

electronic and paper-based diaries at two different time-points.

Results: Baseline BMI of participants (mean \pm standard deviation (SD)) was $30.4 \pm 2.9 \text{ kg/m}^2$, body weight was $87.6 \pm 13.4 \text{ kg}$, and age was 42.3 ± 7.7 years. Fifty four percent ($n=41$) of the cohort were female. Bland Altman plots for total energy, and percentage of total energy intake from fat, carbohydrate, and protein, indicated that the two methods of dietary data collection were in agreement. Participants rated the electronic food diary as easier to use and more fun than the traditional paper-based estimated food diary.

Conclusion: These results show that the Boden Food Plate would be as valid and reliable as current data collection methods and is therefore a practical, and easier, means of collecting data on dietary energy and macronutrient for future studies.

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Invited talk: Managing children and adolescents affected by overweight and obesity: Implications for health systems



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While there has been a recent plateauing in the prevalence of obesity in Australian children – although not adolescents – the prevalence of severe or morbid obesity in this age group continues to increase, as does that of central adiposity. Children and adolescents affected by overweight and especially obesity also present more frequently to primary, secondary and tertiary care services than would be expected from the background prevalence of the problem, although they are only infrequently treated for it. At the same time, most paediatric health professionals feel ill-equipped to manage patients affected by obesity; existing clinical services in Australia and New Zealand are sparse, poorly coordinated and at times inequitable; and there remains significant institutional, health professional and community stigma towards affected individuals.

The chronic disease care pyramid provides a model for delivering services to people with obesity. This is based upon a tiered level of service delivery relating to severity of disease, at primary, secondary and tertiary level. Thus, although most

people affected by the problem of obesity can be managed via self-care or family-based care, with support from primary care or community-based health-service professionals, treatment by multi-disciplinary care teams and possibly tertiary care clinics is needed for those who are more severely affected. Access to bariatric surgery should also be available at the tertiary care level. Individual clinicians and health service providers/funders should be aware of the presence of other services within their geographical region, and the capacity of these services to take referrals or to co-manage patients. These services could include group programs, individual consultations with allied health professionals or nurses, or specialised tertiary services.

There is a need for development and evaluation of cost-effective healthcare pathways that fit in with existing paediatric clinical services and which have broad reach, especially to more socially disadvantaged people. Further, significant investment in ongoing health care professional training is required at undergraduate and postgraduate level at different levels of intensity.

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Invited talk: Key learnings from the PEACH program in Queensland



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PEACHTM (Parenting, Eating and Activity for Child Health) is a healthy lifestyle community program targeting Queensland families with overweight primary school children. PEACHTM aims to assist parents to build knowledge, skills and confidence around health eating and physical activity. The program implements an evidenced-based intervention consistent with clinical practice guidelines.

Methods were designed with the RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) framework in mind and the following data are collected:

Reach: Family demographics

Effectiveness: Changes in parental knowledge, skills and confidence; child anthropometry, diet and