2026 KACO Posts

January

A recent study out of Chicago's "failure" is far less discouraging than it might appear.

Children from lower-income households are less likely to benefit from weight management interventions, even though they're almost twice as likely to be obese. Historically, program attendance predicts weight loss outcomes, and lower socioeconomic status predicts lower attendance. A recent study provided in home sessions to address this barrier to care and assess their efficacy.

The Creating Healthy Environments for Chicago Kids(CHECK) randomized controlled trial provided 6- to 12-year-old children from lower-income households with BMI >85 percentile with a weight management program. The plan consisted of a family-based pediatric weight management program with 12 monthly telephone support calls and 18 in-person sessions. The only difference in the treatment arms was the location of the 18 in-person sessions; home-delivered(n=133) vs clinic-delivered(n=136).

This study was unfortunately plagued by COVID restrictions. Delivering family-based weight management in the home setting did not improve 12 month zBMI change(the primary study outcome) relative to the clinical setting when patients were evaluated in aggregate. However, the pre-pandemic patients who were randomized to home-delivered treatment did experience larger zBMI reductions prep pandemic. This effect was not significant in the peri- nor post pandemic patients. Why this reversal during the pandemic? It may be that participants had to perform 46 "in-person" sessions via video or telephone conference due to COVID restrictions. Stated differently, during the pandemic, for both arms, many of the "in-person" sessions weren't performed in-person.

Pre pandemic participants received the interventions per study design and without pandemic historical confounding. Peri and post pandemic participants were subjected to an altered intervention and historical confounding.

Overall, being in the home-delivered treatment arm did increase session attendance and in-person contact time, which was associated with better weight loss outcomes amongst all study participants. The home-delivered and clinic-delivered groups had a median of 500 minutes(8.3 hours) and 315.5 minutes(5.3 hours) contact time, respectively(P= 0001). It is worth noting that this is far fewer than the USPSTF's recommended 26 hours of contact.

Despite these challenges, 13.7% of participants had clinically significant weight loss(zBMI 0.25) in the home-delivered arm and 8.6% in the clinic-delivered arm, though these differences weren't statistically significant (OR = 1.53, 95% CI [0.61–3.81]; P = .36).

This study, taken at face value, could be used to dismiss home-delivered interventions. However, given significant historical confounding and protocol changes due to unique pandemic challenges it is inappropriate to claim this study proves home-delivered interventions are ineffective. If anything, it reinforces the importance of in-person contact.

This study demonstrated clinically significant BMI reductions in 11% of participants, even though it falls short of the providing the recommended minimum of 26 contacts hours.

Home-delivery of in person care provided reassuring appearing results pre-pandemic and increased in-person contact hours with patients. It would be interesting to see a similar study that met USPSTF contact hour recommendations and wasn't confounded by a global pandemic. Bravo to the study authors for doing their best to stick to their original study design, despite significant and unforeseeable challenges.

PS-
There were also fewer adverse events amongst patients and their families in the in-home intervention arm(6) vs in clinic arm(18), and most events occurred in adult family members. None were serious.

https://publications.aap.org/pediatrics/article/155/4/e2024069282/201163/Home-Delivered-Pediatric-Weight-Management-for-Low?autologincheck=redirected

February

Something that obesity and autism have in common.

If you are like me, you can appreciate a good podcast on a drive. I love podcasts that take a deep dive into a subject that a two-minute report can't do justice to. The Daily from The New York Times is one such podcast. The November 24, 2025, episode "The Autism Diagnosis Problem" is a 30-minute podcast that does a nice job of addressing the challenge we pediatricians face in grouping a wide range of patients into a single diagnosis. I would recommend listening to the podcast. As you do, ask yourself, "Is there a parallel with obesity as a diagnosis?" I could not stop thinking that we need to be more granular when thinking about our patients with overweight and obesity and severe obesity. The patient with overweight shares very little with the patient with severe obesity, and the patient with obesity at age two has many different needs than a patient whose obesity only shows up in adolescence. As pediatricians, what do we need to do to be there for **all** our patients with excess adiposity?

You can find the podcast HERE on Spotify or HERE on Apple Podcasts. If you listen elsewhere, search for "The Daily: The Autism Diagnosis Problem".

March

The new *Dietary Guidelines for Americans* tends to stray from the recommendations of their own Dietary Guidelines Advisory Committee (DGAC). The Administration claims to do so to be “free from ideological bias, institutional conflicts, or predetermined conclusions.”

Let’s review the evidence-based recommendations made by the Dietary Guidelines Advisory Committee and compare them with the patient-forward information, as well as the disclosed conflicts of interest.

In *The Scientific Foundation For The Dietary Guidelines For Americans*, it is stated that “over 35% of our nation’s kids have excess body weight, more than 20% meet the criteria for obesity, 1 in 14 are severely obese, and 25% are prediabetic.” Much of the blame is placed on “the Standard American Diet—a typical U.S. diet high in processed foods, added sugars, unhealthy fats, and sodium, while being low in fruits, vegetables, and whole grains.” The DGAC has consistently recommended “reorganizing protein food subgroups to prioritize beans, peas, and lentils while listing meats, poultry, and eggs last.” This is consistent with any number of other national guidelines.* The DGAC encouraged plant-based fat and protein replacements. However, the Trump administration remained critical of the reorganization of protein sources as well as fat and protein replacement with plant sources and criticized the DGAC for not focusing on highly processed foods and not taking a stronger position on limiting added sugar for children. This criticism seems unwarranted; the DGAC’s 14th, 24th and 25th recommendations, which recommend limiting food and drinks high in added sugars, were accepted into the Guidelines.**

Examples of the DGAC's science-based recommendations that were not implemented in the new guidelines, include but are not limited to:

7. Enhance the guidance (replace saturated fat with unsaturated fat, particularly PUFA) to indicate that replacement with MUFA and PUFA should focus on plant-based sources.

10. Reorganize the order of the Protein Foods Subgroups to list Beans, Peas, and Lentils first, followed by Nuts, Seeds, and Soy Products, then Seafood, and finally Meats, Poultry, and Eggs.

11. Continue to emphasize consumption of low-fat or nonfat dairy and unsaturated fats.

12. Limit consumption of red and processed meat, foods high in saturated fat, and salty/savory snacks. (Partial)

16. Include more nutrient-dense plant-based meal and dietary recommendation options.

18. The Eat Healthy Your Way Dietary Pattern supports flexibility in the proportions of plant- to animal-based Protein Foods consumed that further increases plant-based and decreases animal-based Protein Foods.

25. Reaffirm current guidance to lower consumption of butter and replace butter with vegetable oils that are higher in unsaturated fatty acids.

26. Promote replacement of plant sources higher in saturated fat, such as coconut oil, cocoa butter, and palm oil, with vegetable oils higher in unsaturated fats.(Yup, even plant-based saturated fats are a bad idea. Animal-based foods just happen to generally be higher in them).

34. Use structured feeding practices to promote children's intake of vegetables and fruits, including making those foods available and accessible in the home, providing repeated exposure to new foods, and modeling healthy eating behaviors.

37. For children, use portion size strategically to promote intake of vegetables and fruits.

50. Conduct consumer research on the dietary pattern and food group and subgroup names: ◦ Recommend new consumer research regarding the food group name, "Protein Foods," because foods in other food groups also contain protein.

55. Consider the findings of 2 other expert committees that are addressing alcoholic beverages and health outcomes.

56. Enhancements to current guidance should focus on feeding practices, which refer to specific goal-oriented behaviors used by caregivers to shape and/or guide children's eating behaviors. The Committee recommends describing feeding practices along higher-order conceptual dimensions of structure, autonomy, support, and control.

The result of ignoring these recommendations is a mixed message. It is a good thing to encourage whole foods while limiting processed foods and added sugars. But the guidelines embrace animal fat and animal protein sources.*** The new pyramid commits an entire corner to protein, showing a large steak, a whole chicken, a large wedge of cheese, and a packet of ground beef, among other things. Elsewhere on the figure, there is an entire stick of butter adjacent to an almond and two peanuts. There are four blueberries, two strawberries, and an entire bunch of bananas. It intuits nothing of portion size. Similarly, the *Dietary Guidelines for Americans* encourages prioritizing protein at every meal, adjacent to a visual of a beef kabob. The text encourages Americans to "consume a variety of protein foods from animal sources, including eggs, poultry, seafood, and red meat, as well as a variety of plant-sourced protein foods, including beans, peas, lentils, legumes,

nuts, seeds, and soy." The very next recommendation is to "consume dairy," and to "include full-fat dairy." This is in direct disagreement with the recommendations of their own DGAC(11).

For these reasons, and many others, the new guidelines fail as an evidence-based visual aid. Not only does it disagree with the recommendations of the DGAC, it seems to have no serious intention of informing the users about portion size nor diet composition. Dietary guidelines should direct people towards what they should eat, how much of it they should eat, and how to eat it. This shows a smattering of mismatched ingredients with no respect to dietary proportions or portion guidance. Note the entire carafe of olive oil.

At least some of the deviations from the evidence-based recommendations, as well as inconsistencies in the patient forward information, can likely be explained by reviewing their disclosed conflicts of interest. The ignored recommendations seem to coincide with many of the disclosed conflicts of interest (starting page 12). You may have guessed, but yes, quite a few conflicts of interest are from the beef and dairy industries.

The biggest deficiency of the *Dietary Guidelines for Americans* is that it won't likely change much of anything for the average American. The problem, historically, hasn't been the quality of the previous guidelines; it has been that the American diet doesn't reflect them. For these Guidelines to make a difference, they need to change how we approach our food supply. Policy must match the evidence, even the limited parts we agree on, to ensure that they have a meaningful positive impact on the American diet. If these guidelines resulted in an expansion of access to healthy foods for SNAP recipients, or consistent, meaningful improvements in the school lunch program, better supplemental nutrition services, or any other number of real-world improvements in the nutrition of Americans, then their shortcoming could easily be forgiven.

Feel free to review *The Scientific Foundation For The Dietary Guidelines For Americans.*

Chapter 8 is dedicated to *Special Considerations for Life Stages and Vegetarians &Vegans;* pediatric specific information can be found there.

https://cdn.realfood.gov/DGA.pdf

https://cdn.realfood.gov/Scientific%20Report_508.pdf

*If you want to check out the Dietary Guidelines of other countries, The Food and Agriculture Organization of the United Nations them available with this link:

https://www.fao.org/nutrition/education/food-dietary-guidelines/regions/countries/united-states-of-america/en/. You will notice a lot of common themes, as well as quite a few that use a triangle or a pyramid. It is important to note that, the shape of the guidelines and the content aren't likely why we're facing our public health crisis. Countries with similar guidelines to ours have vastly different outcomes. If you want to direct your patients to more sane guidelines, there are lots of good options here. I wonder if this wouldn't be a better resource for our recently arrived patient families with different cultural eating patterns.

**14. Continue to limit foods high in added sugars, including sweetened beverages and foods.

23. Recommend plain drinking water as the primary beverage for people to consume. Water beverages flavored with a small amount of 100% fruit juice may also be suggested as a healthy option.

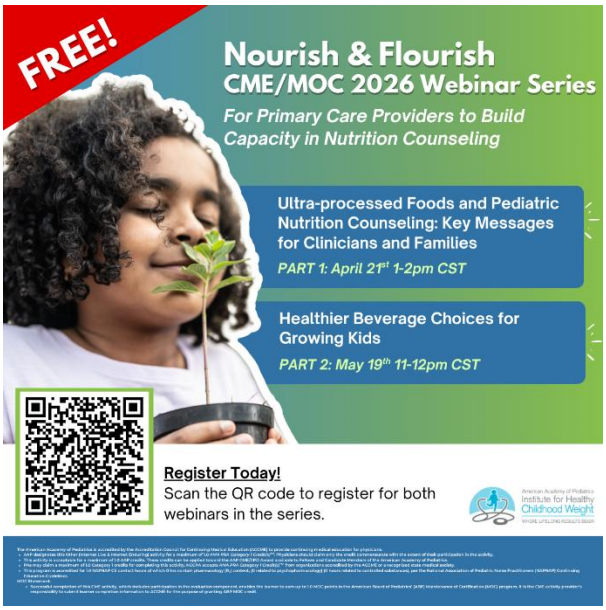
24. Recommend intakes of sugar-sweetened beverages and other beverages that contain added sugars with minimal or no beneficial nutrients should be limited, rather than reduced/decreased.

*** https://cdn.realfood.gov/DGA.pdf

April

Looking for practical guidance on ultra-processed foods and healthy drinks for your patients?

Consider registering for the following webinars presented by the AAP's Nourish and Flourish program. The webinars focus on recent changes to recommendations, content to target with families, and strategies for helping implement changes. The program is free and provides CME and MOC Part 2 credit.



May

The AAP recently updated its 2013 policy statement on “The Crucial Role of Recess.” Since that initial statement on recess, the AAP has described The Role of the Pediatrician in the Promotion of Healthy, Active Living and advocated for Healthy Active Lifestyles for Families as well as Helping Kids Build Healthy Active Lives. Advocating for recess provides us an opportunity to make movement a fun routine, while addressing other important developmental needs and improving health outcomes.

The AAP has explored the need for physical activity and our role in advocating for it. But is there an evidence basis for what specifically we should advocate for with respect to recess? What should we seek with respect to time, duration, supervision, etc.?

First, let’s explore the updated policy “The Crucial Role of Recess in School: Policy Statement” and then, let’s explore some of the specific recommendations.

The policy statement treats recess as a need. No longer optional nor at the discretion of an individual teacher, it is described as a “necessary break for optimizing a child’s social, emotional, physical, and cognitive development.” They further define it as “personal time” that should not be interfered with, neither for academic nor punitive reasons. It is to be supervised, “regularly

scheduled period in the school day for physical activity and play" where students of all grade levels "are encouraged to be physically active and engaged…in activities of their choice." Child-directed socialization and autonomy are encouraged in a safe, supervised environment. Recess should provide regular restorative breaks free of cognitive effort.

By elevating recess, the policy chooses to develop the whole child for the intellectual, social, and emotional rigors of adulthood, as opposed to preparing them for laboring in a fashion in which break times are viewed as existing in competition with academics or work. To develop the whole child, three core benefits of recess are described: social and emotional benefits, physical benefits, and cognitive benefits. There is evidence that suggests physical activity can foster improvement in learning and enhanced long-term memory. Recess could even provide wakeful rest, which helps to consolidate short term, newly acquired fragile memory into long-term storage.

Want to advocate for recess? What would be the ideal recess? The policy admonishes that "quality recess hinges on quality planning."

Specific recommendations are suggested:

- Outdoor and natural spaces preferred
- Students should be involved in the planning, especially adolescents
- Inclusive of students with physical, mental, emotional disadvantages
- Inclusive of students who might otherwise experience social isolation
- Recess before lunch
- Multiple breaks throughout the day
- Minimum of 20 minutes a day
- Promote appropriate language for self-expression
- Demonstrate best measures for conflict resolution
- Should be monitored directly and indirectly by staff
- Monitor for physical safety
- Monitor for bullying/emotional safety
- Maintain physical space and equipment

CDC and SHAPE America have published strategies to support positive physical and social experiences during recess. The Consumer Product Safety Commission's Playground Safety Handbook and checklist can help with physical safety.

The evidence supports these recommendations, generally. Longer minutes of recess and physical education time are associated with "lower rates of obesity or obesity trajectory." More specifically, the LiiNK project provided 3rd and 4th grade children with 60 and 45 minutes of unstructured, outdoor play, respectively, relative to 30 minutes in the controls. The intervention children demonstrated a reduction in body fat percentage relative to an increase in the controls.

Recess is useful way to help kids build healthy, active lives.

Farbo D, Zhang Y, Braun-Trocchio R, Rhea DJ. The Effects of the LiiNK Intervention on Physical Activity and Obesity Rates among Children. Int J Environ Res Public Health. 2024 Sep 30;21(10):1304. doi: 10.3390/ijerph21101304. PMID: 39457277; PMCID: PMC11507997.

Gray HL, Buro AW, Barrera Ikan J, Wang W, Stern M. School-level factors associated with obesity: A systematic review of longitudinal studies. Obes Rev. 2019 Jul;20(7):1016-1032. doi: 10.1111/obr.12852. Epub 2019 Apr 23. PMID: 31013544.

Murray R, Ramstetter C, Woolridge D, Woodham Brickman C; Council on School Health. The Crucial Role of Recess in School: Policy Statement. Pediatrics. 2026 May 11:e2026077025. doi: 10.1542/peds.2026-077025. Epub ahead of print. PMID: 42107976.

Natalie D. Muth, Christopher Bolling, Tamara Hannon, Mona Sharifi, SECTION ON OBESITY, COMMITTEE ON NUTRITION; The Role of the Pediatrician in the Promotion of Healthy, Active Living. *Pediatrics* March 2024; 153 (3): e2023065480. 10.1542/peds.2023-065480

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Interested in a deeper exploration of the topic, aided by OpenEvidence? Here is OE's attempt to design recommendations based on the existing evidence: **Composite Evidence-Based Recess Policy Summary for Educators and Healthcare Providers**