



**Testimony of  
Yolandra Hancock, MD  
Attending Pediatrician  
Children's National Medical Center**

**Assistant Professor, Pediatrics  
George Washington University**

**American Academy of Pediatrics-District of Columbia Chapter**

**Bill 18-564  
Healthy Schools Act of 2009  
Committee on Government Operations and the Environment  
Committee of the Whole  
Council of the District of Columbia**

**February 10, 2010**

Children's National Medical Center, a 283 bed not-for-profit academic medical center located at 111 Michigan Avenue, NW, has provided hope to sick children and their families throughout the Washington metropolitan region for more than 140 years. With Children's Hospital, seven primary care facilities, one outpatient center, two facilities providing specialty care services, and two pediatric practices located in the District of Columbia, Children's National is proud to provide convenient, high quality pediatric primary and specialty care to the District's children and families.

**Children's Obesity Institute**

There is no magic pill that will solve the problem of childhood obesity. Of course, healthy eating and exercise are key components to losing weight and leading a healthy lifestyle, but the factors that contribute to childhood obesity are complex and numerous. Home and play environments, family traditions and attitudes toward food, and psychological and social issues all play a role in contributing to childhood obesity.

Children's National founded a world-class Obesity Institute to address every arena of obesity in the community. Through the Obesity Institute, Children's National seeks to reduce childhood obesity using a multidisciplinary approach that draws upon our clinical expertise, as well as research, policy and advocacy partners in the region.

The Obesity Institute's vision is to be recognized regionally, nationally and internationally as a leader in developing and disseminating best practices for the prevention and treatment of obesity. The Obesity Institute will execute the strategies and initiatives to reduce childhood obesity through clinical treatment, advocacy, research of best-practice treatments and genetic composition that leads to greater incidences of obesity and education for medical staff, families, and communities.

Representatives from the Obesity Institute were involved in crafting Children's policy statement concerning childhood obesity that was enacted by the Children's National Board of Directors in April 2008. The policy statement is included in the written testimony. Two major pieces of the policy statement encourage strategies to examine physician reimbursement for the treatment of obesity and the appropriate use of obesity screening for children. As part of this statement, Children's National recommends a community-based strategy that incorporates the following components:

1. Promoting healthy food choices in schools and neighborhoods.
2. Ensuring schools offer mandatory physical education.
3. Creating easily accessible and safe recreational activities and play spaces in all neighborhoods.
4. Coordinating culturally competent health education messaging.
5. Body Mass Index (BMI) screening is most appropriately carried out in the primary care medical home.

Children's National does not endorse mandatory BMI screening in public schools. Children's National believes school resources are more appropriately directed to ensuring children receive nutritious meals and snacks and appropriate physical and health education.

#### **Comments on the Healthy Schools Act**

As a pediatrician with a special interest in childhood obesity and as a former elementary school teacher, the Healthy Schools Act is near and dear to my heart. The bill incorporates all of the key elements needed to encourage the practice of a healthy lifestyle for every student in the District of Columbia. Its enactment will not only serve as a model for the mid-Atlantic region, but also for the nation, as it demonstrates the importance of an integrated educational approach to wellness. This bill encompasses essential aspects of school wellness, including school nutrition, physical education, utilization of community food resources, and sustainable environmentally-protective practices.

My clinical experiences as a pediatrician in Ward 8 have made me painfully aware of the need for school-based wellness initiatives, such as those included in this act. For a significant number of my patients, their only opportunity for healthy eating options and physical education is while they are in school. For others, limited resources in their schools do not allow them the same opportunity. I have an 11-year-old obese hypertensive African-American patient who, at the time of her well-child check-up, reported that she did not participate in any form of physical activity. When I asked her and her mother if she participated in physical education at school, they both chuckled and informed me that she had not participated in "gym" since she was in elementary school. The middle school, per this family's report, did not have the resources to provide physical education. Unfortunately, she represents the numerous overweight and obese patients in our practice who desperately need healthy eating options and routine physical activity in order to establish and maintain a healthy lifestyle.

As you all may be aware, obesity rates in the District of Columbia are higher than the national average. According to the Pediatric Community Needs Assessment, over 50 percent of children in Ward 8 are overweight. In addition to supporting this research, Children's response to this epidemic was to create the Obesity Institute, where we work collaboratively to design a multifaceted approach in tackling the District's pediatric obesity epidemic. We have developed five community-based prevention/behavior modification programs throughout the District. Without actions such as those taken by Children's and the City Council through the passage of the Healthy Schools Act, this epidemic will continue to grow. This will be the first generation to have a life expectancy shorter than that of their parents.

As a former elementary school teacher, I appreciate the importance of well-balanced meals and physical activity for students. All too often, students either arrived to my classroom hungry or became hungry later in the morning as their breakfasts consisted of high sugar cereals and Pop-Tarts. The school lunches were not much of an improvement; children were offered such food items as taco boats and strawberry slushies. Many times the only vegetable offered was a packet of ketchup on the tray. The school nutrition component of this act will ensure that this is not the case for students in the District of Columbia. All children will be provided with well-balanced healthy meals.

As a teacher, I also observed the challenges in providing physical education on a routine basis. In the elementary school where I taught in South Central Los Angeles, teachers, without additional training, were supposed to provide physical education to their students. Although I am ashamed to admit it now as a pediatrician, this didn't always happen when I taught. Lunch time play was sometimes cut short and physical education was often sacrificed in order for us to achieve the day's goals or to prepare for standardized exams. I was not required to nor did I know how to provide standardized physical education. Consequently, it was sacrificed. Between the missed and unhealthy meals and forgone physical activity, I am surprised that I was able to contain 20 first graders. Perhaps that's the reason why I went into medicine. The Healthy School Act's phased approach of implementation and provision of subsidies, along with the efforts of the District of Columbia's Public Schools (DCPS), the Director of Health and Wellness, and the Office of the State Superintendent of Education (OSSE), will allow for the incorporation of these practices into the daily curriculum.

The benefits of the passage of this bill are immeasurable. Multiple studies have demonstrated the cognitive and behavioral benefits of providing a healthy school breakfast and lunch. Research has also shown a strong positive association between physical activity and improved school performance, including improvements in standardized test scores. The act will also aid in improving the health of the children in the District. There is a multitude of evidence in the medical literature that demonstrates significant improvements in health status, such as better asthma control and prevention of obesity, resulting from the promotion of well-balanced nutrition and physical education.

The synergy between nutrition and physical activity that is represented in this act is not just about preventing and treating childhood obesity and other chronic diseases. It is also about allowing each student in the District to reach his or her full potential. A school day without well-balanced nutrition and active living denies all students the opportunity to reach this potential, even if all of the ideal academic components are present, including enthusiastic and well-trained teachers, abundant educational resources, and stimulating learning environments.

I urge the City Council to pass this bill as a way to ensure the health and academic achievement of each and every student in the District.

### **About Childhood Obesity**

According to the Centers for Disease Control and Prevention, more than nine million children between the ages of six and 19 are overweight or obese - a number that has tripled since 1980. The United States Department of Health and Human Services estimates that overweight adolescents have a 70 percent chance of becoming overweight or obese adults. This increases to 80 percent if one or more parent is overweight or obese.

The Trust for America's Health 2008 report, *F as in Fat*, estimates that 22.3 percent of adults in the District are obese and 35.4 percent of children ages 10-17 are overweight. The same report estimates 17.8 percent of high school students in the District are overweight and are at risk of obesity. At Children's National, we see children with complications from obesity that are normally exhibited as an adult, such as diabetes, hypertension, dyslipidemia, liver disease, sleep apnea, and heart disease.

According to a 2005 U.S. Government Accountability Office (GAO) report, the rise in obesity-related health conditions also introduces added economic costs. GAO estimates that nationwide, obesity-related health expenditures accounted for more than 25 percent of the growth in health care spending between 1987 and 2001. In 2000, an estimated \$117 billion was spent for health-related expenditures due to obesity, with direct costs accounting for an estimated \$61 billion.

Children's National Medical Center recently presented a first-of-its-kind study from the RAND organization, the Pediatric Health Needs Assessment for Washington, DC. The report is a comprehensive study of the health and health care of the 100,000 youth who reside in the District of Columbia. According to this report, rates of obesity/overweight among children are high and have been rising across the United States, and the District is no exception. Among youth ages 6-12 in the District, 19 percent are reportedly obese, and an additional 15 percent are overweight. Similarly, 15 percent of District youth ages 13-17 are obese, and an additional 15 percent are overweight. Some data suggest that overweight and obesity are even more of an issue in the District than nationally: A greater percentage of youth in grades 9-12 are reportedly obese in the District (18 percent) compared to the nation (13 percent).

For more information from this report, please go to this link:

<http://www.childrensnational.org/files/PDF/advocacy/PediatricCommunityNeedsAssessmentReport.pdf>

### **Additional Recommendations**

Services that encourage children and families to develop healthier behaviors need to be accessible. This involves identifying and aligning community and government programs and resources that will encourage healthy behaviors.

In schools, places such as cafeterias, vending machines, and neighborhood grocery stores should be providing healthy food options to children. In particular, vendors for DCPS should be able to provide healthy content/choices for its programs. Another way to improve access to healthier foods is through increasing the capacity of farmers' markets to accept food stamps and increasing availability of affordable fresh produce and other healthy options in all 8 wards.

In addition, programs should engage children in physical activity during school. In addition to mandatory physical education classes, physical education programs in schools should also include programs such as obesity walks and family fitness days. Parks and recreation facilities should also be accessible for children to engage in physical activity. It should also be noted that law enforcement can also play a role by ensuring that neighborhoods are safe and clean to allow children and families to be active outdoors.

It should be noted that these recommendations cannot be adequately implemented without education for teachers and families regarding the risk factors associated with childhood obesity and behaviors that should be exhibited to reduce obesity. In addition to teachers and families, social workers and school nurses, who deal directly with children, should receive training about the impact and treatment of childhood obesity. Special attention should be paid towards developing a culturally appropriate health campaign that will provide a unified educational message about practicing healthy behaviors.

### **Recommendations Regarding Children's School Nurses: Childhood Obesity**

Children's School Services School Health Program provides nursing and health services in 164 public and public charter schools in the District of Columbia. This ensures that every child in the District's public schools has access to a school nurse through Children's School Services. The program operates through a contract with the District of Columbia Department of Health.

The program's mission is to enhance education by maximizing the health and well-being of youth in the District's public schools. Recognizing the diversity of the student population, the nurse works with school personnel, families and community resources to minimize and eliminate health-related barriers to learning.

The program incorporates the physical, psychological, socio-cultural, and spiritual needs of students. Health and nursing services focus on prevention and early identification and intervention to address student health problems.

Clearly, school nurses have an important role in addressing the epidemic of childhood obesity. However, even though the school nurse program was expanded in the comprehensive school health plan, the school nurse cannot be expected to be the sole health care or healthcare-related professional actively implementing an obesity reduction program.

Public schools and public charter schools are natural settings to influence the health and well-being of students. School nurses can provide leadership in helping students maintain a healthy weight to decrease the burden of illness and increase in quality of life and life expectancy in a variety of ways. However, the primary role for the school nurse, in collaboration with the student's Primary Care Provider (PCP), is to re-enforce nutritional education and monitor changes in the student's weight.

School nurses have knowledge and expertise in the areas of nutrition, weight maintenance, and exercise. This knowledge can be applied in prevention programs and interventions for students at-risk or overweight. He or she can work with students, parents, school personnel, and health care providers to identify students who are at risk for being overweight or obese by screening for height and weight, skin fold testing, and measuring body mass index (BMI). The school nurse can also refer and follow up with students who may not be seeing a health care provider on a regular basis. In addition, the school nurse can be involved with support programs, counseling services, referrals, follow-up, and support.

To achieve optimal impact regarding the childhood obesity epidemic and positively impact obesity-related outcomes, it is strongly recommended that a District-wide, comprehensive, multidisciplinary, standardized and realistic plan is developed that include, at a minimum:

- centralized leadership to coordinate the District's obesity abatement efforts;
- a plan to develop a database of baseline data for targeted grades;
- design and development of nutrition standards;
- age-appropriate nutritional education;
- from a standardized curriculum delivered by nutritional specialists or health educators;
- an increase in structured physical activity;
- reduction in the availability of nutrient deficient foods during the school day;
- recognition of the impact of limited healthy food options as a contributor to increasing obesity for District students; and
- movement towards a more pedestrian friendly city.

### **Recommendations Regarding Children's School Nurses: Asthma**

Asthma also impacts children's quality of life. Asthma accounts for more than 100 million days of restricted activity annually and contributes to avoidance of school and activities. Children who have had interrupted sleep due to nighttime asthma symptoms come to school tired and may fall asleep in the classroom. They can also be lethargic or irritable. Additionally, students who experience difficulty in breathing find it difficult to concentrate on schoolwork, and those who need breathing treatments during school hours miss class time. When severe episodes occur, children also miss time from class and school. Furthermore, the side effects from some medications used in the treatment of asthma can interfere with performance and concentration as well, particularly when the child's medication regimen is not well-managed or monitored (Environmental Protection Agency, 2001).

Indirect costs from the burden of asthma are attributed to lost workdays, school absences, and decreased productivity. An estimated 11.8 million missed school days per year are attributed to asthma (Weiss, Sullivan, & Lyttle, 2000), making it the leading cause of school absenteeism due to a health condition. Other indirect costs include caretaker's lost workdays and costs associated with asthma deaths. With 5,000 deaths - 246 in children - occurring each year from asthma, the seriousness of this disease cannot be overlooked. And, both hospitalization and death rates among young children are increasing (Centers for Disease Control, 2001; U.S. Department of Health and Human Services, 2001).

Consistent with the National Association of School Nurses, Children's School Services believe that the role of school nurses in managing asthma in the school setting requires that the school nurse:

- Serves as a liaison between the school and the child's home and between the school and health-care providers in an effort to promote adherence with health-care providers' orders related to asthma management.
- Develops and implements, in coordination with healthcare providers and the educators, the child's asthma management plan.
- Establishes and monitors compliance with local government and school policy related to the management of children with asthma during the school day.
- Implements Standards of Care in the management of students with asthma and/or who experience acute respiratory distress at school.
- Provides or supervises proper medication administration.
- Supports education of the child in self-management of medications prescribed to manage the child's asthma and monitors the child's condition and response to the treatment regimen prescribed by the physician or other healthcare provider.
- Advocates for the child's inclusion in school-related activities; and works with school staff to assure that accommodations are in place for the child's well-being.

Additionally, school nurses can further contribute to the effective management of students with asthma in the school setting by:

- Educating the student and his/her family in asthma management, including content about pathology, pharmacology, environmental irritants and allergens,

and proper use of treatment and management devices, such as peak flow meters, metered dose inhalers, and nebulizers.

- Delivering developmentally-appropriate asthma self-management skill lessons.
- Developing asthma care plans and asthma action plans in collaboration with the student, his/her family, school staff, and the student's health-care provider.
- Gathering asthma materials and resources for students, parents, and staff and disseminating these appropriately through a variety of media.
- Educating school staff about the effective use of individual asthma action plans.
- Educating the school community and school staff about asthma and asthma triggers in the school that need to be controlled and decreasing exposure to allergens and irritants by educating school staff about how its activities affect air quality.
- Introducing resources and/or experts and proposing the development of indoor air quality teams in the school so that school staff is involved in making necessary changes to improve air quality.
- Working with local community groups to mobilize community resources for a comprehensive, culturally and linguistically competent approach to controlling asthma.
- Helping parents understand the importance of sharing appropriate information about the child's asthma with the school nurse and others in the school community involved with the child, including teachers, school staff, coaches, on-site or after-school day care providers, etc.

In a prior draft of the bill, there was a specific requirement that nurses be certified in asthma education. There is some concern regarding giving preference to school nurses certified as asthma educators. Currently, this is not included as a requirement in the current job descriptions and it is not currently a requirement for employment. Based on preliminary research, the National Asthma Education Certification Board offers a certification program. Below are the costs:

- \$275 for the initial examination
- \$150 for a second examination
- \$275 for recertification, which is required every five years.

These are significant costs and would need to be addressed before requiring school nurses to obtain this certification.

Additionally, the effectiveness of this requirement is not currently known. Outcome studies to evaluate the effectiveness of education by Certified Asthma Educators are in the planning stages to assess the benefit of this process and to help guide the recertification process.

More importantly, as already mentioned in childhood obesity, school nurses clearly have an important role in addressing asthma. However, even though the school nurse program was expanded in the comprehensive school health plan, the school nurse cannot be

expected to be the sole health care or healthcare-related professional actively implementing an asthma management program.

When students arrive at school, their conditions have been appropriately managed by their healthcare providers. There is a requirement that they/their parents are educated regarding asthma and the management of asthma. There is also a requirement that children authorized to self-administer asthma medications/treatments must be deemed competent to do so as a component of the Asthma Action Plan developed by the LIP.

It is the recommendation of Children's School Services that the role of the school nurse has already been identified as described above. Therefore, additional legislative language regarding asthma education certification for school nurses is not needed. Further information is needed about the effectiveness of asthma education certification before making this a requirement.

### **Children's National's IDEAL Clinic**

Children's National's IDEAL Clinic (Improved Diet, Exercise & Activity for Life) treats children and teens ages two to 18 who are at risk of obesity and who have been classified as obese and develops multidisciplinary management plans for the patients and their families. Patients have access to psychologists, dieticians, and exercise therapists as well as nurses, physicians, and specialists in gastroenterology, endocrinology, cardiology, sleep medicine, psychology, and exercise therapy. The IDEAL Clinic is the only comprehensive multidisciplinary treatment program for children with obesity in the metropolitan region.

After a child is admitted into the IDEAL Clinic, they are followed by specialists intensively for six months, followed by monthly visits for approximately 12-18 months. During treatment, the child may receive dietary, nutritional, and weight management counseling, as well as group health education and physical activity classes. In addition, parents receive individual education to create an environment conducive for the child to manage their weight.

The IDEAL Clinic is part of the Goldberg Center for Community Pediatric Health (Goldberg Center). One of Children's National's clinical Centers of Excellence, the Goldberg Center offers a community-based model that focuses on comprehensive primary care, prevention, diagnoses and treatment of pediatric health conditions prevalent in the region. Through the Goldberg Center's broad scope of services, Children's National Medical Center's presence extends into neighborhoods as an integral component of community life in the District.

Due to the success of the program, there is an excess of demand for children to be admitted to the clinic. Currently, there is a two year waiting list for treatment.

### **Children's Healthy Schools Program**

Children's Healthy Schools Program partners with the District of Columbia Public Schools, Department of Health, and Physical Education and Athletics to improve the health and well-being of children in the District of Columbia.

The program uses the a community-driven nutrition and physical activity curriculum created by Children's to bring a science-based health and fitness component directly into schools to change behaviors and influence youth to make lifelong healthy eating and fitness decisions.

Health and physical education teachers are trained on the curriculum and integrate the lessons into their already existent curriculum for pre-K through 5th grades.



## Children's National Medical Center Policy Statement: Childhood Obesity

*On this day, the eighth day of April, 2008, Children's National Medical Center's Committee on Advocacy & Public Policy unanimously recommends to the Board of Directors adoption of the following institutional position on childhood obesity:*

Childhood obesity is an escalating national health crisis. It affects children across all ages, races, gender, cultures, and economic means. Nationally, the prevalence of obesity among children is increasing at an epidemic rate.

- ✓ 16 percent of children (more than 9 million) between the ages of 6-19 years are overweight or obese -- a number that has tripled since 1980.<sup>1</sup>
- ✓ Over the past three decades, the childhood obesity rate has more than doubled for preschool children aged 2-5 years and adolescents aged 12-19 years, and it has more than tripled for children aged 6-11 years.<sup>1</sup>
- ✓ Overweight adolescents have a 70 percent chance of becoming overweight or obese adults. This increases to 80 percent if one or more parent is overweight or obese.<sup>2</sup>

Locally, the situation is even worse. Data from the DC Partnership to Improve Children's Healthcare Quality from 2006 estimates almost 50 percent of children in the District of Columbia are overweight or obese. Overweight children are at risk for serious health conditions like type 2 diabetes, high blood pressure, and high cholesterol, all once considered almost exclusively adult diseases. Overweight children may also be prone to low self-esteem that stems from being teased, bullied, or rejected by peers.

According to a 2005 U.S. Government Accountability Office report, the rise in obesity-related health conditions also introduces added economic costs. Between 1979 and 1999, obesity-associated hospital costs for children between the ages of 6 and 17 more than tripled, from \$35 million to \$127 million. Moreover, because studies suggest that obese children are likely to become overweight or obese adults--particularly if the children are obese during adolescence--the increase in the number of obese children will also contribute to health care expenditures when they become adults. Obesity-related health expenditures are estimated to have accounted for more than 25 percent of the growth in health care spending between 1987 and 2001. In 2000, an estimated \$117 billion was spent for health-related expenditures due to obesity, with direct costs accounting for an estimated \$61 billion.<sup>3</sup>

As the largest non-governmental provider of pediatric care in the District of Columbia and one of the nation's leading children's hospitals, Children's National Medical Center (Children's National) should make prevention and treatment of childhood obesity an institutional priority. As such, Children's National, through its Child Health Advocacy Institute and Obesity Institute, will take a leadership role in

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<sup>1</sup> Centers for Disease Control and Prevention. (2004, Oct. 4). *Prevalence of overweight and obesity among children and adolescents: United States, 1999-2002*.

<sup>2</sup> U.S. Department of Health & Human Services. (2007, Jan. 11). The Surgeon General's call to action to prevent and decrease overweight and obesity. Retrieved from [http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact\\_adolescents.htm](http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_adolescents.htm).

<sup>3</sup> U.S. Government Accountability Office. (2005, Oct. 7). *Childhood obesity: Most experts identified physical activity and the use of best practices as key to successful programs*, GAO-06-127R.

improving conditions that inhibit children locally, regionally, and nationally from leading healthy, active lifestyles.

A comprehensive plan to effectively address and combat childhood obesity should include three primary strategies:

**I. Conduct an internal hospital review to assess existing policies and practices that may contribute to obesity in the hospital environment. Implement changes that promote a healthy environment for patients, families, and staff.**

Children's hospitals strive to be archetypes of healthfulness and wellness for families. Yet, the physical sites themselves are suboptimal health environments and may be promoting obesity. Vending machines and fast food outlets, common in children's hospitals, in particular promote practices and communicate messages to families that act directly *against* the health education efforts of clinicians. "Practicing what we preach" by modeling a healthful environment and practices is an essential first step to educating patients, families, and staff about the importance of obesity prevention.

**II. Engage in coordinated, preventive, and community-based advocacy interventions.**

In many jurisdictions, there are significant efforts among pediatric health stakeholders to address obesity and promote healthy eating and increased physical activity; however, there lacks a collective and comprehensive approach that brings together community-wide efforts to leverage resources and maximize the economies of scales to positively improve the health status of children and their families. A piecemeal approach to community-based interventions will not have the impact necessary to affect meaningful change.

Children's National recommends a community-based strategy that incorporates the following components:

1. Mobilizing medical resources around obesity identification, prevention, and treatment.
2. Promoting healthy food choices in schools and neighborhoods.
3. Ensuring schools offer mandatory physical education.
4. Creating easily accessible and safe recreational activities and play spaces in all neighborhoods.
5. Coordinating culturally competent health education messaging.

**III. Seek legislative and/or regulatory policy interventions to improve access to comprehensive obesity treatment services and to establish appropriate school nutrition and physical education standards.**

Body Mass Index Screening

A. Body Mass Index (BMI) is the most widely used measure of weight-related health risk. Children's National believes BMI measurement is most appropriately carried out in the primary care medical home. Some states, however, have implemented mandatory BMI screening in public schools as a means to assess the weight status of individual students and provide this information to parents with guidance for action. Based on clinical evidence and the lack of proven efficacy<sup>4</sup>, Children's National does not endorse mandatory BMI screening in public schools. Children's National believes school resources are more appropriately directed to

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<sup>4</sup> Body mass index measurement in schools. (2007, December). *Journal of School Health*, 77(10).

ensuring children receive nutritious meals and snacks and appropriate physical and health education. Children's National would, as necessary, support legislative and regulatory approaches to establishing nutrition and physical education standards.

#### Poor Reimbursement as a Barrier to Care

**B.** Despite the health risks associated with obesity, patients and physicians get little support from health insurers in terms of treatment. Many insurers will not cover weight-loss treatments unless the patient has an obesity-related secondary condition such as diabetes or hyperlipidemia. One study of 191 children in a hospital weight-management program found a median reimbursement rate of 11 percent, with variations from 0 to 100 percent.<sup>5</sup> Third-party payers' failure to recognize obesity as a primary and reimbursable diagnosis code creates a barrier for patient access to comprehensive obesity treatment services. It also results in under-reporting of the prevalence of obesity.

Children's National endorses the following strategies as a means to collect more accurate data on the prevalence of childhood obesity, establish more reliable physician reimbursement for obesity care, and increase children's access to comprehensive obesity care.

- **Seek recognition of obesity and overweight as reimbursable primary ICD9 diagnosis codes.** The American Medical Association (AMA), Health Resources and Services Administration (HRSA), American Academy of Pediatrics (AAP), and others have endorsed and published new clinical guidelines around diagnosis, assessment, treatment, and prevention of childhood obesity.<sup>6</sup> This evidence-based best practice provides the optimal framework to ensure that adequate reimbursement aligns with clinical care recommendations.
- **New reimbursement models should be piloted to ensure all components of recommended obesity care can be appropriately delivered and fairly reimbursed.** Following the AAP/AMA/HRSA guidelines, children who don't respond to basic community-based care need referral to a comprehensive obesity treatment program. These programs are appropriately multidisciplinary and include: medical, behavioral, diet/nutrition, exercise, and endocrine/metabolic specialists. These require appropriate reimbursement to cover expenses without the burden of multiple, repetitive, and duplicative pre-authorizations over the defined treatment timeframe. Currently, many of the non-physician services are either not included, limited, or carved-out of existing benefit packages.
- **As per Current Procedural Terminology (CPT) rules, providers should be able to bill for obesity-related care *in addition to* a preventive care visit on same day of service.** While BMI measurement and obesity screening should be expected as part of the routine preventive care visit, there is additional work for providers to provide the next step in care management for children identified as obese. The recommended "Prevention Plus" obesity visits should also be appropriately recognized and reimbursed.

*Approved by the Children's National Medical Center Board on the 24<sup>th</sup> day of April 2008.*

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<sup>5</sup> A. M. Tershacovec and others. (1999). Insurance reimbursement for the treatment of obesity in children, *Journal of Pediatrics*, 134, 573-78.

<sup>6</sup> American Medical Association. (2007). *Appendix: Expert committee recommendations on the assessment, prevention and treatment of child and adolescent overweight and obesity*. Retrieved from <http://www.ama-assn.org/ama/pub/category/11759.html>.