

Solutions and Treatment in Obesity Management and Prevention: An analysis on the efficacy of family-focused treatment in managing childhood obesity for high risk populations in East Los Angeles

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Introduction:

In February of 2012, AltaMed launched a very extensive campaign to eliminate the major health disparities it had seen in over 40 years of service to the underprivileged populations of Southern California. *Keep the Promise* was slated to be a 3-year fund-raising and quality care improvement program that would focus on three major concerns within the AltaMed Community: childhood obesity, services for the uninsured, and teen rescue. Of the three major areas of focus, childhood obesity topped the list, generating the highest concern within AltaMed's leadership. Childhood obesity impacts low-income communities and people of color much more than other communities and potentially leads to the greatest burden in primary care. Childhood obesity is potentially costly; it associated later-life obesity, along with other chronic disease states that require numerous pharmaceutical treatments, potential hospital stays, surgeries, and even end-stage organ management. In order to manage the epidemic of childhood obesity, AltaMed began a pediatrician-directed, evidence-based interventional program to promote healthy weight management in children in the Orange County. Operating out of the AltaMed Santa Ana Clinic, the PLAY program (Promote Lean Active Youth), utilized tools, such as medical examinations and patient education to encourage healthy lifestyle changes in children and their families. The program also included weekly exercise sessions to increase physical activity in a positive environment for its participants. PLAY was very well-received in

the community, with over 70% of its participants meeting weight reduction goals upon completion of the program.

Following the success of the PLAY program in Santa Ana, AltaMed went on to expand its childhood obesity programs to the Los Angeles County with the implementation of STOMP (Solutions and Treatment in Obesity Management and Prevention). Feeling very strongly about the importance of full-family participation in a childhood obesity treatment plan, Vilma Andari, Director of the AltaMed's Obesity Task Force, contended that parents and siblings should be tracked along-side participants with regards to weight management. The objective of this study was to evaluate and emphasize the importance of parent participation in a childhood obesity treatment plan.

Background:

It is well-known that rapidly changing dietary practices, along with an increasingly sedentary lifestyle, place individuals at risk for obesity-related conditions: impaired-metabolic syndrome, type 2 diabetes mellitus (T2DM), coronary artery disease (CAD), hypertension (HTN), and non-alcoholic fatty liver disease (NAFLD). Americans are at greater risk; currently two-thirds of Americans are overweight and of that, nearly half are obese. This epidemic is now beginning to affect younger populations in the United States. Childhood obesity continues to be a major focus of public health efforts, as an increasing number of children that been reported as overweight and obese. In 2007-2008, 16.8% of US Children and adolescents had a body mass index (BMI) equal to or greater than the 95th percentile on the BMI-for-age growth charts and were considered obese (LA County Department of Public Health 2009). Short and long-term issues of child and adolescent obesity have been reviewed in several studies to determine various future health-burdens associated with the disease. Of these studies, 4 found that there was an increased risk of premature mortality. As many as 11 studies reported that overweight stature and obesity were

associated with significantly increased risk of later cardio-metabolic morbidity in adulthood.

This is very alarming given the recent trend of childhood obesity that is currently being observed.

According to the Centers for Disease Control and the Healthy People Report 2010, obesity rates have doubled in children and tripled in adolescents over the last two years; even infants and toddlers were affected. Latinos have even higher rates of obesity than the non-Hispanic white population (adults: 37.9% versus 34.9%; youth: 39.1% versus 27.9%). Mexican-American boys have the highest rates of obesity, compared to non-Hispanic whites and African-American boys (40.5% versus 30.1% versus 36.9%). In Los Angeles, the obesity rates are markedly different across the various Service Planning Areas (SPAs) and municipal zones. Rates are significantly lower in the West-Municipal zoning areas (6.2%), compared to lower-income SPAs in East Los Angeles (32.7%). Among the communities with the lowest prevalence for obesity, high levels of income, socioeconomic status, and high levels of education were observed: Manhattan Beach (3.4%), Calabasas (5.0%), Hermosa Beach (5.1%), and Beverly Hills (5.4%). In contrast, SPA 7 (East Los Angeles) reported a 26% childhood obesity prevalence (County Department of Public Health 2009, Healthy People 2010, Healthy People 2020).

The determinants of obesity are complex and are intermingled with social cultural and personal strata. Main determinants for obesity have been attributed to diet and exercise. These include: poor health literacy and ignorance of healthy lifestyles, poor access to healthy food options as opposed to high-caloric meals, and lack of green space or limited resources that prevent families from seeking low-cost exercise options (Reilly, et al. 2011, Ramirez, et al. 2013). AltaMed understands that the key to understanding, combating, and ultimately reducing childhood obesity in its communities is by employing a multi-faceted approach that focuses on family, community, and school interventions that lead to individual change. Through the various programs

implemented by the its Obesity Task Force, AltaMed aims to reduce the impact of obesity in the communities it serves by improving healthy eating habits and increasing physical activity.

AltaMed's new direction is to focus on community-based and family-focused strategies that will help reverse the childhood obesity crisis and its associated chronic diseases.

Methodology:

Using the same model in Santa Ana for guidance, AltaMed launched STOMP its Boyle Heights clinic to serve the East Los Angeles Community. STOMP aims to reduce obesity and promote healthy weight management in children and adolescents ages 6-18 with Medi-Cal coverage, as well as their families. Since obesity is measured as a function of BMI, patients are enrolled based on BMI measurements and then integrated into the ongoing pediatric program. What differentiates the STOMP program from its counterpart in Santa Ana is that parents are not only required to participate, but are now also held accountable for the quality measures that were originally tracked in their children. This, in theory, fosters healthy lifestyle changes at a family level and generates a more conducive environment for patient and parent compliance (Davidson, et al. 2013).

Families have one consultation and an orientation with their provider and staff before commencing the 12-week medically supervised curriculum with a Nutritionist (RD) and a Physical Activity Specialist (PAS). One-on-one provider follow-up visits occur throughout class time. Parents attend educational lessons on nutrition, healthy food choices, and chronic disease while their children participate in 60-minute exercise sessions each week. After completing the 12-week program, families undergo an additional 9 months of weekly follow-up maintenance including check-ins with the RD and exercise sessions with the PAS. Families and patients also continue monthly follow-up visits with the Medical Provider for up to twelve months. The program staff supports enrolled families in other ways, by providing supplemental resources for

mental health and socioeconomic issues. A copy of the STOMP schedule is included in item 1 of the appendix. The program receives funding via grants from the US Department of Education, and is staffed by 1 physician, 2 medical assistants, 1 registered dietician, 1 physical activity specialist, and 1 Community Health Corps Navigator.

At the beginning of the intervention, children and parents are medically assessed through:

1. Height and weight measurements, blood pressure, pulse, and other vital signs
2. Lab work for lipids, chemistries, blood glucose levels, and TSH
3. BMI and body fat composition

In addition, children undergo testing for physical fitness with carefully-selected exercises.

Families sign a contract to complete homework and maintain certain commitments during the intervention:

1. Daily exercises for both children and parents
2. Attendance requirements
3. Restrictions or limits of time spent in front of the television
4. Elimination of caloric drinks at home

The STOMP clinical sessions are offered on Saturdays from 9:00am to 4:30pm. Take-home incentives are provided throughout the intervention, including AltaMed water bottles, bags, and pedometers. Upon completion of the program, participants receive a certificate of recognition, a graduation ceremony, and supermarket gift cards. Families that miss more than one weekly session are considered as “voluntarily withdrawn” and are re-enrolled for the next session.

Although compliance is largely monitored via self-reporting, clinical data is retrieved again, half-way through the 12-week program, and at the end of the intervention for quality measurement.

Moreover, children are assessed once again through physical fitness tests at week twelve. A portion of the family contract is included in item 2 of the appendix.

A total 24 children were enrolled into the STOMP Program in May. All children were required to attend sessions with at least one of their parents. Attendance was mandatory; if a family missed more than one session within the 12-week intervention, they were dropped and slated to re-enroll in the next program. BMI was chosen as the primary quality measure to track at each session because height and weight measurements are easy to obtain, cost-effective, and not as affected by a child's growth pattern. BMI was tracked for both children and parents to see if there was a correlation between the weight changes observed for children in relation to their parents.

Results:

A total 24 children and their families were enrolled into the STOMP Program in May based on BMI criteria for obesity (being defined as BMI > 95th percentile). Nearly all the parents for those children were overweight or obese (overweight: BMI > 25 and obese: BMI > 30):

- 9 children from the ages of 6-8; 1 overweight parent & 7 obese parents
- 10 children from the ages of 9-12; 3 overweight parents & 6 obese parents
- 5 children ages 13 and over; 1 overweight parent & 4 obese parents

There were also 2 sets of siblings within the same age group, with one parent attending sessions for both children. Initial measurements showed a strong correlation between a child's BMI and his or her parent's BMI. Moreover, this information also emphasizes the strong relationship between weight trends across the family unit. One pair of siblings from the 6-8yr age group and another pair of siblings from the 9-12yr age group were both enrolled in the program due to similar BMI measurements.

Because all children were required to attend sessions with at least one of their parents, drop-out rates were anticipated to be high throughout the program. Attendance was mandatory; if a family missed more than one session within the 12-week intervention, they were dropped and

slated to re-enroll in the next program. Based on these criteria, 7 families were withdrawn halfway through the program and re-enrolled in to the next session:

- 3 children from the 6-8 age group
- 2 children from the 9-12 age group
- 2 children from the 13+ age group

Of the families that remained in the program, there were significant changes in BMI found in both children and parents during the intervention. Numerical results for each case in the STOMP program are summarized in item 3 of the appendix.

Within the 6-8yr age group, two children reduced their BMI by over 1 point; one child reduced his BMI by less than 1 point. The remaining children essentially gained weight, with BMI increases ranging from +0.271 to +5.74. In the 9-12yr age group, 6 children saw reductions in BMI, ranging from -0.378 to -3.018. Minor weight gain was noted in 2 children; the greatest increase of BMI was recorded at +0.283. Changes in BMI were observed in the 13+yr age group as well; two children dropped BMI by over 1 point. Across all age groups and cases, there was a direct correlation found between the change in a child's BMI and their parent's BMI. For all children who showed a decrease in BMI, their parents dropped in BMI as well. Likewise, for all children who increased BMI during the intervention, their parents increased in BMI. Of note, similar changes and relationships were noted in children whose siblings were enrolled in the program. One pair of siblings in the 6-8yr age group was withdrawn and re-enrolled into the following session. Another pair of siblings in the 9-12yr age group both showed reductions in BMI of greater than 1 point.

Discussion:

Preliminary results from the Boyle Heights STOMP program emphasize the importance of full-family participation in a childhood obesity treatment plan. Initial screening of the parents prior

to intervention showed that BMI was elevated in most family members of STOMP participants, warranting a need for family-focused treatment. Tracking of weight management for both parents and children during the intervention can have many benefits. First, this makes parents accountable for compliance in treatment plans, as well as commitment to healthy lifestyle changes. Second, this fosters community effort within the family, making the transition to new and healthier behaviors more acceptable. Lastly, this prevents alienation or targeting of the child as an outcast, by setting the recommended lifestyle changes as a “social norm.” The last two benefits may even be expanded more towards “healthy competition” in older children.

Although preliminary data from the STOMP analysis shows promise, there are still limitations that should be addressed. Statistical significance is difficult to determine half-way into study. A more accurate analysis would include mid-point data at week 6 of the intervention, end-point data upon completion of the 12-week intervention, and follow-up data after conclusion of 1 year. Other limitations would include integrity of the data itself: fluctuations of body weight from day to day, small sample size, and calibration of tools used to measure the data. It is impractical to analyze statistical significance (p-value) for the data obtained because of these reasons. Despite its limitations, preliminary results from analysis of the STOMP program show clinical significance. This suggests that family-focused weight management programs should be given more consideration.

Recommendations:

In order to ensure the effectiveness of the STOMP intervention, measures to generate full-family compliance should be strengthened. Programs should screen parents and siblings of the participant for BMI to see if other family members are at risk for or affected by obesity and its associated chronic conditions. Treatment plans should encompass the family with exercises and “homework” that require group participation in order to be completed. All family members,

including parents and siblings, at risk for or affected by obesity should be monitored for progress on healthy weight management during the intervention. This generates a sense of accountability that may motivate the parent to comply with treatment. Surveys should be administered to determine attitudes toward the intervention and identify barriers to effective intervention. Surveys can also help shed light on specific needs within the family such as mental health issues associated with being overweight, particularly in adolescents. Proposed surveys in both English and Spanish are included in item 6 of the appendix.

Conclusion:

In summary, given the essential and pivotal role that parents play in shaping the lifestyle behaviors of their children, the management and prevention of obesity in youth populations requires a focus on families. Simply informing family members of interventions is not sufficient, as previously seen in the results generated by the Healthy and Fit Programs in Santa Ana. Parents are not held accountable for their child's progress; nor are they monitored for progress on their own weight management. Family-centered interventions that accommodate the social, cultural, and economic needs of parents are needed. More importantly, parents must be a primary target for addressing behavior change in the development of an effective treatment plan for childhood obesity. Parents must not only be educated in healthy lifestyle choices; they should also be held accountable for their commitment and compliance to healthy weight management habits. This was a major differentiating factor for the STOMP Program.

The STOMP program was developed to foster active parent participation in their child's healthy lifestyle change. STOMP is an action-oriented model that focuses on parent participation and accountability to generate more effective and sustainable results. This was demonstrated during preliminary analysis of the BMI for parents in relation to their children. At initial enrollment both child and parent in each case had significantly elevated BMI, classifying them as

overweight or obese. Changes were observed in BMI values for children and parent half-way through the intervention. There was a strong correlation between the child's progress and their parent's BMI at midpoint: for children who decreased overall BMI, their parents did as well. Conversely, parents who increased BMI had children who increased in BMI as well. The same trend was seen across siblings.

The results from BMI analysis for both parents and children for the STOMP program show clinical significance: The participation of parents is a key determinant in the effectiveness of any childhood obesity treatment plan. Parents should be held accountable for compliance with their child's weight management program and should enforce healthy behaviors throughout the entire household. Parents should set a healthy example for their children and other household members to follow in order to generate realizable healthy lifestyle changes. It is strongly recommended to make parents accountable for entire-family participation in all future obesity management or prevention programs.

References:

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Appendix:

1. AltaMed STOMP schedule
2. STOMP parent and child contract signature page
3. Tables tracking individual patient results
4. Tables tracking overall patient and parent results
5. Graphs
6. STOMP proposed parent questionnaire



OUTLINE OF PEDIATRIC HEALTH PROGRAM

Week 1: Orientation: Nutrition Orientation/Pre-test

Week 2: Class 1*: Nutrition Guidelines/Tips

Week 3: Class 2*: Reading Nutrition Labels

Week 4: Class 3*: Balance between Meals and Portions

Week 5: Class 4*: My Plate

Week 6: Class 5*: Rule of 3 & Eating Out

Week 7: Class 6*: How to Handle Holidays & Parties & Cooking Demonstration (Health Ed Class #2)

Week 8: Class 7*: Healthy Fats, Glycemic Index, & Rethink Your Drink

Week 9: Class 8*: Chronic Conditions (Health Ed Class #1)

Week 10: Class 9*: Stress Management (Health Ed Class #3)

Week 11: Class 10*: Maintenance Tips and Review

Week 12: Final Review and Exam

*At the end of each lesson do a fun assessment with the class using a game. *Can also do 3 key questions to make sure the students can answer when the lesson finalizes a pop quiz. Previous idea a wheel that spins or have the questions in a box so they can pick.



Name/Nombre _____

DOB/Fecha de nacimiento _____

Parent/Guardian Homework

Parents are required to walk with their kid for 15 min. per day for the duration of the program. During this time the parents will ask their child if they have done their exercises that day and if they did the other 30 min of an activity after school. Parents will also sign their signature in the journal for that day. For each day the parents sign the journal, they are saying that they have walked with the child that day.

Parent or Guardian Signature: _____

Tarea para la casa para los padres o guardianes

Los padres o guardianes tienen que caminar con los niños por lo menos 15 minutos diarios durante las ocho semanas del programa.

Durante este tiempo tienen que hablar con los niños acerca de los ejercicios del día y si hicieron los otros 30 minutos de actividad después de la escuela. También tendrán que firmar el diario de los niños cada día y al firmar están confirmando que caminaron con los niños.

Firma del padre o Guardián: _____

Tracking by Case: Age Group 6-8yrs		
Case	Child's Δ in BMI	Parent's Δ in BMI
Case 1	0.271	0.343
Case 2	5.740	0.318
Case 3	-1.350	-0.968
Case 4	-0.793	-0.523
Case 5	-1.430	-3.730
Case 6	1.760	0.732
Average Δ in BMI	0.700	-0.638

Tracking by Case: Age Group 9-12yrs		
Case	Child's Δ in BMI	Parent's Δ in BMI
Case 1	-0.378	-0.649
Case 2	-1.037	-0.954
Case 3	0.283	0.732
Case 4	-0.386	-0.781
Case 5	0.156	0.448
Case 6	-1.840	-1.080
Case 7	-3.018	-1.080
Case 8	-0.836	-0.591
Average Δ in BMI	-0.882	-0.494

Tracking by Case: Age Group 13 years+		
Case	Child's Δ in BMI	Parent's Δ in BMI
Case 1	-1.647	-0.886
Case 2	-1.242	-1.368
Case 3	1.280	0.976
Average Δ in BMI	-0.536	-0.426

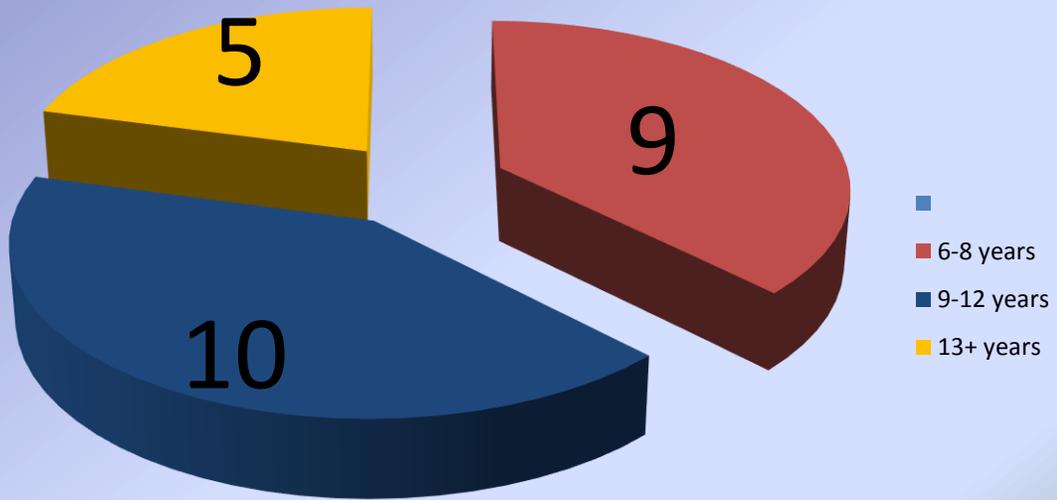
Initial Enrollment	
Age Group	# of Patients
6-8 years	9
9-12 years	10
13+ years	5
Total	24

Parent Statistics at Initial Enrollment		
Age Group	# of Patients w/ Overwt Parents	# of Patients w/ Obese Parents
6-8 years	1	8
9-12 years	3	7
13+ years	0	5
Total	4	20

Patient Statistics at Mid-program		
Age Group	# of Patients who decreased BMI	# of Patients who increased BMI
6-8 years	3	3
9-12 years	6	2
13+ years	2	1
Total	11	6

Parent Statistics at Mid-program		
Age Group	# of Parents who decreased BMI	# of Parents who increased BMI
6-8 years	3	3
9-12 years	6	2
13+ years	2	1
Total	11	6

Initial Enrollment # of Patients



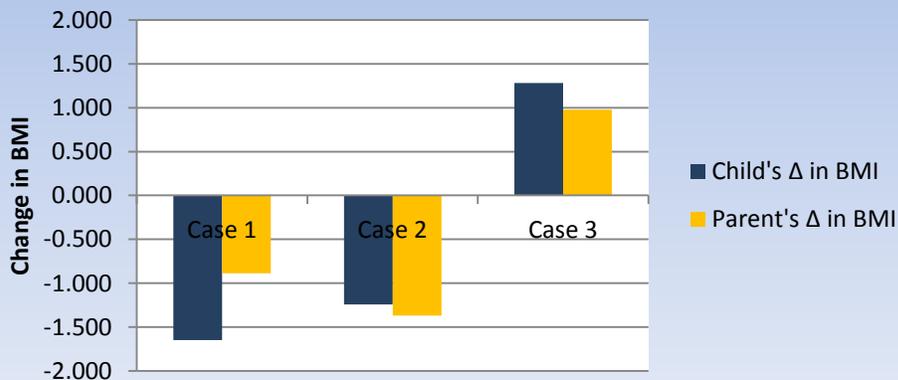
BMI Tracking by Case: 6-8yrs age group



BMI Tracking by Case: 9-12yrs age group



BMI Tracking by Case: 13+yrs age group





PARENT SURVEY STOMP PROGRAM FOR KIDS

1. Did you set a goal with your child for the program?
 - No. We did not set a goal.
 - Yes. I set a goal for my child.
 - Yes. We each set a goal, but we have different goals.
 - Yes. We set the same goal and a reward for when we get it.

2. Are other people in the family/household participating in this goal?
 - No. Only my child is working on the goal.
 - Yes. But only my child and I are participating. The others are not.
 - Yes. Everyone is participating, but they are not happy about it.
 - Yes. Everyone is participating and they are all supportive of it.

3. How do you do the exercise homework for this program?
 - I ask my child if he or she has done the exercises each day.
 - I make sure my child does the exercises each day.
 - I do the exercises with my child each day.
 - Everyone in the house does the exercises together each day.

4. What do you think is the hardest part about this program?
 - It is hard to avoid all other drinks besides water and non-fat milk.
 - It is hard to avoid fast food, or to eat meals at home.
 - It is hard to avoid TV, or to keep my children from watching TV.
 - It is hard to do the exercise every day.
 - Other: _____

5. What do you think would make this program easier for you or your child?
 - I want more help with nutrition: recipes, coupons, ideas.
 - I want more help with exercise: workouts, activities, fun ideas.
 - I want more help with mental health: resentment or rebellion.
 - I want more help motivating my family to participate.
 - Other: _____

6. Which nutrition class did you learn the most from?
- Reading Nutrition Labels
 - Balance between Meals and Portions / My Plate
 - Rule of 3 & Eating Out
 - How to Handle Holidays, Parties and Cooking Demonstration
 - Other: _____
7. Which nutrition class did you learn the least from?
- Reading Nutrition Labels
 - Balance between Meals and Portions / My Plate
 - Rule of 3 & Eating Out
 - How to Handle Holidays, Parties and Cooking Demonstration
 - Other: _____
8. How do you think your child will do on the physical exercise test?
- Very confident. I know we prepared well for the test.
 - Confident. I think we did our best to prepare for the test.
 - Not confident. We tried to prepare for the test, but it was hard.
 - I don't know.
 - Other: _____
9. Would you like someone to help you keep this healthy lifestyle change?
- Yes
 - No
 - I am not sure
10. How can we improve this program for you or future families?
-
-
-
-



ENCUESTA PARA LOS PADRES EL PROGRAMA “STOMP”

1. ¿Ha definido una meta con su hijo para el programa?
 - No. No se fijó una meta.
 - Sí. Me puse una meta para mi hijo.
 - Sí. Tenemos, pero tenemos diferentes objetivos.
 - Sí. Ajustamos el mismo objetivo y una recompensa también.

2. ¿Hay otras personas en la familia que está participando en este objetivo?
 - No. Sólo mi hijo está trabajando en el objetivo.
 - Sí. Pero sólo mi hijo y yo estamos participando. Los otros no lo son.
 - Sí. Todo el mundo participa, pero no son felices con él.
 - Sí. Todo el mundo participa y son todo apoyo de él.

3. ¿Cómo lo haces la tarea de ejercicio para este programa?
 - Pido a mi hijo si él o ella ha hecho los ejercicios cada día.
 - Me aseguro de que mi hijo hace los ejercicios cada día.
 - Yo hago los ejercicios con mi hijo cada día.
 - Todos en la casa hacen los ejercicios juntos cada día.

4. ¿Qué crees que es la parte más difícil de este programa?
 - Evitar todas las demás bebidas además de agua y leche (sin grasa?).
 - Evitar la comida rápida, o para comer en casa.
 - Evitar la TV, o para evitar que mis hijos viendo la televisión.
 - Hacer el ejercicio todos los días.
 - Otro: _____

5. ¿Qué crees que haría que este programa sea más fácil para usted o su hijo?
 - Quiero más ayuda con la nutrición: recetas o cupones.
 - Quiero más ayuda con ejercicio: entrenamientos o actividades.
 - Quiero más ayuda con la salud mental: resentimiento o rebelión.
 - Quiero más ayuda para motivar a mi familia a participar.
 - Otro: _____

6. ¿En qué clase de nutrición aprendieron más?

- Leer las etiquetas de nutrición
- Equilibrio entre las comidas y las porciones / mi placa
- Regla de 3 y comer fuera
- Cómo manejar los días de fiesta, fiestas y demostración de cocina
- Otro: _____

7. ¿En qué clase de nutrición aprendieron menos?

- Leer las etiquetas de nutrición
- Equilibrio entre las comidas y las porciones / mi placa
- Regla de 3 y comer fuera
- Cómo manejar los días de fiesta, fiestas y demostración de cocina
- Otro: _____

8. ¿Cómo crees que hará a su niño en la prueba de ejercicio físico?

- Muy confiado. Sé que hemos preparado bien para la prueba.
- Seguros. Creo que hicimos nuestro mejor esfuerzo para prepararse para el examen.
- No seguro. Probamos a prepararse para el examen, pero fue difícil.
- No sé.
- Otro: _____

9. ¿Te gusta alguien para ayudarle a mantener este cambio de estilo de vida saludable?

- Sí
- No
- No estoy seguro

10. ¿Cómo podemos mejorar este programa para ti o para futuras familias?
