid and cursive, with a large initial "J" and "W".

Jonathan Woodson, M.D.

**Attachments:**

As stated

## **Guidance: Management and Prevention of Adult Obesity**

### **Attachment 1**

#### **Background**

Adult obesity rates in the United States have reached epidemic proportions. Results from the 2007–2008 National Health and Nutrition Examination Survey indicate that 33.8 percent of adults in America are obese<sup>1</sup>. Over two-thirds of American adults are either overweight or obese (68 percent). Obesity is a risk factor for many different chronic diseases such as diabetes, hypertension, high cholesterol, stroke, heart disease, certain cancers, and arthritis<sup>2</sup>. Excess mortality, primarily from cardiovascular disease, diabetes, and certain cancers is related to higher grades of obesity<sup>2,3</sup>. Of the conditions related to obesity, type II diabetes is the most closely linked, with significant increases in the prevalence of diagnosed diabetes in the United States from 1988–1994 through 2005–2006<sup>4</sup>.

While reports on rates of adult obesity within the Military Health System (MHS) generally show that they are lower than comparable rates nationally, it is still a serious concern. Data from the Department of Defense's (DoD's) electronic medical record, Armed Forces Health Longitudinal Technology Application (AHLTA), during 2010, that were subsequently extracted from the Clinical Data Mart, show that 26 percent of adults were considered obese. However, the combined rate of overweight and obesity in adults was 66 percent, very similar to the national rate. Work still needs to be done to decrease rates of obesity in MHS adults and to help those in the overweight category reach a healthy weight and not progress to obesity.

#### **Measurement, Diagnosis, and Documentation**

The U.S. Preventive Services Task Force recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Body Mass Index (BMI), which is a measure of body weight adjusted for height, is a useful tool to assess body fat and to determine whether an individual is overweight or obese. BMI is defined as weight (in kilograms) divided by the square of height (in meters). To appropriately calculate a patient's BMI, a patient's weight and height should be objectively determined. A patient's self-reported height and weight should not be used. A person with a BMI of 25 to 29.9 kg/m<sup>2</sup> is defined as overweight, while someone who has a BMI of 30 to 40 kg/m<sup>2</sup> falls into the obese category and a BMI of greater than or equal to 40 kg/m<sup>2</sup> constitutes morbid obesity, according to Centers for Disease Control and Prevention's (CDC's) definitions. While CDC's definitions should be used for diagnosis in most cases, each patient should be considered individually, taking into account their body composition, particularly in heavily muscled or very athletic individuals.

In order to properly document and provide necessary care, primary care providers should, at each visit, ensure that the patient's objective height and weight are measured; assess the patient's BMI using CDC's guidelines to determine if the patient is overweight or obese; and, if the patient is found to be in either category, to enter the diagnosis into the patient's problem list. The patient's height and weight should be entered into the vital

signs module of AHLTA, which will automatically calculate the BMI and display it with the other vital signs. If a patient falls into any of the CDC categories listed above, an appropriate diagnosis should be entered into the patient's assessment and problem list. This will ensure that whenever the patient is seen, whether by a primary care practitioner or a specialist, the diagnosis will be in the forefront of the patient's medical issues and can be addressed within the context of the particular visit. Nutritional counseling provided at a visit should be documented using appropriate codes by linking to the obesity or overweight diagnosis in the patient's assessment portion of the progress note in AHLTA. In addition, all patients should receive appropriate education and counseling, at least once yearly, regardless of risk, on the prevention and treatment of being overweight or obese. A list of resources to help providers accomplish this can be found in attachment 2. TRICARE Management Activity (TMA) will develop and implement a communication plan to encourage network primary care providers to accomplish these same measurement, diagnosis, documentation, treatment, and prevention efforts when a TRICARE beneficiary is seen by them.

### **Treatment and Management**

The MHS has already dedicated itself to the implementation of Patient-Centered Medical Homes (PCMHs) across our primary care venues, providing improved care coordination and integration. In order to incorporate our efforts of combating obesity, primary care providers should follow the Veterans Affairs/DoD Clinical Practice Guideline for the Screening and Treatment of Overweight and Obesity ([http://www.healthquality.va.gov/obesity/obe06\\_final1.pdf](http://www.healthquality.va.gov/obesity/obe06_final1.pdf)) in their practices. Similarly, TMA will encourage network primary care providers to follow nationally recognized, evidence-based clinical practice guidelines for the screening and treatment of overweight and obesity. Additionally, TMA will review and update, as appropriate, its nutritional and obesity counseling benefits.

### **Prevention**

While the development of weight reduction strategies needed to treat patients once they are diagnosed as being overweight or obese is necessary, initiatives focusing on changing lifestyle behaviors to prevent obesity are imperative. In order to halt the obesity epidemic, efforts must be targeted at all patients and their families. Primary care providers should discuss with patients the actions they can take personally and within their family to help prevent overweight and obesity. This discussion should address healthy eating habits, increased physical activity, and decreased time spent watching television and using electronic devices for entertainment (screen time). The previously described communication plan will additionally encourage network primary care providers to counsel their patients on obesity prevention when a TRICARE beneficiary is seen by them.

### **Community Involvement**

While medical guidance is important, obesity prevention encompasses behavioral changes and activities in many areas of life and within the entire family. Programs available on military installations, and in the community, such as in schools, wellness centers, youth programs, and recreation centers, as well as changes in food environments,

such as commissaries, cafeterias, and vending machines to make healthy foods more accessible are integral as well. TMA will support obesity prevention initiatives in non-medical areas.

#### References

1. Flegal K, Carroll M, Ogden C, Curtin L Prevalence and Trends in Obesity Among US Adults, 1999-2008. *JAMA*, January 20, 2010; 303(3):235-241.
2. Malnick SD, Knobler H. The medical complications of obesity. *QJM*. 2006;99(9):565-579.
3. Flegal KM, Graubard BI, Williamson DF, Gail MH. Cause-specific excess deaths associated with underweight, overweight, and obesity. *JAMA*. 2007;298(17):2028-2037.
4. Cowie CC, Rust KF, Ford ES, et al. Full accounting of diabetes and pre-diabetes in the US population in 1988-1994 and 2005 2006. *Diabetes Care*. 2009;32(2):287-294.