



Child & Adolescent Obesity Provider Toolkit



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www.cmanet.org

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California Medical Association Foundation

3835 North Freeway Boulevard, Suite 100
Sacramento, CA 95834
Phone: 916.779.6620
Fax: 916.779.6658
Website: <http://www.thecmafoundation.org/>

California Medical Association

1201 J Street, Suite 200
Sacramento, CA 95814
Phone: 800.786.4262
Fax: 916.551.2036
Email: info@cmanet.org
Website: <http://www.cmanet.org/>

California Department of Public Health and Department of Health Care Services, Office of Multicultural Health

1501 Capitol Avenue, Suite 6130, MS 0022
Sacramento, CA 95814
Phone: 916.440.7560
Fax: 916.440.7565
Website: www.cdph.ca.gov/programs/OMH/Pages/default.aspx

U.S. Department of Health and Human Services, Office of Minority Health, State Partnership Grant Program

1101 Wootton Parkway, Suite 600
Rockville, MD 20852
Phone: 240.453.2882
Fax: 240.453.2883
Website: www.minorityhealth.hhs.gov

In order to continue to improve the information we make available to you, we ask that you provide us with feedback once you have read and use this resource. Your feedback will be essential in helping us continuously improve this toolkit and provide ongoing support and information that focuses on key messages and issues that are important to California health care providers.

The online survey is available at:
<http://www.zoomerang.com/Survey/WEB22CV8TGQQDY/>

This provider toolkit is also available in an electronic format. If you would like to download a free copy, please visit the Obesity Prevention Project website at <http://www.thecmafoundation.org/projects/obesityProject.aspx>

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2011-2012



Preface



Dexter Louie, MD
Chair, Board of Directors
CMA Foundation

Dear Colleagues,

Nearly one-third of our nation's children are overweight or obese. In California, 30% of our children are overweight or obese. Higher rates of obesity are found in our state's ethnic minority and underserved communities. A combination of poor diet and lack of physical activity has caused our children to

be at greater risk for major chronic diseases such as type 2 diabetes, heart disease and cancer.

It is no surprise that many health care providers feel overwhelmed and frustrated by the daunting task of addressing weight issues with their patients, given the physical, emotional, social, and environmental factors associated with obesity and weight management. Providers hear a variety of messages about the prevention, treatment and management of obesity that make it increasingly difficult to determine the best plan of action to take with patients.

The California Medical Association (CMA) Foundation convened an expert panel of physicians and other health care providers to update our Child and Adolescent Obesity Provider Toolkit with the support and partnership of the California Department of Public Health and Department of Health Care Services, Office of Multicultural Health, and The U.S. Department of Health and Human Services, Office of Minority Health, State Partnership Grant Program (Grant No. STTMP051006-01-00).

The expert panel:

- Broadened the Toolkit's resources for organizing our offices.

- Updated the Toolkit's resources to include the most up-to-date clinical preventive and weight management guidelines.
- Reviewed and updated the Toolkit to include the 2011 USDA Dietary Guidelines.
- Strengthened the Toolkit's section on patient/provider communications adding new resources on multicultural communications.
- Ensured that a stronger component of multicultural and multilingual patient education materials and resources was included.
- Addressed the link between clinical prevention and community advocacy, offering health care providers the opportunity to become one of the CMA Foundation's Advocacy Champions.
- Updated the Toolkit section on billing and coding procedures.

Because part of the battle to reverse the childhood obesity epidemic is in the office and part is in the community, this Toolkit provides clinical preventive resources along with advocacy interventions to address childhood obesity at the community level.

Please join with the CMA Foundation in our efforts to reverse the childhood obesity trend by utilizing this resource developed by health care providers for health care providers. The toolkit and additional resources are available on the CMA Foundation website.

For more information visit: www.thecmafoundation.org/projects/obesityProject.aspx.

Sincerely,

A handwritten signature in black ink that reads "Dexter Louie MD". The signature is written in a cursive style.

Chair, Board of Directors, CMA Foundation

Toolkit Purpose

In 2008, the CMA Foundation collaborated with commercial and Medi-Cal managed care health plans, practicing physicians and other health provider organizations to complete a Child and Adolescent Obesity Provider Toolkit addressing the prevention, early identification, and weight management education of overweight and obesity.

In 2011, the CMA Foundation and an Expert Panel again convened to update the clinical components and guidelines in this toolkit and added new resources addressing culturally competent care, multicultural communications and stronger patient education materials. This work brought together thought leaders from academic medical centers, physicians, physician assistants and nurse practitioners working daily with our children and their families as well as dietitians, nutritionists, health educators, experts in multicultural communications and health plan leadership. Expert panel members shared their daily experiences of working to address the growing obesity epidemic in their practice and community and their clinical, practice and communication expertise to strengthen this Toolkit.

Through these collaborative efforts, the Child and Adolescent Obesity Provider Toolkit has been updated to address overweight and obesity prevention and management in children and adolescents for all of California's children.

The objective of the Child and Adolescent Obesity Provider Toolkit is to equip health care providers with strategies and tools to assess, prevent and effectively manage pediatric patients who are overweight and obese, and to offer pertinent information for providers to consider when discussing healthy lifestyles and weight management with their patients, including those from diverse and underserved communities.

Disclaimer

This toolkit is intended for health care providers to consider in managing the care of their patients for overweight and obesity. While the toolkit describes recommended courses of prevention, assessment, and treatment, it is not intended as a substitute for the advice of a physician or other knowledgeable health care professional. This toolkit represents best clinical practice at the time of publication, but practice standards may change as more knowledge is gained.

We would like to thank the California Department of Public Health and Department of Health Care Services, Office of Multicultural Health and the U.S. Department of Health and Human Services, Office of Minority Health, State Partnership Grant Program (Grant No. STTMP051006-01-00), for their support in the development of this Toolkit, strengthening its focus on multicultural communities.



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Sergio Aguilar-Gaxiola, MD

Professor Of Internal Medicine
Director, Center for Reducing Health Disparities
UC Davis School of Medicine

Shikha Anand, MD, MPH

Physician Champion
National Initiative for Children's Healthcare & Quality
Boston MA

Rene Bravo, MD

Private Practicing Pediatrician
San Luis Obispo CA

Dennis Carrillo, MPH

Health Promotion Specialist
Health Net of California

Ron Chapman, MD, MPH

Chief Medical Officer
Partnership Health Plan

Lakshmi Dhanvanthari, MD, FAAP

Regional Medical Director -
State Health Program Health Net

Joseph Duke, MD

Director
CHDP Program
Los Angeles County

Beth Grivett, PA-C

CA Association of Physician Assistants

Lawrence Hammer, MD

Professor of Pediatrics
Stanford University School of Medicine

Kathy James, DNSc, NP

Associate Professor of Nursing
University of San Diego

Cindy Juarez, MPH

Obesity Program Health Educator
LA Care Health Plan

Margaret Juarez, MD

Private Practicing Physician
President, California Latino Medical Association
Los Angeles CA

Helen Jones, MD

Private Practicing Physician
Fresno CA

Christina Kan, RD

Chinese American Medical Society
Of Southern California

Dexter Louie, MD, JD, MPA

CMA Foundation Board Chair

Vivian Matiossian, MS, RD, CDE

Lead Dietician & Certified Diabetes Educator
Healthcare Partners

Suzanne Michaud, MPH

Health Promotion Educator
CenCal Health

NJ Mitchell

Partner
Human Communication Institute

Frank Navarro

CMA Reimbursement Specialist



María J. Ortega, MPH, CHES

Senior Cultural and Linguistic Specialist
Health Net of California

Hermia Parks, RN

Director of Public Nursing
Riverside Department of Public Health
Community Health Agency

Maggie Parks Cho, MD

Private Practice Pediatrician
Stockton CA

Pamela S Perkins

Founder & CEO
Human Communications Institute

Paul Quaquandah, MD

Physician
American Academy of Pediatrics
Chapter 4

Sherril Rieux, MD

Private Practice Physician
Assoc of Black Women Physicians

Mayra Rosado, MD

Lead Physician
HealthCare Partners – El Monte

Harvinder Sareen, PhD, MPH, CHIE

Director, Health Care Quality and
Innovations, State Sponsored
Business
WellPoint State Sponsored Business

Hilary Seligman, MD, MAS

Assistant Professor of Medicine and Epidemiology and
Biostatistics
Division of General Internal Medicine, University of California
San Francisco
Center for Vulnerable Populations at San Francisco General
Hospital

Razia Sheikh, MD

Private Practicing Physician
Fresno CA

Wendy Slusser, MD

UCLA School of Medicine
Department of Pediatrics

Judy Sundquist, MPH

Consultant
California Dept of Healthcare Services

Gayle Tang, MSN, RN

Nat'l Linguistic & Cultural Programs
Kaiser Permanente

Jennifer Trapp, MD

Staff Physician, Department of
Family Medicine
Sharp Rees-Stealy Medical Group

Seleda Williams, MD, MPH

Medical Consultant
California Department of Health Care Services
Medi-Cal Managed Care Division, Medical Policy Section

Christine Wood, MD, FAAP

Private Practice Pediatrician
San Diego County Childhood
Obesity Initiative

Nancy Wongvipat, MPH

Director, Health Education (SHP) / Cultural & Linguistic
Services

Sophia Yen, MD, MPH

Clinical Instructor, Division of
Adolescent Medicine
Lucille Packard Children's Hospital at Stanford University
Medical Center

Table of Contents

Chapter 1: Understanding Childhood Obesity.....	10
Trends in Overweight and Obesity	10
Definition of Overweight and Obesity	11
Determinants of Child Health	11
Health Conditions Associated with Overweight & Obesity	16
End Notes.....	17
Chapter 2: Organizing the Office.....	22
Resources for the Office	22
Leading by Example	23
Office Procedures for the BMI.....	24
Language Access Resources for Limited English Proficient Patients	26
Culturally Competent Care.....	30
End Notes.....	32
Chapter 3: Patient-Provider Communication.....	36
Overview - Patient Centered Communication	36
Multicultural Communications.....	36
Nonverbal Communications	40
Preventive Counseling	42
Sample Patient-Provider Dialogue	46
3 Point Plan.....	48
End Notes.....	50
Chapter 4: Prevention & Treatment of Overweight and Obesity	54
Expert Committee Recommendations	54
Implementation Guide Tables	56
Pharmacotherapy Recommendations	63
Bariatric Surgery Abstract.....	64
Screening for Food Insecurity.....	65
End Notes.....	68
Chapter 5: Patient Education Resources	72
MyPlate - USDA Dietary Guidelines	72
MyPyramid for Kids.....	73
Tips for Families	74
Decide What to Eat.....	75
Reading Food Labels.....	76



What is a Serving Size?	77
MyPyramid Worksheet (Food Diary)	78
Ethnic Food Pyramids	79
Healthy Cultural Recipes	81
Being Physically Active	83
5-2-1-0 Good Health Club	85
“Little Changes. Big Rewards. Are you Ready?” Posters	87
Self-Love = Healthy-Love Handout	89
Chapter 6: Online Resources	92
Web Resources for Parents	92
Web Resources for Teens	94
Resources for Children	94
Web Resources for Providers	95
Culturally Appropriate Resources	96
Nutrition/Physical Activity/Health Information Web Resources	101
Ethnic Provider Organizations	102
End Notes	102
Chapter 7: Community/Environmental Advocacy	106
Healthcare Professionals are Natural Advocates	106
Understanding Advocacy	106
Linking Community Advocacy with Clinical Practice	107
Matching the Advocacy Activity to the Time Available	108
CMAF Healthcare Professionals for Healthy Communities Initiative	109
Online Resources	110
End Notes	111
Chapter 8: Billing & Coding	114
Obesity Coding Fact Sheet: Expert Panel Recommendation Stages	114
AAP/AMA Obesity & Related Co-Morbidities Coding Fact Sheet for Primary Care Providers	117
CHDP Provider Notices Related to Obesity Prevention and Co-Morbidities	125
Toolbox	154
A. NICHQ California State Fact Sheet	154
B. Self-Worth Assessment Tool	156
C. Adolescent Resources	159
D. CDC Growth Charts	160
E. Health Plan Interpreter Services	162
F. Multicultural Assessment	166
G. Healthy Lifestyle Questionnaire	170
H. Care Planning Guide	171
I. 3 Point Plan	174
J. Food Security Surveys	175
K. MyPlate Food Model Guidelines	177
L. Multicultural Patient Communications Vignette	180





1

Understanding Childhood Obesity

- Trends in Overweight and Obesity
- Definition of Overweight and Obesity
- Determinants of Child Health
- Health Conditions Associated with Overweight & Obesity

Learning Objectives:

1. Understand the trends associated with overweight and obesity and how California compares to national trends.
2. Define overweight and obesity and the risk factors that can influence a child's health and weight.
3. Describe how body image and self-esteem can be influenced by culture and how to address this with your patient.

Chapter 1

Understanding Childhood Obesity

Trends in Overweight and Obesity

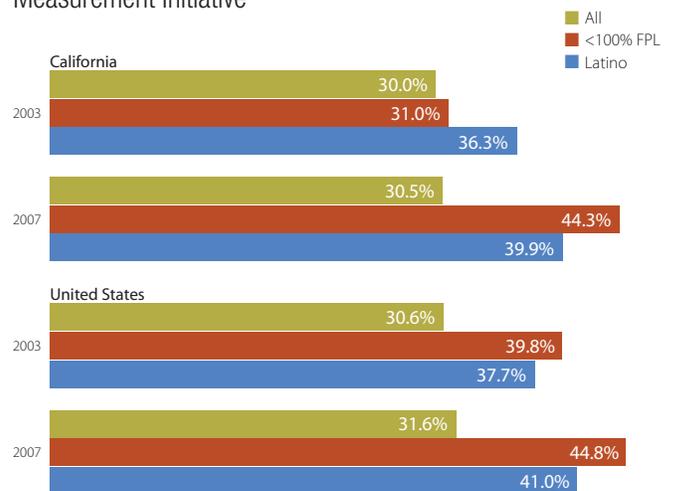
If current trends continue unchecked, today's children will become the first generation to live shorter life spans than their parents. Since the early 1970s, the prevalence of overweight and obesity has approximately doubled among 2-to-5 and 6-to-11-year-olds and tripled among 12-to-19-year-old adolescents. According to the most recent National Health and Nutrition Examination Survey (NHANES), 16.9% of children ages 2 to 19 are obese and 31.7% are overweight or obese.¹ Overweight and obesity increase one's lifelong risk for type 2 diabetes, high blood pressure, osteoarthritis, stroke, certain kinds of cancer and many other debilitating diseases.² There are also significant health disparities with African-American and Latino children and youth showing significantly higher rates of overweight and obesity.

According to the 2007 National Survey of Children's Health, California ranked 24th in overall prevalence with 30.5% percent of children considered either overweight or obese, compared to 31.6% nationally. The California prevalence of overweight and obese children has risen since 2003. The 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, reported that 33% of low-income children ages 2 to 5 were overweight or obese in California.³ For additional overweight and obesity data in California, please see the National Initiative for Children's Healthcare Quality (NICHQ) California State Fact Sheet located in the Toolbox Appendix A.

Childhood Obesity⁴

California vs. United States, 2003 and 2007

National Initiative for Children's Healthcare Quality, Child Policy Research Center, and Child and Adolescent Health Measurement Initiative



Note: Includes children ages 10 to 17 years. Children with a BMI at or above the 85th percentile based on height and weight as reported by the parent or guardian are classified as overweight or obese. FPL stands for federal poverty level.

Costs Associated with Obesity in Children

Obesity places an enormous burden on the health care system and the economy as a whole. Obese children's health care costs are roughly three times more than those for the average child.

- Childhood obesity is estimated to cost \$14 billion annually in direct health expenses, and children covered by Medicaid account for \$3 billion of those expenses.⁵
- The average total health expense for a child treated for obesity under private insurance is \$3,743 annually, while the average health cost for all children covered by private insurance is about \$1,108.⁶
- Annually, the average total health expense for a child treated for obesity under Medicaid is \$6,730, while the average health cost for all children on Medicaid is \$2,446.

- Childhood obesity costs Medicaid more than \$3 billion annually.⁷
- Annual obesity-related hospital costs for children and adolescents were \$238 million in 2005, nearly doubling between 2001 and 2005.⁸
- In 2000, the annual total cost of obesity (including medical fees and lost productivity) for adults and children in the United States was estimated at \$117 billion.⁹

Definition of Overweight and Obesity

The clinical definition of childhood overweight and obesity is based on the ratio of weight to height using age and gender specific references. The Body Mass Index (BMI) is a widely accepted measure for adiposity. The CDC and the American Academy of Pediatrics (AAP) recommend the use of the BMI to screen for overweight in children annually beginning at two years of age. It is calculated by dividing weight (in kilograms) by height (in meters) squared. Based on the BMI, a child or adolescent is considered obese when the BMI is at or above the 95th percentile, with respect to gender-specific BMI for age growth charts provided by the CDC. When the BMI is at or above the 85th percentile but less than the 95th percentile, a child or adolescent is defined as overweight.

The BMI is only a screening tool. BMI is not a diagnostic tool. A child may have a high BMI for age and gender, but to determine if overweight is a problem, other assessments need to be performed. These may include diet and physical activity evaluation, medical and family history, BMI trajectory, assessment of body fat distribution, laboratory testing, and other appropriate health screenings.¹⁰

As of June 2007 the AMA/CDC Expert Committee on Childhood Obesity groups children as follows:

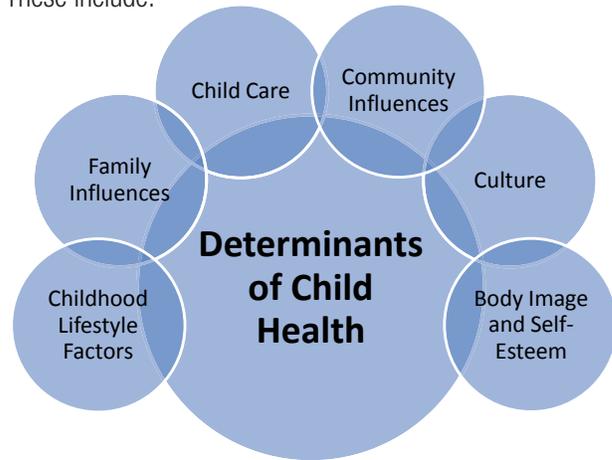
BMI Percentile	Nutritional Status
< 5 th Percentile	Underweight
5 th - 84 th Percentile	Healthy Weight
85 th - < 95 th Percentile	Overweight*
≥ 95 th Percentile	Obese**
> 99 th Percentile	Severely Obese

*Formerly classified as “at-risk for overweight”

**Formerly classified as “overweight”

Determinants of Child Health

A number of factors are determinants of child health. These include:



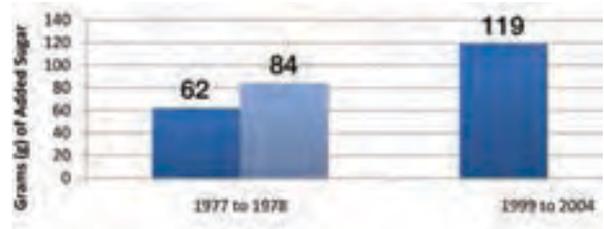
Childhood Lifestyle Factors

Diet - Before our children can make their own food choices, what they eat can influence their development of overweight.

Consumption of added sugars has increased substantially in recent decades. Studies show that the consumption of added sugars is positively associated with multiple measures known to increase cardiovascular disease risk.¹¹ Sugars used to sweeten soft drinks have become the largest single source of calories in the U.S. diet.¹²

Average Daily Consumption of Added Sugars Among Adolescents

Consumption of Added Sugars and Indicators of Cardiovascular Disease Risk Among US Adolescents. *Circulation: Journal of the American Heart Association.*



★ Quick Tip

Added Sugars are refined calorie-containing sweeteners added to foods and beverages during processing or preparation.



High levels of sweetened beverages are associated with increased risk of overweight, including fruit juices and sodas with high sugar content.



Fruit and vegetable consumption along with consumption of foods with low caloric density and water have a healthy effect on body weight.

Physical Activity - There is a dramatic link between sedentary behavior and overweight. When children watch television or play video games, they experience a decrease in energy output. Children with televisions in their bedrooms have also been shown to have lower levels of physical activity compared to children without televisions in their bedrooms and are at a higher risk for becoming overweight.

Family Influences & Parental Modeling

Most early childhood experiences are shaped by parent and cultural beliefs, practices and routines. Parents are the primary influence in a young child's development.¹³ Children with two obese parents are 10 times more likely to become overweight compared to children with non-obese parents.¹⁴ The prenatal environment influences the development of child overweight as well. Children born to mothers with gestational diabetes have an increased risk of overweight, as do children with higher birth weights.¹⁵ An infant with a birth weight of 4,000 grams (8.8 pounds) or greater is more likely to become an overweight child or adult than an infant whose birth weight is low or within the normal range. Less than 5 percent of childhood obesity can be attributed to endocrine and genetic disorders.

★ Quick Tip

Family Influences on a Child's Weight

- Family Mealtime
- Perception of Healthy or Attractive Shape or Weight
- Food Choices Deemed Appropriate for Children
- Attitudes Toward Physical Activity
- Degree of Parental Authority

Parents are important role models for their children. When parents eat right and are physically active, they demonstrate the importance of these behaviors to their families, helping their children make the same healthy choices. In addition to modeling healthy behaviors, parents can create family habits that establish a support system in which everyone helps everyone to make healthy food and physical activity choices. Parents can also exert influence over how much television their children watch on a daily basis, limit the number of televisions in the house and limit the number of hours the television is on.

The average American family today dines outside of the home on a regular basis, thus encountering "super-sized" servings of food on a regular basis. Whether you eat in a restaurant or fast food chain, the majority of the meals will come in larger portions than necessary. In this way, restaurants are helping to redefine what society believes to be a "normal portion," and children are learning at an early age to expect more food each time they eat.

Child Care

A large percentage of young children are in some form of child care, and the amount of time children spend in child care each week has increased in recent years. The 2005 NHANES reports that 74% of all U.S. children ages 3 to 6 years not yet in kindergarten were in some form of non-parental care, and 57% were in center-based child care.¹⁶ Furthermore, it has been reported that many children from low-income backgrounds consume 50% to 100% of their Recommended Dietary Allowances in a child care setting and many children spend the majority of their waking hours out-of-home.¹⁷

Child care facilities may serve as home-away-from-home settings, where children adopt early nutrition, physical activity and television viewing behaviors. These behaviors are often a result of interactions with parents and other caregivers.¹⁸ Young children in particular are more likely to be influenced by adults in an eating environment.¹⁹ Child care settings are an important environment for forming good health habits for dietary intake, physical activity, and energy balance and thus combating the childhood obesity epidemic.²⁰

Community Influences

Even though the cause of the obesity epidemic is consumption of excess calories through unhealthy eating habits and insufficient physical activity, these individual eating and activity behaviors and choices are shaped by factors in the communities' social and physical environments. Obesity results from this complex interaction between diet, physical activity, and the environment. The built environment encompasses a range of physical and social elements that make up the structure of a community and may influence obesity.

Community influence can contribute to a child's risk for becoming overweight through factors including:

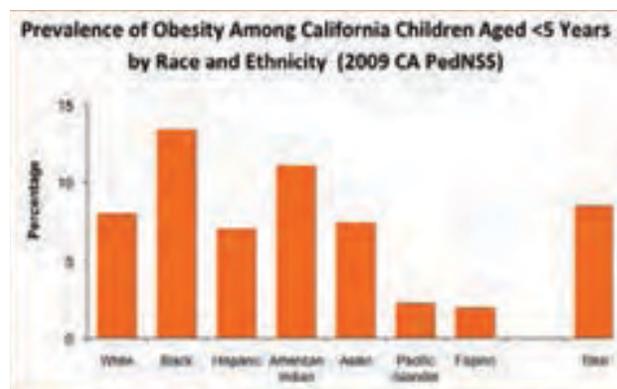
- Limited access to healthy food, especially fresh fruits and vegetables. Many low-income neighborhoods are without full-service grocery stores or farmers' markets, a situation often referred to as a "food desert."
- Schools in lower-income neighborhoods are more likely to have fewer resources for physical activity, both during and after the school day.
- Neighborhoods may not have parks to play in or sidewalks for safe walking or bike riding.
- The neighborhood may not be safe and may limit opportunities for physical activity.
- Physical activity outside the home normally takes place along neighborhood streets, on walking or biking trails, in parks, or in exercise facilities such as gymnasiums or pools. Lack of access to such places may discourage physical activity and promote obesity. Walking, the most common physical activity in the United States frequently occurs along neighborhood streets, making streets with sidewalks important for physical activity.

Culture

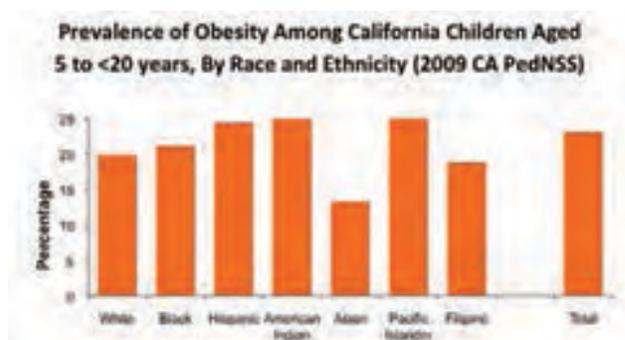
Culture represents the knowledge, beliefs, customs and habits a group of people share that guide behavior. Culture influences how we look at weight, body size and body shape. While the rising trend in obesity rates cuts across all social classes, the prevalence of obesity is higher and the severity of consequences from obesity-related diseases,

such as diabetes, is particularly troublesome in underserved and ethnically diverse communities. Within equivalent levels of socioeconomic status, race still serves as a determinant of health. Children, as a subgroup, are more racially and ethnically diverse than the nation's population as a whole, and overweight and obesity prevalence rates are highest among children and adolescents of color.

Black and American Indian children in California, two through four years of age, have the highest rates of obesity, at roughly 13% for young Black children and 11% for young American Indian children. This compares to roughly 20% of American Indian children and approximately 17% of Hispanic children of this age group who are obese nationwide..²¹



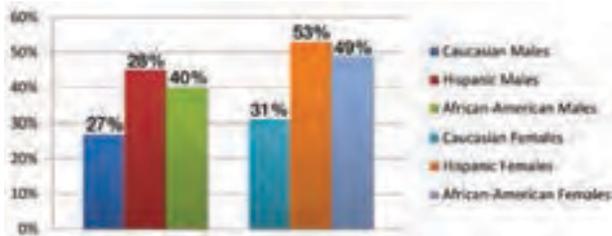
This pattern changes dramatically as children increase in ages. Pacific Islander, American Indian and Hispanic children, 5 to 19 years of age in California are more likely to be obese than Asian, White, Filipino and Black children. 25% of Pacific Islander and Native American children and almost 25% of Hispanic children are obese compared to only approximately 12% of Asian and 20% of White children in this age group..²²



Hispanic or Latino and African-American children are more likely to develop diabetes than white children. White males born in 2000 have a 27% risk of being diagnosed with diabetes during their lifetimes, while Hispanic or Latino and African-American males have a 45% and 40% lifetime risk, respectively. White females born in 2000 have a 31% risk of being diagnosed with diabetes during their lifetimes, while Hispanic or Latino and African-American females have a 53% and 49% lifetime risk, respectively.²³

Risk of Being Diagnosed with Diabetes

Lifetime Risk for Diabetes Mellitus in the United States.
Journal of the American Medical Association.



Reducing overweight and obesity in these communities will require a comprehensive approach that takes into account factors related to culture, language, and the social and physical environment of the community.

★ Quick Tip

There is a strong focus in our society on appearance. How we look is often more important than our health.

Body Image and Self-Esteem

An important factor to consider in addressing overweight and obesity is the link between body image, self-esteem, healthy weight and overall health. Body image dissatisfaction occurs before the onset of puberty. Children, particularly girls as young as six or seven, already exhibit a preference for body figures thinner than their own.²⁴ For teenagers today, there is a greater emphasis on their body image and physical appearance than on what is happening inside their body that can lead to ill health. There are a number of family and cultural threads that run through the development of teens' self-esteem linked to body image. It

is critical to consider how to effectively frame the message of body image and health, both for teens and their families. Through words and actions, families can convey their focus on body image and health, and how this affects their children's self perception.

★ Quick Tip

All parents want their children to be healthy and don't want to unintentionally do anything to hurt them.

It is therefore important to focus your message to parents and patients on behaviors that make our children healthier on the inside, not about how they look on the outside.

Teen girls, in particular, are very aware of and concerned about their body image. Body image is strongly linked with their self-esteem. Young boys can feel concern about their body image as well, particularly if they have been made fun of because of their overweight appearance.

Differences, however, may be seen in race and ethnicities in how body image is linked with self-esteem. Among many white and Asian-American girls, being thin is often the desired norm. Think back to the 1960s and the images in fashion magazines. Young girls and women saw models who had shapes similar to theirs. Today, the average teen girl looks through similar magazines and sees models who, on average, weigh 20% less than them. What's the message to these young girls? "Lose weight and look like me."

In studies with African-American teens, body image did not appear to play out in this manner.²⁵ Young girls did not judge themselves in terms that linked weight to health. In one study, young African-American girls described themselves as "thick," not overweight. Fat and thick were two different things. Thick described a young girl who was curvaceous, with larger hips, a rounded backside and ample thighs. This was their most desired body shape. Having a body shape without differentiated curves was considered to be fat and unattractive.

Within the Latino community, a mix of messages about body image may be seen. In families recently emigrated from

more impoverished countries, “chubby” children are viewed as healthy children because historically they have been better able to survive childhood diseases. In many of these countries, weight may also be seen as a sign of wealth and prosperity. It has the same cultural value as thinness in the U.S..²⁶ In a study conducted to assess the role of BMI on a Latino child’s perceived ideal body weight among more acculturated Latino families, the child’s BMI did appear to influence perception of ideal weight. Children who were overweight or obese were more likely to view thinner figures as ideal than non-overweight children. By contrast, non-overweight children in the study were more likely to view a heavier figure as ideal.²⁷ Girls were more likely to base attractiveness on weight than young boys.

Tips for Health Care Providers Communicating with Teens

Teen Self-Image

Teenagers experiencing problems with body image bring special concerns to the provider/patient communication experience as health care providers seek to communicate effectively beyond “teen walls” or barriers. These barriers may be apparent in a variety of verbal and nonverbal behaviors exhibited during clinic visits, and include:

- Sullenness or moodiness
- Unwillingness to communicate
- A lack of desire to express deep-seated feelings
- Feelings that adults do not understand the pressures of “fitting in”
- The sense that long-term health remedies will not fix immediate self-worth/esteem concerns

The additional peer and societal pressures to be “thin and beautiful” weigh heavily on the minds of young teens who desperately seek approval and inclusion. These teens are not only dealing with their own feelings of how they see themselves (self-esteem) but also the issues of comparative worth (self-worth) that consistently drive them to live in the world of social comparisons. This can be especially detrimental to teens dealing with being overweight or obese.

Communication Tips

Teens relate best to adults who can engage on a more empathetic level than those who provide only a list of “do’s and don’ts”. Below are a few Communication Tips to help health care providers in their efforts to engage teenagers and encourage their road to improved health:

- Ask teen to take the Self-Worth Assessment Tool provided in the Toolbox Appendix B to gauge their level of personal comfort with their body image.
- Ask teen if he/she has any specific issues he/she would like to discuss that would help you understand his/her relationship to eating and physical activity.
- Make sure that you use nonverbal communication such as direct eye contact, a caring tone of voice and facial expressions that express recognition and concern.
- Share any “personal” stories that may create a more empathetic connection between you and the teen providing reassurance that you are there to help the teen through this difficult but manageable time of adolescence (assure him/her this is not a forever situation)!
- Ask teens if they feel there is a connection between how they feel about themselves and their eating habits.
- Ask if there are any concerns at home or school that may be creating stress in their lives and inadvertently causing them to seek comfort in eating or unhealthy eating patterns.
- Ask teens if they feel any pressures around approval or inclusion due to weight (especially if they are interested in dating).
- Ask teens if they are experiencing any problems at school or in their social surroundings with bullying due to weight concerns.
- Share Self-Love = Healthy-Love Handout, provided in Chapter 5: Patient Education Resources, to encourage new patterns of thinking.

★ Quick Tip

When speaking to adolescents, never say “fat” or “diet,” but say “healthy lifestyle/eating plan.”

Sophia Yen, M.D., MPH

Clinical Instructor, Division of Adolescent Medicine
Lucille Packard Children’s Hospital at Stanford
University Medical Center

Chapter 3 of the Provider Toolkit discusses in depth the issues of communicating effectively with young patients and their families to better support the provider/patient engagement and desired health goals. For additional information, Resources for Teen Health Care Providers Regarding Obesity is provided in the Toolbox Appendix C.

The Voice of the Patient

In a study conducted by the California Department of Public Health’s Network for a Healthy California, when mothers from varying race, ethnicity and lower socioeconomic backgrounds were asked to share their understandings, challenges and successes to help their families more effectively adopt healthy behaviors, a number of patterns emerged.²⁸ Many of the mothers who participated in this study shared that they were taking a variety of steps to try to promote family health. They were cutting back on screen and phone time and serving their children more juice, water and fruit rather than sodas, sweets and unhealthy snacks. When they shopped, they were more likely to look at labels and were trying to control what food products were in the house. Although they were taking these steps, many admitted that trying to increase fruit and vegetable consumption and physical activity, while important, was not a top priority within their family. For many of the mothers, higher prices for healthier foods, a lack of time to cook, lack of skill in cooking vegetables and resistance from family members were barriers to making and sustaining change.

Many mothers working at making change within their families feel sad and guilty about having to say “no” all the time to their children, and about times when they fail to be a role model for healthy eating and physical activity.

Many mothers in the study also stated that influential family members often did not support their efforts for change, including husbands, grandparents, aunts and uncles. These mothers felt like they had to choose between healthy behaviors for their families, especially their children, and working in opposition to others in the family.

Those mothers who had some success in increasing vegetables in their family’s diet had let their children choose the vegetables to be served. They also disguised the vegetables in other dishes. Many watched TV food channels and looked at *Parents* magazine with their children to pick out new recipes and meal ideas.

A key factor for success, then was enlisting the children as allies in making change. Many mothers shared that their children were learning about healthy food choices in school and bringing this information home. Another key factor was framing the obesity issue as it relates to the health problems that can come from a child being overweight or obese.

An important factor that motivated the mothers to continue their efforts to promote healthy eating and physical activity to their children was the concern about damaging health consequences associated with overweight and obesity. They were particularly concerned about the likelihood that their children could develop diabetes and heart problems later in life.

Health Conditions Associated with Overweight and Obesity

Roughly 60% of overweight children ages 5 to 10 have at least one cardiovascular risk factor associated with being overweight, including hyperlipidemia, high LDL, low HDL and high triglycerides, abnormal glucose metabolism and elevated blood pressure.²⁹ Studies indicate that as many as 39% of pediatric patients whose BMI is \geq 95th percentile have at least two complications.³⁰

Health Consequences Resulting from Obesity

The ultimate cost of obesity is the dramatically reduced quality of life and shorter life span. Being overweight or obese puts children at risk for an array of associated health problems:³¹

- Overweight and obesity increase one's lifelong risk for type 2 diabetes, high blood pressure, osteoarthritis, stroke, certain kinds of cancer and many other debilitating diseases.³²
- Researchers estimate that one out of every three males and two out of every five females born in the U.S. in the year 2000 will be diagnosed with diabetes.³³
- More than 100,000 children ages 5 to 14 suffer from asthma each year because of overweight and obesity.³⁴
- Researchers predict that if current adolescent obesity rates continue, by 2035 there will be more than 100,000 additional cases of coronary heart disease attributable to obesity.³⁵

Moreover, children who are obese in their preschool years are more likely to be obese in adolescence and adulthood.^{36,37} It is therefore important to screen for co-morbidities that may be associated with overweight and obesity.

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2 Organizing the Office

- Resources for the Office
- Leading by Example
- Office Procedures for the BMI
- Language Access Resources for Limited English Proficient Patients
- Culturally Competent Care

Learning Objectives:

1. Identify ways to organize the office to communicate healthy eating and physical activity messages.
2. Describe ways to involve staff as team members in your office to increase healthy eating and physical activity among patients.
3. Develop approaches to most effectively record and track the patient's BMI and BMI Percentile.
4. Determine ways to organize the office to more effectively work with Limited English Proficiency (LEP) Patients.
5. Increase understanding of the importance of providing culturally competent care.

Chapter 2

Organizing the Office

Primary care providers are on the front lines of addressing the obesity epidemic in their offices. The office environment and visit provide opportunities to communicate key messages to patients focusing on healthy weight, how to achieve it, and why it is important for the overall health of children and their families, including working with families who are limited English proficient (LEP).

What follows are a number of suggested actions health care providers and their staff can take to organize the office most effectively to communicate these messages.

Resources for the Office

The Waiting Area¹

Time that patients spend in the waiting area can be used to support key messages about the importance of healthy eating and physical activity for the patient and his or her family. The waiting area can be used to display messages and resources for patients to read and take with them to support these key health messages.

- Posters are most effective when placed in areas where visitors are not otherwise engaged in communication with their health care provider, such as in the waiting room.
- Posters can reinforce the verbal advice given by a health care provider during the visit. Hang physical activity and healthy eating posters in the waiting room.
- Consider setting up sections or tables that address different health topics. For example, there can be a nutrition section with recipes for healthy foods, handouts and a list of programs for overweight children. A breastfeeding section can highlight positive associations with children maintaining a healthy weight.
- Brochure racks in the waiting area allow patients to take materials with them to reinforce these positive health messages. These can be organized by topics. Areas relating to healthy weight management include healthy

eating at home, tips for dining out, physical activity and tips for becoming more involved in children's diet and activity choices.

- Create a bulletin board. Monthly or quarterly updates can feature:
 - A list of community sports and physical activity programs that patients and children can sign up for
 - Resources and news articles for patients and children
 - Seasonal activities
 - Fruit or vegetable of the month
- Consider having some open-arm chairs that can support a child, adolescent or family member of larger size or heavier weight.
- Play videos that show children taking part in nontraditional sports and other physical activities.
- Play videos of children trying new fruits and vegetables.
- Display books, puzzles and activity sheets that support healthy eating and active living to entertain children.

Exam Rooms

Exam rooms present the opportunity to reinforce health messages. Posters and brochure racks can be placed in locations that are at the eye level of the child or parent. Rooms might also have themes such as a "healthy eating" room and a "physical activity" room.

Have handouts ready to provide to patients on the key topics associated with their preventive visit. These can aid in teachable moments specific to healthy eating or physical activity, during or at the end of the visit.

To accommodate patients of a higher weight, you may want to add a body weight scale with a capacity of 300 pounds or more. Also consider having larger patient gowns. Blood

pressure cuffs should be large enough to cover 80 percent of a patient's arm.

Leading by Example

Be sure that the habits of office staff reflect a healthy environment. Encourage healthy snacks and lunches and keep food in the staff lunchroom instead of at the reception desk.

- Avoid using food as a reward for children. Instead, use stickers, bookmarks, pencils and other non-food items to convey a healthy message to children and their parents.
- Model healthy eating in the office. You and your staff will be role models for your patients.
 - If the office or clinic operates vending machines, stock them with water, 100 percent fruit juices and other healthy snacks instead of candy, chips or sodas.
 - Provide healthy food options for staff during the workday and at all staff meetings.
 - Discourage sugared beverage consumption by staff.
 - Do not offer sugared or unhealthy treats or beverages to patients (i.e., lollipops).
- If there are stairs in your office building, take the stairs to your office, rather than ride the elevator.
- Provide onsite lactation support and consultation in your practice both for your patients and for employees who are nursing mothers. Providing nursing mothers, both employees and mothers of your patients, a breastfeeding-friendly environment can help remove barriers often experienced with breastfeeding.
- Demonstrate your personal commitment to maintaining a healthy weight to your staff and patients by taking time during the day to go for a walk or wear a pedometer in the office. Some physicians are also setting up a “Walk with Your Doc” program, meeting patients for a weekly walk.

Involving Staff

Work with your staff to make healthy eating and active living a part of their lives.

- Encourage staff to also take the stairs rather than the elevator if your office is not on the first floor of your building.
- Have a staff contest to create an office slogan or universal message about healthy lifestyles.
- Offer samples of a fruit or vegetable of the month - select items from different cultures to try.
- Host a healthy eating lunch.
- Provide a 10-minute physical activity or walk break during the workday.
- Work with staff to become aware of locations in the community where affordable fresh fruits and vegetables are readily available, including farmers' markets and food banks.
 - Farmers' Markets across California can be found at: www.farmersmarketonline.com/fm/California.htm.
 - Food banks in California can be found at: www.cafoodbanks.org/Find_A_Food_Bank.html.
- Understand national food programs and identify local resources to better serve your patients who are food insecure, including CalFresh (formerly the Food Stamp Program) and the WIC Program. (See Chapter 4's section on food insecurity.) For example, recent revisions to the WIC food package increased the amount of whole grains, fruits and vegetables participants receive, making it even easier for lower-income mothers and children to eat the healthy foods recommended by the U.S. Dietary Guidelines.

Another important way to involve staff is to provide support and training for them to strengthen their communication with patients.² For example, to build a stronger rapport with patients, staff can:

- Make sure to address patients by their last name. If the patient isn't clear about how he or she would like to be addressed, ask, “How would you like to be addressed?”
- When speaking with patients, focus attention on the patient, not work on a desk or table.
- Make sure to find out if the patient needs an interpreter.

- Document the patient's preferred language in the chart.
- Organize how interpreter services will be provided.
- Make sure patient materials are accessible for the patient.

Office Procedures for the BMI

The body mass index, or BMI, is to be recorded at each office visit. (See the following page for information on how to calculate the BMI.)

Office staff will most likely be responsible for measuring and recording the child or adolescent's BMI. Offices vary in the type of prompts that trigger a focus for the visit. It is important that staff get in the habit of recording the patient's BMI at each visit.

★ Quick Tip

Consider the BMI a vital sign for all patients.

If a paper chart is being used, the receptionist can place a chart sticker or prompt to remind the medical assistant to calculate the child's BMI. The sticker can include the BMI and where the child fits in the continuum from healthy weight to obesity:

BMI: _____

Height: _____

Weight: _____

- Underweight
- Normal Weight Range
- Overweight
- Obese
- Severely Obese

BMI is calculated as follows:

Weight in kilograms (kg) divided by the square of height in meters (m ²).	Weight in pounds (lbs) divided by the square of height in inches (in ²). Then multiply the result by 703.
BMI = $\frac{\text{Weight (kg)}}{\text{Height squared (m}^2\text{)}}$	BMI= $\frac{\text{Weight (lbs)}}{\text{Height squared (in}^2\text{)}} \times 703$

The BMI is considered a HEDIS (the Health care Effectiveness Data and Information Set) measure used by more than 90 percent of America's health plans to assess performance on important dimensions of care and service. For children and adolescents, the HEDIS measure focuses both on

- Weight Assessment using the BMI, and
- Counseling for nutrition and physical activity

The measure determines the percentage of patients 2 to 17 years of age who had an outpatient visit with a primary care provider and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

As part of current health care reform efforts, **for those health care providers who are taking steps to implement an electronic health care record (EHR) in their office, calculation of the BMI can play a role. These providers will need to reach Meaningful Use in the implementation of their EHR.** Measures will need to be identified as Meaningful Use Objectives. For those offices seeing children and adolescents, conducting a weight assessment using the BMI and counseling for nutrition and physical activity can serve as one of these objectives.

Calculating the BMI

The well child visit is the ideal time to address and counsel on issues relating to healthy eating, physical activity and ways the family can strengthen their support for their child's healthy weight.

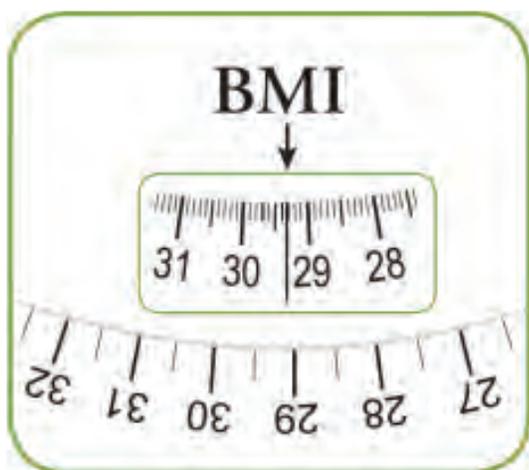
The first step in this process is the calculation of the body mass index (BMI). The American Academy of Pediatrics recommends the BMI be calculated on a yearly basis for children 2 years and older.

There are numerous methods available for calculating BMI:

- Mathematical formula (see above)
- BMI Wheel Calculator
 - Align weight and height values.

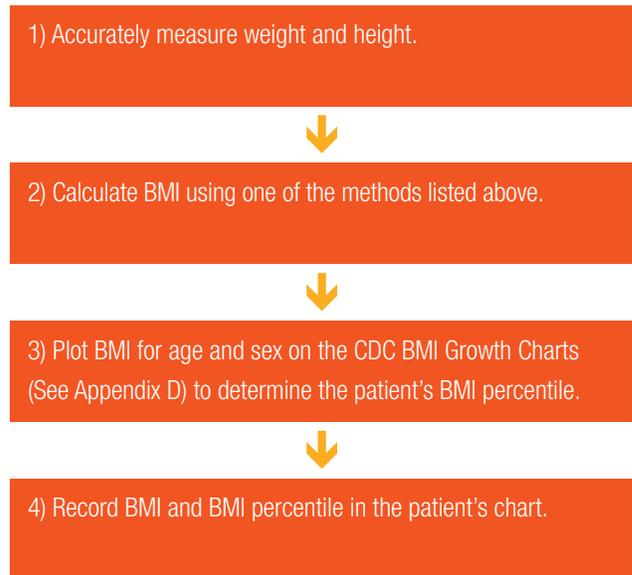


- Read BMI in the windows at the bottom of the wheel. If weight or height exceeds child limits, use the adult side of the BMI wheel. (This is a great resource for clinical staff to use. It is also great for physician offices without Internet access.)



- Online BMI Calculator
 - <http://apps.nccd.cdc.gov/dnpabmi/calculator.aspx>
- Smart phone software program

In calculating, plotting, and tracking BMI and BMI percentile, four steps should be followed to ensure accurate tracking of BMI:



Sample BMI Calculation

Charles is a 10-year-old boy who is 4'7" tall and weighs 100 pounds.

What is Charles' BMI?

$$\text{BMI} = (\text{weight [lbs]} / [\text{height (inches)}]^2) \times 703$$

$$\text{BMI} = (100/[55]^2) \times 703$$

$$\text{BMI} = 23.2$$

What does a BMI of 23.2 for Charles represent?

BMI Percentile	Nutritional Status
< 5 th Percentile	Underweight
5 th - 84 th Percentile	Healthy Weight
85 th - < 95 th Percentile	Overweight*
≥ 95 th Percentile	Obese**
> 99 th Percentile	Severely Obese

According to the Centers for Disease Control and Prevention's gender-and-age specific charts for BMI (Toolbox Appendix D), Charles' BMI is greater than the 95th percentile. Therefore, Charles is obese.

*Formerly classified as "at-risk for overweight"

**Formerly classified as "overweight"

Involving staff in the collection and recording of the BMI will be essential to increase its collection and accuracy in the practice. There are at least three ways staff can be involved with the BMI:

Step One - Hold a Daily Huddle: Each morning in preparation for the day's visits, hold what's called a "Daily Huddle" between the health care provider and office manager to briefly review the schedule. This should take about five to seven minutes.

★ Quick Tip

- Identify the patient's preferred language.
- Have language appropriate health education materials available.

- During this time, those patients coming in for well child visits and patients above a healthy weight can be identified. If a paper chart is being used, the chart prompt for the BMI can be placed on the outside of the chart to make sure the BMI is measured and recorded.

Step Two - Office Staff Meetings: Staff meetings will provide the opportunity for staff and the health care provider to discuss ways to strengthen efforts to both accurately record and discuss the BMI with patients. Time can also be spent determining ways to most effectively reach out and stay in touch with those families whose children's BMIs are increasing or have not decreased.

Step Three - Staff Training: The CHDP program has designed resources for local CHDP staff to provide training for office staff in calculating and recording the BMI and BMI Percentile. These resources can be found online at: <http://www.dhcs.ca.gov/services/chdp/Pages/BMITraining.aspx#training>. The purpose of the training is to assist office staff in calculating the BMI, plotting the BMI value on the patient's growth chart, determining the BMI-for-age percentile and interpreting the weight category.

- If your office is interested in having a training conducted, reach out to your local CHDP program office.

Finally, during the time the child is weighed and his or her BMI is calculated, have the staff member taking the measurements ask questions about the patient's meals, diet, physical activity levels, video game usage and television watching. This information can be recorded in the chart or on a routine assessment form for a new patient and placed in the chart for review by the health care provider.

Language Access Resources for Limited English Proficient Patients

Organizing the Office for Limited-English-Proficiency (LEP) Patients³

According to data from the United States Census of 2000, of the more than 12 million Californians who speak a language other than English in the home, approximately 4.3 million speak an Asian dialect or **another** language other than Spanish. The top five languages other than English most widely spoken by Californians in their homes are Spanish, Chinese, Tagalog, Vietnamese and Korean. Together, these languages are spoken by approximately 83 percent of all Californians who speak a language other than English in their homes.

★ Quick Tip

- Over 200 languages are spoken in California.⁴
- One in five Californians, between 6 and 7 million residents, are limited English proficient, meaning they speak English less than very well.⁵

To most effectively serve LEP patients in your practice, some practical steps can be taken. These include first identifying the languages spoken in your practice, locating existing resources and then, determining additional resources that can help you and your staff to most effectively address issues of overweight and obesity with your LEP patients.

Three areas to focus on include:

- Signage
- Patient Education Resources
- Interpreter Services

The first step in this process is to identify the most common languages, other than English, spoken by patients in your practice. Can you estimate the percent of patients who speak these languages? If you can estimate this frequency, it will help you to prioritize the language access needs in your practice.

If you do not already do so, develop a process to record this in the patient's chart. In this way, you and your staff will be better prepared to address the language needs of your patient prior to them being seen. Staff can help identify LEP patients. Add a color or letter code to the patient's chart to identify those who need an interpreter and to note which language.

Consider hiring staff proficient in another language. If staff members will be used as interpreters, they should receive training in medical interpretation.

Signage

Signage and forms should also be made available in non-English languages (for example, "please be seated" signs or registration paperwork). Having signs placed in key locations and providing forms in the most common languages of your practice is a simple way to make this a more welcoming place to your LEP patients.

- At the patient check-in desk, there should be a 'greeting' sign in at least the three to five major languages spoken in your practice.
- Also consider places where safety directions and other information are typically displayed, such as fire and emergency exits, directions to restrooms and drinking fountains, and similarly applicable common areas.
- If you use an over-the-phone interpreter service, a wall poster or desktop poster announcing that an interpreter is available could also be posted at check-in.
- Another solution is to provide nonverbal signs that include universally understood illustrations in areas where multiple-language signage is needed, such as for patient bathrooms.

Patient Education Resources

Posters and patient handouts should be available in the multiple languages reflective of your patient population.

- Consider featuring a "fruit- or vegetable-of-the-month" bulletin board. Select foods from different cultures.

- Health education handouts are available in multiple languages at the following sites:

- Tufts/Spiral: Selected Patient Information in Asian Languages. <http://spiral.tufts.edu>

SPiRAL is maintained by Tufts University Hirsh Health Sciences Library to increase access to Asian-language health information for consumers and health care providers. The SPiRAL website is a collection of links to Asian-language patient care documents that have been created by authoritative sources and are freely available online. Links are organized by topic and language.

Resources found on the site include:

Eat More Fruits & Vegetables	Good Food for Kids	Nutrition and Physical Activity for Children
Get Active Each Day	Healthier Snacks	Bullying
Helping Children Maintain a Healthy Weight		

Also found on the site is an Asian Food Pyramid in eight languages: Cambodian (Khmer), Chinese, Hmong, Japanese, Korean, Laotian, Thai and Vietnamese.

- MedlinePlus Health Information in Multiple Languages. www.nlm.nih.gov/medlineplus/languages/languages.html

Information in over 40 languages from the National Library of Medicine's premier consumer health website.

Resources include:

Exercise and Physical Fitness	Obesity	Weight Control
Healthy Living		Weight Management

Resources are available in Arabic, Spanish, Vietnamese, Chinese, French, Hindi, Hmong, Japanese, Korean, Russian, Somali, Ukrainian, Bosnian, Portuguese, Tagalog and Vietnamese.

- Healthy Roads Media. www.healthyroadsmedia.org

Health education materials on a variety of topics tailored to low literacy and limited English proficient populations. Materials are available in audio, multimedia and written formats. Topics include children/infants, food/nutrition, diabetes, heart health and more.

Languages include Arabic, Bosnian, English, Russian, Somali, Spanish and Vietnamese. This website also includes a page of useful links.

- **EthnoMed.** www.ethnomed.org

EthnoMed offers patient education materials, including videos, brochures, and handouts, in at least 12 languages. It is also a reference for education meetings on cultural proficiency, language access and health disparities.

The site contains background information on cultural groups, as well as identifying cross-cultural health issues, with links to a number of additional multicultural health websites.

★ **Quick Tip**

Please see Chapter 5 for Patient Education Resources.

- **Multicultural Health Communication Service.**

www.mhcs.health.nsw.gov.au/

Multicultural Health Communication Service offers more than 450 multilingual health information publications in a wide range of languages, with new publications posted monthly.

- **Foundation for Healthy Communities.**

www.healthynh.com/fhc/resources/translateddocuments.php

Access to documents created and translated by New Hampshire health agencies and organizations. Languages include Albanian, Arabic, Bosnian, Chinese, English, French, Indonesian, Portuguese, Russian, Somali, Spanish, Swahili and Vietnamese.

- **Refugee Health Information Network (RHIN).**

<http://rhin.org>

RHIN offers resources for those providing care to resettled refugees and asylees, including: health education materials in various languages and formats (brochures, fact sheets, videos), provider tools (including information on refugee populations and cultures) and links to related websites.

Resources are available covering physical activity and exercise, healthy eating, eating disorders, overweight, obesity, obesity prevention and walking. Resources are available in up to 95 languages.

Interpreter Services

When a patient who speaks little or no English comes to your office, how does your staff know whether he or she will need an interpreter? How do you and/or your staff communicate with the patient? If an interpreter is needed, does your practice have access to trained interpreters or use family members or staff to interpret? These are key questions that will need to be answered to help you most effectively organize your practice to work with your LEP patients.⁶

Once you know the answers, record the information in the patient's record for future reference. If you use a paper chart, record the language needed in the chart. If an EHR is available, add a question on your registration form.⁷

Given the language and cultural diversity of California's population, it is critical to provide resources and support to strengthen a patient's language access. One concrete way to begin this process is to provide a language identification tool, such as "I speak" cards for your patients to complete. These cards will enable patients to let the office staff and health care provider know the language with which they will be most comfortable with during their visit. "I Speak" cards are available at <http://www.calcomui.org/sb853translation-services.html>.

The language cards state:

"I speak (language stated)."

"I need an (language stated) interpreter for my health care appointment. Please write my spoken language and my interpretation need in the patient chart."

The statement is written in the individual's preferred language and then in English. The cards are available in the following 24 languages:

Arabic	Hindi	Mandarin	Tagalog
Bengali	Hmong	Nepali	Tamil
Bosnian	Igbo	Romanian	Thai
Cantonese	Indonesian	Russian	Turkish
Farsi	Japanese	Samoan	Ukrainian
Fijian	Korean	Spanish	Vietnamese

These cards can be used to help your patients share with you their preferred language so that the necessary resources are available to assist you and the patient with their visit.

Interpreter Options

It is important to assess how your office typically communicates with patients who do not speak English well. Do you speak another language well enough to conduct an effective clinical interview with a patient? If yes, then no interpreter will be needed and you will be able to speak directly to the patient with no intermediary.

Office-Based Process

Many offices rely on bilingual staff to provide translation within one or two primary languages. Staff play a key role to speak through you so that the patient engages in a dialog addressing your questions. With some training, bilingual staff can serve as your interpreter during the visit.

When hiring new staff, think about the language needs in your practice. Consider including bilingual speaking ability as either a desired or required position responsibility and place your job announcement in ethnic newspapers in your area. During the interview, ask about language skills and how these language skills have been used in previous positions. If you think that your bilingual staff member(s) will be spending significant amounts of time interpreting during patient visits, consider sending them to a medical interpretation training.⁸

Health Plan Interpreter Services

When an interpreter is needed for a patient visit, in California both commercial and Medi-Cal managed care health plans are required to provide interpreter services and in-language resources to their members. SB 853, passed in 2009, requires managed care organizations and insurance plans to provide language services.

Each health plan in California is required to provide a series of services to its members at no cost to the member or the health care provider. These services are provided in the threshold languages designated by each health plan. A threshold language is one spoken by at least 5 percent of the health plan's enrollees. The types of services that may be available by the health plans include:

- Access to telephone advice nurse
- Access to telephone interpreter

- Access to a face-to-face interpreter during business hours
- Training health care providers and office staff in how to get an interpreter for a member's medical visit.

The first step in accessing the health plan interpreter service is to determine the patient's health plan coverage and then reach out to that health plan. You can visit the website of the California Office of Patient Advocate, which provides information on these health plan services, http://opa.ca.gov/report_card/languageservices.aspx.

★ Quick Tip

Please see Toolbox Appendix E for a list of health plan contacts for interpreter services.

Typically, if a request is to be made for a face-to-face interpreter, patients or offices need to contact the health plan three days in advance of the appointment. When the call is made the following information will need to be given:

★ Quick Tip

Patient's Name
Patient's Health Plan Member Number
Doctor's Name and Phone Number
Date, Time and Address for the Appointment
Male or Female Interpreter Requested
Name of Interpreter if One Has Been Used in the Past
Language Spoken

If an in-person interpreter cannot be arranged to meet the patient at your office, the health plan will arrange for an interpreter by telephone. If the patient fails to attend his or her appointment, no charge will be made to the patient or the health care provider for the interpreter's services. This cost will be borne by the health plan.

If a telephone interpreter will be used for the patient's visit, this can be arranged for when the patient arrives at the office.

Family & Friends as Interpreters

There may be times when your only option is to use an untrained interpreter, likely a family member or friend. Do not use children as interpreters. This distorts power relationships within families and diminishes parents in the eyes of their children. It often provides poor-quality interpretation because children may have limited native language skills.

Untrained interpreters will need more guidance. It will be important to try to determine the interpreter's level of English skills. Remind the interpreter to avoid paraphrasing or answering for the patient and to let you know if you need to repeat yourself, explain something you've said or slow down.⁹

Be sure to position the interpreter next to and a bit behind the patient. By getting the interpreter out of sight, there is a better chance that you and the patient will communicate instead of having the patient talk to the interpreter.

Particularly in working with an untrained interpreter, check in frequently with the patient, asking him/her to repeat back to the interpreter what you have said. Remember to speak simply, pausing between sentences. This is very important for an untrained interpreter who will likely not be familiar with medical terminology. And, be prepared to interrupt the interpreter if you believe he or she is getting off point and not being complete in the translation.

Maximizing the Interpreter's Effectiveness¹⁰

If you choose to work with an interpreter during office visits, some tips to maximize his/her effectiveness include:

- Briefly check in with the interpreter prior to seeing the patient and inform him/her of the goal of the visit.
 - Explain the reason for the visit and the type of information you will be discussing with the patient.
 - Determine if there are any time constraints on the interpreter.
 - Ask if the interpreter has any concerns to share with you before the visit.
- If the interpreter is in the room, say where you want him or her to sit or stand.

- In back of the patient is best because the patient looks at you and not the interpreter.

- Assure the patient that ALL communications are bound by confidentiality.
 - Let the patient know that once the visit begins, all communication will be interpreted.
- If the interpreter is in the room, be sure to direct your questions to the patient, not to the interpreter unless they are meant for the interpreter.
 - If you are going to pause and ask the interpreter a question in English, tell the patient that this is what you will be doing.
 - Ask one question at a time, avoiding the use of jargon, slang or metaphor(s).
- Briefly check in with the interpreter after the visit.
- Gender and age of the interpreter may be very important.
 - In many ethnic groups, women and girls prefer a female interpreter and some men and boys prefer a male. Older patients may want a more mature interpreter.
- Write down the interpreter's name and the interview language on the progress note.

Culturally Competent Care

A culturally competent professional has been defined as one who is able to facilitate mutually rewarding interactions and meaningful relationships in the delivery of effective services for children and their families whose cultural heritage differs from his or her own.¹¹ Cultural competence extends beyond addressing language barriers and translation services and hiring an ethnically diverse group of staff. It requires health care providers to demonstrate a high degree of self-awareness in regard to their own cultural beliefs and values. It also requires that health care providers develop the communication skills necessary to elicit information about their patient's cultural beliefs and understand how these might impact their patient's health and how they understand the health care provider's message.¹² When this happens, patients are more likely to take the right action to improve their health or that of their children.

There are a number of reasons it is important to focus attention on a practice's cultural competence in providing patient care.

- For the patient and health care provider to understand one another's perspectives about how their weight affects their health status, enabling them to plan together the steps to improve their health.
- For patients to have a positive feeling and satisfaction with their visit because feeling like they are part of the team will increase their willingness participate in the plan to achieve a healthy or healthier weight.
- Ultimately, for improved clinical outcomes.

★ Quick Tip

“Developing cultural competence is a lifelong journey rather than a destination – a verb rather than a noun.”

Robert Like, M.D., MS

Director, Center for Healthy Families and Cultural Diversity
UMDNJ-Robert Wood Johnson Medical School

This commitment to developing culturally competent care is an investment in the health and well-being of patients that can pay off in terms of greater follow-through and time savings for the practice.

The health care system can be difficult and confusing for many patients to navigate, regardless of their preferred language and race or ethnicity. Imagine though, how this difficulty can increase due to language barriers, poor health literacy or different cultural norms and beliefs. Incorrect diagnoses or treatment instructions that arise because of cultural barriers can turn misunderstandings into mistakes. Patients who have an unpleasant experience as a result of cultural insensitivity will not look forward to returning to their health care provider and may not take the steps discussed to address their issues, resulting in an unhealthy weight for their child or themselves.

Culturally competent care can have a positive impact in addressing these matters and strengthens the trust between the patient and his or her health care provider. It requires a commitment from health care providers and their staff to understand and be responsive to different attitudes, values, and body language. Cultural competency does create a compelling case for understanding the different ways patients act in a clinical setting and for communicating with patients to ensure the best possible clinical outcome.¹³

Our increasing diversity also requires us to identify opportunities within clinical practices to strengthen the cultural competency of the care provided. A first step in this process is for practices to complete an assessment of their cultural competency. A number of assessment tools have been developed by the National Center for Cultural Competence housed at Georgetown University. The assessment tools provide health care providers and their staff the opportunity to identify current strengths and opportunities to improve the cultural competency of their patient care. The assessment tools address:

- Physical environment, materials and resources in the office
- Communication styles
- Values and attitudes

★ Quick Tip

Please see Toolbox Appendix F for Promoting Cultural and Linguistic Competency, Self-Assessment Checklist for Personnel Providing Primary Health Care Services.

Take the assessment with your staff and use the results to plan out steps to strengthen your communication and relationship with your patients.

End Notes

1. NICHQ. "Creating a Healthy Pediatric/Family Practice Office Environment."
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3. California Academy of Family Physicians Foundation. "Addressing Language and Culture A Practice Assessment for Health Care Professionals." (2007).
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6. Addressing Language and Culture: A Practice Assessment for Health Care Professionals. Sponsored by the California Academy of Family Physicians Foundation.
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12. Harvinder Sareen, PhD, Diane Vicensio, RN, MPH, Shirley Russ, MB, ChB, MPH, Neal Halfon, M.D., MPH. The Role of State Early Childhood Comprehensive Systems in Promoting Cultural Competence and Effective Cross-Cultural Communication. National Center for Infant and Early Childhood Health Policy. No. 8. July 2005.
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3

Effective Patient-Provider Communication

- **Overview - Patient Centered Communication**
- **Multicultural Communications**
- **Nonverbal Communications**
- **Preventive Counseling**
- **Sample Patient-Provider Dialogue**
- **3 Point Plan**

Learning Objectives:

1. Name the three components of patient-centered communication.
2. Describe at least one interviewing and communication mnemonic that can improve multicultural communication skills.
3. Identify three tips to maximize nonverbal communications.
4. Share at least one technique to determine a patient's readiness to make change to increase healthy eating or physical activity.
5. Explain the 3 Point Plan to outline the patient's change commitments.

Chapter 3

Effective Patient-Provider Communication

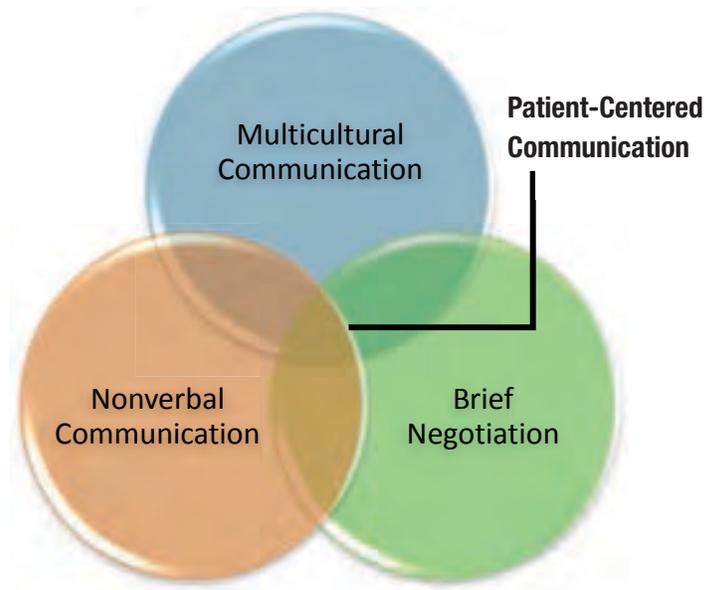
Overview – Patient Centered Communication

Communication between the patient and health care provider is a central function of each patient visit and an essential factor for a positive outcome. Many health care providers worry about the time it often takes to engage a patient in a dialog about a health issue. Now factor into this equation a difference in language and culture.

Effective patient/provider communication will require focus and attention. Patient-centered communication can enable the practice to save time and be more productive and effective in the following ways:

- If the patient and health care provider understand one another, the visit can take less time.
- A patient who feels respected when in the office and with staff and the health care provider, will feel more inclined to listen and communicate.
- If the health care provider and patient find agreement about the steps needed for a child or adolescent to maintain a healthy weight, there is greater likelihood the patient will take action to support a healthy lifestyle for the family.
- If the patient or patient's parent understands what needs to be done to help a child or adolescent achieve a healthy weight and why this is important for health, and has been part of the decision-making process, there is a greater likelihood he or she will attempt to make changes to support the child. This can result in the practice spending less time on referrals and patient follow-up. The patient will also achieve a greater health status.

There are three key elements that support effective patient/provider communication:



In this chapter, we will outline the key elements of these three patient-centered communication components and provide tips and tools to maximize the chances for an effective dialog and positive health outcome.

Multicultural Communications

Being aware of and sensitive to a patient's cultural background can strengthen patient/provider communications and improve a patient's health. To improve patient communication and patient care, health care providers need to close the gap between the culture of medicine and the beliefs and practices underlying patients' value systems, which include ethnicity, race and family origin.¹

Why is effective multicultural communication important and necessary? As seen in Chapter One, when we look at child and adolescent obesity, greater prevalence for overweight and obesity is seen among several groups. Important among these factors are a child's race and ethnicity and socioeconomic status.

Multicultural communications is a key component of culturally competent health care to help eliminate long-standing disparities in the health status of individuals of diverse racial, ethnic and cultural backgrounds. It is essential in strengthening the quality of services provided and patient health outcomes. It is also an important factor for health care providers to gain a competitive edge in the marketplace and decrease the likelihood of liability and malpractice claims.²

How Health Care Providers Can Engage in Effective Multicultural Communications

The first step is to realize that a patient's culture has a significant influence on how health and illness are viewed. Their culture, including their beliefs, values and behaviors, socioeconomic status, race, ethnicity, the number of generations from their country of origin, level of acculturation to Western culture, and English proficiency

will impact how, when and where patients seek care, and what they believe to be appropriate care received.³ Also critical is for health care providers to understand the ways their own personal and professional experiences influence how they provide care and shape their views of their patient's cultural practices.

As we focus on overweight and obesity in children and adolescents, it is important to acknowledge that food and diet play an important part in ethnic identity, cultural practices and family traditions, including not only the foods prepared but the sharing of meals. Partnering with families to achieve a healthy weight for their child or adolescent may therefore be more involved than simply exchanging one food item for another. Socioeconomic status can also limit availability of and access to quality food sources and healthy alternatives.

What follows are "Snapshots" of diets and discussion that can provide some background and a starting point to initiate conversation with patients to increase healthy eating in the family. Using a patient centered approach, the health care provider will learn about the individual practices in the family and build on these. This allows the health care provider to not stereotype the patient.

★ Quick Tip

"The ability to communicate and connect with patients of different backgrounds and provide quality care that respects their personal values and beliefs is a critical skill for obgyns. Health care should not be one size fits all. When we acknowledge and attempt to understand the cultural identities of our patients, we're better able to deliver beneficial and individualized care."

Maureen G. Phipps, M.D.

Chair of ACOG Committee on Health Care for Underserved Women

Cultural Snapshots

African-American Culture

Families may include immediate, extended, or matriarchal members. The father or eldest male will speak for the family. Grandparents, especially grandmothers, play a crucial role.

- Women prepare meals. The female head of the household does the meal planning.
- Food preparation may include frying, barbecuing, and heavy use of gravy and sauces.
- The family may not put a significant focus on preventive health.
- Emphasize the importance of the family role models in achieving a healthy weight for the child or adolescent.

Suggest:

- Reduce intake of fried foods and avoid late, heavy dinners.
- Switch to canola, safflower or olive oil.
- Avoid reusing oil to fry foods because reused oil is higher in fat.
- If foods are fried, fry foods at hotter temperatures to soak up less oil.
- Prepare gravy with low-fat ingredients, such as low-sodium broth, low-fat milk and whole-grain flours.
- Use artificial sweeteners and limit all sodas, including diet and caffeine-free.
- Include fresh vegetables and fruits with each meal.

Cambodian Culture

Cambodian culture is patriarchal but in the family, the husband and wife often share authority. Extended families are common, headed by an older parent or grandparent.

- Patients may avoid eye contact. Avoiding eye contact is a sign of the health care provider's respect for the patient.
- The head is considered sacred. Begin physical exams at the top of the body and move down.
- Address meal planning discussion to the female head of the household.
- Rice is fried, steamed, and used for noodles; fish is served fresh, dried, or salted.

Suggest:

- Increased use of whole-grain rice.
- Encourage steaming vegetables, such as Chinese broccoli, bok choy, and mustard greens.
- Fruits in the Cambodian diet are generally sweet. Suggest limiting those portions or choosing alternatives, such as apples and oranges.
- Encourage limiting or using sugar-free alternatives for desserts, such as coconut milk with bananas.

Chinese Culture

Often an extended family of children, parents and grandparents live together. Major decisions usually require input from the male head of household.

- Many do not believe in preventive health measures. Prefer to seek care, whether traditional Chinese or Western, when they are symptomatic.
- Obtaining complete information may be difficult as it can be considered disrespectful to disagree with a health care provider.
- Encourage family support.
- Meal planning is the role of female head of household.

Suggest:

- Explain the benefits of whole grains and fiber.
- Increase bok choy, Chinese broccoli, mustard greens, bitter melons, tangerines, and pumelo.
- Eliminate or reduce pastries and sweet buns, especially those with fillings high in fat and sugar.
- Limit fried foods, soy sauce, fish sauce, and oil in stir-fries.
- Switch to canola, safflower or olive oil.
- Eat fresh fruits and vegetables daily.

Filipino Culture

Speak to both the patient and the eldest family member, when possible, as this latter person is the family's chief spokesperson and caregiver. In the absence of parents, this will be the eldest child.

- Health is balance – illness is imbalance. Stress positive aspects of preventive care.
- Many believe that an overweight child is a healthy child. Focus on the connection between an overweight child and the risk of developing diabetes and other health problems.
- Traditional diet includes white rice and noodles, seafood, vegetables, fruits and meats. Canned and processed foods, such as corned beef, Spam® and Vienna sausages, are common items.

Suggest:

- Limit rice and noodles and switching to whole-grain rice and noodles.
- Use canola and olive oil.
- Switch to light coconut milk.
- Reduce processed foods as listed above.
- Eat fresh fruits and vegetables daily.

Cultural Snapshots

Hmong Culture

Family is important. Households often consist of married sons and their families. Family structure is patriarchal and major decisions may involve communal discussion.

- Patients may avoid eye contact with their health care providers, as many feel that direct and lengthy eye contact is rude.
- Illness is believed to be the result of the soul wandering from the body, angry ancestors, hostile spirits, spells, curses or the violation of taboos.
- Hmong may use a combination of Western medicine and Hmong shamans.
- Many Hmong are resistant to or uninformed about self-care and preventive care.
- Address meal planning discussion with the female head of house. The traditional diet includes chicken, pork, rice, and vegetables in a broth.

Suggest:

- Encourage fresh fruits and vegetables daily.
- Limit the use of oil in stir-fries and fried foods.
- Switch to canola, safflower or olive oil.
- Use low-salt replacements for soy sauce and fish sauce.
- Limit rice or replace with brown rice.

Korean Culture

Families of Korean descent are egalitarian in large part, although parents are closely involved in making decisions for their children. Women are often busy with work and child care. As much as possible, confer with family members and check for understanding and agreement when delivering patient education.

- Many believe health to be the equilibrium between soul and physical being. There is a belief that illness is related to karma (past wrongdoing).
- Patients will avoid eye contact and may refuse advice at first. This is considered to be cultural politeness.
- Offer suggestions and advice numerous times, and allow ample time for questions, which may be slow in coming.
- Do not point or beckon patient with index finger. It is considered offensive.

Suggest:

- Reduce fried foods.
- Switch to lighter cooking methods using canola, safflower or olive oil.
- Eat fresh fruits and vegetables daily.

Latino Culture

Family is often involved in decision-making. It is important to develop a personal relationship with Latino patients to develop trust. Females may place their needs beneath those of the family, and males may not assume personal responsibility for their health care. Involve both females and males as often as possible in patient discussion. Food is an integral aspect of socialization among Latinos.

- Latinos are often deferential toward health care providers.
- Focus on small, achievable goals for patients. Give positive encouragement when these changes are met successfully.
- Aloe juice (jugo de savila), a staple in some Latino households, is very high in carbohydrates. Suggest alternatives.
- 7 Up® is a popular treatment for upset stomach. Suggest a sugar-free alternative.

Suggest:

- Eat earlier in the evening; avoid late-night suppers.
- Eat fresh fruits and vegetables daily.
- Take a 15-to-30 minute walk after the evening meal.
- Replace fats, including lard, with more healthful choices such as canola or olive oil.
- Limit tortillas (2 to 3 corn or 1½ flour per day).

Vietnamese Culture

Decisions are made by the father or eldest son. Family is informed and part of the decision-making process.

- Many Vietnamese believe that health maintenance is the equilibrium of two natural forces – hot (duong) and cold (am).
- Touching may be an issue, as the head is considered sacred (and the feet profane). Ask permission before touching the patient, especially on the head. Begin a physical exam at the top of the body and move down.
- White flour, pastries and white rice are popular elements of the Vietnamese diet. Address meal planning discussion to female head of household.

Suggest:

- Whole-grain and reduced-sugar alternatives.
- Reduce red meat in favor of lean white meat, fish and more vegetables.
- Encourage eating fruit daily.
- Reduce the use of fried foods.
- Limit use of coconut oil or coconut milk in foods; light coconut milk is preferable.

These snapshots have been adapted from Health Net of California's "Diabetes and Culture - A Guide for Physicians"

The Use of Mnemonics

There are a number of clinical interviewing and communication mnemonics that may help to improve skills in multicultural communications. Included in these are LEARN⁴, ETHNIC⁵ and BATHE.⁶

As an example: A health care provider recommends that a teen patient increase his daily physical activity, as one step to help achieve a healthy weight and the teen does not follow through. The health care provider can use the ETHNIC model to start a dialogue to discover:

1. Why the patient might be concerned about starting his daily physical activity routine.
2. If other options, such as addressing dietary changes, are being tried to help achieve a healthy weight.
3. How to reach a mutually acceptable approach.
4. Whether family members or school or other community resources might be available to help the patient achieve and stay with his plan.

Incorporating the use of a mnemonic with an understanding of a patient's cultural background helps the health care provider to work with the patient and his or her family as individuals, all striving together to develop a more realistic plan to achieve the goal—in this case, achieving a healthy weight.

An example of a patient/provider communication focusing on adolescent obesity can be found on *The Provider's Guide to Quality and Culture*. In the section addressing Clinical Exchanges, you can watch the interaction and decision-making process between an African-American teen and his Caribbean physician as they negotiate small steps to bring about changes in his eating habits. The communication vignette can be found at: <http://erc.msh.org/mainpage.cfm?file=4.1.0.htm&module=provider&language=English>

★ Quick Tip

Please see Toolbox Appendix L for Multicultural Patient Communications Vignette.

Nonverbal Communications^{7, 8}

Nonverbal communication is the single most powerful form of communication. More than voice or words, nonverbal communication provides a focus on what another individual may be thinking or feeling. Nonverbal communication ranges from facial expressions to body language. Gestures and use of space are also elements of nonverbal communication.

Multicultural differences in facial expressions, hand and arm gestures, use of personal space, touching, eye contact and physical posture may occur. Understand the key nonverbal communication behaviors important to the significant groups in your practice.

Mnemonic	Application
LEARN Listen, Explain, Acknowledge, Recommend, Negotiate	Integral to history taking and helps to elicit a patient's perspective and explanation regarding the onset, etiology, duration, and treatment expectations for his or her illness or problem.
ETHNIC Explanation, Treatment, Healers, Negotiate, Intervention, Collaborate	Framework to provide culturally appropriate care. Can be used to elicit and negotiate cultural issues during health care encounters with all patients.
BATHE Background, Affect, Trouble, Healing, Empathy	Model for supplementing the biomedical clinical information gathered to assess the patient's psychosocial status. Helps health care providers connect with and develop a therapeutic rapport with their patients.

Facial Expressions

- Although smiling is an expression of happiness in most cultures, it can also signify other emotions. Some Chinese may smile when they are discussing something sad or uncomfortable.
- Some Filipinos may sometimes point to an object by shifting their eyes toward it or pursing their lips and gesturing with their mouth, rather than use their hands.
- Expressions of pain or discomfort such as crying are also specific to various cultures. Some cultures may value a more stoic affect while others may encourage a more outgoing, emotive demeanor. Expressions of pain and discomfort are also learned from one's family illness experiences and impressions.

Personal Space

- Comfortable distance between people as they sit, stand, or talk varies. Most Latinos require less personal space and may feel uncomfortable with distance. Asians and Pacific Islanders require more personal space and may feel uncomfortable with closeness.
- People from the Middle East may stand quite close when talking with each other.
- In some Muslim cultures, a woman may be alarmed if a man, even a male physician, stands or sits too close to her.

Touching

- In some cultures, light touching of the arm or a light kiss on the cheek is very common, even among people who have just met. People from Latin America and Eastern Europe may be very comfortable with this kind of touching, whereas people from many Asian cultures may prefer less physical contact.
- Touching another person's head is considered offensive by some people from Asia and the Middle East, because the head is considered a sacred part of the body. It is therefore inappropriate to pat a child on the head.
- Some Chinese may be uncomfortable with physical contact early in a relationship. Although many Chinese will use a handshake to greet a Westerner, any other contact may be considered inappropriate. This is especially

important to remember when dealing with older people and those in authority.

- Throughout the Middle East, it is the custom to reserve the left hand for bodily hygiene. For this reason, one should never offer the left hand to shake hands or accept a gift. This is also true of some African cultures.
- A Western woman should not initiate a handshake with a man in India. Many Indian women will shake hands with a foreign woman, but not a foreign man.

Eye Contact

- Making direct eye contact is a sign of disrespect in some cultures. In other cultures, refusing to make direct eye contact is a sign of disrespect. Many Asians may be reluctant to make eye contact with an authority figure. For example, when greeting a Chinese patient, it is best to avoid prolonged eye contact as a sign of respect.
- In Latin America, good eye contact is important in both social and business situations.
- In mainstream Western culture, eye contact is interpreted as attentiveness and honesty. We are taught that we should "look people in the eye" when talking. In many cultures, including Latino, Asian, Middle Eastern and Native American, and lack of eye contact does not mean that a person is not paying attention. It may be thought to be rude. Women especially may avoid eye contact with men because it can be taken as a sign of sexual interest.

Physical Posture

- In many cultures throughout the world, it is impolite to show the bottom of the shoe, which is often dirty. Therefore, one should not sit with the foot resting on the opposite knee.
- In some Latin American countries, standing with the hands on the hips suggests anger, or a challenge.
- In many cultures, slouching or poor posture is considered disrespectful. Good posture is important in Taiwan, with Taiwanese men usually sitting with both feet firmly fixed to the floor.

Gestures

- There are a number of gestures commonly used in the U.S. that may have a different meaning and/or be offensive to those from other cultures. One common example is the use of a finger or hand to indicate “come here please.” This is the gesture used to beckon dogs in some cultures and is very offensive.
- Pointing with one finger is also considered to be rude in some cultures. Asians typically use their entire hand to point to something.

★ Quick Tip

Some key tips for health care providers to maximize their nonverbal communications include:

- Follow the patient's lead. If the patient moves closer or touches you in a casual manner, you may do the same.
- Use hand and arm gestures with great caution. Gestures can mean very different things in different cultures.
- Be careful in interpreting facial expressions.
- Don't force a patient to make eye contact with you. He or she may be treating you with greater respect by not making eye contact.

It is also important to monitor your voice tone and behaviors with limited-English-proficient patients who may not understand your words and must rely on tone and nonverbal cues of attitude.

Preventive Counseling

Assessing Readiness for Change

Determining a patient's readiness for change is essential for success. Discussing changes when a patient is not ready often leads to resistance, denial of problems and frustration that may hamper future efforts. The following tool provides a basis for starting discussions with patients. Using questionnaires may also provide valuable insight while saving valuable office visit time.

There are three levels of communication that are tailored to address the focus of the communication needed with the patient based on the diagnosis related to a healthy weight.

These include:

Type of Advice	Appointment Type	Time Commitment	Who
Lifestyle advice	<ul style="list-style-type: none">• Well child visit• Urgent visit	< 1 minute	Children not currently overweight
Brief focused advice	<ul style="list-style-type: none">• Well child visit	< 3 minutes	Children who are overweight or obese
Brief negotiation and cognitive behavioral skills	<ul style="list-style-type: none">• Follow-up visit• Weight management intervention	> 10 minutes: Single or multiple sessions	Children who are overweight or obese

It is normal for patients to feel ambivalence about their readiness to make behavioral changes to improve their health. It is important to look at this ambivalence as normal, rather than an obstacle.

When you begin to discuss with your patient areas and opportunities for change, encourage them to express this ambivalence. As they do, you can help them explore the potential benefits of change. As you work with your patient, it is also important to recognize that:

- Your advice must match the motivational level the patient is experiencing.
- Your advice must seek out the main issues that underlie their concerns or health issue.
- Unwelcome advice will usually invite resistance, so you will need to gain permission to offer advice.

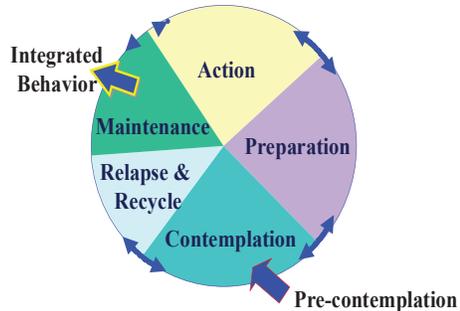
As you work with your patient, you will:

- Ask open-ended questions.
- Use reflective, active listening.
- Affirm their feelings and struggles.
- Explore the ambivalence they are feeling.
- Assess their readiness to change.
- Offer advice after gaining their permission.
- Work with them to set goals and make a plan.
- Summarize what has been agreed to as you close the dialogue.

Effective Communication with Families

Scott Gee, M.D.; Jodi Ravel, MPH; Sandra Roberts, R.N.;
Amanda Wylie, Regional Health Education – Kaiser Permanente
Northern California

Stages of Behavior Change



Prochaska & Di Clemente: *Transtheoretical Model of Behavior Change*

Communication Techniques

Lifestyle Advice—Well Child or Urgent Visit

- < 1 minute
- Children not currently at risk for overweight

Brief Focused Advice – Well Child Visit

- < 3 minutes
- Children who are overweight or at risk for overweight

Brief Negotiation & Cognitive Behavioral Skills - Follow-up Visit or Weight Management Intervention

- 10 + minutes: single or multiple sessions
- Children who are overweight or at risk for overweight

Whom Do You Communicate With?

2 - 5 Years Old

- Communicate with Parent
- Child in Room

6 - 12 Years Old

- Communicate with parent or both
- The first encounter, consider taking parent to your office to discuss in private first

Over 12 Years Old

- Communicate with teen or both
- The first encounter, consider having parent leave exam room first

Brief Negotiation Skills

Particularly Effective for Contemplative / Ambivalent Patients

- Asking open-ended questions
- Listening
- Summarizing
- Clinician Style: empathetic, accepting, collaborative

Cognitive Behavior Skills

For Patients Ready and Willing to Make Changes

- Develop awareness of eating habits, activity and parenting behavior
- Identification of problem behaviors
- Problem-solving and modification of problem behaviors
- Weekly goal-setting for children and parents on dietary, activity and self-esteem/parenting goals
- Positive reward systems
- Record-keeping
- Weight checks

Lifestyle Advice

To stay healthy and energized:

- Get up and play hard, 30-60 minutes a day
- Limit TV and video games to 60 minutes or less a day
- Make half your plate fruit and vegetables
- Limit sodas and juice drinks to 1 cup or less a day

Brief Focused Advice

Step # 1: Engage the Patient / Parent

- Can we take a few minutes together to discuss your health and weight?
- How do you feel about your health and weight?

Step # 2: Share Information (optional)

- Your current weight puts you at risk for developing heart disease and diabetes.
- What do you make of this?
- Some ideas for staying healthy include
- What are your ideas for working toward a healthy weight?

Step # 3: Make a Key Advice Statement

I strongly encourage you to...

- Get up and play hard, 30-60 minutes a day
- Limit TV and video games to 60 minutes or less a day
- Make half your plate fruits and vegetables
- Limit sodas and juice drinks to 1 cup or less a day
- Use patient ideas from step # 2

Step # 4: Arrange for Follow-up

- Would you be interested in more information on ways to reach a healthier weight? AND / OR
- Let's set up an appointment in ___ weeks to discuss this further.

Brief Negotiation

Open the Encounter

Ask Permission

- “Would you be willing to spend a few minutes discussing your weight?”
 - “Are you interested in discussing ways to stay healthy and energized?”

Ask an Open-Ended Question — Listen — Summarize

- “What do you think / How do you feel about your weight?”
 - “What have you tried so far to work toward a healthier weight?”

Share BMI / Weight / Risk Factors (Optional)

- Your current weight puts you at risk for developing heart disease and diabetes.
 - Ask for the patient’s interpretation: “What do you make of this?”
 - Add your own interpretation or advice as needed AFTER eliciting the patient’s / parent’s response.

Overweight Sensitivity

“Do no harm”

- | | |
|-------------------------------|---------------------------------|
| • Obesity | • Overweight |
| • Ideal Weight | • Healthier Weight |
| • Personal Improvement | • Family Improvement |
| • Focus on Weight | • Focus on Lifestyle |
| • Diets or “Bad Foods” | • Healthier Food Choices |
| • Exercise | • Physical Activity |

Negotiate the Agenda

- There are a number of ways to achieve a healthy weight. They include:
 - Get up and play hard
 - Eat 5 helpings of fruits and vegetables a day
 - Cut back on TV and video games
 - Cut down on soda and juice

- “Would you like to discuss any of these further today—or perhaps you have another idea that isn’t listed here?”

Assess Readiness

- “On a scale from 0 to 10, how ready are you to consider (option chosen above)”
- Straight question: “Why a 5?”
- Backward question: “Why a 5 and not a 3?”
- Forward question: “What would it take to move you from a 5 to a 7?”



Explore Ambivalence

- Step 1: Ask a pair of questions to help the patient explore the pros and cons of the issue:
 - What are the things you like about _____? And What are the things you don’t like about _____?
 - What are the advantages of keeping things the same? And What are the advantages of making a change?
- Step 2: Summarize Ambivalence:
 - “Let me see if I understand what you’ve told me so far . . .”
 - Begin with reasons for maintaining the status quo, end with reasons for making a change
 - Ask: “Did I get it all? / Did I get it right?”

Tailor the Intervention

Stage of Readiness	Key Questions
<p>Not Ready: 0 – 3</p> <ul style="list-style-type: none"> ▪ Raise Awareness ▪ Elicit Change Talk ▪ Advise and Encourage 	<ul style="list-style-type: none"> ▪ Would you be interested in knowing more about reaching a healthy weight? ▪ How can I help? ▪ What might need to be different for you to consider a change in the future?
<p>Unsure: 4 – 6</p> <ul style="list-style-type: none"> ▪ Evaluate Ambivalence ▪ Elicit Change Talk ▪ Build Readiness 	<ul style="list-style-type: none"> ▪ Where does that leave you now? ▪ What do you see as your next steps? ▪ What are you thinking / feeling at this point? ▪ Where does _____ fit into your future?
<p>Ready: 7 – 10</p> <ul style="list-style-type: none"> ▪ Strengthen Commitment ▪ Elicit Change Talk ▪ Facilitate Action Planning 	<ul style="list-style-type: none"> ▪ Why is this important to you now? ▪ What are your ideas for making this work? ▪ What might get in the way? How might you work around the barriers? ▪ How might you reward yourself along the way?

Close the Encounter

- Summarize: “Our time is almost up. Let’s take a look at what you’ve worked through today...”
- Show Appreciation / Acknowledge willingness to discuss change: “Thank you for being willing to discuss your weight.”
- Offer advice; emphasize choice, and express confidence: “I strongly encourage you to be more physically active. The choice to increase your activity, of course, is entirely yours. I am confident that if you decide to be more active you can be successful.”
- Confirm next steps and arrange for follow-up: “Are you able to come back in one month so we can continue to work together?”

2004 - Regional Health Education - Kaiser Permanente

Sample Patient-Provider Dialogue

Before entering the exam room you note the patient’s age, gender, BMI and percentile, blood pressure, and pulse, which have been taken by your medical assistant.

Patient Info:

Name	Alex
Gender	Male
Age	10 years
Ethnicity	Latino
Preferred Language	English
Height	55 inches
Weight	100 lbs
BMI	23.2 (95 th percentile for age and gender)

MD: Good morning! I see you are in for your annual well-check. Do you have any concerns about your health?

Alex: No, my mom made me come in.

MD: Can we take a few minutes together to talk about your health and weight?

Alex: I guess so.

MD: How do you feel about your weight?

Alex: I know I'm bigger than most kids I hang out with.

MD: Have you tried to do anything to get to a healthier weight?

Alex: Not really – I just eat what all my friends eat.

MD: Your family has a history of diabetes. Did you know that your current weight makes you more likely to develop diseases like diabetes?

Alex: No, but my grandpa always complains about his diabetes.

MD: Yes, diabetes is not easy to live with – I can understand why he complains. OK, well let's see what we can do to help you get to a healthier weight. Here are some ideas that my patients told me are usually helpful: eating at least 5 fruits and vegetables per day, cutting back on the number of sodas they drink, being physically active for 30 minutes or more, and reducing the amount of time they spend watching TV or playing on the computer. Do you want to talk about any of these, or do you have any other ideas?

Alex: Would riding my bike to school count as physical activity?

MD: It sure would! On a scale from 1 to 10, how ready do you think you are to start riding your bike to school?

Alex: Probably a 5.

MD: Why a 5?

Alex: Well, I don't have anyone to ride with and there are a couple of busy streets.

MD: I see how that would make it sort of scary. What sounds good about riding your bike to school?

Alex: Riding my bike is pretty fun. And I wouldn't have to wait in traffic in the car and be late for school.

MD: So the busy streets and having no one to ride with may make this change difficult, but you like to ride your bike and traffic wouldn't make you late for school if you were on your bike. Did I get it right?

Alex: Yeah.

MD: What do you think your next step is?

Alex: I guess I'll try riding my bike to school one day next week. Maybe I'll find someone to ride with along the way.

MD: Great. I think you are making a very healthy choice for yourself. Thank you for being so willing to discuss this with me. When you come back next month for your flu shot I want to hear how things are going.

★ Quick Tip

For additional training in these interviewing techniques, visit: <http://learn.kp.org/>

The 3-Point Plan

By Sophia Yen, M.D., MPH, Adolescent Medicine Specialist

The 3-Point Plan provides a mechanism to capture the discussion with your patient using the Brief Negotiation technique. The plan creates a contract between the patient and health care provider that memorializes the child's or adolescent's commitment to change. The plan is put in the patient's chart and provides a vehicle for ongoing communications and monitoring of the patient's progress toward changing behaviors that can lead to reaching a healthy weight.

On a progress note that goes into the patient's permanent medical record, write:

Contract for _____ (Patient's Name)'s Healthy Lifestyle

Based on your conversation with the patient, ask the patient to write out one goal under each of the following categories:

1. Increase healthy food choices
2. Decrease total screen and phone time
3. Increase physical activity

Have the patient (not parent, though you can have the parent sign also) sign and date the contract; provide a copy for the patient to take home.

Contract for Alex's Healthy Lifestyle

1. I will drink only 1 soda per day.
2. I will cut down computer time to 3 hours per day.
3. I will ride my bike to school 3 times a week.

Alex F. March 2, 2011
Patient's Signature Date

Point 1

Give the example: “If you drink a glass of whole milk for breakfast, a glass of orange juice for lunch, and a soda for dinner, you will gain about a pound a week. However, if you can switch to nonfat milk, lemonade made with a sugar substitute, and diet soda, you will lose a pound a week up to a certain point.”

Ask, “How many oranges does it take to make a glass of orange juice?” Tell patients it takes 6 to 8 oranges. Then say, “I could drink 3 glasses of orange juice right now, no problem. How many oranges is that?” This tests their math and shows them how fast you can take in a lot of calories. Finish with “Eat your fruit, don’t drink your fruit.”

Point 2

Point 2 is based on Dr. Tom Robinson’s work in elementary schools where a simple intervention was conducted to decrease television viewing time—it was not an intervention to change diet or increase physical activity.⁹ When students turned off the television, they lost weight. Let parents know that without a change in diet or an increase in activity, but simply by turning the TV off after 2 hours, children can lose weight.

Point 3

Ask the patient to start with as little as 5 minutes of physical activity a day, 3 times a week. You can refer to the book *8 Minutes in the Morning* by Jorge Cruise, which includes around 50 different exercises. Ask the patients: “Who doesn’t have 8 minutes sometime in their day—either in the morning or before bed?” Give the patient a handout that has muscle-building exercises that can be done as long as they have gravity and their body. Patients can say: “My neighborhood is not safe. It’s raining outside. I can’t afford to join a gym.” As long as they have gravity and their body, they can do these exercises.

You can also tell them that working out the big muscles such as the quads and gluts increases energy consumption to burn up fat, so it’s a good idea to start with lunges or quad squats.

For all the points, you want to quantify and be specific. For example, one contract point should not be “decrease juice.” Instead, it should be “decrease from 3 glasses a day to 2 glasses a day.” For physical activity: “3 times a week on Monday, Wednesday, Friday, for 5 minutes running or doing quad squats.” Specific goals are better than general ideas.

Having the patient sign the contract is novel. Tell the patient, “Don’t write something down in the contract that you won’t or can’t do. I will see you in one month and remind you that you promised to do this. I don’t want to set you up for failure, so don’t write/sign something you can’t do.” This helps ensure the contract be realistic. Also, kids are used to parents signing things, but now they get to sign and take ownership.

Follow up each month and modify the points each time. For example, if they accomplished decreasing to 2 cups of juice a day, then next would be 1 cup a day. If they are doing well, increase the time between visits. If they are not doing well, move the visits closer together.

★ Quick Tip

Please see Toolbox Appendix I for a blank 3-Point Plan template

End Notes

1. Laurie Barclay, M.D. ACOG Statement: Cultural Sensitivity Allows Quality Care. May 2, 2011.
2. National Center for Cultural Competence. Referenced in Educating Physicians to Provide Culturally Competent, Patient-Centered Care. Robert C. Like, M.D., MS; Theresa J. Barrett, M.S.; Jeffrey Moon. Summer 2008.
3. Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department. A Provider's Handbook on Culturally Competent Care, Asian and Pacific Islander Population, 2nd edition (2003).
4. Berlin EA, Fowkes WC. A Teaching Framework for Cross-Cultural Health Care - Application in Family Practice. *West J Med.* 1983; 139(6): 934-8.
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8. The Provider's Guide to Quality and Culture. Nonverbal Communication, Management Sciences for Health. <http://erc.msh.org/>.
9. Robinson, T. (1999). Reducing Children's Television Viewing to Prevent Obesity. *JAMA*, 282(16), 1561-1567. ■





4 Prevention & Treatment of Overweight and Obesity

- **Expert Committee Recommendations**
- **Implementation Guide Tables**
- **Pharmacotherapy Recommendations**
- **Bariatric Surgery Abstract**
- **Screening for Food Insecurity**

Learning Objectives:

1. Summarize the Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity.
2. State the laboratory tests to perform for an overweight or obese child based on their BMI percentile.
3. Understand the importance of screening for food insecurity and Identify key food assistance programs to support patients struggling with food insecurity in their household.

Chapter 4

Prevention & Treatment of Overweight and Obesity

Across the Continuum of Care

Overview

In February 2004, the American Medical Association convened an expert committee, representing 15 professional organizations, to formulate a series of recommendations concerning the assessment, prevention, and treatment of child and adolescent obesity.

The Expert Committee used a conceptual framework of chronic care, with an emphasis on self-management and family involvement, in all aspects of assessment, prevention, and treatment (Barlow et al 2007). The Expert Committee endorsed a sequenced approach to treatment, with four stages of care. Steps 1 through 3 are broken into four stages to address increased intensity with a child or adolescent's severity of obesity and their experience with previous stages of treatment (Spear et al 2007).

Chapter 4 follows this staged approach. The chapter provides the step-by-step Implementation Guide outlining the Expert Committee's Recommendations along with additional clinical resources to help health care providers best manage their patients wherever they are along this continuum of care.

The Implementation Guide provides a sequenced approach to assess, prevent and treat child and adolescent overweight and obesity. These steps are labeled as Steps 1 through 3, with increasing intensity in the child or adolescent's severity of obesity and their experience with previous stages of treatment.¹ Three key steps to the implementation of the 2007 Expert Committee Recommendations include:

- Step 1 - Obesity Prevention at Well Care Visits (Assessment & Prevention)
- Step 2 - Prevention Plus Visits (Treatment)
- Step 3 - Going Beyond Your Practice (Prevention & Treatment)

Step 1, outlines the components that focus on assessment and prevention. This step describes the key actions to be completed during the child or adolescents well care visit, beginning by calculating the patient's BMI. During this step the health care provider will complete the patient's family history as well as assess food consumption and physical activity behaviors and attitudes. A physical exam is completed and blood pressure is also taken. Appropriate lab tests are also taken based on the patient's BMI percentile. For example, a fasting lipid profile is recommended for patients with a BMI between the 85th and 94th percentile without risk factors. For children 10 years of age or older with risk factors, a fasting lipid profile, ALT, AST and fasting glucose are also recommended. It is also recommended that communications with the patient using techniques such as Brief Focused Negotiations be used to reach a more positive outcome and change for the patient.

★ Quick Tip

In different cultures, the words "exercise" and "physical activity" may carry different meanings. A patient may think they must go to the gym to exercise. Physical activity may include playing sports, dancing, or doing chores.

Step 2, endorses a variety of change targets, such as reducing sweetened beverages, increasing fiber, fruits and vegetables, ensuring breakfast is completed each day, along with other recommendations. Prevention Plus is described in Stage 1. The Expert Committee recommends that Prevention Plus be used in working with any child or adolescent, two through 18 years of age, whose BMI exceeds the 85th percentile with a goal of weight maintenance, leading to a slow reduction in BMI percentile over time. For children and adolescents unable to reduce their BMI in Prevention Plus, the patient moves to Step 3.

Step 3, focuses on those children and adolescents unable to reduce their BMI percentile in Prevention Plus, moving to treatment Stage 2, also called Structured Weight Management. Structured Weight Management can be offered in the setting of the medical home or primary care office, including a more structured dietary plan while insuring adequate energy and protein intake. Structured Weight Management also includes more effective behavioral strategies to reinforce reduction in screen time to less than one hour daily and an increase in supervised physical activity to at least one hour daily. Effective use of Structured Weight Management should result in weight loss, generally less than 1 lb per week for those up to 11 years of age less and than 2 lb per week for those 12 to 18, with follow-up on a monthly basis.

After 3 to 6 months in Structured Weight Management, insufficient progress leads to more intensive management in Stage 3, called Comprehensive Multidisciplinary Intervention. Comprehensive Multidisciplinary Intervention incorporates all of the components of Structured Weight Management, at a higher intensity, generally outside the primary care setting. In a Stage 3 pediatric weight management program, more frequent professional contact is maintained, at least weekly, for a minimum of 8-12 weeks. This provides ongoing monthly follow-up, either face-to-face, by telephone or using other electronic modalities. Comprehensive Weight Management incorporates more formal parental involvement, at least until 12 years of age, with gradual reduction in parent involvement in the behavioral components of the program during the teen years to reinforce more change in diet and physical activity. This more intensive, structured, approach should result in weight loss up to 2 lbs per week for children 6 to 18 years of age, or up to 1 lb per week for those 2 to 5 years of age.

Severely obese patients who are unable to achieve success after 3 to 6 months with Comprehensive Multidisciplinary Intervention, begin Stage 4, or Tertiary Care Intervention. Stage 4 incorporates the elements of Comprehensive Multidisciplinary Intervention through a multidisciplinary team of professionals with expertise in child obesity, behavioral counseling, nutrition and exercise. Tertiary Care Intervention may be offered in a tertiary care center or in the context of a residential setting (e.g. camp, boarding school), or in the home setting, and may include meal replacement, very low calorie diets, pharmaceutical treatment, and bariatric surgery. Tertiary Care Intervention would generally be recommended for adolescents older than 11 years of age with BMI 95th percentile and significant comorbidities of obesity, or with BMI 99th percentile who have not already shown improvement during Stages 1 to 3.

These four stages of prevention and treatment may all be considered as a continuum that is based on the importance of achieving a healthy weight, with BMI under the 85th percentile. With the goal of achieving a healthy weight also comes the long-term goal of reducing the comorbidities associated with obesity.

Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity: Implementation Guide

The Implementation Guide provides a sequenced approach to assess, prevent and treat child and adolescent overweight and obesity. These are labeled as Steps 1 through 3, with increasing intensity in the child or adolescent's severity of obesity and their experience with previous stages of treatment.²

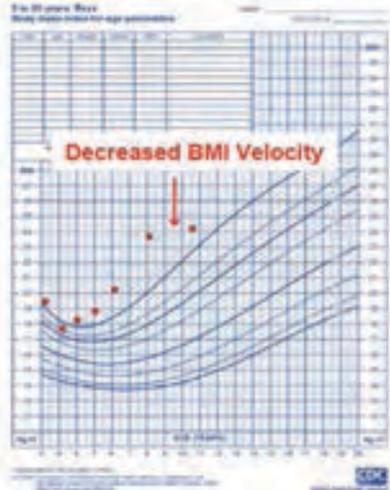
Step 1 - Obesity Prevention at Well Care Visits (Assessment & Prevention)

Action Steps	Expert Recommendations	Tips and Tools
Assess all children for obesity at all well care visits, ages 2 through 18 years of age	Physicians and allied health care providers should perform, at a minimum, a yearly assessment.	A presentation for your staff and colleagues can help implement obesity prevention in your practice.
Use BMI to screen for obesity	<ul style="list-style-type: none"> • Accurately measure height and weight • Calculate BMI • Plot BMI on BMI Growth Chart • Not recommended: skin fold thickness, waist circumference 	BMI is very sensitive to measurement errors, particularly height. Having a standard measurement protocol as well as training can improve accuracy. Utilize CHDP BMI Training & CDC BMI %tile for age growth charts.
Make a weight category diagnosis using BMI percentile	<ul style="list-style-type: none"> • <5%ile – Underweight • 5-84%ile – Healthy Weight • 85-94%ile – Overweight • 95 – 98%ile – Obese • \geq 99%ile – Severely Obese 	<p>Until BMI 99%ile is added to the growth charts, Table 1 on page 62 can be used to determine the 99%ile cut-points by age and gender.</p> <p>Health care providers should exercise judgment when choosing how to inform the family. Using more neutral terms such as weight, excess weight, body mass index, BMI, or risk for diabetes and heart disease can reduce the risk of stigmatization or hard to self-esteem.</p>
Measure blood pressure	<ul style="list-style-type: none"> • Use a large enough cuff to cover 80% of the upper arm • Measure pulse in the standard manner 	Diagnose hypertension using NHLBI tables . An abbreviated Table 2 is shown on page 62 .
Take a focused family history	<ul style="list-style-type: none"> • Obesity • Type 2 Diabetes • Cardiovascular Disease (hypertension, cholesterol) • Early deaths from heart disease or stroke 	A child with one obese parent has a threefold increased risk of becoming obese. This risk increases to 13 fold with 2 obese parents. Using a clinical documentation tool can be helpful. See Appendix H for a sample Weight Management Assessment Tool.
Take a focused review of systems	<ul style="list-style-type: none"> • Identify health conditions associated with Overweight & Obesity by Body System. 	See Table 3 on page 62.
Assess behaviors and attitudes	<p>Diet Behaviors</p> <ul style="list-style-type: none"> • Sweetened-beverage consumption • Fruit and vegetable consumption • Frequency of eating out and family meals • Consumption of excessive portion sizes • Daily breakfast consumption <p>Physical Activity Behaviors</p> <ul style="list-style-type: none"> • Amount of moderate physical activity • Level of screen time and other sedentary activities <p>Attitudes</p> <ul style="list-style-type: none"> • Self-perception or concern about weight • Readiness to change • Successes, barriers and challenges 	See Appendix G for the sample Healthy Lifestyle Questionnaire.
Perform a thorough physical examination	<ul style="list-style-type: none"> • Perform a thorough physical examination 	Use a clinical documentation tool.

<p>Order the appropriate laboratory tests</p>	<p>BMI 85-94%ile Without Risk Factors</p> <ul style="list-style-type: none"> • Fasting Lipid Profile <p>BMI 85-94%ile Age 10 Years Older With Risk Factors</p> <ul style="list-style-type: none"> • Fasting Lipid Profile • ALT and AST • Fasting Glucose <p>BMI \geq 95%ile Age 10 Years & Older</p> <ul style="list-style-type: none"> • Fasting Lipid Profile • ALT and AST • Fasting Glucose • Other tests as indicated by health risks 	<p>Consider ordering ALT, AST and glucose tests beginning at 10 years of age and then periodically (every two years).</p> <p>Discussing lab results with the patient and his or her family can be one way to open the conversation about weight and health.</p>
<p>Give consistent evidenced-based messages for all children regardless of weight</p>	<ul style="list-style-type: none"> • Limit sugar-sweetened beverages • Eat at least 5 servings of fruits and vegetables • Moderate to vigorous physical activity for at least 60 minutes a day • Limit screen time to no more than two hours per day • Remove television from children's bedrooms • Eat breakfast every day • Limit eating out, especially fast food • Have regular family meals • Limit portion sizes 	<p>5210 Explained:</p> <ul style="list-style-type: none"> • 5 fruits and vegetables • 2 hours or less of TV per day • 1 hour or more of physical activity • 0 servings of sweetened beverages <p>Exam and waiting room posters and patient education materials can help deliver these messages and facilitate dialog. Encourage an authoritative parenting style in support of increased physical activity and reduced TV viewing. Discourage a restrictive parenting style regarding child eating. Encourage parents to be good role models and address as a family issue rather than the child's problem.</p>
<p>Use Brief Negotiations to strengthen the effectiveness of your communications</p>	<p>Assess self-efficacy and readiness to change.</p> <ul style="list-style-type: none"> • Determine the patient's understanding of the issue • What do they want to know? • How ready are they to make a change? <p>Provide</p> <ul style="list-style-type: none"> • Advice or information • Choices or options <p>Elicit</p> <ul style="list-style-type: none"> • The type of changes the patient is considering • A plan to take action 	<p>See Chapter 3 Sample Dialogues using Brief Negotiations and Appendix I for 3 Point Plan.</p>



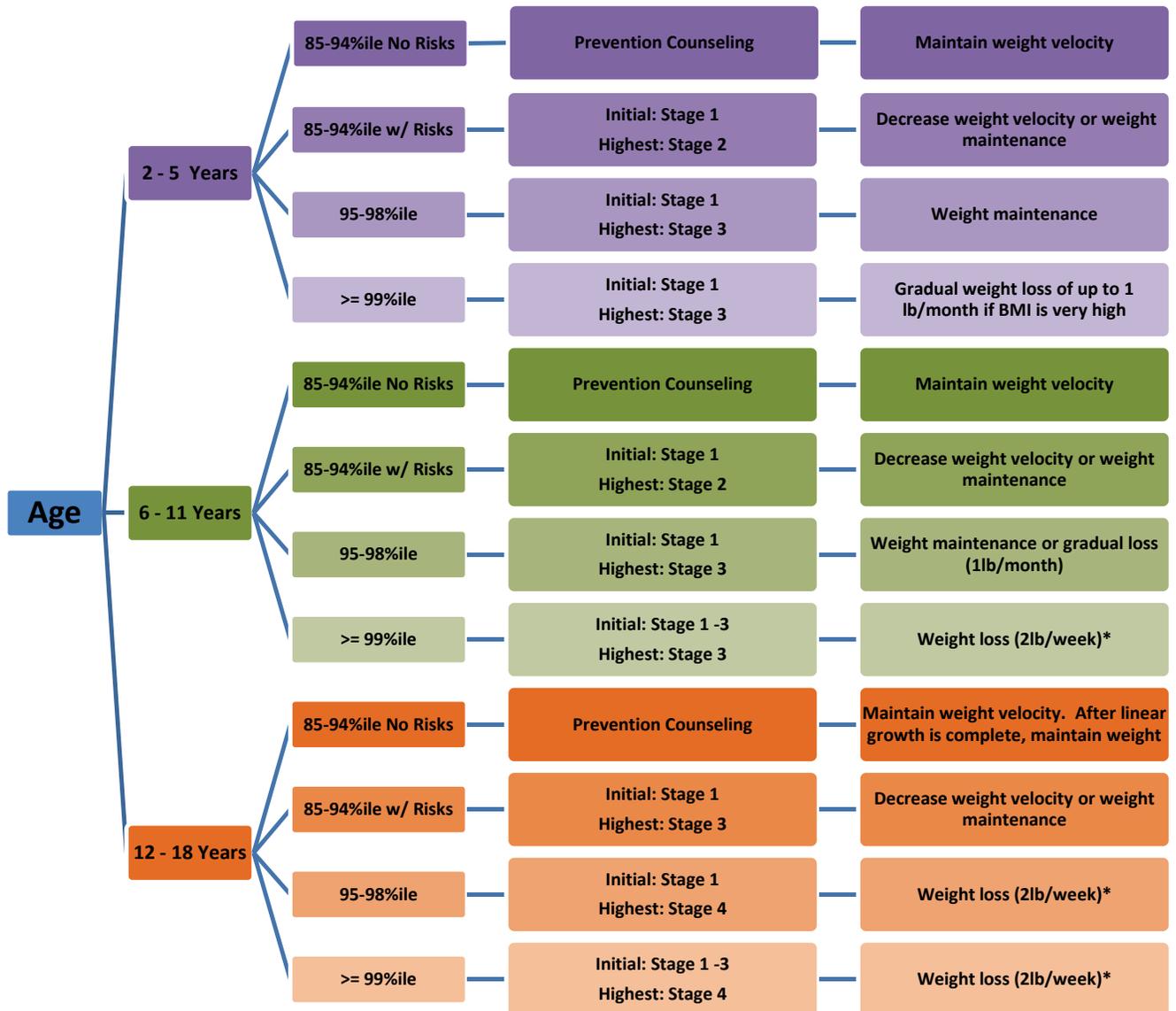
Step 2 – Prevention Plus Visits (Treatment)

Action Steps	Expert Recommendations	Tips and Tools
<p>Develop an office based approach for follow up of overweight and obese children</p>	<p>A staged approach to treatment is recommended for ages 2-19 whose BMI is 85-94%ile with risk factors and all whose BMI is \geq95%ile.</p> <p>In general, treatment begins with Stage 1 Prevention Plus and progresses to the next stage if there has been no improvement with weight/BMI or velocity after 3-6 months and the family is willing/ready.</p> <p>The recommended weight loss targets are shown in Table 4 on page 63.</p> <p>Stage 1 – Prevention Plus</p> <ul style="list-style-type: none"> • Family visits with physician or health care provider who has had some training in pediatric weight management/behavioral counseling. • Can be individual or group visits. • Frequency – Individualized to family needs and risk factors, consider monthly. <p>• Behavioral Goals –</p> <ul style="list-style-type: none"> • Decrease screen time to 2 hr/day or fewer • No sugar-sweetened beverages • Consume at least five servings of fruits and vegetables daily • Be physically active 1 hour or more daily • Prepare more meals at home as a family (the goal is 5 to 6 times per week) • Limit meals outside the home • Eat a healthy breakfast daily • Involve the whole family in lifestyle changes • More focused attention to lifestyle changes and more frequent follow up distinguishes Prevention Plus from Prevention Counseling. <p>• Weight Goals –</p> <ul style="list-style-type: none"> • Weight maintenance or a decrease in BMI velocity. The long term BMI goal is <85%ile although some children can be healthy with a BMI 85-94%ile. • Advance to Stage 2 (Structured Weight Management) if no improvement is weight/BMI or velocity in 3-6 months and family willing/ready to make changes. 	<p>Prevention Plus visits may include:</p> <ul style="list-style-type: none"> • Health education materials • Behavioral risk assessment and self monitoring tools • Action planning and goal setting tools • Counseling protocols • Other health care providers such as dietician, psychologists and health educators <p>Besides behavioral and weight management goals, improving self esteem and self efficacy (confidence) are important outcomes.</p> <p>Although weight maintenance is a good goal, more commonly, a slower weight gain reflected in a decreased BMI velocity is the outcome seen a lower intensity behavioral interventions such as Prevention Plus. Measuring and plotting BMI after 3 to 6 months is an important step to determine the effectiveness of obesity treatment.</p> 
<p>Use motivational interviewing at Prevention Plus visits for ambivalent families and to improve success of action planning</p>	<p>Use patient centered counseling – motivational interviewing</p>	<p>Research suggests that motivational interviewing may be an effective approach to address childhood obesity prevention and treatment. Instead of telling patient what changes to make, you elicit “change talk” from them, taking their ideas, strengths and barriers into account.</p>
<p>Develop a reimbursement strategy for Prevention Plus visits</p>		<p>Coding strategies can help reimbursement for Prevention Plus visits.</p> <p>See chapter 8 for Obesity Coding Fact Sheet.</p>

Step 3 – Going Beyond Your Practice (Prevention & Treatment)

Action Steps	Expert Recommendations	Tips and Tools
<p>Advocate for improved access to fresh fruits and vegetables and safe physical activity in your community and schools</p>	<p>The Expert Committee recommends that physicians, allied health care providers and professional organizations advocate for:</p> <ul style="list-style-type: none"> • The Federal Government to increase physical activity at school through intervention programs as early as grade 1 through the end of high school and college, and through creating school environments that support physical activity in general. • Supporting efforts to preserve and enhance parks as areas for physical activity, informing local development initiatives regarding the inclusion of walking and bike paths, and promoting families' use of local physical activity options by making information and suggestions about physical activity alternatives available in doctors' offices. 	<p>Health care professionals can play a key role in advocating for policy and environmental changes to support healthy eating and physical activity in communities, child care settings, and schools (including after-school programs). Advocacy tools and resources can be helpful in advocacy efforts. Partnering with others and using evidenced based strategies are also critical to the success of community interventions. Please view Chapter 7 which includes the CMA Foundation's Health Care Professionals for Healthy Communities Initiative.</p>
<p>Identify and promote community services which encourage healthy eating and physical activity</p>	<p>Promote physical activity at school and child care settings (including after school programs), by asking children and parents about activity in these settings during routine office visits.</p>	
<p>Identify or develop more intensive weight management interventions for your families who do not respond to Prevention Plus</p>	<p>The Expert Committee recommends the following staged approach for children between the age of 2 and 19 years of age whose BMI is 85-94%ile with risk factors and all whose BMI is ≥ 95%ile:</p> <ul style="list-style-type: none"> • Stage 2 – Structured Weight Management Family visits with physician or healthcare provider specifically trained in weight management. Monthly visits can be individual or group. • Stage 3 – Comprehensive, Multidisciplinary Intervention Multidisciplinary team with experience in childhood obesity. Frequency is often weekly for 8-12 weeks with follow up. • Stage 4 – Tertiary Care Intervention Medications –Orlistat, Very low calorie diets, weight control surgery- gastric bypass and banding. Recommended for select patients only when provided by experienced programs with established clinical or research protocols. Gastric banding is in clinical trials and not currently FDA approved. 	<p>Stage 2 could be done without a tertiary care center if community professionals from different disciplines collaborated. For example, if a physician provided the medical assessment, a dietician provided the classes and the local YMCA provided an exercise program.</p> <p>Partnering with your community tertiary care center can be an effective strategy to develop or link to more intensive weight management interventions. (Stages 3 and 4) as well as referral protocols to care for families who do not respond to Prevention Plus visits. Provider guidelines can be helpful when choosing appropriate treatment and referral options. Weight management protocols and curriculum can also be helpful when getting started.</p> <p>See Table 5 for further discussion on Pharmacotherapy in treatment of overweight and obesity on page 63.</p> <p>See Bariatric Surgery Abstract on page 64 for further discussion on surgical interventions.</p>

Childhood Obesity Assessment and Treatment Algorithm

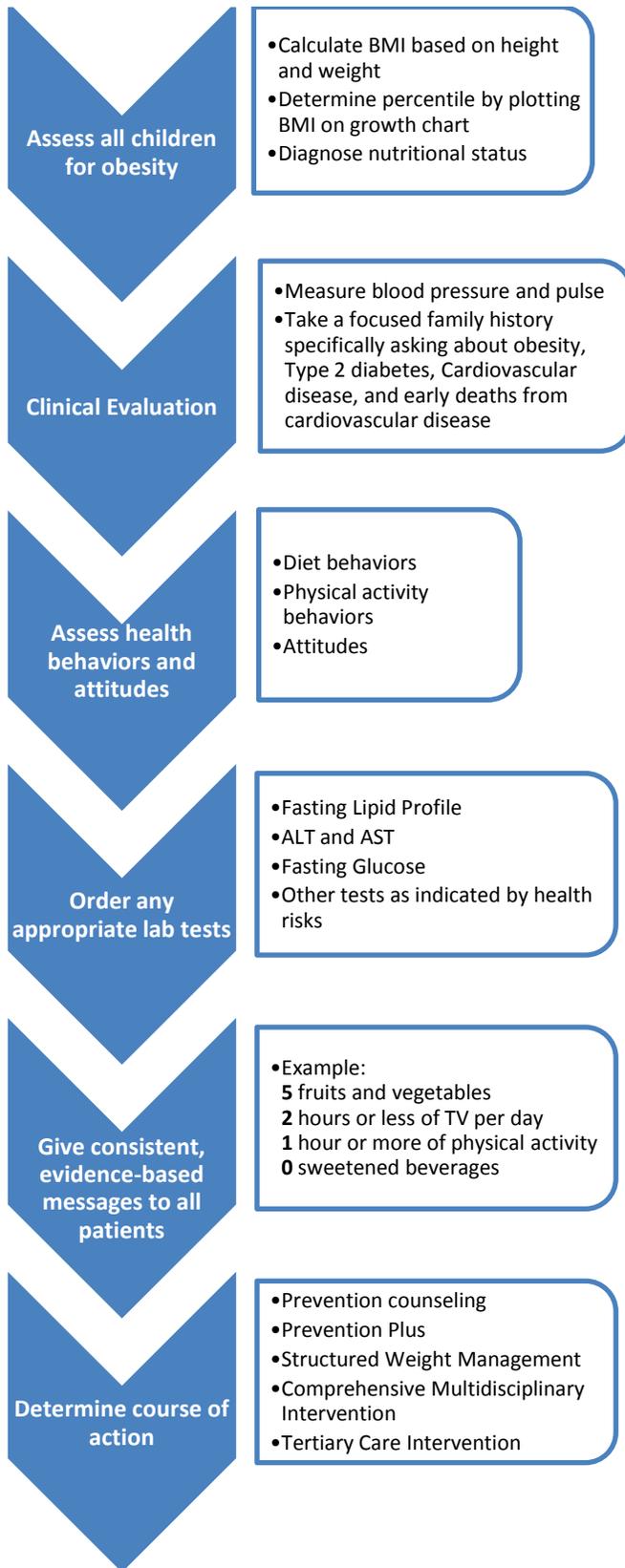


*Evaluate excessive weight loss for high risk behaviors.

Stage	Technique	Provider	Key Components
1	Prevention Plus	Primary Care Office	<ul style="list-style-type: none"> Individual or group visits with the family Occur monthly Healthcare professional sets behavioral goals If no improvement after 3-6 months, patient moves to next stage.
2	Structured Weight Management	Primary Care Office with Support	<ul style="list-style-type: none"> Includes family visits with physician or health professional specifically trained in weight management. Monthly visits can be individual or group.
3	Comprehensive, Multidisciplinary Intervention	Pediatric Weight Management Center	<ul style="list-style-type: none"> Conducted by a multidisciplinary team with experience in childhood obesity. Frequency is often weekly for 8 – 12 weeks with follow up.
4	Tertiary Care Intervention	Tertiary Care Center	<ul style="list-style-type: none"> Interventions include medications, very-low-calorie diets, and weight control surgery. Recommended for select patients only when provided by experienced programs with established clinical or research protocols.

Adapted from NICHQ Childhood Obesity Action Network Implementation Guidelines

Childhood Obesity Assessment and Treatment Algorithm



Quick Reference

BMI Percentile	Nutritional Status
< 5 th %ile	Underweight
5 th – 84 th %ile	Healthy Weight
85 th - <95 th %ile	Overweight
≥ 95 th %ile	Obese
≥ 99 th %ile	Severely Obese

Risk Factors

- Family history of overweight/obesity
- Diet behaviors
- Physical activity behaviors
- Ethnicity

Implementation Guide Tables

Table 1 – BMI 99%ile Cut-Points (kg/m²)

Age (Years)	Boys	Girls
5	20.1	21.5
6	21.6	23
7	23.6	24.6
8	25.6	26.4
9	27.6	28.2
10	29.3	29.9
11	30.7	31.5
12	31.8	33.1
13	32.6	34.6
14	33.2	36.0
15	33.6	37.5
16	33.9	39.1
17	34.4	40.8

Table 2 – Abbreviated NHLBI Blood Pressure Table
Blood Pressure 95% by Age, Sex and Height %

Age	Boys Height %		Girls Height %	
	50%	90%	50%	90%
2 Yr	106/61	109/63	105/63	108/65
5 Yr	112/72	115/74	110/72	1132/73
8 Yr	116/78	119/79	115/76	118/78
11 Yr	121/80	124/82	121/79	123/81
14 Yr	128/82	132/84	126/82	129/84
17 Yr	136/87	139/88	129/84	131/85

Table 3 – Symptoms and Signs of Conditions Associated with Obesity

Symptoms	Signs
<ul style="list-style-type: none"> • Anxiety, school avoidance, social isolation (Depression) • Polyuria, polydipsia, weight loss (Type 2 diabetes) • Headaches (Pseudotumor cerebri) • Night breathing difficulties (Sleep apnea, hypoventilation syndrome, depression) • Abdominal pain (Gastroesophageal reflux, Gall bladder disease, Constipation) • Hip or knee pain (Slipped capital femoral epiphysis) • Oligomenorrhea or amenorrhea (Polycystic ovary syndrome) 	<ul style="list-style-type: none"> • Poor linear growth (Hypothyroidism, Cushing's, Prader-Willi syndrome) • Dysmorphic features (Genetic disorders, including Prader-Willi syndrome) • Acanthosis nigricans (NIDDM, insulin resistance) • Hirsutism and Excessive Acne (Polycystic ovary syndrome) • Violaceous striae (Cushing's syndrome) • Papilledema, cranial nerve VI paralysis (Pseudotumor cerebri) • Tonsillar hypertrophy (Sleep apnea) • Abdominal tenderness (Gall bladder disease, GERD, NAFLD) • Hepatomegaly (Nonalcoholic fatty liver disease) • Undescended testicle (Prader-Willi syndrome) • Limited hip range of motion (Slipped capital femoral epiphysis) • Lower leg bowing (Blount's disease)

Table 4 – Weight Loss Targets

	BMI 85-94%ile No Risks	BMI 85-94%ile With Risks	BMI 95-98%ile	BMI \geq 99%ile
2-5 Years	Maintain weight velocity	Decrease weight velocity or weight maintenance	Weight maintenance	Gradual weight loss of up to 1lb. a month if BMI is very high (>21 or 22 kg/m^2)
6-11 Years	Maintain weight velocity	Decrease weight velocity or weight maintenance	Weight maintenance or gradual loss (1 lb/month)	Weight loss (average is 2 lbs/week)*
12-18 Years		Decrease weight velocity or weight maintenance	Weight loss (average is 2 lbs/week)*	Weight loss (average is 2 lbs/week)*

*Excessive weight loss should be evaluated for high risk behaviors

Table 5 - Pharmacotherapy

The cornerstone of obesity treatment is lifestyle management that incorporates dietary management, physical activity, and behavioral modifications. Only one anti-obesity medication has FDA approval for use with pediatric patients – Orlistat. Prior to 2008, two medications were on the market. In October 2010, Subutramine (Meridia), was removed from the market due to issues related to risk of heart attack and stroke.

Medication	Approved Age Group	Function	Comments
Orlistat (Xenical®) By prescription	14 years and older	Gastrointestinal lipase inhibitor	<ul style="list-style-type: none"> • Demonstrated statistically significant weight loss of 0.86 BMI units in clinical trial. • Adverse side effects include fatty/oily stools, oily spotting, and fecal incontinence. • On May 26, 2010, the FDA approved a revised label for Xenical® to include safety information about cases of severe liver injury that have been reported rarely with the use of this medication.
Orlistat (Alli®) OTC	14 years and older	Gastrointestinal lipase inhibitor	<ul style="list-style-type: none"> • Approved for over-the-counter sale at a lower dosage. • Only advisable as an adjunct to individuals engaged in an active weight loss program that focuses on a healthy diet, caloric restriction and increased physical activity.

Medication should only be used with pediatric patients when incorporated in a behavioral treatment program.^{3,4}

★ Quick Tip

Many cultures hold beliefs about the efficacy, potency, or spiritual effects of taking a medication. When prescribing medications, inquire about these belief systems and assess how they may affect adherence. Seek to agree on a mutually acceptable, realistic intervention plan.

Obesity Best Practice Updates for Pediatric /Adolescent Weight Loss Surgery

Abstract

The objective of this study is to update evidence-based best practice guidelines for pediatric/adolescent weight loss surgery (WLS). We performed a systematic search of English-language literature on WLS and pediatric, adolescent, gastric bypass, laparoscopic gastric banding, and extreme obesity published between April 2004 and May 2007 in PubMed, MEDLINE, and the Cochrane Library. In light of evidence on the natural history of obesity and on outcomes of WLS in adolescents, guidelines for surgical treatment of obesity in this age group need to be updated.

We recommend the modification of selection criteria to include adolescents with BMI > 35 and specific obesity-related comorbidities for which there is clear evidence of important short-term morbidity (i.e., type 2 diabetes, severe steatohepatitis, pseudotumor cerebri, and moderate-to-severe obstructive sleep apnea). In addition, WLS should be considered for adolescents with extreme obesity (BMI > 40) and other comorbidities associated with long-term risks.

Key considerations for in-patient safety include carefully designed criteria for patient selection, multidisciplinary evaluation, choice of appropriate procedure, thorough screening and management of comorbidities, optimization of long-term compliance, and age-appropriate fully informed consent.

Janey S.A. Pratt, Department of Surgery, Massachusetts General Hospital, MGH Weight Center; Carine M. Lenders, Department of Pediatrics, Boston Medical Center; Emily A. Dionne, Department of Psychiatry, Tufts-New England Medical Center; Alison G. Hoppin, MGH Weight Center; George L.K. Hsu, Department of Psychiatry, Tufts-New England Medical Center; Thomas H. Inge, Department of Pediatric Surgery, Cincinnati Children's Hospital; David F. Lawlor, Department of Surgery, Massachusetts; Margaret F. Marino, Department of Pediatrics, Boston Medical Center; Alan F. Meyers, Department of Pediatrics, Boston Medical Center; Jennifer L. Rosenblum, MGH Weight Center; Vivian M. Sanchez, Department of Surgery, Beth Israel Deaconess Medical Center, Boston, Massachusetts.

Obesity, Volume 17 Number 5 May 2009; 901-910.

Screening for Food Insecurity⁵

Training clinical staff on the health consequences of food insecurity, childhood hunger and the importance of screening is a critical element to establish the clinical setting as a safe place to discuss the sensitive issues of food insecurity. Families need to know they will be treated with respect and dignity by all staff members.

★ Quick Tip

Food Insecurity

- The term “food insecurity” is used to describe the experience of not having the financial resources to regularly purchase food.
- At mild or moderate levels this situation results in anxiety, limited nutritional options, and trade-offs between food and other basic needs.
- In more severe cases, food insecurity results in hunger and extended periods of time without food.

Adapted from: California Pan-Ethnic Health Network. “The Inextricable Connection Between Food Insecurity and Diabetes.”

Health care providers can incorporate a food insecurity risk question as part of a review of systems or social history. Asking if the household has sufficient resources to feed their family a healthy diet will be more revealing than asking if the family eats a ‘balanced diet.’⁶ Regardless of who asks, or how the risk question(s) are asked, trust between the patient and provider is key in determining the family’s ability to feed their children.

Household Food Security Surveys

The full range of food insecurity and hunger cannot be captured by any single indicator. Instead, a household’s level and severity of food insecurity or hunger must be determined by obtaining information on a variety of specific conditions, experiences, and behaviors. Household surveys, usually conducted in person or by telephone, are commonly used to get this information. To assess a household’s level and severity of food insecurity or hunger, the following USDA Household Food Security Surveys U.S. Department

of Agriculture, Food and Nutrition Service are available in Toolbox, Appendix J.

For patients’ ages 11 and younger, please administer to patients’ parent/guardian:

U.S. Household Food Security Survey Module: Six-Item Short Form

For patients’ ages 12 and older, please administer: Self-Administered Food Security Survey Module for Children Ages 12 Years and Older

Upon assessment, referrals may be necessary to assist the patient in securing adequate food. An understanding of the household structure will assist health care providers in making appropriate referrals.

Food Assistance Programs⁷

A variety of U.S. Department of Agriculture programs are available across the United States, and others are unique to particular communities, to help people get food. Food assistance programs increase food security and reduce hunger by providing children and low-income individuals access to food, a healthful diet, and nutrition.

★ Quick Tip

Two quick screening questions are: (response options are OFTEN, SOMETIMES, or NEVER TRUE)

1. “Within the past 12 months we worried whether our food would run out before we got money to buy more.”
2. “Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.”

Adapted from: Hager, E.R., Quigg, A.M., BlackM, M.M., Coleman, S.M., Heeren, T., Rose-Jacobs, R., Cook, J.T., de Cuba, S.A., Casey, P.H., Chilton, M., Cutts, D.B., Meyers, A.F., Frank, D.A.. Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics Vol. 126 No. 1 July 1, 2010. (doi: 10.1542/peds.2009-3146).

Programs	Program summary, referral information, and Web site addresses
<p>Supplemental Nutrition Assistance Program (SNAP); Previously called the Food Stamp Program. SNAP is the national program name. Some States may call it something else; known in California as CalFresh.</p>	<p>Enables low-income families to buy nutritious food with coupons and Electronic Benefits Transfer cards. SNAP recipients spend their benefits to buy eligible food in authorized retail food stores. Refer patients to the local food stamp office.</p> <p>Web address: http://www.fns.usda.gov/snap/</p>
<p>Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and WIC Farmers' Market Nutrition Program</p>	<p>Provides supplemental foods, nutrition education and counseling, and access to health services to low-income pregnant, breastfeeding, and nonbreastfeeding postpartum women, and to infants and children up to 5 years of age, who are found to be at nutritional risk. As part of the WIC Farmers' Market Nutrition Program, a variety of fresh, nutritious, unprepared, locally grown fruits, vegetables, and herbs may be purchased with coupons. Refer patients to the local WIC agency.</p> <p>Web addresses: http://www.fns.usda.gov/wic and http://www.fns.usda.gov/wic/FMNP/FMNPfaqs.htm</p>
<p>National School Lunch and School Breakfast Programs</p>	<p>Provides nutritionally balanced, low-cost or free breakfasts and lunches to children enrolled in public and nonprofit private schools and residential child care institutions. Also provides snacks served in after-school educational and enrichment programs for children through 18 years of age. Refer patients to local schools.</p> <p>Web addresses: http://www.fns.usda.gov/cnd/lunch/default.htm and http://www.fns.usda.gov/cnd/breakfast/default.htm</p>
<p>Summer Food Service Program</p>	<p>Provides nutritious breakfasts, lunches, and snacks to ensure that children in lower-income areas continue to receive nutritious meals during long school vacations when they do not have access to school lunch or breakfast. Refer children to local summer programs. Area schools may have information about available programs.</p> <p>Web address: http://www.summerfood.usda.gov</p>
<p>Feeding America Network Programs: BackPack Program</p> <p>Kids Café</p> <p>National Produce Program (previously called the Fresh Foods Initiative)</p>	<p>The BackPack Program is designed to meet the needs of hungry children at times when other resources are not available, such as weekends and school vacations.</p> <p>Kids Cafe programs provide free meals and snacks to low-income children through a variety of community locations where children already congregate—such as Boys & Girls Clubs, churches or public schools.</p> <p>The National Produce Program offers a comprehensive array of services built around securing and distributing fresh produce throughout the Feeding America network of more than 200 food banks. If you have a need for fresh produce, access http://feedingamerica.org/foodbank-results.aspx to locate a food bank member closest to you.</p> <p>Web address: http://feedingamerica.org/</p>
<p>Expanded Food and Nutrition Education Program</p>	<p>Helps limited-income families and youth acquire knowledge, skills, attitudes, and behavior changes necessary to maintain nutritionally sound diets and enhance personal development (basic nutrition, food preparation, resource management). Refer clients to the county extension office.</p> <p>Web address: http://www.csrees.usda.gov/nea/food/efnep/efnep.html</p>

<p>Food Distribution Programs such as:</p> <ul style="list-style-type: none"> - Child Nutrition Commodity Support - Nutrition Services Incentive Program (formerly the Nutrition Program for the Elderly) - Commodity Supplemental Food Program - Food Assistance in Disaster Situations - Food Distribution Program on Indian Reservations - Emergency Food Assistance Program - State Processing Program - Nutrition Assistance Program for Puerto Rico, American Samoa, and the Northern Marianas - Homeless Children Nutrition Program 	<p>Overall, these programs support the nutrition safety net through commodity distribution and other nutrition assistance to low-income families, emergency feeding programs, Indian reservations, and the elderly. Refer clients to local food banks and pantries or other agencies/organizations, including faith-based groups, where supplemental foods are distributed. Your local food bank can be accessed through America's Second Harvest.</p> <p>Web addresses: http://www.secondharvest.org http://www.fns.usda.gov/fdd http://www.fns.usda.gov/fns/</p>
<p>National Meals on Wheels Foundation</p>	<p>Dedicated to the delivery of meals to homebound senior citizens and those at congregate sites. Programs are organized by a variety of groups, including local communities, churches, charitable organizations, and concerned citizens. Refer clients directly to programs. The Area Agency on Aging may be helpful.</p> <p>Web address: www.mowaa.org</p>
<p>Senior Farmers' Market Nutrition Program</p>	<p>Provides low-income seniors with coupons that can be exchanged for eligible foods (fresh, nutritious, unprocessed fruits, vegetables, and fresh-cut herbs) at farmers' markets, roadside stands, and community-supported agriculture programs during the harvest season. Refer clients to local programs. The Area Agency on Aging may be helpful.</p> <p>Web address: http://www.fns.usda.gov/wic/seniorFMNP/SFMNPmenu.htm</p>

Community involvement by health care providers also can benefit patients. Initiating the development of a food pantry within a medical office or personally assisting the local food bank with a food drive or food recovery project (www.usda.gov/news/pubs/gleaning/content.htm) can benefit patients and the community.

Food Security Information Resources

Congressional Hunger Center - <http://www.hungercenter.org/>

Community Food Security Coalition - <http://www.foodsecurity.org>

Food Research and Action Center - <http://www.frac.org>

Food Security in the U.S. Briefing Room - <http://www.ers.usda.gov/briefing/foodsecurity>

Why Hunger - <http://www.whyhunger.org/>

U.S. Department of Agriculture Community Food Security Initiative - <http://www.fns.usda.gov/fsec/Resources.htm>

World Hunger Site - <http://www.thehungersite.com>

End Notes

1. Barlow, S. E. and Expert Committee. Expert Committee Recommendation Regarding the Prevention, Assessment and Treatment of Childhood and Adolescent Overweight and Obesity: Summary Report. *Pediatrics* 2007; 120; S164-192.
2. Barlow, S. E. and Expert Committee. Expert Committee Recommendation Regarding the Prevention, Assessment and Treatment of Childhood and Adolescent Overweight and Obesity: Summary Report. *Pediatrics* 2007; 120; S164-192.
3. Berkowitz, R. I., Wadden, T. A., Tershokovec, A. M., and Cronquist, J.L. Behavior Therapy and Sibutramine for the Treatment of Adolescent Obesity. (2003). *JAMA*, 289, 1805-1812.
4. Chanoine, J.-P., Hampl, S., Jensen, C., Boldrin, M., and Hauptman, J. Effects of Orlistat on Weight and Body Composition in Obese Adolescents. (2005). *JAMA*, 293, 2873-2883.
5. Childhood Hunger Coalition. Oregon Childhood Hunger Coalition Statewide Provider Survey Report. (2009).
6. Messer, E., Ross, E. M. and Ldn. Talking to Patients About Food Insecurity. *Nutrition in Clinical Care*, 5: 168–181. doi: 10.1046/j.1523-5408.2002.00303.x. (2002)
7. Holben, D., Myles, W. Food Insecurity in the United States: Its Effect on Our Patients. *American Family Physician*. 2004 Mar 1;69(5):1058-1064 ■



5

Patient Education Resources

- **MyPlate - USDA Dietary Guidelines**
- **MyPyramid for Kids**
- **Tips for Families**
- **Reading Food Labels**
- **Decide What to Eat**
- **What is a Serving Size?**
- **MyPyramid Worksheet (Food Diary)**
- **Ethnic Food Pyramids**
- **Healthy Cultural Recipes**
- **Being physically active**
- **5-2-1-0 Good Health Club**
- **“Little Changes. Big Rewards. Are you Ready?” Posters**
- **Self-Love = Healthy-Love Handout**

Chapter 5

Patient Education Resources

On the following pages, you will find patient education resources that address healthy eating and physical activity.

Included on these pages you will find some materials that incorporate the new USDA Dietary Guidelines. During this time of transition, we have also included the Food Pyramid in both English and multiple languages.

At this time, these are the only multicultural and multilingual resources available from the USDA. When the new Dietary Guidelines are put into a multicultural framework, these pages will be substituted for those currently in this chapter.

MyPlate - USDA Dietary Guidelines



★ Quick Tip

Please see Toolbox Appendix K for additional information on the MyPlate Food Model Dietary Guidelines.

★ Quick Tip

Take Action on the Dietary Guidelines by making changes in these 3 areas:

Choose steps that work for you and start today!

Balance Calories

- Enjoy your food, but eat less.
- Avoid oversized portions.

Foods to Increase

- Make half your plate fruits and vegetables.
- Make at least half your grains whole grains.
- Switch to fat-free or low-fat (1%) milk.

Foods to Reduce

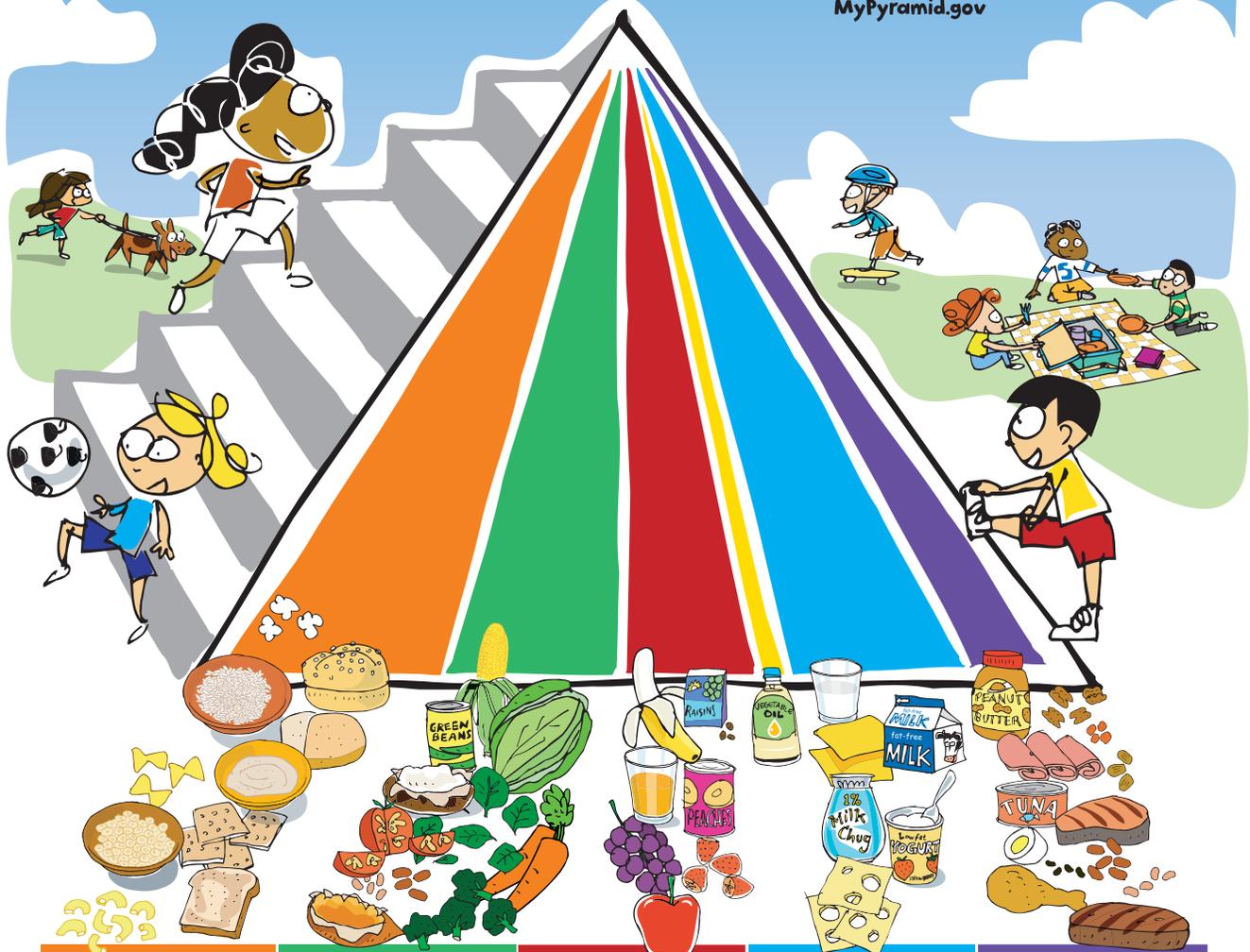
- Compare sodium in foods like soup, bread and frozen meals – and choose foods with lower numbers.
- Drink water instead of sugary drinks.

MyPyramid

For Kids

Eat Right. Exercise. Have Fun.

MyPyramid.gov



Grains Make half your grains whole	Vegetables Vary your veggies	Fruits Focus on fruits	Milk Get your calcium-rich foods	Meat & Beans Go lean with protein
<p>Start smart with breakfast. Look for whole-grain cereals.</p> <p>Just because bread is brown doesn't mean it's whole-grain. Search the ingredients list to make sure the first word is "whole" (like "whole wheat").</p>	<p>Color your plate with all kinds of great-tasting veggies.</p> <p>What's green and orange and tastes good? Veggies! Go dark green with broccoli and spinach, or try orange ones like carrots and sweet potatoes.</p> 	<p>Fruits are nature's treats – sweet and delicious.</p> <p>Go easy on juice and make sure it's 100%.</p>	<p>Move to the milk group to get your calcium. Calcium builds strong bones.</p> <p>Look at the carton or container to make sure your milk, yogurt, or cheese is lowfat or fat-free.</p> 	<p>Eat lean or lowfat meat, chicken, turkey, and fish. Ask for it baked, broiled, or grilled – not fried.</p> <p>It's nutty, but true. Nuts, seeds, peas, and beans are all great sources of protein, too.</p>

For an 1,800-calorie diet, you need the amounts below from each food group. To find the amounts that are right for you, go to MyPyramid.gov.

Eat 6 oz. every day; at least half should be whole	Eat 2 1/2 cups every day	Eat 1 1/2 cups every day	Get 3 cups every day; for kids ages 2 to 8, it's 2 cups	Eat 5 oz. every day
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Oils Oils are not a food group, but you need some for good health. Get your oils from fish, nuts, and liquid oils such as corn oil, soybean oil, and canola oil.

<p>Find your balance between food and fun</p> <ul style="list-style-type: none"> Move more. Aim for at least 60 minutes everyday, or most days. Walk, dance, bike, rollerblade – it all counts. How great is that! 	<p>Fats and sugars – know your limits</p> <ul style="list-style-type: none"> Get your fat facts and sugar smarts from the Nutrition Facts label. Limit solid fats as well as foods that contain them. Choose food and beverages low in added sugars and other caloric sweeteners.
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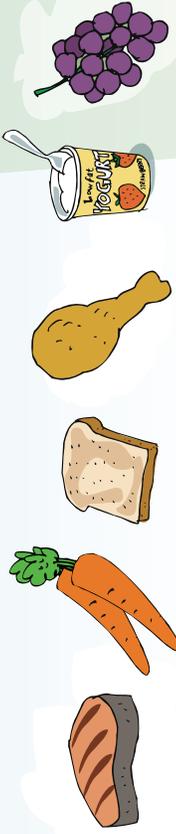


TIPS FOR FAMILIES



EAT RIGHT

- 1 Make half your grains whole.** Choose whole-grain foods, such as whole-wheat bread, oatmeal, brown rice, and lowfat popcorn, more often.
- 2 Vary your veggies.** Go dark green and orange with your vegetables—eat spinach, broccoli, carrots, and sweet potatoes.
- 3 Focus on fruits.** Eat them at meals, and at snack time, too. Choose fresh, frozen, canned, or dried, and go easy on the fruit juice.
- 4 Get your calcium-rich foods.** To build strong bones serve lowfat and fat-free milk and other milk products several times a day.
- 5 Go lean with protein.** Eat lean or lowfat meat, chicken, turkey, and fish. Also, change your tune with more dry beans and peas. Add chick peas, nuts, or seeds to a salad; pinto beans to a burrito; or kidney beans to soup.
- 6 Change your oil.** We all need oil. Get yours from fish, nuts, and liquid oils such as corn, soybean, canola, and olive oil.
- 7 Don't sugarcoat it.** Choose foods and beverages that do not have sugar and caloric sweeteners as one of the first ingredients. Added sugars contribute calories with few, if any, nutrients.



EXERCISE

- 1 Set a good example.** Be active and get your family to join you. Have fun together. Play with the kids or pets. Go for a walk, tumble in the leaves, or play catch.
- 2 Take the President's Challenge as a family.** Track your individual physical activities together and earn awards for active lifestyles at www.presidentschallenge.org.
- 3 Establish a routine.** Set aside time each day as activity time—walk, jog, skate, cycle, or swim. Adults need at least 30 minutes of physical activity most days of the week; children 60 minutes everyday or most days.
- 4 Have an activity party.** Make the next birthday party centered on physical activity. Try backyard Olympics, or relay races. Have a bowling or skating party.
- 5 Set up a home gym.** Use household items, such as canned foods, as weights. Stairs can substitute for stair machines.
- 6 Move it!** Instead of sitting through TV commercials, get up and move. When you talk on the phone, lift weights or walk around. Remember to limit TV watching and computer time.
- 7 Give activity gifts.** Give gifts that encourage physical activity—active games or sporting equipment.



HAVE FUN!



READ IT *before you EAT IT!*

How many servings are you eating?



Nutrition Facts

Serving Size 1 cup (228g)
Servings Per Container 2

Amount Per Serving

Calories 250 **Calories from Fat** 110

% Daily Value*

Total Fat 12g **18%**

Saturated Fat 3g **15%**

Cholesterol 30mg **10%**

Sodium 470mg **20%**

Total Carbohydrate 31g **10%**

Dietary Fiber 0g **0%**

Sugars 5g

Protein 5g

Vitamin A 4% • Vitamin C 2%

Calcium 20% • Iron 4%

* Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs:

Calories: 2,000 2,500

Total Fat Less than 65g 80g

Sat Fat Less than 20g 25g

Cholesterol Less than 300mg 300mg

Sodium Less than 2,400mg 2,400mg

Total Carbohydrate 300g 375g

Dietary Fiber 25g 30g

What food would have this Nutrition Facts label? *Answer below.**

Get What You Need!



Get LESS

5% or less is low

20% or more is high



Get ENOUGH

5% or less is low

20% or more is high



What's the Best Choice for You?

Use the 5%-20% Guide to Daily Values to choose foods.

*Answer: Box of macaroni and cheese.

How do your choices stack up? The photos show approximate serving sizes from the five major food groups of the Food Guide Pyramid. This combination of food choices shows the servings from the Pyramid for an older child, a teen girl, an active woman, and most men, for one day. Teen boys and active men may need more servings of food.

www.fns.usda.gov/tn

United States Department of Agriculture • Food and Nutrition Service • October 2002
USDA is an equal opportunity provider and employer.

How Much Do YOU Eat?

Use these everyday items to estimate the amount you eat.



Amounts of foods
For 2,000 calories

½ cup of fruit juice
= size of a 4 oz juice box

1 small apple = 1 cup
= size of a baseball

½ cup of sliced fruit
= size of a small computer mouse

2 cups
Fruit Group

½ cup of carrots or other vegetables
= size of a small computer mouse

10 medium fries counts as ½ cup
= size of a deck of cards

1 cup of raw vegetables
= size of a baseball

2½ cups
Vegetable Group

1 cup of milk
= an 8 oz carton of milk

1 cup of yogurt
= size of a baseball

1½ oz. of low-fat natural cheese*
= size of two 9-volt batteries

3 cups or equivalent
Milk Group

2-3 oz. of meat, poultry or fish
= size of a deck of cards

1 tablespoon of peanut butter counts as 1 oz
= size of one 9-volt battery

½ cup of beans counts as 2 oz
= size of a small computer mouse

5½ ounces or equivalent
Meat & Beans Group

½ cup of cooked pasta = 1 oz
= size of a small computer mouse

1 cup of dry cereal = 1 oz
= size of a baseball

1 slice of bread counts as 1 oz
= size of a CD*

6 ounces or equivalent
Grains Group

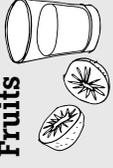
*About the thickness of 10 CDs (¼ inch)

MyPyramid Worksheet

Name: _____

MyPyramid FOR KIDS

Check how you did yesterday and set a goal for tomorrow

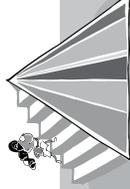
Write In Your Choices From Yesterday	Food and Activity	Tip	Goal (Based On a 1800 Calorie Pattern)	List Each Food Choice In Its Food Group*	Estimate Your Total
Breakfast: _____ _____ _____	Grains 	Make at least half your grains whole grains.	6 ounce equivalents (1 ounce equivalent is about 1 slice bread, 1 cup dry cereal, or 1/2 cup cooked rice, pasta, or cereal)		____ ounce equivalents
Lunch: _____ _____ _____	Vegetables 	Color your plate with all kinds of great tasting veggies.	2 1/2 cups (Choose from dark green, orange, starchy, dry beans and peas, or other veggies).		____ cups
Snack: _____ _____ _____	Fruits 	Make most choices fruit, not juice.	1 1/2 cups		____ cups
Dinner: _____ _____ _____	Milk 	Choose fat-free or lowfat most often.	3 cups (1 cup yogurt or 1 1/2 ounces cheese = 1 cup milk)		____ cups
_____ _____ _____	Meat and Beans 	Choose lean meat and chicken or turkey. Vary your choices—more fish, beans, peas, nuts, and seeds.	5 ounce equivalents (1 ounce equivalent is 1 ounce meat, chicken or turkey, or fish, 1 egg, 1 T. peanut butter, 1/2 ounce nuts, or 1/4 cup dry beans)		____ ounce equivalents
Physical activity: _____ _____ _____	Physical Activity 	Build more physical activity into your daily routine at home and school.	At least 60 minutes of moderate to vigorous activity a day or most days.		____ minutes

* Some foods don't fit into any group. These "extras" may be mainly fat or sugar—limit your intake of these.

How did you do yesterday? Great So-So Not So Great

My food goal for tomorrow is: _____

My activity goal for tomorrow is: _____



Ethnic Food Pyramids:

MiPirámide: Pasos Hacia Una Mejor Salud

www.mypyramid.gov/sp-index.html

USDA. Center for Nutrition Policy and Promotion.
Spanish Version of MyPyramid. MyPyramid replaces the 1992 Food Guide Pyramid and associated materials. It incorporates recommendations from the 2005 Dietary Guidelines for Americans, released by the US Department of Agriculture (USDA) and US Department of Health and Human Services (HHS) in January, 2005.

Native American Food Pyramid

www.pbpindiantribe.com/sub/clinic/NAFGP.html
Prairie Band Potawatomi Health Center.
Pictorial representation of the Food Guide Pyramid with traditional Native American Foods.

Asian Diet Pyramid

www.oldwayspt.org/asian-diet-pyramid
OLDWAYS Preservation Trust.
Pictorial representation of the Food Guide Pyramid using foods found in the traditional Asian diet. This 8 1/2 x 11 color printout is available for purchase.

Mediterranean Diet Pyramids

www.oldwayspt.org/med_pyramid.html
OLDWAYS Preservation Trust.
Pictorial representation of the Food Guide Pyramid using foods traditionally found in the Mediterranean diet. Download the adult or child pyramid in PDF or high resolution JPG file.

Japanese Food Guide Spinning Top

www.mhlw.go.jp/bunya/kenkou/pdf/eiyou-syokujij5.pdf
Japanese Ministry of Health, Labor and Welfare; Ministry of Agriculture, Forestry and Fisheries.
Graphic representation of Japanese food guidance.

Healthy Diet Pyramid, Singapore

www.hpb.gov.sg/hpb/default.asp?pg_id=865&aid=316
Singapore Government. Health Promotion Board.
Guide to healthy eating issued by the Singapore Government.

The following ethnic food pyramids are available from the Southeastern Michigan Dietetic Association (SEMDA) at www.semda.org. In addition, SEMDA also offers:

- Combinations of Foods within the food pyramids
- Recipes
- Nutritional Analysis (per serving) of the recipes

Mexican Food Pyramid

www.semda.org/info/pyramid.asp?ID=27

Thai Food Pyramid

www.semda.org/info/pyramid.asp?ID=4

Arabic Food Pyramid

www.semda.org/info/pyramid.asp?ID=1

Indian Food Pyramid

www.semda.org/info/pyramid.asp?ID=2

Italian Food Pyramid

www.semda.org/info/pyramid.asp?ID=6

Soul Food Pyramid

www.semda.org/info/pyramid.asp?ID=7

Caribbean Islands Food Pyramid

www.semda.org/info/pyramid.asp?ID=8

Japanese Food Pyramid

www.semda.org/info/pyramid.asp?ID=10

Polish Food Pyramid

www.semda.org/info/pyramid.asp?ID=12

Portuguese Food Pyramid

www.semda.org/info/pyramid.asp?ID=16

English Food Pyramid

www.semda.org/info/pyramid.asp?ID=22

Yugoslavian Food Pyramid

www.semda.org/info/pyramid.asp?ID=24

Cuban Food Pyramid

www.semda.org/info/pyramid.asp?ID=25

Chinese Food Pyramid

www.semda.org/info/pyramid.asp?ID=28

Russian Food Pyramid

www.semda.org/info/pyramid.asp?ID=30

Irish Food Pyramid

www.semda.org/info/pyramid.asp?ID=3

★ Quick Tip

For Patient Education Resources in languages other than English, please see section on “Culturally Appropriate Resources” under Chapter 6: Online Resources.

Sample of an Ethnic Food Pyramid



★ Quick Tip

The core recommendation for individuals to consume large amounts of grains, vegetables, and fruit with moderate intake of meat, milk and dairy products is consistent throughout all international food guides.

- Adapted from the "Comparison of International Food Guide Pictorial Representations" from the Journal of the American Dietetic Association

Healthy Cultural Recipes:

Food Stamp Nutrition Connection Recipe Finder in English and Spanish: <http://recipefinder.nal.usda.gov/>

Latino Recipes

Latino: From CA Dept Public Health: www.cdph.ca.gov/programs/cpns/Documents/Network-FV-LC-HealthyLatinoRecipes.pdf (English)

www.cdph.ca.gov/programs/cpns/Documents/Network-RecetasLatinasSaludables.pdf (Spanish)

From the Latino Nutrition Coalition: www.oldwayspt.org/sites/all/files/Latino%20Living%20Eng-Sp_rzd.pdf

From NHLBI: www.nhlbi.nih.gov/health/public/heart/other/sp_recip.pdf

African American

Soulful: From CA Dept Public Health: www.cdph.ca.gov/programs/cpns/Documents/Network-FV-AA-Cookbook-2008.pdf

From NHLBI: www.nhlbi.nih.gov/health/public/heart/other/chdblack/cooking.pdf

From University of Maryland: http://dpch.umd.edu/research/partners_docs/Cookbook.pdf

Asian Recipes

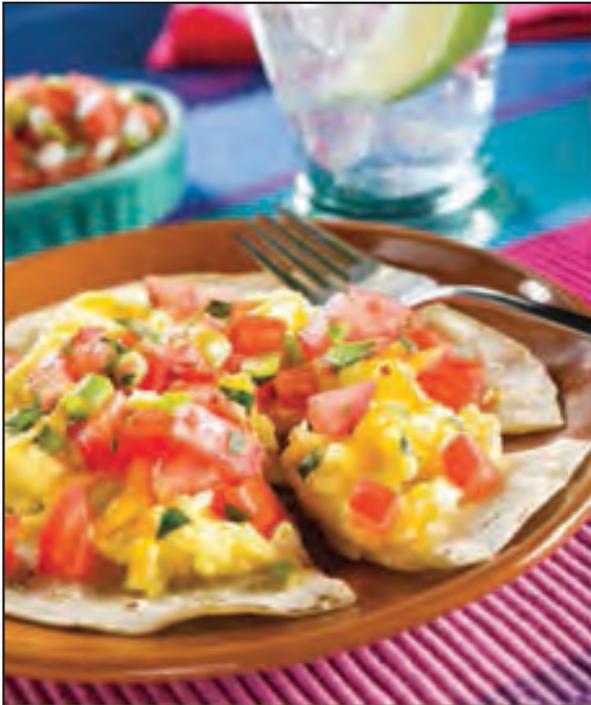
Indian: From American Association of Physicians of Indian Origin: <http://aapiusa.org/uploads/files/docs/ebook/Nutrition%20EBook.pdf>

“Asian American exchange list” from NHLBI: www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/asian.htm

Chinese: From CA Dept Public Health: www.cdph.ca.gov/HealthInfo/healthyliving/nutrition/recipes/Documents/HealthyChineseCookbook.pdf

Tagalog version of the REACH Healthy Asian Recipes handbook: <http://www.ichs.com/pdfs/recipes/recipesTagalog.pdf>

Sample of a Healthy Latino Recipe



A healthy version of a Latino breakfast dish!

Makes 2 servings - 1 tortilla per serving

Prep time: 10 minutes

Cook time: 15 minutes

Number of ingredients: 8 items

Calories: 140 Total Fat: 10g Saturated Fat: 5g Total Cholesterol: 10mg Total Carb: 20g Protein: 10g Sodium: 100mg

Huevos Rancheros with Fresh Salsa

Ingredients

- | | |
|------------------------------|--|
| 4 (6-inch) corn tortillas | 2 tablespoons shredded Cheddar or Monterey Jack cheese |
| 1½ tablespoons vegetable oil | 2 cups Pico de Gallo (see page 8) |
| nonstick cooking spray | 1½ teaspoon ground black pepper |
| 1½ cups egg substitute | |

Preparation

1. Preheat oven to 450°F.
2. Lightly brush tortillas with oil on both sides and place on a baking sheet. Bake for 5 to 10 minutes or until tortillas are crisp on the edges and starting to brown. Remove from the oven and set aside.
3. Spray a large skillet with nonstick cooking spray.
4. Pour egg substitute into skillet. Cook over medium heat for 2 to 3 minutes until eggs are cooked through.
5. Place an equal amount of eggs on each tortilla and top each with ½ tablespoon cheese.
6. Place under the broiler for about 2 minutes until cheese is melted. Spoon ½ cup Pico de Gallo on each tortilla and top with ground black pepper. Serve warm.

BREAKFAST (17)

Enjoy Moving

Be physically active every day*

Less

Sitting Around



Enough

Stretching and Building Your Muscles



More

Making Your Heart Work Harder



Plenty

Moving Whenever You Can



* Children and teens should be physically active for at least 60 minutes on most, preferably all, days of the week.



U.S. Department of Agriculture
Food and Nutrition Service
May 2007
FNS-403

USDA is an equal opportunity provider and employer.

Enjoy Moving

Be physically active every day

Children and teens should be physically active for at least 60 minutes on most, preferably all, days of the week.

Do Plenty

Moving Whenever You Can

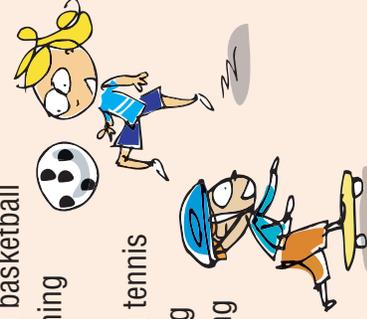
- Walking the dog
- Sweeping
- Taking the stairs instead of the elevator
- Playing outside
- Vacuuming
- Dusting
- Riding a bike
- Throwing a ball



Do More

Making Your Heart Work Harder

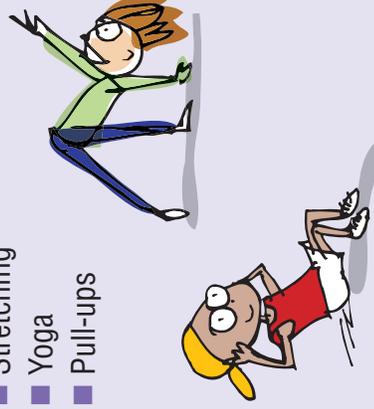
- Playing baseball or softball
- Playing soccer
- Jumping rope
- Skateboarding
- Gardening/Yard work
- Running/Jogging
- Playing basketball
- Swimming
- Hiking
- Playing tennis
- Dancing
- Skipping



Do Enough

Stretching and Building Your Muscles

- Sit-ups
- Push-ups
- Martial arts
- Lifting free weights or strength training
- Stretching
- Yoga
- Pull-ups



Do Less

Sitting Around

- Playing on the computer
- Watching television
- Playing electronic games
- Talking on the phone
- Sitting still for hours



Find your balance between eating and physical activity.

Eating smart choices from every food group and being physically active work together for a healthier you!

For more information go to: MyPyramid.gov and teammnutrition.usda.gov.





BlueCross BlueShield
of New Mexico

An Independent Licensee of the Blue Cross
and Blue Shield Association



Assessment

Name: _____

Date of Birth: _____

Height: _____

Weight: _____

BMI: _____

BMI %: _____

Risk Level: _____

Date of Assessment: _____

Get on a healthy track by adding these tips to your daily routine.

**Eat 5 servings
of fruits and
veggies every
single day.**



Examples:

Fruits

- Apples, bananas, oranges
- Berries, grapes
- Pears, plums, melon
- Canned fruit (packed in 100% juice or water)

Vegetables

- Asparagus, broccoli
- Beans, lentils, peas
- Carrots, celery
- Spinach, collard greens
- Tomatoes, peppers
- Canned veggies

**Limit screen
time to 2 hours
or less.**



Screen time includes:

- Watching TV, videos or DVDs
- Playing or being on a computer
- Playing regular and hand-held video games
- Going to the movies
- Instant messaging or online chatting



**Get at least 1 hour
of physical activity.**

Make sure an adult is there.

- Walk to and/or from school
- Jump rope
- Ride a bike
- Play catch
- Jump, skip or hop to music

Review provided by leading experts:
American Academy of Pediatrics
American Diabetes Association

Every meal should be balanced.

1/2 of plate =

Vegetables, salads and fruit

- 1 cup of raw leafy vegetables
- 1/2 cup of cooked vegetables
- 1 cup of fruit = 1 medium apple, orange or pear



1/4 of plate =

Grains, rice or bread

- 1 fist = 1 serving of cereal flakes



1/4 of plate =

Meat, poultry or fish

- A deck of cards = a portion of meat, poultry or fish



Know your serving sizes.

Limit sweetened drinks to 0.

Examples of sweetened drinks to stay away from:

- Soft drinks, soda, pop
- Juice drinks
- Chocolate milk
- Sports drinks

Instead, drink:

- Water with lemon, lime or orange to add flavor
- 1% or skim milk
- Unsweetened drinks
- Ask your physician about other healthy drink options



Eat 5 servings of fruits and veggies every single day.



- Read the labels on food, including labels on soda, juice and fruit-based products that have a lot of sugar.
- Involve your child in shopping and meal planning. Children may want to eat healthier meals if they help make them.
- Encourage your child to try new, healthy foods. Try one new healthy recipe or food each week.
- Avoid using food as a reward or punishment.
- Remember your portion sizes: 3 oz. of meat is the size of a deck of playing cards, a 4 oz. bagel is the size of a hockey puck, one cup of pasta is the size of a tennis ball, and 1 oz. of cheese is the size of four dice.
- Put food on small plates, like salad plates, instead of large dinner plates.
- Eat meals at home and try to eat meals with the whole family each day.
- Avoid eating at fast-food restaurants.

Limit screen time to 2 hours or less.



- Encourage your child to be active before letting him or her watch TV, play video games or use a computer.
- Limit the time your child sits at the computer, plays video games and watches movies.
- Limit the amount of time your child can watch TV (for example, if your child gets five hours of screen time a day, limit screen time to four hours initially and gradually decrease screen time to two or less hours per day).
- Avoid putting a TV in your child's bedroom.
- Have "family time" after dinner and play games, tell stories or do other fun things.
- Avoid eating food in front of the TV.

Get at least 1 hour of physical activity.



- Walk 10 minutes with your child every day to make sure your family is getting enough exercise.
- Have a family contest to see who is the most active every day.
- Tell your child to play basketball, soccer or their favorite outdoor game with other children.
- Do jumping jacks or other quick activities while watching commercials with your kid.
- Go fly a kite with your kids.
- Have your kids play active games like jumping rope to music or hula hooping.
- Take your kids for a bike ride around the neighborhood.
- Wash the car with your kids.
- When you are at the mall, have your kids walk with you.
- Play inside with your child by dancing around the living room to fun music.
- Play tag with your kids.
- Have your children walk or bike to school.
- Other activities: _____

Limit sweetened drinks to 0.



- Drink water or low-fat/nonfat milk instead of sweetened drinks like juice, sweet tea, sports drinks or soft drinks.
- Read the labels on soda, juice and fruit-based drinks to avoid those that have a lot of sugar.
- Tell everyone in your family to avoid drinks that have sugar.



Little changes. Big rewards. Are you ready?



Every body needs a balance of nutritious foods and active living to achieve a healthy weight and prevent problems such as diabetes and heart disease. As a parent, you have the power to teach your children healthy habits that will last a lifetime.

Here are some simple steps that can bring big rewards for your entire family.

Get moving

- Aim for at least 60 minutes of activity a day.
- Escape the pull of the couch—get up and get moving.

Pull the plug

- Limit screen time (TV, computers, and video games) to 1 to 2 hours a day.
- Move the TV out of the bedroom.

Eat smart

- Aim for 5 to 9 servings of fruits and vegetables a day.
- Fuel up with breakfast every morning.

Drink well

- Choose water or non-fat milk.
- Limit soda, sports drinks, juice, and sweetened drinks—one can is equal to drinking a candy bar!

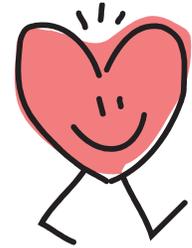


Child Health and Disability Prevention Program
Children's Medical Services, California Department of Health Care Services



KAISER PERMANENTE®

Remember: **YOU** take **YOU** Wherever **YOU** Go!



If you want to experience your unique, one-of-a-kind life to its fullest potential, think about and act on these ideas. Talk them over with parents, guardians, teachers, family and friends.

- ❖ Monitor (pay attention to) negative emotions that make you eat emotionally or become inactive and adjust your thoughts!
- ❖ Really start seeing yourself being more active, taking little steps like walking up instead of escalator, volunteering to walk the dog, housework or yard work, riding your bike, swimming, DANCING!!! JUST MOVE!



- ❖ Monitor (think about) the thoughts that constantly go through your Mind and make sure they are lifting you up not down.
- ❖ Ask yourself “are these thoughts helpful or harmful to how I feel about myself”.
- ❖ Think thoughts that focus on:
 - Making your hopes and dreams come true
 - How you can help others with your talents
 - About the beauty of nature and uplifting music



- ❖ Accept yourself for who you are, do not want to be anyone else. You will miss out on YOUR life.
- ❖ *Be a first rate version of yourself and not a second rate version of someone else!* (Judy Garland, The Wizard of Oz)
- ❖ Try very hard to say that that make you feel good about yourself and others.
- ❖ It is important that you use your words to say exactly what you want, not what you do not want.
- ❖ Speak kind words to others and try to be kind and fair when you must correct.
- ❖ Do not compare yourself to others; instead seek to feel good about yourself by thinking the thoughts and doing the actions that show you love yourself.
- ❖ If you feel good about yourself then you never need to hear it from others in order for it to be true.



Have a Wonderful Day! It's Always Your Choice!



6 Online Resources

- **Web Resources for Parents**
- **Web Resources for Teens**
- **Resources for Children**
- **Web Resources for Providers**
- **Culturally Appropriate Resources**
- **Nutrition/Physical Activity/Health Information Web Resources**
- **Ethnic Provider Organizations**

Chapter 6

Online Resources

Web Resources for Parents

Childhood Overweight

Weight Control Information Network (WIN)

<http://www.win.niddk.nih.gov/publications/index.htm>

The Weight-control Information Network (WIN) is an information service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health (NIH) that produces, collects, and disseminates materials on obesity, weight control, and nutrition. WIN provides fact sheets, brochures, videos, e-newsletters and more. Parents can find links to fact sheets on “Helping Your Overweight Child”, “Tips for Parents”, “Teenagers Guide to Better Health”.

Healthy Eating

USDA's Food and Nutrition Service (FNS) Eat Smart. Play Hard.™ Campaign

www.fns.usda.gov/eatsmartplayhardhealthylifestyle/

Eat Smart. Play Hard.™ Healthy Lifestyle! website is specifically designed for parents and caregivers to provide information and resources to eat better, be more physically active and be a role model for kids.

Everyday Healthy Meals - Champions for Change

www.cachampionsforchange.net

Online recipes (www.cachampionsforchange.net/en/Recipes.php) and some ‘mom-tested’ tips (www.cachampionsforchange.net/en/KitchenTips.php) on how to get your family to eat more fruits and vegetables and be more physically active.

Healthy Cultural Recipes

Please see Chapter 5: Patient Education Resources.

Ethnic Food Pyramids

Please see Chapter 5: Patient Education Resources.

Fitness & Physical Activity ¹

Families Finding the Balance: A Parent Handbook

www.nhlbi.nih.gov/health/public/heart/obesity/wecan_mats/parent_hb_en.pdf

- Order the handbook online: www.nhlbi.nih.gov/health/public/heart/obesity/wecan_mats/parent_hb_en.htm
- Available in Spanish: ¡Nosotros Podemos! Familias Encontrando el Balance: Manual para Padres: www.nhlbi.nih.gov/health/public/heart/obesity/wecan_mats/parent_hb_sp.pdf
- Order the Spanish-language version online: www.nhlbi.nih.gov/health/public/heart/obesity/wecan_mats/parent_hb_sp.htm

Offers practical tips from We Can!® to help parents help their families find the right balance of eating well and being physically active to maintain a healthy weight. The Parent Handbook received the 2005 NIH Plain Language Award for an Outstanding Plain Language Product.

We Can! Make Physical Activity Fun Tip Sheet

http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/downloads/tip_physical_activity.pdf

Try these tips from We Can!® to help increase daily physical activity and have fun at the same time.

Tips to Eat Well and Move More: Tip Sheet | Tracking Sheet

- Tip Sheet: www.nhlbi.nih.gov/health/public/heart/obesity/wecan/downloads/tips.pdf
- Tracking Sheet: www.nhlbi.nih.gov/health/public/heart/obesity/wecan/downloads/tracking-sheet.pdf

Try these We Can!® tips to help you learn how to eat well and use the tracking sheet to help you track your activities. See how easy taking small steps toward a healthier life can be.

Portion Distortion Quiz

- Portion Distortion Quiz Part 1: <http://hp2010.nhlbihin.net/portion/portion.cgi?action=question&number=1>
- Portion Distortion Quiz Part 2: <http://hp2010.nhlbihin.net/portion/portion2.cgi?action=question&number=1>

In addition to providing helpful information about how portions have changed over the past two decades, these quizzes also provide useful information about the amount of physical activity required to burn off the extra calories provided by today's portions.

Portion Distortion Slide Sets

- Slide Set 1: http://hp2010.nhlbihin.net/oei_ss/PD1/slide1.htm
- Slides Set 1 PowerPoint: http://hp2010.nhlbihin.net/oei_ss/PD1/download/ppt/PD1.ppt
- Slide Set 1 PDF: http://hp2010.nhlbihin.net/oei_ss/PD1/download/pdf/PD1.pdf
- Slide Set 2: http://hp2010.nhlbihin.net/oei_ss/PDII/slide1.htm
- Slide Set 2 PowerPoint: http://hp2010.nhlbihin.net/oei_ss/PDII/download/ppt/PD2.ppt
- Slide Set 2 PDF: http://hp2010.nhlbihin.net/oei_ss/PDII/download/pdf/PD2.pdf

NHLBI offers these slide sets for public use. The slides can be downloaded for use in computer slide shows, conventional slide presentations, or for online viewing via the Web site.

Your Guide to Physical Activity and Your Heart

- Brief Version: www.nhlbi.nih.gov/health/public/heart/obesity/phy_active_brief.pdf
- Full-length Version: www.nhlbi.nih.gov/health/public/heart/obesity/phy_active.pdf

Know you should be more physically active, but are confused, concerned, or just can't get started? This guide developed by the National Heart, Lung, and Blood Institute uses science-based information to help adults develop a safe and effective program of physical activity that can be

sustained. All research indicates that regular, moderate physical activity will improve your heart health and how you look and feel. Find out about the importance of physical activity in reducing heart disease risk, and how to begin or maintain an activity program that's right for you!

Media-Smart Youth: Eat, Think, and Be Active!®

www.nhlbi.nih.gov/health/public/heart/obesity/wecan/tools-resources/curricula-toolkits.htm#mediasmart

A 10-lesson curriculum designed to help youth ages 11 to 13 understand the connections between media and health.

CATCH® Kids Club

www.nhlbi.nih.gov/health/public/heart/obesity/wecan/tools-resources/curricula-toolkits.htm#catchkids

An evidence-based curriculum for after-school and community recreation settings that includes lessons and activities to motivate heart-healthy behavior in children in grades K-5.

SPARK™ PE and SPARK™ After School

www.nhlbi.nih.gov/health/public/heart/obesity/wecan/tools-resources/curricula-toolkits.htm#spark2

Evidence-based programs designed to promote physical activity in youth from K-12, and ages 5-14, respectively. They include curricula, training, equipment, and follow-up support components.

We Can! Energize Our Families: Parent Program

www.nhlbi.nih.gov/health/public/heart/obesity/wecan/tools-resources/curricula-toolkits.htm#parentprogram

A multi-session program for parents and caregivers that includes one session dedicated to reducing screen time and increasing physical activity in youth.

President's Council on Physical Fitness and Sports

<http://www.fitness.gov/>

Learn more about physical activity on this Web site developed by the President's Council on Physical Fitness and Sports, an advisory committee of volunteer citizens who advise the President through the Secretary of Health and Human Services about physical activity, fitness, and sports in America.

CDC Physical Activity Web Page

<http://www.cdc.gov/physicalactivity/>

The Centers for Disease Control and Prevention's (CDC) Division of Nutrition, Physical Activity, and Obesity provides online information about physical activity, including how much physical activity your children should get.

Ten Tips Nutrition Education Series

<http://www.choosemyplate.gov/tipsresources/tentips.html>

Provides consumers and professionals with high quality, easy-to-follow tips in a convenient, printable format. These are perfect for posting on a refrigerator.

Web Resources for Teens

Center for Science in the Public Interest

www.cspinet.org/smartmouth/index1.html

Center for Science in the Public Interest interactive website with games, recipes and fast facts for teens.

TeenGrowth

www.teengrowth.com

Interactive website geared toward teens with information on a number of health issues including nutrition and exercise. Website includes a BMI calculator.

BAM! Body and Mind

www.bam.gov

BAM! Body and Mind is a CDC site designed for youth ages 9 to 13 with games and information on a number of health issues including food, nutrition and physical activity--using kid-friendly lingo, games, quizzes, and other interactive features.

Take Charge of Your Health: A Guide For Teenagers

- HTML: http://win.niddk.nih.gov/publications/take_charge.htm

- PDF: <http://win.niddk.nih.gov/publications/PDFs/teenblackwhite3.pdf>

A booklet from the National Institute of Diabetes and Digestive and Kidney Diseases that is designed to help teenagers take small and simple steps to keep a healthy weight. It provides basic facts about nutrition and physical activity, and offers practical tools to use in everyday life, from reading food labels and selecting how much and what foods to eat, to replacing TV time with physical activities.

Resources for Children

MyPlate Coloring Sheet

www.choosemyplate.gov/images/MyPlateImages/JPG/myplate_bw_dairy.jpg

Decorate the plate by matching drawn or cut out healthy foods or alternative substitutes to the appropriate sections.

Blast Off Game

http://www.choosemyplate.gov/kids/kids_game.html

An interactive computer game where kids can reach Planet Power by fueling their rocket with food and physical activity. "Fuel" tanks for each food group help students keep track of their food choices.

Kids Poster

A 2-sided poster for kids. One side of the poster, for younger children (http://teamnutrition.usda.gov/Resources/mpk_poster.pdf), highlights a simplified kids graphic. The other side, for advanced elementary students (http://teamnutrition.usda.gov/Resources/mpk_poster2.pdf), features both the kids graphic and healthy eating and physical activity messages.

MyPyramid for Kids

http://teamnutrition.usda.gov/resources/mpk_close.pdf

A step-by-step explanation of the key concepts of the MyPyramid for Kids symbol.

Tips for Families

http://teamnutrition.usda.gov/resources/mpk_tips.pdf

A 2-sided kids mini-poster with the kids graphic on one side and eating and physical activity tips on the other side.

Disponible en Español: Sugerencias para la Familia. www.mypyramid.gov/kids/KidsTIPS-espanol.pdf

A Close Look at MyPyramid

http://teamnutrition.usda.gov/resources/mpk_close.pdf

A step-by-step explanation of the key concepts of the kids symbol.

Kids Coloring Page of MyPyramid

http://teamnutrition.usda.gov/resources/mpk_coloring.pdf

Black and white line art of the kids symbol for kids to color.

Kids MyPyramid Worksheet

http://teamnutrition.usda.gov/resources/mpk_worksheet.pdf

Worksheet to help kids track how their food choices match up to dietary recommendations. Print out this helpful meal tracking worksheet and set a food and activity goal for tomorrow.

Internet Resources for Providers

Centers for Disease Control and Prevention:

www.cdc.gov/ncccdphp/dnpa/bmi/index.htm

Information about BMI, online calculators (Adults, Child/Teen), and links to additional BMI resources, and growth charts.

PDA Software (Free Downloads for use on Palm OS and Pocket PC)

http://hp2010.nhlbihin.net/bmi_palm.htm

Provides information on BMI, PDA calculators (English and Metric measurements), and adult BMI classification tables.

BMI Calculator iPhone Application

<http://apps.usa.gov/bmi-app/>

The National Heart, Lung, and Blood Institute's BMI (Body Mass Index) calculator is a useful tool to screen for weight categories that may lead to health problems. The downloadable phone application puts the fully functioning calculator right on your phone, along with links to resources on the NHLBI site.

Adolescent Health Working Group

http://www.ahwg.net/assets/library/99_bodybasicsmodule.pdf

Body Basics – Adolescent Provider Toolkit that includes materials for health care providers and their patients focusing on nutrition, physical activity, body image, overweight and eating disorders among teenagers.

Childhood Obesity Action Network (COAN)

www.nichq.org/NICHQ/Programs/ConferencesAndTraining/ChildhoodObesityActionNetwork.htm

The Childhood Obesity Action Network is a web-based national network of health care professionals in all 50 states and 5 countries working on childhood obesity. Register to receive access to COAN Papers and Publications, Members' Resources, Share a New Resource, Discussions/Questions, Conferences and Training, and Childhood Obesity News.

American Dietetic Association (ADA)

www.eatright.org

The American Dietetic Association is the world's largest organization of food and nutrition professionals. ADA is committed to improving the nation's health and advancing the profession of dietetics through research, education and advocacy.

Be Our Voice Online Resources ²

Obesity Fact Sheets

www.nichq.org/advocacy/obesity_resources/obesity_rates_map.html

These Fact Sheets are a resource that makes relevant data more readily available to local advocates and decision makers. NICHQ's Obesity Fact Sheets provide the most recent national, state, and county-based data regarding childhood overweight and obesity prevalence and the environmental and behavioral factors that influence health. There are two kinds of Fact Sheets available: State Fact Sheets and County Fact Sheets (categorized by state).

Resource Guide for Health Care Professionals Interested in Advocating for Children's Health

www.nichq.org/advocacy/obesity_resources/toolkit.html

- The Advocacy Resource Guide: <http://www.nichq.org/advocacy/advocacy%20documents/Advocacy%20Resource%20Guide.pdf>

- Advocacy Toolbox: <http://www.nichq.org/advocacy/advocacy%20documents/Advocacy%20Toolbox.pdf>

Designed to assist health care professionals to take a stand in their communities and workplaces to advocate for healthy eating and active living for children and their families. Whatever your level of time commitment, know that every effort you make is improving the health and wellbeing of children and families in your local area.

Be Our Voice Advocacy Training Curriculum

www.nichq.org/advocacy/advocate_training/hostatraining.html

Hold a training to get other health care professionals involved in advocating for community change to impact the reversal of childhood obesity. By training others and building a coalition, your voice to advocate for children can be strengthened.

Be Our Voice Self Study Resources and Webinars

www.nichq.org/advocacy/advocate_training/selfstudy.html

Self-study resources and webinars were developed through the BOV technical assistance calls from the sites. Choose the resources that best fit the needs in your community.

Culturally Appropriate Resources ³

Cultural Competency Resources

Center for Healthy Families and Cultural Diversity (CHFCD) at UMDNJ-Robert Wood Johnson Medical School
http://rwjms.umdnj.edu/departments_institutes/family_medicine/chfcd/index.html

The Center for Healthy Families and Cultural Diversity serves as a multicultural education resource center for information about family-centered health care and ethnic and cultural diversity.

DHHS Office of Minority Health

<http://minorityhealth.hhs.gov/>

OMH programs address disease prevention, health promotion, risk reduction, healthier lifestyle choices, use of health care services, and barriers to health care and works in partnership with communities and organizations in the public and private sectors. These collaborations support a

systems approach for eliminating health disparities, national planning to identify priorities, and coordinated responses through focused initiatives.

OMH provides funding to state offices of minority health, multicultural health, and health equity; community and faith-based organizations, institutions of higher education, tribes and tribal organizations; and other organizations dedicated to improving health.

Think Culturally, sponsored by the Office of Minority Health

www.thinkculturalhealth.hhs.gov

Think Culturally offers the latest resources and tools to promote cultural competency in health care. You may access free online courses accredited for continuing education credit as well as supplementary tools to help you and your organization promote respectful, understandable, and effective care to your increasingly diverse patients.

- A Physician's Practical Guide to Culturally Competent Care (<http://cccm.thinkculturalhealth.hhs.gov/>) is a free online educational program accredited for physicians, physician assistants, and nurse practitioners.

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

<http://minorityhealth.hhs.gov/templates/browse.aspx?vl=2&vlID=15>

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

National Center for Cultural Competence (NCCC) of the Georgetown University Center for Child and Human Development (GUCCHD)

<http://nccc.georgetown.edu/>

The NCCC provides training, technical assistance, and consultation, creates tools and resources to support health and mental health care providers and systems, contributes

to knowledge through publications and research and supports leaders to promote and sustain cultural and linguistic competency, and collaborates with an extensive network of private and public entities to advance the implementation of these concepts.

The Provider's Guide to Quality & Culture

<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English&ggroup=&mgroup>

Provides information that health care professionals can use to improve the quality of their interactions with patients whose culture may differ from their own.

- Video resources available: Clinical Exchanges are video scenarios illustrating patient provider interactions accompanied by learning exercises to help viewers recognize the effect of provider behavior on clinical outcomes. <http://erc.msh.org/mainpage.cfm?file=4.1.0.htm&module=provider&language=English>

Disparities Solutions Center (DSC) at Massachusetts General Hospital

<http://www2.massgeneral.org/disparitiessolutions/index.html>

The Disparities Solutions Center provides publications that highlight practical solutions to identify and address disparities within hospitals and other health care organizations and other resources related to health care disparities elimination.

Resources with Items in Multiple Languages

EthnoMed

<http://ethnomed.org>

Cultural Competency Resources and Patient Education Materials for: Amharic, Cambodian, Chinese, Eritrean, Ethiopian, Oromo, Somali, Spanish, Tigrayan, Vietnamese and others.

Foundation for Healthy Communities

www.healthynh.com/fhc/resources/translatreddocuments.php

Access to documents created and translated by New Hampshire health agencies and organizations; languages include Albanian, Arabic, Bosnian, Chinese, English, French, Indonesian, Portuguese, Russian, Somali, Spanish, Swahili and Vietnamese.

Health Info Translations

www.healthinfotranslations.com

Use the drop-down box to choose a language - Chinese Simplified and Traditional, French, Japanese, Korean, Russian, Somali, Spanish, Ukrainian, Hindi, Vietnamese, and Arabic.

Healthy Roads Media

www.healthyroadsmedia.org

Provides audio, written and multimedia versions of resources in English, Spanish, Vietnamese, Arabic, Somali, Bosnian, Russian, Hmong, and Khmer.

How to Order NIH Publications in Languages Other Than English

<http://nlm.gov/outreach/consumer/multi.html>

Contains links to National Institutes of Health publications in languages other than English.

Maternal and Child Health Library at Georgetown University Non-English Materials and Resources

www.mchlibrary.info/nonenglish.html

Includes materials for consumers and professionals in numerous languages other than English, and the Organizations Database identifies additional sources for these materials.

MedlinePlus Health Information in Multiple Languages

www.nlm.nih.gov/medlineplus/languages/languages.html

Information in over 40 languages from the National Library of Medicine's premier consumer health website.

New Americans Health Information Portal

<http://palantir.lib.uic.edu/nahip/>

Information in 19 languages, includes audio, multimedia, podcast and video format.

New South Wales Multicultural Health Communication Service

www.mhcs.health.nsw.gov.au

A rich resource with numerous health topics that provide health information in 50 languages.

Non-English Guides to PubMed

<http://nml.gov/training/resources/intlpubmedlinks.html>

Learn to use PubMed, languages: French, German, Italian, Japanese, Norwegian, Portuguese, Russian, Spanish and Vietnamese.

Ohio State University Medical Center Patient Education Materials

<https://patienteducation.osumc.edu/Pages/Home.aspx>

Copyrighted materials; includes handouts in Spanish and Somali.

Refugee Health Information Network

www.rhin.org

Multilingual information for health professionals, refugees and asylees (in print, audio and video formats)

Refugee Health - Immigrant Health

http://bearspace.baylor.edu/Charles_Kemp/www/refugee_health.htm

Covers issues in refugee and immigrant health and includes general background information on numerous incoming populations.

Resources for Specific Languages

American Sign Language

DeafMD.org

www.deafmd.org

Provides accurate, concise, and valuable health information in American Sign Language using health information created by the Centers for Disease Control and the National Institutes of Health.

Arabic

Urban Health Partners

www.lib.wayne.edu/shiffman/urbanhealth/

From the Shiffman Medical Library and Learning Resources Centers of Wayne State University. See the Arabic Language Health Materials links.

Minhaal

www.minhaal.ae/portal/portal/mhp/HomeAE

www.minhaal.ae/portal/portal/mhp/HomeEN (English Language Portal)

Minhaal (the source) is the first dual-language Arab portal that provides healthcare related information.

Cambodian/Khmer

SPIRAL: Selected Patient Information Resources in Asian Languages

<http://spiral.tufts.edu/khmer.shtml>

Provides consumer information in Cambodian/Khmer, (in addition to Chinese, Hmong, Korean, Laotian, Thai, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Chinese

Asian Pacific Islanders Women's Health

www.apanet.org/~fdala/

This multi-lingual site offers several languages to help Asian Pacific Islander women understand the importance of having mammograms and pap smears at regular intervals. There is information about how to make appointments and prepare for the procedures. Clinicians will find special materials they can use to personally recommend mammography and pap smears to their patients.

Health Information Translations

www.healthinfotranslations.com/

From the Ohio State Medical Center, includes health information and hospital signage documents. Languages include: Arabic, Chinese Simplified, Chinese Tradition, English, French, Hindi, Japanese, Korean, Marshallese, Portuguese Brazilian, Russian, Somali, Spanish, Tagalog, Ukrainian and Vietnamese.

SPIRAL: Selected Patient Information Resources in Asian Languages

<http://spiral.tufts.edu/chinese.shtml>

Provides consumer information in Chinese, (as well as Cambodian/Khmer, Hmong, Korean, Laotian, Thai, and Vietnamese and on a wide variety of Internet resources

including National Library of Medicine and Tufts University resources.

French

Public Health Agency of Canada

www.phac-aspc.gc.ca/index-fra.php

PHAC's primary goal is to strengthen Canada's capacity to protect and improve the health of Canadians and to help reduce pressures on the health-care system.

Heart and Stroke Foundation of Canada

<http://ww2.heartandstroke.ca/>

Information in English and French on heart disease, stroke, healthy living, and more is available on this Canadian non-profit's website.

CiSMeF Patients

www.chu-rouen.fr/cismef/

Catalog and Index of French Language Health Resources on the Internet is a quality-controlled health gateway to catalog and index the most important and quality-controlled sources of institutional health information in French.

German

Welt der Gesundheit

www.gesundheit.com

From AIDS to Zappelphilipp syndrome (or ADHD), this site gives information on hundreds of health topics in German.

Patienten-Informationsdienst

www.patienten-information.de

The portal offers over 1000 reliable sources of consumer health information in German.

Medicine-Worldwide

www.medicine-worldwide.de

Medicine and health topics in German. Read everything about illnesses, therapies, diagnosis procedures, health and a lot more.

Hmong

Hmong Health Website

www.hmonghealth.org

The goal of the Hmong Health Education Network's website is to provide access to health information for Hmong people and those who provide health, education and social services to the Hmong community. Categories of topics include family health, healthy living, traditional healing, talking with health providers, and more.

SPIRAL: Selected Patient Information Resources in Asian Languages

<http://spiral.tufts.edu/hmong.shtml>

Provides consumer information in Hmong (as well as Cambodian/Khmer, Chinese, Hmong, Korean, Laotian, Thai, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Korean

SPIRAL: Selected Patient Information Resources in Asian Languages

<http://spiral.tufts.edu/korean.shtml>

Provides consumer information in Korean (as well as Cambodian/Khmer, Chinese, Hmong, Laotian, Thai, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Laotian

SPIRAL: Selected Patient Information Resources in Asian Languages

<http://spiral.tufts.edu/laotian.shtml>

Provides consumer information in Laotian (as well as Cambodian/Khmer, Chinese, Hmong, Korean, Thai, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Russian

Eurasia Health (Links to Central and Eastern Europe and the former Soviet Union languages)

www.eurasiahealth.org/index.jsp?lng=ru

Online clearinghouse featuring a library of multilingual health resources, databases, and interactive forums.

Spanish

Agency for Healthcare Research and Quality en español

www.ahrq.gov/consumer/espanoix.htm

CDC - Centers for Disease Control and Prevention en español

www.cdc.gov/spanish

Community Tool Box/Caja de Herramientas Comunitarias

<http://ctb.ku.edu/es/>

Consumer Health Materials in Spanish

<http://nml.gov/outreach/consumer/chspanish.html>

Denver Public Library Salud y Medicina

<http://espanol.denverlibrary.org/health/index.html>

Familydoctor.org Pamphlets in Spanish

<http://familydoctor.org/online/famdoces/home.html>

FDA Center for Food Safety and Applied Nutrition

<http://www.fda.gov/Food/ResourcesForYou/EnEspanol/default.htm>

Substance Abuse and Mental Health Services Administration en español

www.hablemos.samhsa.gov/espanol/

Healthfinder en español

www.healthfinder.gov/espanol

InfoSIDA

<http://infosida.nih.gov/>

MedlinePlus en español

<http://medlineplus.gov/esp>

Merck Manual of Medical Information - Home Edition

www.msd.es/publicaciones/mmerck_hogar/index.html

MiPiramide

www.mypyramid.gov/sp-index.html

United States Department of Agriculture's food pyramid Spanish language portal.

Multimedia Medical Spanish Translator

<http://polyglot.topsailmultimedia.com/polyglot.html>

Includes audio files so you can listen to the translated words and phrases.

National Institute of Diabetes and Digestive and Kidney Diseases

www.niddk.nih.gov/health/spanish.htm

National Institute of Neurological Disorders and Stroke

<http://espanol.ninds.nih.gov/>

National Institutes of Health en español

<http://salud.nih.gov/>

National Women's Health Information Center en español

<http://www.womenshealth.gov/espanol/>

National Library of Medicine's Tox Town en español

<http://toxtown.nlm.nih.gov/espanol/>

National Library of Medicine's Tox Mystery (select the español tab)

<http://toxmystery.nlm.nih.gov/>

NOAH - New York Online Access to Health

www.noah-health.org

Oficina de Salud de las Minorias/ Office of Minority Health

<http://minorityhealth.hhs.gov/espanol/>

University of Michigan Health System Health Topics A-Z; en español
<http://www.med.umich.edu/espanol/healthtopics.htm>

Thai

SPIRAL: Selected Patient Information Resources in Asian Languages
<http://spiral.tufts.edu/thai.shtml>

Provides consumer information in Thai (as well as Cambodian/Khmer, Chinese, Hmong, Korean, Laotian, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Vietnamese

SPIRAL: Selected Patient Information Resources in Asian Languages
<http://spiral.tufts.edu/vietnamese.shtml>

Provides consumer information in Vietnamese (as well as Cambodian/Khmer, Chinese, Hmong, Korean, Laotian, and Thai) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Nutrition/Physical Activity/Health Information Web Resources

American Academy of Family Physicians (AAFP)
<http://familydoctor.org/online/famdocen/home/healthy/food/kids/343.html>

American Academy of Pediatrics
www.aap.org/obesity

American Dietetic Association
www.eatright.org

Center for Disease Control and Prevention
www.cdc.gov/nccdphp/dnpa/obesity/childhood/index.htm

Center for Medicare & Medicaid Services
www.cms.hhs.gov/home/schip.asp

National Heart Lung and Blood Institute
www.nhlbi.nih.gov/health/public/heart/obesity/wecan/index.htm

National Eating Disorders Organization
<http://www.nationaleatingdisorders.org/>

The Obesity Society
<http://www.obesity.org/>

Obesity Help
www.obesityhelp.com/morbidobesity/information/childhood-obesity/

US Department of Agriculture (USDA)
www.nutrition.gov

US Food and Drug Administration (FDA)
<http://www.fda.gov/Food/ResourcesForYou/default.htm>

Robert Wood Johnson Foundation Center to Prevent Childhood Obesity
www.reversechildhoodobesity.org/webfm_send/121

Bright Futures Nutrition Family Fact Sheets
www.brightfutures.org/nutritionfamfact/index.html

Consumer Information Center
www.pueblo.gsa.gov

Food and Drug Administration - How to Lose and Manage Weight
<http://www.fda.gov/Food/ResourcesForYou/Consumers/NFLPM/ucm275438.htm>

Fruit and Veggies, More Matters - CDC
www.fruitsandveggiesmorematters.gov

Fruit and Veggies, More Matters - PBH
<http://www.fruitsandveggiesmorematters.org/>

HealthWorld Online
www.healthy.net/

Institute of Medicine (IOM) Fact Sheet on Preventing Childhood Obesity

www.iom.edu/?id=22593&redirect=0

InteliHealth Database (John Hopkins Health Information)

www.intelihealth.com/IH/ihlH/WSIHW000/408/408.html

Mayo Health Oasis (Mayo Clinic Database)

www.mayoclinic.com

MyPyramid Materials - Ordering and General Information

www.mypyramid.gov/global_nav/contact.html

Nutrition Action Healthletter

www.cspinet.org/nah/index.htm

Nutrition.Gov

www.nutrition.gov

Produce for Better Health Foundation

www.pbhcatalog.com

SNAP-Ed Nutrition Education Materials

<http://snap.nal.usda.gov/>

We Can! Ways to Enhance Children's Activity & Nutrition

<http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/about-wecan/index.htm>

Ethnic Providers Organizations

American Association of Physicians of Indian Origin

<http://aapiusa.org/>

Association of American Indian Physicians

www.aaip.org

National Coalition of Ethnic Minority Nurse Organizations

www.ncemna.org

National Council of Asian Pacific Islander Physicians

<http://ncapip.org/>

National Hispanic Medical Association

www.nhmamd.org

National Medical Association

<http://nmanet.org/>

Philippine Academy of Family Physicians

<http://thepafp.org/>

Vietnamese American Medical Association

<http://vamausa.org/cms2/index.php>

AMA International Medical Graduates

www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/international-medical-graduates.page

End Notes

1. Physical Activity Tools and Resources. National Heart, Lung, and Blood Institute, National Institutes of Health, and Department of Health and Human Services. <http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/tools-resources/physical-activity.htm>
2. Advocacy Resources to Fight Against Childhood Obesity. National Initiative for Children's Healthcare Quality. *Be Our Voice*. http://www.nichq.org/advocacy/obesity_resources/index.html
3. Consumer Health Information in Many Languages Resources. National Network of Libraries of Medicine. <http://nnlm.gov/outreach/consumer/multi.html>



7 Community / Environmental Advocacy

- **Healthcare Professionals are Natural Advocates**
- **Understanding Advocacy**
- **Linking Community Advocacy with Clinical Practice**
- **Matching the Advocacy Activity to the Time Available**
- **CMAF Healthcare Professionals for Healthy Communities Initiative**
- **Online Resources**

Learning Objectives:

1. Understand why healthcare professionals are natural advocates.
2. Define advocacy and the link between community advocacy and clinical practice.
3. Describe ways to engage in advocacy activities based on availability and how to connect with other advocates.

Chapter 7

Community / Environmental Advocacy

Health Care Professionals Are Natural Advocates¹

As a health care professional, you are a natural and powerful advocate on behalf of children's health. You have a voice that resonates with others on a profound level and speaks to your first hand experiences with children. Consider the following reasons why you are uniquely suited for advocacy:

You Put a Human Face to the Statistics: You care for children every day who are affected by the environments in which we live and work. When you tell your story, you make the issue of childhood obesity tangible to people in a way that fact sheets or statistics alone cannot.

You Have Credibility: By the nature of your profession, education and training, people in your community respect and trust you. When you speak out on an issue, you bring credibility and relevance to that issue.

You Have Influence: Because you instill trust in others and add credibility to your cause, your investment in the community can inspire others to do likewise. Moreover, your voice is listened to when other voices are not—a survey of parents revealed that they are more likely to have communicated with a health care professional about childhood obesity prevention than with school officials, grocery store or restaurant owners, or government officials.

Your Patients Are Depending on You: Children cannot vote. They need your help to tell their story. You have the power not only to advocate for children, but to consolidate the message of their families into a cohesive advocacy voice. Through advocacy, you can help ensure that decision makers are not simply recognizing children's health and

well-being as an important issue, but actively working to improve their health and their lives.

You Have Passion: Advocacy allows you to dig deeper into your interests and touches on why you originally became a health care professional. Through advocacy, you can channel your passion for health and well-being into meaningful and lasting change. Advocacy allows you to help improve the lives of children while simultaneously strengthening the role of your profession within the community.

You Have Well-Suited Skills: Health care professionals already have the skill set of an advocate. The same skills you use every day to establish trust, develop relationships, and develop solutions with your patients can be applied in your community advocacy work.

Research Is on Your Side: The issues you care about are backed by research. Through advocacy, you can convey both the personal and factual importance of the environmental factors that influence childhood obesity.

You Are Not Alone: Through advocacy, you can join other health care professionals, school personnel, youth organizers, agricultural groups and others who, through their efforts and community partnerships, are making children's health a priority and working to eradicate childhood obesity. There is strength in numbers!

Understanding Advocacy

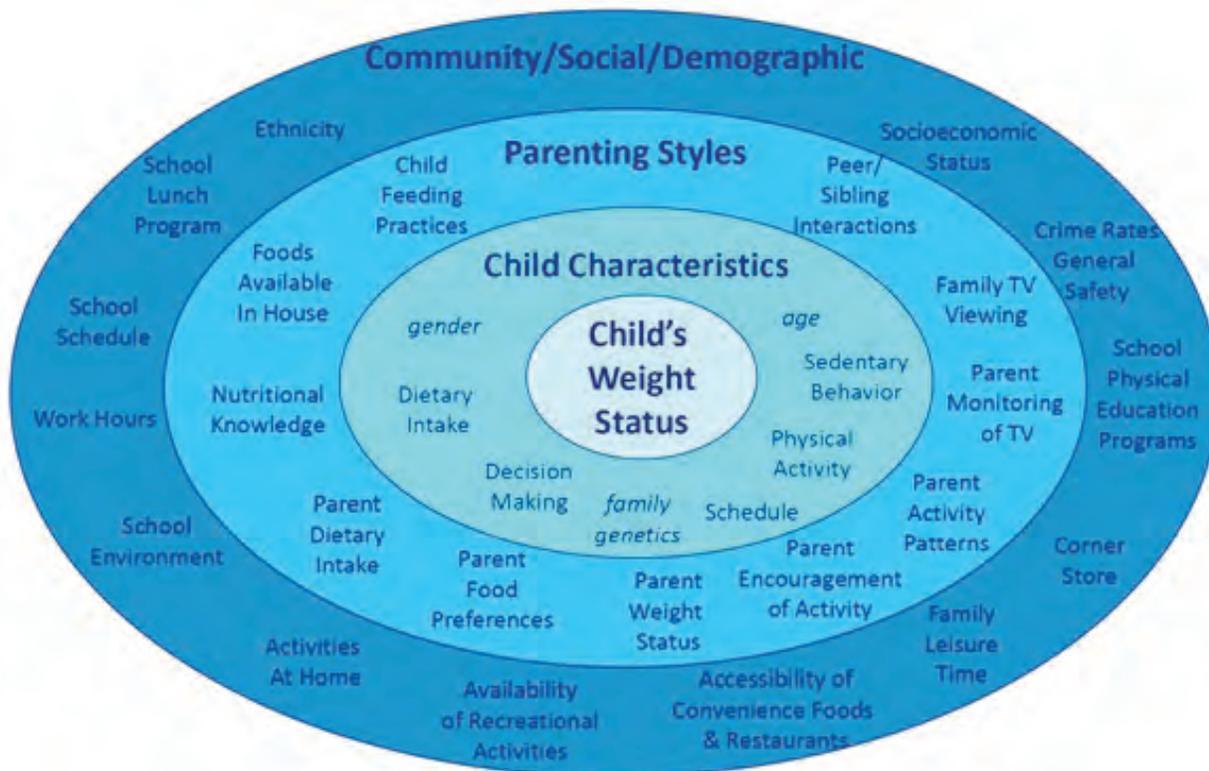
Advocacy simply means speaking out on your patients' and clients' behalf. Advocacy brings about changes to benefit the health of children in your community. Now more than ever, advocacy is crucial in shaping local policy change. Today's local issues often become tomorrow's state or national legislation.

★ Quick Tip

Advocacy means speaking on behalf of a group of people within the public sphere around a particular issue.

Linking Community Advocacy with Clinical Practice

Factors that influence a child's ability to achieve and maintain a healthy weight come from a number of sources. The diagram below shows the link between the child's genetic influences, individual behaviors, parent and family influences and influences found at the community or environmental level that can influence a child's health.



As we move from the center of the grid, to its furthest ring, the opportunities for change move from an individual to a systems and policy focus.

It is therefore essential to identify community-based approaches, with the payoff being to reverse this epidemic among our nation's children and youth. The following policy priorities as reported by the Robert Wood Johnson Foundation have been identified as demonstrating the greatest and longest-lasting impact on children and their families:²

1. Ensure that all foods and beverages served and sold in schools meet or exceed the most recent dietary guidelines for Americans.
2. Increase access to high-quality, affordable foods through new or improved grocery stores and healthier corner stores and bodegas.
3. Increase the time, intensity and duration of physical activity during the school day and out-of-school programs.
4. Increase physical activity by improving the built environment in communities.
5. Use pricing strategies - both incentives and disincentives - to promote the purchase of healthier foods.
6. Reduce youth exposure to unhealthy food marketing through regulation, policy and effective industry self-regulation.

The AAP created its Prevention of Obesity Policy Opportunities Tool for those health care professionals who have not been exposed to these community policy initiatives and may not readily see the link between what they encounter with patients and clients each day and these policy approaches. (Located in the "Online Resources" section of this chapter.)

When you make this connection, you become empowered to share powerful stories describing the negative impacts of policy inaction on your patients, and you become a strong partner in addressing policy change to reverse the childhood obesity epidemic.

Matching the Advocacy Activity to the Time Available³

Advocacy is achievable and it doesn't require a lot of time. The table below provides an overview of the types of community advocacy activities physicians and other health care professionals can engage in based on their time availability. We need your involvement. Change is difficult. It is in the aggregate that we can make significant changes, changes that will make a difference.

Activity	< 1 Hour a Month	1 Hour a Month	>1 Hour a Month
Vote	X	X	X
Call, email or write a letter to a decision-maker addressing your advocacy issue.	X	X	X
Contribute to a nonprofit advocacy organization that focuses on your advocacy issue.	X	X	X
Sign up for 1 or 2 email lists that are related to your advocacy issue.	X	X	X
Patronize businesses that donate a percentage of their profits to health issues related to preventing overweight and obesity in children.	X	X	X
Cultivate long-term relationships with a public official or other decision-maker in your community who can impact your advocacy issue.		X	X
Write a letter to the editor of your local newspaper about your advocacy issue.		X	X
Talk to other health care professionals and parents you come into contact with about the advocacy issue you care about. Encourage them to get involved.		X	X
Submit an article on your advocacy issue to your professional association's newsletter or website.		X	X
Attend community forums and events sponsored by decision makers who may have a say on your advocacy issue.		X	X
Testify before the state legislature or participate in community forums about your advocacy issue.			X
Apply for community advocacy grants.			X
Set up a booth in your professional setting that explains the issue you are working on and provides information and resources for getting involved.			X
Serve as a spokesperson for a local or community-based organization that is also addressing your advocacy issue.			X
Volunteer as a board member of a health organization that is supportive of your advocacy issue.			X

★ Quick Tip

Effective advocacy can, and should be scaled to the time you have available to maximize the likelihood that you will continue your efforts.

California Medical Association Foundation's (CMAF) Health Care Professionals for Healthy Communities Initiative

Please join the California Medical Association Foundation's Obesity Prevention Project: Health Care Professionals for Healthy Communities Initiative, to promote important policy and environmental changes in schools and neighborhoods that counteract the obesity epidemic and support improved access to healthy food and opportunities to be physically active. The initiative provides health care professionals with training on community collaboration, nutrition messages, and advocacy techniques to promote healthy eating and active living throughout California.

For more information, please see the following one-pager or visit CMAF online at <http://thecmafoundation.org/>. To join the Health Care Professionals for Healthy Communities Initiative, please fill out and submit the subsequent form.

Health Care Professionals for Healthy Communities

An Initiative of the California Medical Association Foundation

30.5% of all children in California are overweight or obese.

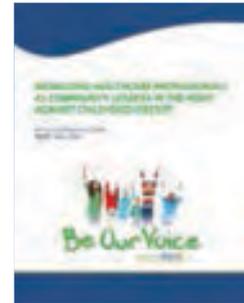
90% of Californians surveyed stated that they wanted physicians to be their primary source of information about nutrition, physical activity and other health issues associated with obesity.

Field Research Poll conducted by the California Endowment (2004)

The CMA Foundation is working to prevent obesity-related diseases by turning health care professionals into community educators and advocates for healthy eating, physical activity and policy change in the battle against obesity. Through diverse partnerships with businesses, government, health plans and community organizations, the CMA Foundation will utilize health care professionals' expertise and credibility to maximize their impact on the obesity epidemic.

CMA Foundation Health Care Professional Champions will receive:

- Provider, Community Outreach, and Advocacy toolkits
- Connections with school boards, city councils and many other organizations to spread the message of healthy living
- Assistance from CMA Foundation staff
- Access to online resources



Available Resources

- **Guide for Health Care Professionals to Partner with Community-Based Organization**

- **Community-Based Organization and Health Care Professional Partnership Guide**

Guides include strategies and tips to partner with health care professionals and community based organizations. Available online at: www.thecmafoundation.org.

"Engaged communities and engaged physicians are vital to the health of Californians. Please consider joining the CMA Foundation's efforts to turn the tide on the obesity epidemic in California."

-Frank Staggers, M.D.

Past Chair, CMA Foundation Board of Directors



For more information about the *Health care Professionals for Healthy Communities* Initiative, please contact Phoua Moua, Director of Obesity Prevention, at (916) 779-6636 or pmoua@thecmafoundation.org, or visit www.thecmafoundation.org/projects/obesityProject.aspx.

Online Resources

Type of Resource	Title	Description
Fact Sheets	Obesity Fact Sheets www.nichq.org/advocacy/obesity_resources/obesity_rates_map.html	NICHQ's Obesity Fact Sheets provide the most recent national, state, and county-based data regarding childhood overweight and obesity prevalence and the environmental and behavioral factors that influence health. There are two kinds of Fact Sheets available: State Factsheets and County Fact Sheets (categorized by state).
Resource Guide	Resource Guide for Health Care Professionals Interested in Advocating for Children's Health www.nichq.org/advocacy/obesity_resources/toolkit.html	The Advocacy Resource Guide (www.nichq.org/advocacy/advocacy%20documents/Advocacy%20Resource%20Guide.pdf) and Advocacy Toolbox (www.nichq.org/advocacy/advocacy%20documents/Advocacy%20Toolbox.pdf) are designed to help health care professionals take a stand in their communities and workplaces to advocate for healthy eating and active living for children and their families. Whatever your level of time commitment, know that every effort you make is improving the health and well-being of children and families in your local area.
Training Curriculum	Be Our Voice Advocacy Training Curriculum www.nichq.org/advocacy/advocate_training/hostatraining.html	Hold a training to get other health care professionals involved in advocating for community change to promote the reversal of childhood obesity. Through training others and building a coalition, your voice to advocate for children can be strengthened.
Webinars	Be Our Voice Self-Study Resources and webinars www.nichq.org/advocacy/advocate_training/selfstudy.html	Self-study resources and webinars were developed through the BOV technical assistance calls from the sites. Choose the resources that best fit the needs in your community.
Monograph	Inspiring Change in our Communities: Physician Champions Making a Difference Monograph http://thecmafoundation.org/projects/ObesityGeneralPDFs/final%20Obesity%20Monograph%207-23.pdf	The CMA Foundation's Obesity Prevention Project "Inspiring Change in our Communities: Physician Champions Making a Difference" Monograph provides a snapshot of the innovative programs implemented by physician champions throughout California. Each of these physicians was inspired by a patient, an incident or a movement. Some have dedicated months and years while others could only spare a few hours; each has changed behavior to break the cycle of childhood obesity by empowering patients to take control of their health.
Initiative	CMAF's Obesity Prevention Project: Health Care Professionals for Healthy Communities Initiative www.thecmafoundation.org/projects/phyChampion.aspx	The Health Care Professionals for Healthy Communities Initiative provides training on community collaboration, nutrition messages, and advocacy techniques to promote healthy eating and active living throughout California. The initiative promotes important policy and environmental changes in schools and neighborhoods to counteract the obesity epidemic and support improved access to healthy food and opportunities to be physically active.
Policy Resource	Prevention of Obesity Policy Opportunities Tool (POPOT) www.aap.org/obesity/matrix_1.html	The POPOT is a dynamic Web-based tool created for health care professionals (HCPs) who have experience in advocacy and are interested in focusing their advocacy efforts on obesity prevention. This tool provides actionable policy strategies and associated resources to prevent obesity. Specific strategies and resources are presented for implementation at the practice, community, school, state and federal levels.
GIS Map	Network for a Healthy California - GIS Map Viewer www.cnngis.org	The Network for a Healthy California mapping application is an interactive, Internet-based Geographic Information System (GIS) that allows users to view and query mapped nutrition data. The application contains a rich set of nutrition and other health related data, including: <ul style="list-style-type: none"> • Nutrition and school health programs • WIC grocery stores and other local nutrition resources • Demographics (race and spoken language) of general and at-risk populations • Various California Department of Public Health regions • Political (Senate and Assembly) districts

End Notes

1. American Academy of Pediatrics (AAP). AAP Advocacy Guide: Pointing You in the Right Direction to Become an Effective Advocate. 2009. Pg. 24
2. Robert Wood Johnson Foundation. Childhood Obesity. March 2011. www.rwjf.org/programareas/ChildhoodObesityFramingDoc.pdf
3. American Academy of Pediatrics (AAP). AAP Advocacy Guide: Pointing You in the Right Direction to Become an Effective Advocate. 2009. Pp 19-21, 25. Available at: www.aap.org/moc/advocacyguide. ■



8

Billing & Coding

- **Obesity Coding Fact Sheet: Expert Panel Recommendation Stages**
- **AAP/AMA Obesity & Related Co-Morbidities Coding Fact Sheet for Primary Care Providers**
- **CHDP Provider Notices Related to Obesity Prevention and Co-Morbidities**

Learning Objectives:

1. Healthcare providers and their staff will understand the coding procedures related to obesity prevention coding and coding for co-morbidities.
2. Healthcare providers and their staff will be able to accurately document and code for the Stages of Care as outlined in the Expert Committee's Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity.
3. Healthcare providers and their staff will be able to describe the CHDP resources and reimbursement related to childhood obesity and its co-morbidities.

Chapter 8

Billing and Coding

Obesity Coding Fact Sheet: American Academy of Pediatrics Expert Panel Recommendation Stages

Prevention:

1. Plot BMI percentiles yearly, assess
2. Reinforce healthy behaviors
3. 5-2-1-0 plan
4. Revisit yearly

The services provided during the Prevention Stage are included in the annual well visit (99381-99385 for new patient, 99391-99395 for established patient). V20.2 is the diagnosis for the well visit. You will also report a code from the V85.51-V85.54 series to record the patient's Body Mass Index:

V85.51 Body Mass Index, pediatric, less than 5th percentile for age

V85.52 Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age

V85.53 Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age

V85.54 Body Mass Index, pediatric, greater than or equal to 95th for age

Step 1 Prevention Plus: Primary Care Office

1. Explore knowledge base; look for risks of low self esteem, negative body image
2. Counsel on 5-2-1-0 message, self monitoring logs
3. Engage whole family in activities
4. Weight goal: maintenance to grow into weight at 85th percentile BMI
5. Revisit w/ family q 1-3 months, if no improvement in 3-6 months proceed to step

The services provided during the Prevention Plus Stage are included in the annual well visit (99381-99385 for new patient, 99391-99395 for established patient). However, if a significant, separately identifiable service is performed, an Office or Other Outpatient Service evaluation and management (E/M) code (99201-99215) is reported in addition to the well visit. Be sure to attach the modifier 25 to this code.

Step 2 Structured Weight Management: Primary Care Office With Support

1. Develop plan for balanced macronutrient intake with emphasis on portion size of high energy dense foods
2. Increase frequency of structured family meals, planning with an RD
3. Reemphasize importance of monitoring logs (age appropriate)
4. Supervised active play 60 minutes /d, community support
5. Weight goal: maintenance or loss of 1#/month (age 2-11) up to 1-2 #/week for obese teens) to achieve 85th percentile BMI
6. Revisit at least monthly with MD, RD, office staff. Reassess in 3-6 months proceed to step 3 prn

This service is performed during a visit separate from the well visit. CPT codes to consider are the Health and Behavior Assessment/Intervention and the Medical Nutrition Therapy codes.

Health and Behavior Assessment/Intervention

96150 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment

96151 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; reassessment

96152 Health and behavior intervention, each 15 minutes, face-to-face; individual

96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)

96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)

96155 Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)

- E/M codes (including Counseling and Risk Factor Reduction and Behavior Change Intervention (99401-99412) should not be reported on the same day.
- For health and behavior assessment and/or intervention performed by a physician, use an E/M code.

Medical Nutrition Therapy

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803 Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804 Medical nutrition therapy; group (2 or more individuals), each 30 minutes

- These services are typically performed by registered dietitians. For medical nutrition therapy performed by a physician, use an E/M code.

Step 3 Comprehensive Multidisciplinary Intervention, Specialized Program

1. Eating and physical activity plans as in phase 2
2. Behavioral support with structured behavior modification program
3. Motivational interviewing

4. Revisit weekly, reassess in 6-12 months, if no progress consider step 4

The Medical Team Conference codes (99366-99368) are reported for these services. Medical team conferences include face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines, with or without the presence of the patient, family member(s), community agencies, surrogate decision makers.

99366 Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional

99367 Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present; participation by physician

99368 participation by non-physician qualified health care professional

- Physicians report time spent in a team conference with the patient and/or family present using an E/M code

Step 4 Tertiary Care: Hospital setting with experienced team

1. BMI >95th with significant co-morbidities, unsuccessful in stages 1-3 and children with BMI >99th unsuccessful in stage 3
2. Experienced Multidisciplinary Team with designated protocol
3. Eating and physical activity plans as in phase 2 with consideration of additions of meal replacement, VLCD, Medication, and surgery

Report the same codes as outlined in Step 3, including the Medical Team Conference codes (99366-99368). In addition, you will report the Inpatient Hospital Care codes (99221-99223 for initial and 99231-99233 for subsequent).

Initial Hospital Care

99221 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- A detailed or comprehensive history
- A detailed or comprehensive examination; and
- Medical decision making that is straightforward or of low complexity

99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- A comprehensive history
- A comprehensive examination; and
- Medical decision making of moderate complexity

99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- A comprehensive history
- A comprehensive examination; and
- Medical decision making of high complexity

Subsequent Hospital Care

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A problem focused interval history
- A problem focused examination;
- Medical decision making that is straightforward or of low complexity

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- An expanded problem focused interval history
- An expanded problem focused examination;
- Medical decision making of moderate complexity

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A detailed interval history
- A detailed examination;
- Medical decision making of high complexity

Obesity and Related Co-Morbidities Coding and Diagnosis Fact Sheet for Primary Care Providers

While coding for the care of children with obesity and related co-morbidities is relatively straightforward, ensuring that appropriate payment is received for such services is a more complicated matter. Many insurance carriers will deny claims submitted with “obesity” codes (i.e. 278.00), essentially carving out obesity-related care from the scope of benefits. Therefore, coding for obesity services is fundamentally a two-tiered system, where the first tier requires that the health care provider submit claims using appropriate codes and the second tier involves the practice-level issues of denial management and contract negotiation.

PART I: Coding

Procedure Codes

Current Procedural Terminology (CPT©) Codes

Body Fat Composition Testing¹

Calorimetry
Oxygen uptake, expired gas analysis; <ul style="list-style-type: none">➤ 94690 Oxygen uptake, expired gas analysis; rest, indirect (separate procedure)➤ 94799 Unlisted pulmonary service or procedure
Glucose Monitoring
<ul style="list-style-type: none">➤ 95250 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording<ul style="list-style-type: none">○ (Do not report 95250 more than once per month)○ (Do not report 95250 in conjunction with 99091)➤ 95251 Interpretation and report<ul style="list-style-type: none">○ (Do not report 95251 more than once per month)○ (Do not report 95251 in conjunction with 99091)
Routine Venipuncture
<ul style="list-style-type: none">➤ 36415 Collection of venous blood by venipuncture➤ 36416 Collection of capillary blood specimen (e.g., finger, heel, ear stick)
Venipuncture Necessitating Physician's skill
<ul style="list-style-type: none">➤ 36406 Venipuncture, under age 3 years, necessitating physician's skill, not to be used for routine venipuncture; other vein➤ 36410 Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)

Laparoscopy²

- **43644**
Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
 - (Do not report 43644 in conjunction with 43846, 49320)
 - (Esophagogastroduodenoscopy [EGD] performed for a separate condition should be reported with modifier 59)
 - (For greater than 150 cm, use 43645)
 - (For open procedure, use 43846)
- **43645**
with gastric bypass and small intestine reconstruction to limit absorption
 - (Do not report 43645 in conjunction with 49320, 43847)

Bariatric Surgery (43770-43775)

- **43770**
Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)
 - (For individual component placement, report 43770 with modifier 52)
- **43771**
revision of adjustable gastric restrictive device component only
- **43772**
removal of adjustable gastric restrictive device component only
- **43773**
removal and replacement of adjustable gastric restrictive device component only
 - (Do not report 43773 in conjunction with 43772)
- **43774**
removal of adjustable gastric restrictive device and subcutaneous port components
 - (For removal and replacement of both gastric band and subcutaneous port components, use 43659)
- **43775**
longitudinal gastrectomy (i.e., sleeve gastrectomy)
 - (For open gastric restrictive procedure, without gastric bypass, for morbid obesity, other than vertical-banded gastroplasty, use 43843)

Other Gastric Restrictive Procedures

- **43842**
Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
- **43843**
other than vertical-banded gastroplasty
 - (For laparoscopic longitudinal gastrectomy [i.e., sleeve gastrectomy], use 43775)
- **43845**
Gastric restrictive procedure with partial gastrectomy, pylorus-preserving

duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)

- (Do not report 43845 in conjunction with 43633, 43847, 44130, 49000)

Gastric Bypass for Morbid Obesity

- **43846**
Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
 - (For greater than 150 cm, use 43847)
 - (For laparoscopic procedure, use 43644)
- **43847**
with small intestine reconstruction to limit absorption
- **43848**
Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
 - (For laparoscopic adjustable gastric restrictive procedures, see 43770-43774)
 - (For gastric restrictive port procedures, see 43886-43888)

Health and Behavior Assessment/Intervention Codes³

- **96150**
Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
- **96151**
re-assessment,
- **96152**
Health and behavior intervention, each 15 minutes, face-to-face; individual
- **96153**
group (2 or more patients), each 15 minutes, face-to-face; individual
- **96154**
family (with the patient present), each 15 minutes, face-to-face; individual
- **96155**
family (without the patient present), each 15 minutes, face-to-face; individual

Note: CPT codes (96150-96155) cannot be reported by a physician nor can they be reported on the same day as Preventive Medicine Counseling codes (99401-99412).

Medical Nutrition Therapy Codes ⁴

- **97802**
Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- **97803**
re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- **97804**
group (2 or more individual(s)), each 30 minutes

Physician Educational Services

- **99078**
Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)

Health Care Common Procedural Coding System (HCPCS) Level II Procedure and Supply Codes ⁵

- **S9445**
Patient education, not otherwise classified, non-physician provider, individual, per session
- **S9446**
Patient education, not otherwise classified, non-physician provider, group, per session
- **S9449**
Weight management classes, non-physician provider, per session
- **S9451**
Exercise classes, non-physician provider, per session
- **S9452**
Nutrition classes, non-physician provider, per session
- **S9454**
Stress management classes, non-physician provider, per session
- **S9455**
Diabetic management program, group session
- **S9460**
Diabetic management program, nurse visit
- **S9465**
Diabetic management program, dietitian visit
- **S9470**
Nutritional counseling, dietitian visit

Diagnosis Codes ⁶

Circulatory System	
401.9	Essential hypertension; unspecified
429.3	Cardiomegaly, Cardiac: dilatation, hypertrophy, Ventricular dilatation
Congenital Anomalies	
758.0	Down's syndrome, Mongolism. Translocation Down's syndrome Trisomy: 21 or 22 G
759.81	Prader-Willi syndrome
759.83	Fragile X syndrome
759.89	Other specified anomalies (Laurence-Moon-Biedl syndrome)
Digestive System	
530.81	Esophageal reflux
564.00	Constipation, unspecified
571.8	Other chronic nonalcoholic liver disease
Endocrine, Nutritional, Metabolic	
244.8	Other specified acquired hypothyroidism
244.9	Unspecified hypothyroidism
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
250.02	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled
253.8	Other disorders of the pituitary and other syndromes of diencephalohypophyseal origin
255.8	Other specified disorders of adrenal glands
256.4	Polycystic ovaries
259.1	Precocious sexual development and puberty, not elsewhere specified
259.9	Unspecified endocrine disorder
272.0	Pure hypercholesterolemia
272.1	Pure hyperglyceridemia
272.2	Mixed hyperlipidemia
272.4	Other and unspecified hyperlipidemia
272.9	Unspecified disorder of lipid metabolism
277.7	Dysmetabolic syndrome X/metabolic syndrome
278.00	Obesity, unspecified
278.01	Morbid obesity
278.02	Overweight
278.1	Localized adiposity
278.8	Other hyperalimentation
Genitourinary System	
611.1	Hypertrophy of the breasts
Mental Disorders	
300.00	Anxiety state, unspecified
300.02	Generalized anxiety disorder
300.4	Dysthymic disorder
307.50	Eating disorder, unspecified
307.51	Bulimia nervosa
307.59	Other and unspecified disorders of eating
308.3	Other acute reactions to stress
308.9	Unspecified acute reaction to stress
311	Depressive disorder, not elsewhere classified

313.1	Misery and unhappiness disorder
313.81	Oppositional defiant disorder
Musculoskeletal System and Connective Tissue	
732.4	Juvenile osteochondrosis of lower extremity, excluding foot
Nervous System and Sense Organs	
327.23	Obstructive sleep apnea (adult) (pediatric)
327.26	Sleep related hypoventilation/hypoxemia in conditions classifiable elsewhere
327.29	Other organic sleep apnea
348.2	Benign intracranial hypertension
Skin and Subcutaneous Tissue	
701.2	Acquired acanthosis nigricans
Symptoms, Signs, and Ill-Defined Conditions	
780.50	Sleep disturbance, unspecified
780.51	Insomnia with sleep apnea, unspecified
780.52	Insomnia, unspecified
780.53	Hypersomnia with sleep apnea, unspecified
780.54	Hypersomnia, unspecified
780.57	Unspecified sleep apnea
780.71	Chronic fatigue syndrome
780.79	Other malaise and fatigue
783.1	Abnormal weight gain
783.3	Feeding difficulties and mismanagement
783.40	Lack of normal physiological development, unspecified
783.43	Short stature
783.5	Polydipsia
783.6	Polyphagia
783.9	Other symptoms concerning nutrition, metabolism, and development
786.05	Shortness of breath
789.1	Hepatomegaly
790.22	Impaired glucose tolerance test (oral)
790.29	Other abnormal glucose; pre-diabetes not otherwise specified
790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase [LDH]
790.6	Other abnormal blood chemistry (hyperglycemia)

Supplementary Classification of Factors Influencing Health Status and Contact with Health Services⁷

Persons with potential health hazards related to personal and family history	
V11.1	Personal history of affective disorders, manic depressive psychosis
V11.8	Personal history of other mental disorders
V12.1	Personal history of nutritional deficiency
V12.2	Personal history of endocrine, metabolic, and immunity disorders
V12.50	Personal history of circulatory disease
V12.70	Personal history of specified digestive disease
V18.0	Family history of diabetes mellitus
V18.11	Family history of multiple endocrine neoplasia [MEN] syndrome
V18.19	Family history of other endocrine and metabolic diseases
V18.59	Family history of other digestive disorders

Persons with a condition influencing their health status	
V49.89	Family history of other specified conditions influencing health status
Persons encountering health services for specific procedures and aftercare	
V58.67	Family history of long-term (current) use of insulin
V58.69	Family history of long-term (current) use of other medications
Persons encountering health services in other circumstances	
V61.01	Family disruption, family member on military deployment
V61.02	Family disruption, return of family member from military deployment
V61.03	Family disruption, divorce or legal separation
V61.04	Family disruption, parent-child estrangement
V61.05	Family disruption, child in welfare custody
V61.06	Family disruption, child in foster care or in care of non-parental family member
V61.07	Family disruption, death of family member
V61.08	Family disruption, other extended absence of family member
V61.09	Other family disruption, family estrangement nonspecific
V61.20	Counseling for parent-child problem, unspecified
V61.29	Other parent-child problems
V61.49	Other care/presence of sick or handicapped person in family or household
V61.8	Other specified problems with family members, sibling relationship problem
V61.9	Unspecified family circumstance
V62.81	Interpersonal problems, not elsewhere classified
V62.89	Other borderline intellectual functioning life circumstance problems
V62.9	Unspecified psychosocial circumstance
V65.19	Other person consulting on behalf of another person
V65.3	Dietary surveillance and counseling colitis, diabetes mellitus, food allergies or intolerance, gastritis, hypercholesterolemia, hypoglycemia, obesity. Note: Use Additional Code to identify Body Mass Index, if known (V85.0-V85.54)
V65.41	Exercise counseling
V65.49	Other specified counseling
V69.0	Lack of physical exercise
V69.1	Inappropriate diet and eating habits
V69.8	Other problems related to lifestyle, self-damaging behavior
V69.9	Problem related to lifestyle, unspecified
Pediatric Body Mass Index (BMI)	
V85.51	Pediatric BMI, less than 5th percentile for age
V85.52	Pediatric BMI, 5th percentile to less than 85th percentile for age
V85.53	Pediatric BMI, 85th percentile to less than 95th percentile for age
V85.54	Pediatric BMI, greater than or equal to 95th percentile for age

PART II: Affordable Care Act - Preventive Services Coverage

Often because of cost, Americans use preventive services at about half the recommended rate. Yet chronic diseases such as heart disease, cancer, and diabetes – which are responsible for 7 of 10 deaths among Americans each year and account for 75% of the nation’s health spending – often are preventable.

Passage of the Affordable Care Act (ACA) will help make wellness and prevention services more affordable and accessible by requiring health plans to cover preventive services and by eliminating cost-sharing. According to a new regulation released by the Department of Health and Human Services, the Department of Treasury and the Department of Labor, on or after September 23, 2010, employer-sponsored health insurance will be required to cover recommended preventive services without charging patients a co-pay, co-insurance or deductible and applies whether or not a child’s health problem or disability was discovered or treated before purchasing insurance coverage.

Childhood preventive services include:

- Well-baby and well-child visits: This includes a doctor’s visit every few months when your baby is young, and a visit every year until your child is age 21. These visits will cover a comprehensive array of preventive health services:
 - Physical exam and measurements
 - Vision and hearing screening
 - Oral health risk assessments
 - Developmental assessments to identify any development problems
 - Screenings for hemoglobin level, lead, tuberculin, and other tests
 - Counseling and guidance from your doctor about your child’s health development
- Screenings and counseling to prevent, detect, and treat common childhood problems like:
 - obesity to help children maintain a healthy weight
 - depression among adolescent children

This new rule will extend benefits and protections to about 162 million non-elderly people insured through employer-sponsored health insurance. The new rule does not apply to “grandfathered” individual health insurance policies. A grandfathered individual health insurance policy is a policy that is purchased by an individual directly from the insurer on or before the rule went into effect on March 23, 2010.

ACA protections will extend to all health insurance sold starting in 2014. Until then, obesity related services may not be covered or considered part of a disease management program, i.e., only covered when rendered by provider and/or group holding a specific contract to perform such services. Disease management agreements are generally closed to a single or small number of providers in a given area. Nonetheless, physicians may want to investigate the possibility of providing disease management services as a new source of revenue.

PART III: References

1. California Medical Association, Taking Charge, Contracting Toolkit, 2008
 2. Physician’s Current Procedural Terminology (CPT)®, 2011 Professional Edition. www.ama-assn.org
 3. Medi-Cal/Medicaid Provider Manual. www.medi-cal.ca.gov/
 4. CHDP Provider Manual and Bulletins. http://files.medi-cal.ca.gov/pubsdoco/chdp_manual.asp
 5. American Academy of Pediatrics - Prevention of Pediatric Overweight & Obesity: Practice Management Resources. www.aap.org/obesity/practice_managementresources.html
 6. National Correct Code Initiative, CCI Validator, 2011, 2nd Quarter, American Medical Association
 7. Health Care Common procedure Coding System (HCPCS), 2011, Level II, 2011, American Medical Association
 8. ICD-9-CM 2011 Volumes 1, 2, and 3, American Medical Association
 9. Netter’s Atlas of Human Anatomy for CPT Coding, 2011
 10. CodeManager®, 2011, American Medical Association
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The goal of this training module is to alert providers and their staff about the availability of this lab testing and the importance of screening for additional co-morbidities. The training is not a required CHDP program activity but it is offered as a topical and relevant training for CHDP providers. It may be used as an adjunctive training for provider offices that demonstrate inconsistent follow-up on childhood obesity. It may be modified by trainers to accommodate the setting and needs of provider offices.

The training builds on other CHDP childhood obesity provider tools, such as "Body Mass Index (BMI) Training," "How to Accurately Weigh and Measure Children for the CHDP Well Child Exam." "Counseling the Overweight Child Training" and the CHDP/Kaiser Permanente "Little Changes. Big Rewards. Are You Ready?" Poster.

If you have additional questions about this or other childhood obesity related training tools, please contact your regional nurse consultant.

Original Signed by Louis R. Rico

Louis R. Rico, Chief
Systems of Care Division





DAVID MAXWELL-JOLLY
Director

State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

August 5, 2009

CHDP Information Notice 09-D

TO: CHDP Directors, Deputy Directors, Nutritionists, Health Educators,
Regional Office Staff

Subject: New CHDP Provider Training, "Counseling the Overweight Child"

A new CHDP provider training, "Counseling the Overweight Child" is now available on the CHDP website at: <http://www.dhcs.ca.gov/services/chdp/Pages/CounselTraining.aspx>

This training was developed by the CHDP Nutrition Subcommittee to assist local CHDP program staff with training provider offices about brief counseling techniques as applied to childhood overweight and obesity. The training module is pre-packaged for local CHDP program staff to use as 30-45 minute trainings in CHDP provider offices.

The following materials are available for download from the CHDP website:

- PowerPoint presentation with detailed talking points
- Training materials with role play skit and counseling tip sheet
- Training documents with useful forms
- Counseling tools for family counseling

Background

Historically, medical providers have been reluctant to engage in discussions regarding overweight and obesity, the most common reason being a lack of time and discomfort with the subject. The goal of this training module is to assist providers and their staff with comfortably using brief counseling techniques for the prevention of overweight and obesity. The technique will enhance the provider's ability to communicate the Body Mass Index (BMI) Percentile and initiate conversation with families about obesity prevention.

CHDP nutritionists' pilot tested the training with health department staff and providers and according to participant evaluations, after the training they felt more confident and better able to deliver obesity prevention messages. Participants also indicated that they would recommend the training to other health care providers. Additionally, this training was recently showcased at the 2009 Childhood Obesity Conference in a pre-conference session and received high rating from attendees.

CHDP Information Notice 09-D
Page 2
August 5, 2009

The training is not a required CHDP program activity but it is offered as a topical and relevant training for CHDP providers. It may be used as an adjunctive training for provider offices that demonstrate inconsistent recording of BMI Percentile. It may be modified by trainers to accommodate the setting and needs of provider offices.

This new training builds on other CHDP childhood obesity provider tools, such as "[Body Mass Index \(BMI\) Training](#)," "How to Accurately Weigh and Measure Children for the CHDP Well Child Exam" and the CHDP/Kaiser Permanente "Little Changes. Big Rewards. Are You Ready?" Poster. In attempt to facilitate a basic and effective approach to the prevention of childhood obesity.

If you have additional questions about this or other childhood obesity related training tools, please contact Judy Sundquist, MPH, RD, CMS Statewide Nutrition Consultant at judy.sundquist@dhcs.ca.gov and 916-322-8785.

Original Signed by Harvey Fry for Luis R. Rico

Luis R. Rico, Acting Chief
Children's Medical Services Branch



State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

February 8, 2008

CHDP Information Notice No.: 8-C

To: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM DIRECTORS, DEPUTY DIRECTORS, NUTRITIONISTS, HEALTH EDUCATORS, STATE CHILDREN'S MEDICAL SERVICES (CMS) BRANCH STAFF AND REGIONAL OFFICE STAFF

Subject: RESOURCE TEMPLATE FOR LISTING COMMUNITY RESOURCES FOR PREVENTION AND TREATMENT OF CHILD AND ADOLESCENT OVERWEIGHT AND OBESITY

The purpose of this CHDP Information Notice is to share a resource template and accompanying tools that local CHDP programs may use to identify community resources for the prevention and treatment of childhood overweight. The lack of resource information for providers has been identified as a significant barrier to the care for children determined to be overweight or obese.

The CHDP Program encourages local programs to inventory community resources for the prevention and treatment of childhood overweight and offer provider assistance. The attached resource template and related tools are standardized for statewide use, can be modified by local CHDP programs and are considered an "optional" activity.

Background:

The CHDP Nutrition and Health Education Subcommittees worked with several local programs to develop tools that can be used statewide to assist local CHDP programs to locate and share information on community resources for children determined to be overweight or obese. The attached resource template, "Resources to Prevent and Treat Child/Adolescent Overweight" is largely based on the Orange County CHDP resource list which has been pilot tested, refined and well received in its provider community over the last three years.

ATTACHMENTS

Attachment #1, the resource template is designed to include the most relevant referral information and identification of program components, such as nutrition and physical activity that correspond to standards of care for overweight children.

The remaining attachments are intended to assist local programs with contacting and researching resources and completing the resource template.

1. **Attachment # 1: Blank Template – “Resources to Prevent and Treat Child/Adolescent Overweight”**- When completed, this resource list can be shared with providers and community programs.
2. **Attachment # 2: Example - “Resources to Prevent and Treat Child/Adolescent Overweight”**, This is an example of a resource template that has been completed and is included for illustration purposes.
3. **Attachment # 3: Template Key**- This checklist corresponds to the blank template; it identifies program description details to consider for inclusion on the resource template.
4. **Attachment # 4: How to Locate Local Resources**- This is a general resource locator tool that helps to identify and initiate contact with regional and statewide organizations who may offer local programs in your area. This tool is intended to help identify “program referral” resources and not “information only” resources. Many communities have obesity coalitions that identify community resources for children who are overweight. Community coalitions may be a good starting place to gather information about local resources.
5. **Attachment # 5: Information Interview**- This is a tool with key questions for interviewing individual programs/resources. It is easy to duplicate and can help ensure collection of complete information.

How to Use the Resource Template

The resource template is designed to be a condensed, alphabetized listing of community resources that may be shared with:

- CHDP Providers
- Other public health programs, community coalitions, health plans, etc.

The resource template may be modified by local CHDP Programs. The resource template can easily expand by adding additional rows or it can be copied and used in an excel format. In larger counties, it may be more useful to develop resources by region in order to accommodate geographical distances. Please note the inclusion of footnotes regarding the disclaimer and the edition date on the bottom of the template. Lastly, the resource template will need periodic updating.

Who Can Help

Local program nutritionists and/or health educators may help local CHDP programs contact and assemble resource information to complete the resource template for your providers. For more information and assistance, please contact Judy Sundquist, CMS Nutrition Consultant and/or Julie Linderman, CMS Health Education Consultant at (916) 327-1400.

Original Signed by Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Chief
Children's Medical Services Branch

Enclosures

ATTACHMENT # 1



Resources to Prevent and Treat Child/Adolescent Overweight - County & Date

Child Health and Disability Prevention (CHDP) Program

Medical	Nutrition	Phys Act	Behavior	Program / Contact	Age / Referral Criteria	Description	Language	Cost	Funded by

Compiled by:
Reviewed/endorsed by:
Last updated:

Send updates and corrections to:

Disclaimer: Information on this form is self-reported; the CHDP program does not specifically recommend nor promote any of the listed programs. Those using the list accept full responsibility. Please directly contact selected programs for more information.

For clinical follow-up/ medical referral information, please contact the local CHDP program at: _____.



ATTACHMENT # 2

Resources to Prevent and Treat Child/Adolescent Overweight - North San Joaquin County - 7/07 EXAMPLE

Child Health and Disability Prevention (CHDP) Program

Program / Contact	Medical	Nutrition	Phys Act	Behavior	Age / Referral Criteria	Description	Language	Cost	Funded by
African Beat Lodi Boys & Girls Club- Elana Gates 945-3211		X			13-19 yrs Co-ed teens	Athletic, invigorating dance workouts and performances led by professional dancer and choreographer. Daily after-school. Saturday evening dances. Guaranteed to burn 500 or more calories per 60-minute session.	Eng Sp	No cost	Delta Community College and Lodi Boys & Girls Club
Basketball Kings King Middle School Woodbridge 356-4323		X			Boys - all ages, Fathers, uncles, grandfathers	Skill development and physical fitness exercise everyday after school. Intramural games on weekends. Professional coach, coordinator.	Eng Sp	No cost	Woodbridge School District; Lodi Unified School District
Buzz Me 800-buzz-me 800-289-9634		X	X	X	All ages	Motivational coaching and support by telephone re physical exercise, food choices, nutrition, behavioral change strategies and tactics.	Eng Sp	No cost	St. Joseph's Medical Center, Dept of Health Ed
Family Moves Lodi Memorial Hospital Dave Meadows 948-4222 Ext. 601		X	X	X	8-13 yrs overweight youth, their parents, guardians	Eight-week interactive, family empowerment, behavioral change, skill development course in nutrition, food choices, food economics, cooking, family meals and family exercise.	Eng Sp	No cost	Blue Cross of California and Health Plan of San Joaquin
Kids in the Kitchen 4600 Lower Sac. Road Brandy Brown 948-4525		X	X	X	8-14 yrs	Five-week hands-on course in wok cooking, grilling and steaming; label reading; food economics; meal planning; shopping; family meals. Instructors are native chefs of Southeast Asia, Central America and Mediterranean cuisines.	Eng Sp Hmong	\$5 for 5 classes; \$10 for 10 classes	Sierra Foundation grant. Pots & Pans Kitchen Supply grant.
Teen Train John Muir High, Lodi Jon Rodriguez, M.Ed 948-4200		X	X	X	13-19 yrs	60 minutes of rigorous exercise and intramural sports; 15 minutes of coaching on super-foods for energy, strength and brain power. Daily after school. Instructors are physical education and nutrition experts.	Eng Sp	No cost	Lodi Unified School District and Public Health WIC
Obesity Clinic UC-Davis Medical Center in Sacramento Bill Jenkins, Director 916-368-4000 djenkins@ucd.org	X	X	X	X	3-19 yrs with a BMI over 95 th percentile, and a medical referral	Six-month clinical outpatient program w/weekly visits to medical and behavioral specialists. Interim telephone support in English. Spanish-speaking patients must be accompanied by fluent bi-lingual Spanish-English speaker. No cost to research subjects when opportunities arise.	Eng	\$26,000 Co-pays: Medi-Cal - \$0-30 Private ins - \$20- \$100	Partial coverage (~80%) public & private insurance plus some gov't programs

Compiled by the CHDP Program of San Joaquin County and the Nutrition and Physical Activity Coalition of San Joaquin. Reviewed by the San Joaquin chapters of the American Academy of Pediatrics and the American Academy of Family Practitioners and the San Joaquin County Office of Education. These groups neither recommend nor promote any of the listings in this resource guide. The guide was prepared to assist local CHDP providers and primary care physicians in north San Joaquin in helping children and their families achieve and maintain healthy weights.

Update: 7/07 - Please send updates and corrections to: Dianna Stern, CHDP Program, San Joaquin Dept of Public Health, dstern@sjcphs.org or (209) 953-3644.

ATTACHMENT # 3

Resources to Prevent and Treat Child/Adolescent Overweight – Template Key



Child Health and Disability Prevention (CHDP) Program
(Suggested elements for each column are identified below)

Medical ²	Nutrition ³	Phys Act ⁴	Behavior ⁵	Program / Contact	Age / Referral Criteria	Description	Language	Cost	Funded by
X	X			<p>Program name</p> <p>Contact information/ registration: phone, fax, email and website</p> <p>City/ location(s)</p>	<p>Age</p> <p>Gender</p> <p>BMI</p> <p>Health status</p> <p>Medical referral required</p> <p>Family participation required</p> <p>Income criteria/ Residency</p>	<p>Main activities/goals: exercise, diet planning, cooking, behavior change</p> <p>Length of program: scheduled meetings, drop-in, on-going</p> <p>Number of classes, days and dates</p> <p>Instructor or leader credentials</p> <p>Format of program: individual, group, classroom, self-directed education (computer modules)</p> <p>Follow-up and/or ongoing support: phone follow-up, support groups</p>	<p>English</p> <p>Spanish</p> <p>Other:</p>	<p>No cost</p> <p>Paid by health plan/ insurance</p> <p>Sliding scale</p> <p>Co-pay</p> <p>Scholarship</p> <p>Cost: \$\$</p>	<p>Coalitions</p> <p>Foundations</p> <p>Grants</p> <p>Health plans: Medi-Cal</p> <p>Healthy Families</p> <p>Healthy Kids Insurance</p> <p>Non-profit organizations: Community/ faith-based</p> <p>Private pay</p> <p>Schools</p>

***Program categories by area of focus- Put an X in the column(s) above for each category of service offered by the program. Some programs may have more than one category checked. Sample category descriptions follow:**

- X **Medical** - Managed/supervised by health professional. May include: medications, counseling, monitor high-risk health conditions, team intervention
- X **Nutrition** - Basic nutrition education, cooking classes, shopping and dining tips, medical nutrition therapy
- X **Physical Activity** - Basic body movement, team sports, skills and performance development, group exercise
- X **Behavioral** - Individual counseling, support group, behavioral change skills, family dynamics



Resources to Prevent and Treat Child/Adolescent Overweight How to Locate Local Resources

A broad listing of available services will help CHDP providers and their patients identify resources that best meet their needs. This suggestion list may help you identify programs and services to include on your local resource list. Suggestions are organized by resource category; they correspond with the blank template, "Resources to Prevent and Treat Child/Adolescent Overweight". The suggestions below are not intended to be comprehensive or a program endorsement but instead they serve as examples of program resources.

To Start:

1. Review the established resource lists used by the county health department, United Way 211 Directory (<http://www.211.org/>) and other referral groups.
2. Contact your local *Network for a Healthy California - Regional Network* to help identify others working in the areas of nutrition and physical activity.
www.dhs.ca.gov/ps/cdic/CPNS/network/rnn.htm
3. Contact local coalitions working on youth and health issues, such as First Five County Commissions <http://ccfc.ca.gov/commission/default.asp>
4. Identify local resources by city/town or county.
5. Use the suggested ideas below to find resources.

Medical Resources:

- Pediatric weight management programs:
 - KidShape- Northern CA only: <http://www.kidshape.com/>
 - PowerPlayMD
 - Stanford Pediatric Weight Control Program: spwcpinst@stanford.edu (email)
 - UCSF School of Medicine Shapedown programs: <http://www.shapedown.com/>
- Hospitals/Clinics:
 - Tertiary and community hospitals
 - Federally Qualified Health Centers and Community Health Clinics: http://findahealthcenter.hrsa.gov/Search_HCC.aspx?byCounty=1
(Identify CA and county)
- Medical provider groups and specialty healthcare providers
- Professional associations:
 - American Academy of Pediatrics, American Dietetic Association, California Medical Association, California Association for Health, Physical Education, Recreation and Dance
- Medi-Cal Managed Care/Medi-Cal
<http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx>
- Private insurance/health plans

Nutrition Resources:

- Government public health nutrition programs:
 - California Nutrition Network: <http://www.dhs.ca.gov/ps/cdic/cpns/network/LFNE.htm>
 - HHS Adolescent Health Project, Office of Women's Health, BodyWorks™ program: <http://www.womenshealth.gov/bodyworks/>
 - Local public health programs: Women, Infants and Children (WIC) program: <http://www.wicworks.ca.gov/resources/laSearch/search.asp>
 - University of CA Cooperative Extension nutritionist: <http://ucanr.org/ce.cfm>

ATTACHMENT # 4

- Commercial weight management programs:
Weight Watchers, Tops, Jenny Craig
- Youth programs:
YMCA, Boys and Girls Club, faith-based, after school
- Educational institutions:
Center for Weight and Health: <http://www.cnr.berkeley.edu/cwh/>
College nutrition department

Physical Activity Resources:

- Government programs:
City/County Parks and Recreation Department: http://www.parks.ca.gov/?page_id=21491
School fitness/teams
- Commercial fitness programs:
Commercial gyms such as, 24 Hour Fitness & Golds
Sports, Play and Active Recreation for Kids (SPARK): <http://www.sparkpe.org/>
- Foundation sponsored programs:
California Adolescent Nutrition and Fitness Program (CANFit): <http://www.canfit.org/>
California Healthy Eating and Active Communities (HEAC) grants:
http://healthyeatingactivecommunities.org/grantee_showcase.php
- Youth program:
YMCA/Boys and Girls Club/Scouts, after school, faith-based
Sports leagues such as soccer, baseball and basketball

Behavior Resources:

- Government programs: county mental health services
- Schools and school counselors
- Hospital, clinic and private practice counselors and psychologists specializing in weight issues

Additional Web Resources:

There are many online resources that provide additional information and community contacts/resources. A few primary web resources are listed for your perusal.

- Bright Futures: <http://www.brightfutures.org/>
- California Medical Association Foundation:
<http://thecmafoundation.org/projects/index.aspx> (Check list of programs)
- California Network for a Healthy California, such as "Champions for Change" and "Power Play": www.dhs.ca.gov/ps/cdic/cpns/
- California Project LEAN (Leaders Encouraging Activity and Nutrition):
<http://www.californiaprojectlean.org/>
- National Heart, Lung and Blood Institute of the National Institute of Health:
<http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/community/find-a-program.htm#California>
- Prevention Institute Healthy Communities Project:
<http://www.preventioninstitute.org/nutrition.html>
- U.S. Department of Agriculture, Center for Nutrition Policy and Promotion:
<http://www.choosemyplate.gov/>



**Resources to Prevent and Treat Child/Adolescent Overweight
Information Interview Tool**

Date: _____			
Program name: _____			
Address: _____			___ Multiple sites (list on reverse)
Contact person: _____			
Name _____	Tel. _____	Fax _____	Email _____
How do interested individuals contact the program? _____			

Program Type

Focus: Medical Nutrition Physical Activity Behavior

What is the main focus of program?	_____
------------------------------------	-------

Age/Referral Criteria

Does the program require a referral to enroll? If yes, from whom?	_____
Does this program serve a specific target population? Or is it open to anyone regardless of age, gender, income, language, culture, etc.?	_____
Is family participation required?	_____

Program Description

Describe the main activities and/or goals of the program.	_____
What is the program format? How is it presented - individual appointment, group, series, self-directed education, classroom, exercise class, etc.?	_____
What is the length of program, number of classes, days, and dates?	_____
Is there follow-up and support?	_____
Does the leader have special credentials?	_____

Language

What languages are used?	_____
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Cost

Is there a cost to the program? How much? Covered by: Medi-Cal, Healthy Families, private health insurance? What are the payment terms: co-pay, sliding scale, scholarships?	_____
--	-------

Funding Source/Endorsements

Who sponsors this program: health plan, community organization, coalition, commercial, faith based?	_____
Who endorses the program: medical organizations, schools, public health program?	_____

Form completed by: _____
Local CHDP Program name/phone #: _____



State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

January 10, 2008

CHDP Program Letter No.: 08-02

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP)
PROGRAM DIRECTORS, DEPUTY DIRECTORS, NUTRITIONISTS,
HEALTH EDUCATORS, STATE CHILDREN'S MEDICAL SERVICES (CMS)
BRANCH STAFF AND REGIONAL OFFICE
STAFF

SUBJECT: BODY MASS INDEX (BMI)-FOR-AGE PERCENTILE JOB AID

Enclosed is CHDP Provider Information Notice (PIN) No.: 08-02 offering CHDP Providers a Body Mass Index (BMI)-for-age percentile job aid. CHDP requires providers to obtain and record BMI-for-age percentile on all children 2 to 20 years of age. This job aid explains and illustrates steps for obtaining BMI-for-age percentile. Please encourage provider offices to post page two of the job aid because it serves as a visual illustration of the steps for obtaining BMI-for-age percentile.

Please distribute this Provider Information Notice without any revisions to providers in your county and complete and return a "Report of Distribution" (DHS 4504). The DHS 4504 can be found at www.dhcs.ca.gov/services/chdp/.

If you have any questions, please contact your Regional Consultant staff.

Original Signed by Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Chief
Children's Medical Services Branch

Enclosure



State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

October 31, 2007

CHDP Provider Information Notice No.: 07-13

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM PROVIDERS

SUBJECT: CHILDHOOD OBESITY IMPLEMENTATION GUIDE FROM THE EXPERT COMMITTEE RECOMMENDATIONS ON THE ASSESSMENT, PREVENTION AND TREATMENT OF CHILD AND ADOLESCENT OVERWEIGHT AND OBESITY- 2007

The purpose of this Provider Information Notice (PIN) is to share an implementation guide for the 2007 Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity. The Expert Committee was convened by American Medical Association (AMA), Centers for Disease Control and Prevention and Health Resource and Services Administration and the initial recommendations were released on June 6, 2007 in a document entitled, "Appendix: Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity":

www.ama-assn.org/ama/pub/category/11759.html

The Childhood Obesity Action Network from the National Initiative for Children's Healthcare Quality developed the attached implementation guide for the recommendations. The implementation guide organizes the recommendations in a ready-to-use format for the primary care practitioner. The CHDP Program supports the recommendations. Step 1, Obesity Prevention at Well Care Visits (Assessment and Prevention) is especially applicable to the CHDP Program. For additional information and provider office tools from the Child Obesity Action Network go to:

<http://www.nichq.org/NICHQ/Programs/ConferencesAndTraining/ChildhoodObesityActionNetwork.htm>

As a reminder, Body Mass Index -for- Age Percentile was added to the Confidential Screening/Billing Report (Standard and Information Only PM 160- Version 8) in an effort to endorse and promote BMI screening. Additionally, Children's Medical Services Branch hosted the roll out of the recommendations by supporting a downlink of the live satellite

CHDP Provider Information Notice 07-13

Page 2

October 31, 2007

presentation, "Prevention, Assessment, and Treatment of Childhood Obesity: Recommendations from the AMA Expert Committee on Childhood Obesity" on June 6, 2007.

Over 50 local CHDP programs and numerous medical providers participated in the downlink presentation. DVDs and videotapes of the 4-hour presentation are available for viewing; please contact your local CHDP program for a copy.

If you have any questions, please contact your local CHDP program office.

Original Signed by Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Chief
Children's Medical Services Branch

Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity - 2007

- An Implementation Guide from the Childhood Obesity Action Network -

Overview:

In 2005, the AMA, HRSA and CDC convened an Expert Committee to revise the 1997 childhood obesity recommendations. Representatives from 15 healthcare organizations submitted nominations for the experts who would compose the three writing groups (assessment, prevention, treatment). The initial recommendations were released on June 6, 2007 in a document titled "Appendix: Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity" (www.ama-assn.org/ama/pub/category/11759.html)

In 2006, the National Initiative for Children's Healthcare Quality (NICHQ) launched the Childhood Obesity Action Network (COAN). With more than 40 healthcare organizations and 600 health professionals, the network is aimed at rapidly sharing knowledge, successful practices and innovation. This Implementation Guide is the first of a series of products designed for healthcare professionals by COAN to accelerate improvement in the prevention and treatment of childhood obesity.

The Implementation Guide combines key aspects of the Expert Committee Recommendations summary released on June 6, 2007 and practice tools identified in 2006 by NICHQ from primary care groups that have successfully developed obesity care strategies (www.NICHQ.org). These tools were developed before the 2007 Expert Recommendations and there may be some inconsistencies such as the term *overweight* instead of *obesity* for BMI \geq 95%ile. The tools are intended as a source of ideas and to facilitate implementation. As tools are updated or new tools developed based on the Expert Recommendations, the Implementation Guide will be updated. The Implementation Guide defines 3 key steps to the implementation of the 2007 Expert Committee Recommendations:

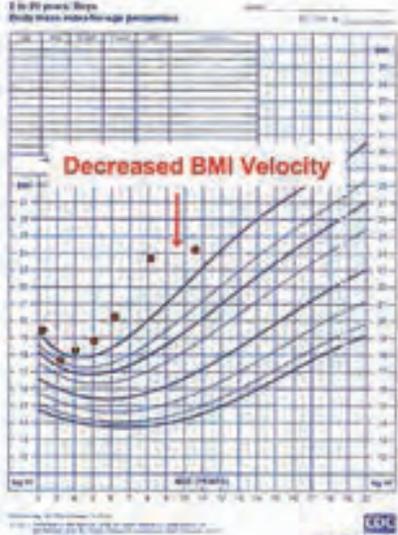
- **Step 1 – Obesity Prevention at Well Care Visits** (Assessment & Prevention)
- **Step 2 – Prevention Plus Visits** (Treatment)
- **Step 3 – Going Beyond Your Practice** (Prevention & Treatment)

Step 1 – Obesity Prevention at Well Care Visits (Assessment & Prevention)

Action Steps	Expert Recommendations	Action Network Tips and Tools
Assess all children for obesity at all well care visits 2-18 years	Physicians and allied health professional should perform, at a minimum, a yearly assessment.	A presentation for your staff and colleagues can help implement obesity prevention in your practice.
Use Body Mass Index (BMI) to screen for obesity	<ul style="list-style-type: none"> • Accurately measure height and weight • Calculate BMI BMI (English): $[\text{weight (lb)} \div \text{height (in)} \div \text{height (in)}] \times 703$ BMI (metric): $[\text{weight (kg)} \div \text{height (cm)} \div \text{height (cm)}] \times 10,000$ • Plot BMI on BMI growth chart • Not recommended: skinfold thickness, waist circumference 	BMI is very sensitive to measurement errors, particularly height. Having a standard measurement protocol as well as training can improve accuracy. BMI calculation tools are also helpful. Use the CDC BMI %ile-for-age growth charts.
Make a weight category diagnosis using BMI percentile	<ul style="list-style-type: none"> • < 5%ile Underweight • 5-84%ile Healthy Weight • 85-94%ile Overweight • 95-98%ile Obesity • \geq 99%ile 	Until the BMI 99%ile is added to the growth charts, Table 1 can be used to determine the 99%ile cut-points. Physicians should exercise judgement when choosing how to inform the family. Using more neutral terms such as <i>weight, excess weight, body mass index, BMI, or risk for diabetes and heart disease</i> can reduce the risk of stigmatization or harm to self-esteem.
Measure blood pressure	<ul style="list-style-type: none"> • Use a cuff large enough to cover 80% of the upper arm • Measure pulse in the standard manner 	Diagnose hypertension using NHLBI tables. An abbreviated table is shown below (Table 2).
Take a focused family history	<ul style="list-style-type: none"> • Obesity • Type 2 diabetes • Cardiovascular disease (hypertension, cholesterol) • Early deaths from heart disease or stroke 	A child with one obese parent has a 3 fold increased risk of becoming obese. This risk increases to 13 fold with 2 obese parents. Using a clinical documentation tool can be helpful.

Take a focused review of systems	Take a focused review of systems	See Table 3. Using a clinical documentation tool can be helpful.
Assess behaviors and attitudes	<p>Diet Behaviors</p> <ul style="list-style-type: none"> Sweetened-beverage consumption Fruit and vegetable consumption Frequency of eating out and family meals Consumption of excessive portion sizes Daily breakfast consumption <p>Physical Activity Behaviors</p> <ul style="list-style-type: none"> Amount of moderate physical activity Level of screen time and other sedentary activities <p>Attitudes</p> <ul style="list-style-type: none"> Self-perception or concern about weight Readiness to change Successes, barriers and challenges 	Using behavioral risk assessment tools can facilitate history taking and save clinician time.
Perform a thorough physical examination	Perform a thorough physical examination	See Table 3. Using a clinical documentation tool can be helpful.
Order the appropriate laboratory tests	<p>BMI 85-94%ile Without Risk Factors</p> <ul style="list-style-type: none"> Fasting Lipid Profile <p>BMI 85-94%ile Age 10 Years & Older With Risk Factors</p> <ul style="list-style-type: none"> Fasting Lipid Profile ALT and AST Fasting Glucose <p>BMI ≥ 95%ile Age 10 Years & Older</p> <ul style="list-style-type: none"> Fasting Lipid Profile ALT and AST Fasting Glucose Other tests as indicated by health risks 	<p>Consider ordering ALT, AST and glucose tests beginning at 10 years of age and then periodically (every 2 years). Provider decision support tools can be helpful when choosing assessment and treatment options.</p> <p>Delivering lab results can be one way to open the conversation about weight and health with a family.</p>
Give consistent evidence-based messages for all children regardless of weight	<ul style="list-style-type: none"> Limit sugar-sweetened beverages Eat at least 5 servings of fruits and vegetables Moderate to vigorous physical activity for at least 60 minutes a day Limit screen time to no more than 2 hours/day Remove television from children's bedrooms Eat breakfast every day Limit eating out, especially at fast food Have regular family meals Limit portion sizes 	<p>An example from the Maine Collaborative:</p> <ul style="list-style-type: none"> 5 fruits and vegetables 2 hours or less of TV per day 1 hour or more physical activity 0 servings of sweetened beverages <p>Exam and waiting room posters and family education materials can help deliver these messages and facilitate dialogue. Encourage an authoritative parenting style in support of increased physical activity and reduced TV viewing. Discourage a restrictive parenting style regarding child eating. Encourage parents to be good role models and address as a family issue rather than the child's problem.</p>
Use Empathize/Elicit - Provide - Elicit to improve the effectiveness of your counseling	<p>Assess self-efficacy and readiness to change. Use Empathize/Elicit - Provide - Elicit to improve the effectiveness of your counseling.</p> <p>Empathize/Elicit</p> <ul style="list-style-type: none"> Reflect What is your understanding? What do you want to know? How ready are you to make a change (1-10 scale)? <p>Provide</p> <ul style="list-style-type: none"> Advice or information Choices or options <p>Elicit</p> <ul style="list-style-type: none"> What do you make of that? Where does that leave you? 	<p>A possible dialogue:</p> <p>Empathize/Elicit</p> <p>"Your child's height and weight may put him/her at increased risk for developing diabetes and heart disease at a very early age."</p> <p>"What do you make of this?"</p> <p>"Would you be interested in talking more about ways to reduce your child's risk?"</p> <p>Provide</p> <p>"Some different ways to reduce your child's risk are..."</p> <p>"Do any of these seem like something your family could work on or do you have other ideas?"</p> <p>Elicit</p> <p>"Where does that leave you?"</p> <p>"What might you need to be successful?"</p> <p>Communication guidelines can be helpful when developing communication skills.</p>

Step 2 – Prevention Plus Visits (Treatment)

Action Steps	Expert Recommendations	Action Network Tips and Tools
<p>Develop an office based approach for follow up of overweight and obese children</p>	<p>A staged approach to treatment is recommended for ages 2-19 whose BMI is 85-94%ile with risk factors and all whose BMI is \geq 95%ile.</p> <p>In general, treatment begins with Stage 1 Prevention Plus (Table 4) and progresses to the next stage if there has been no improvement in weight/BMI or velocity after 3-6 months and the family is willing/ready.</p> <p>The recommended weight loss targets are shown in Table 5.</p> <p>Stage I - Prevention Plus</p> <ul style="list-style-type: none"> ▪ Family visits with physician or health professional who has had some training in pediatric weight management/behavioral counseling. ▪ Can be individual or group visits. ▪ Frequency - individualized to family needs and risk factors, consider monthly. ▪ Behavioral Goals – <ul style="list-style-type: none"> - Decrease screen time to 2 hr/day or fewer - No sugar-sweetened beverages - Consume at least 5 servings of fruits and vegetables daily - Be physically active 1 hour or more daily - Prepare more meals at home as a family (the goal is 5-6 times a week) - Limit meals outside the home - Eat a healthy breakfast daily - Involve the whole family in lifestyle changes - More focused attention to lifestyle changes and more frequent follow-up distinguishes Prevention Plus from Prevention Counseling ▪ Weight Goal – weight maintenance or a decrease in BMI velocity. The long term BMI goal is <85%ile although some children can be healthy with a BMI 85-94%ile. ▪ Advance to Stage 2 (Structured Weight Management) if no improvement in weight/BMI or velocity in 3-6 months and family willing/ready to make changes. 	<p>Prevention Plus visits may include:</p> <ul style="list-style-type: none"> ▪ Health education materials ▪ Behavioral risk assessment and self-monitoring tools ▪ Action planning and goal setting tools ▪ Clinical documentation tools ▪ Counseling protocols ▪ Other health professionals such as dietitians, psychologists and health educators. <p>Besides behavioral and weight goals, improving self-esteem and self efficacy (confidence) are important outcomes. Although weight maintenance is a good goal, more commonly, a slower weight gain reflected in a decreased BMI velocity is the outcome seen in lower intensity behavioral interventions such as Prevention Plus. Measuring and plotting BMI after 3-6 months is an important step to determine the effectiveness of obesity treatment.</p> 
<p>Use motivational interviewing at Prevention Plus visits for ambivalent families and to improve the success of action planning</p>	<p>Use patient-centered counseling – motivational interviewing</p>	<p>Research suggests that motivational interviewing may be an effective approach to address childhood obesity prevention and treatment. Motivational interviewing is particularly effective for ambivalent families but can also be used for action planning. Instead of telling patients what changes to make, you elicit “change talk” from them, taking their ideas, strengths, and barriers into account. Communication guidelines and communication training can be helpful with skill development.</p>
<p>Develop a reimbursement strategy for Prevention Plus visits</p>		<p>Coding strategies can help with reimbursement for Prevention Plus visits. Advocacy through professional organizations to address reimbursement policies is another strategy.</p>

Step 3 – Going Beyond Your Practice (Prevention & Treatment)

Action Steps	Expert Recommendations	Action Network Tips and Tools
<p>Advocate for improved access to fresh fruits and vegetables and safe physical activity in your community and schools</p>	<p>The Expert Committee recommends that physicians, allied healthcare professionals, and professional organizations advocate for:</p> <ul style="list-style-type: none"> • The federal government to increase physical activity at school through intervention programs as early as grade 1 through the end of high school and college, and through creating school environments that support physical activity in general. • Supporting efforts to preserve and enhance parks as areas for physical activity, informing local development initiatives regarding the inclusion of walking and bicycle paths, and promoting families' use of local physical activity options by making information and suggestions about physical activity alternatives available in doctors' offices. 	<p>Physicians and health professionals can play a key role in advocating for policy and built environment changes to support healthy eating and physical activity in communities, child care settings, and schools (including after-school programs). Advocacy tools and resources can be helpful in advocacy efforts. Partnering with others and using evidence-based strategies are also critical to the success of multi-faceted community interventions.</p>
<p>Identify and promote community services which encourage healthy eating and physical activity</p>	<p>Promote physical activity at school and in child care settings (including after school programs), by asking children and parents about activity in these settings during routine office visits.</p>	<p>Public Health Departments and Parks and Recreation are good places to start looking for community programs and resources.</p> <p>You can work on developing your own partnerships with community organizations (Physical Activity Directory template and/or referral forms).</p>
<p>Identify or develop more intensive weight management interventions for your families who do not respond to Prevention Plus</p>	<p>The Expert Committee recommends the following staged approach for children between the ages of 2 and 19 years whose BMI is 85-94thile with risk factors and all whose BMI is ≥ 95thile:</p> <ul style="list-style-type: none"> • Stage 2 - Structured Weight Management (Family visits with physician or health professional specifically trained in weight management. Monthly visits can be individual or group.) • Stage 3 - Comprehensive, Multidisciplinary Intervention (Multidisciplinary team with experience in childhood obesity. Frequency is often weekly for 8-12 weeks with follow up.) • Stage 4 - Tertiary Care Intervention (Medications - sibutramine, orlistat, Very-low-calorie diets, weight control surgery - gastric bypass or banding.) Recommended for select patients only when provided by experienced programs with established clinical or research protocols. Gastric banding is in clinical trials and not currently FDA approved. 	<p>Stage 2 could be done without a tertiary care center if community professionals from different disciplines collaborated. For example, if a physician provided the medical assessment, a dietitian provided classes, and the local YMCA provided an exercise program.</p> <p>Partnering with your community tertiary care center can be an effective strategy to develop or link to more intensive weight management interventions (Stages 3 and 4) as well as referral protocols to care for families who do not respond to Prevention Plus visits. Provider decision support tools can be helpful when choosing appropriate treatment and referral options. Weight management protocols and curriculum can also be helpful when getting started.</p>
<p>Join the Childhood Obesity Action Network to learn from your colleagues and accelerate progress</p>		<p>The Childhood Obesity Action Network has launched "The Healthcare Campaign to Stop the Epidemic." Join the network (www.NICHQ.org) to learn from our national obesity experts, share what you have learned and access the tools in this guide. <i>Together we can make a difference!</i></p>

Implementation Guide Authors: Scott Gee, MD, Victoria Rogers, MD, Lenna Liu, MD, MPH, Jane McGrath, MD

Implementation Guide Contact: obesity@nichq.org

Table 1 – BMI 99%ile Cut-Points (kg/m²)

Age (Years)	Boys	Girls
5	20.1	21.5
6	21.6	23.0
7	23.6	24.6
8	25.6	26.4
9	27.6	28.2
10	29.3	29.9
11	30.7	31.5
12	31.8	33.1
13	32.6	34.6
14	33.2	36.0
15	33.6	37.5
16	33.9	39.1
17	34.4	40.8

Table 2 – Abbreviated NHLBI Blood Pressure Table

Blood Pressure 95% by Age, Sex and Height %

AGE	BOYS HEIGHT %		GIRLS HEIGHT %	
	50%	90%	50%	90%
2 Yr	106/61	109/63	105/63	108/65
5 Yr	112/72	115/74	110/72	112/73
8 Yr	116/78	119/79	115/76	118/78
11 Yr	121/80	124/82	121/79	123/81
14 Yr	128/82	132/84	126/82	129/84
17 Yr	136/87	139/88	129/84	131/85

Pediatrics Vol. 114 No. 2 August 2004 pp. 555-576

Table 3 – Symptoms and Signs of Conditions Associated with Obesity

Symptoms	Signs
<ul style="list-style-type: none"> > Anxiety, school avoidance, social isolation (Depression) > Polyuria, polydipsia, weight loss (Type 2 diabetes mellitus) > Headaches (Pseudotumor cerebri) > Night breathing difficulties (Sleep apnea, hypoventilation syndrome, asthma) > Daytime sleepiness (Sleep apnea, hypoventilation syndrome, depression) > Abdominal pain (Gastroesophageal reflux, Gall bladder disease, Constipation) > Hip or knee pain (Slipped capital femoral epiphysis) > Oligomenorrhea or amenorrhea (Polycystic ovary syndrome) 	<ul style="list-style-type: none"> > Poor linear growth (Hypothyroidism, Cushing's, Prader-Willi syndrome) > Dysmorphic features (Genetic disorders, including Prader-Willi syndrome) > Acanthosis nigricans (NIDDM, insulin resistance) > Hirsutism and Excessive Acne (Polycystic ovary syndrome) > Violaceous striae (Cushing's syndrome) > Papilledema, cranial nerve VI paralysis (Pseudotumor cerebri) > Tonsillar hypertrophy (Sleep apnea) > Abdominal tenderness (Gall bladder disease, GERD, NAFLD) > Hepatomegaly (Nonalcoholic fatty liver disease (NAFLD)) > Undescended testicle (Prader-Willi syndrome) > Limited hip range of motion (Slipped capital femoral epiphysis) > Lower leg bowing (Blount's disease)

Table 4 – A Staged Approach to Obesity Treatment

	BMI 85-94%ile No Risks	BMI 85-94%ile With Risks	BMI 95-98%ile	BMI >= 99%ile
Age 2-5 Years	Prevention Counseling	Initial: Stage 1 Highest: Stage 2	Initial: Stage 1 Highest: Stage 3	Initial: Stage 1 Highest: Stage 3
Age 6-11 Years	Prevention Counseling	Initial: Stage 1 Highest: Stage 2	Initial: Stage 1 Highest: Stage 3	Initial: Stage 1-3 Highest: Stage 3
Age 12-18 Years	Prevention Counseling	Initial: Stage 1 Highest: Stage 3	Initial: Stage 1 Highest: Stage 4	Initial: Stage 1-3 Highest: Stage 4

Stage 1	Prevention Plus	Primary Care Office
Stage 2	Structured Weight Management	Primary Care Office with Support
Stage 3	Comprehensive, Multidisciplinary Intervention	Follows Weight Management Center
Stage 4	Tertiary Care Intervention	Tertiary Care Center

Table 5 – Weight Loss Targets

	BMI 85-94%ile No Risks	BMI 85-94%ile With Risks	BMI 95-98%ile	BMI >= 99%ile
Age 2-5 Years	Maintain weight velocity	Decrease weight velocity or weight maintenance	Weight maintenance	Gradual weight loss of up to 1 pound a month if BMI is very high (>21 or 22 kg/m ²)
Age 6-11 Years	Maintain weight velocity	Decrease weight velocity or weight maintenance	Weight maintenance or gradual loss (1 lb per month)	Weight loss (average is 2 pounds per week)*
Age 12-18 Years	Maintain weight velocity. After linear growth is complete, maintain weight	Decrease weight velocity or weight maintenance	Weight loss (average is 2 pounds per week)*	Weight loss (average is 2 pounds per week)*

* Excessive weight loss should be evaluated for high risk behaviors



State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

July 19, 2007

CHDP Provider Information Notice No.: 07-08

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
PROVIDERS AND MEDI-CAL MANAGED CARE PLANS

SUBJECT: REVISION OF CHILD HEALTH AND DISABILITY PREVENTION (CHDP)
PROGRAM CONFIDENTIAL SCREENING/BILLING REPORT FORM
(PM 160)

The CHDP program has begun issuing new versions of the Standard and Information Only PM 160 (version 8) Confidential Screening/Billing Report. The new version will accommodate:

1. Recording of a child's BMI percentile.
2. The changes necessary to process the PM 160 in the CHDP payment system when the National Provider Identifier (NPI) is implemented.

Additions/Revisions to the Forms:

- **Body Mass Index (BMI) Percentile**
This new field will be used to record a child's BMI percentile based on height (inches) and weight (pounds). CDC BMI Growth Charts have been added to the Appendix section of the CHDP provider manual for use in plotting BMI percentile. The BMI percentile is recorded using whole numbers only.
- **Service Location**
This field was previously titled "Provider of Service." Implementation of NPI will require providers to include the street address, city, state, and nine-digit zip code where services were provided.

The service location for the NPI number used to bill CHDP on the PM 160 must match an address on the CHDP provider master file (PMF). If the address on the PM 160 does not match an address on the PMF, a Provider Correction Request (PCR) will be sent to the provider. If you receive a PCR and determine that the information on the PM 160 is correct, please contact your local CHDP program for help in correcting the PMF. Changes to the PMF must be completed within 90 days of receipt of the PCR or the claim will be denied.

- **Provider Number**

This field has been expanded to make space for the 10-digit NPI number.

- **Place of Service (POS)**

This is a new two-digit field that must be completed when the NPI is implemented. The POS is linked to the provider type and is used to describe where the CHDP services were rendered. For example, a laboratory would use POS code 81. Applicable POS codes are defined below and may also be found on the back of the new PM 160 (version 8) or in the *conf clm comp* section of the CHDP provider manual:

Place of Service Code	Description
11	Office (any location other than POS code 22 or 71)
22	Outpatient Hospital
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

If the POS does not match information on the PMF, a PCR will be generated.

- **Diagnosis Codes**

This field was previously titled "ICD 9 Codes." In anticipation of prospective conversion to the International Classification of Diseases (ICD) 10 version of the ICD codes, the field was expanded to accommodate an increased number of digits.

Existing Stock of PM 160 (version 7)

It is not necessary to begin using version 8 of the PM 160 until NPI is implemented in November 2007. You are encouraged to exhaust your existing stock of the PM 160 (version 7). Please allow enough time prior to implementation of the NPI to order and receive version 8. After implementation of NPI, use of version 8 will be required.

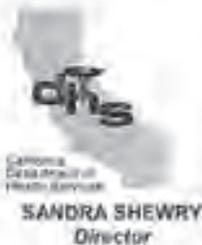
Reminders related to new PM 160

- Implementation of NPI is scheduled for November 2007. Only version 8 of the PM 160 will be accepted after NPI implementation.
- Exhaust existing PM 160 (version 7) stock. Allow enough time to order and receive version 8 prior to NPI implementation.
- The CHDP payment system will not edit against the Service Location and Place of Service fields until NPI is implemented. However, as you phase in use of version 8 of the PM 160, you are encouraged to become familiar with these fields by entering the required data in these fields prior to NPI implementation.
- Ensure all of your service locations have been registered with the appropriate NPI number.
- When billing, using version 8 prior to NPI implementation, you must continue to use your Medi-Cal or CHDP-only provider number in the Provider Number field. Use of the NPI number prior to implementation will result in the return or denial of the claim.

Your continuing participation in the CHDP Program is greatly appreciated. If you have any questions about the revisions to the PM 160, please contact your local CHDP program office.

Original Signed by Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Chief
Children's Medical Services Branch



State of California-Health and Human Services Agency
Department of Health Services



ARNOLD SCHWARZENEGGER
Governor

December 28, 2005

CHDP Provider Information Notice No.: 05-22

**TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP)
PROGRAM PROVIDERS AND MEDICAL MANAGED CARE PLANS**

**SUBJECT: UPDATE TO PROVIDER INFORMATION NOTICE (PIN): 05-16,
CONCERNING ADDITION OF FASTING BLOOD GLUCOSE AND
CHOLESTEROL SCREENING TESTS AS CHDP BENEFITS**

The purpose of this Provider Information Notice (PIN) is to inform you that effective retroactively to October 1, 2005, glucose and cholesterol testing can be repeated as medically appropriate, instead of limited to annually as specified in CHDP PIN: 05-16. This change has occurred in recognition that an elevated test result may need to be repeated to confirm an abnormality, or that some children/adolescents may need testing more than annually.

Your continuing participation in the CHDP Program is greatly appreciated. If you have any questions about this Provider Information Notice or other CHDP issues, please contact your local CHDP Program office.

Original signed by Harvey Fry for Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Acting Chief
Children's Medical Services Branch

End Notes

1. There is no separate CPT code for body fat composition testing. This service would be included in the examination component of the evaluation and management (E/M) code reported.

2. Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure), use 49320.

3. "Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems." "The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments." "The focus of the intervention is to improve the patient's health and wellbeing utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems." (AMA, CodeManager® 2011 Q2.)

4. These codes cannot be reported by a physician. For medical nutrition therapy assessment and/or intervention performed by a physician, see Evaluation and Management or Preventive Medicine service codes. Obesity and Related Co-Morbidities Coding Fact Sheet for Primary Care Pediatricians, American Academy of Pediatrics, 2006.

5. CPT codes are also known as Health Care Common Procedure Coding System (HCPCS) Level I codes. The Health Care Common Procedure Coding System also contains Level II codes. Level II codes (commonly referred to as HCPCS ("hick-picks") codes) are national codes that are included as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard procedural transaction coding set along with CPT codes. HCPCS Level II codes were developed to fill gaps in the CPT nomenclature. While they are reported in the same way as CPT codes, they consist of one alphabetic character (A-V) followed by four digits. In the past, insurance carriers did not uniformly recognize HCPCS Level II codes. However, with the implementation of HIPAA,

carrier software systems must now be able to recognize all HCPCS Level I (CPT) and Level II codes. Obesity and Related Co-Morbidities Coding Fact Sheet for Primary Care Pediatricians, American Academy of Pediatrics, 2006.

6. International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Codes

7. "This classification is provided to deal with occasions when circumstances other than a disease or injury classifiable to categories 001-999 (the main part of ICD) are recorded as "diagnoses" or "problems." This can arise mainly in three ways:

a) When a person who is not currently sick encounters the health services for some specific purpose, such as to act as a donor of an organ or tissue, to receive prophylactic vaccination, or to discuss a problem which is in itself not a disease or injury. This will be a fairly rare occurrence among hospital inpatients, but will be relatively more common among hospital outpatients and patients of family practitioners, health clinics, etc.

b) When a person with a known disease or injury, whether it is current or resolving, encounters the health care system for a specific treatment of that disease or injury (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change).

c) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury. Such factors may be elicited during population surveys, when the person may or may not be currently sick, or be recorded as an additional factor to be borne in mind when the person is receiving care for some current illness or injury classifiable to categories 001-999"

"In the latter circumstances the V code should be used only as a supplementary code and should not be the one selected for use in primary, single cause tabulations. Examples of these circumstances are a personal history of certain diseases, or a person with an artificial heart valve in situ." (AMA, CodeManager® 2011 Q2.) ■



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Toolbox

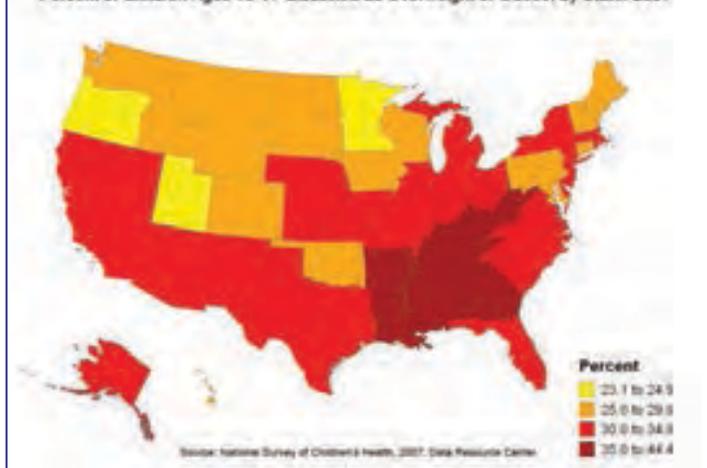
- A. NICHQ California State Fact Sheet**
- B. Self-Worth Assessment Tool**
- C. Adolescent Resources**
- D. CDC Growth Charts**
- E. Health Plan Interpreter Services**
- F. Multicultural Assessment**
- G. Healthy Lifestyle Questionnaire**
- H. Care Planning Guide**
- I. 3 Point Plan**
- J. Food Security Surveys**
- K. MyPlate Food Model Guidelines**
- L. Multicultural Patient Communications Vignette**

CALIFORNIA STATE FACT SHEET

KEY POINTS

- California ranks 24 in overall prevalence with 30.5% of children considered either overweight or obese.
- The California prevalence of overweight and obese children has risen since 2003.
- According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in WIC, 33% of low-income children age 2-5 are overweight or obese in California.

Percent of Children Ages 10-17 Classified as Overweight or Obese, by State, 2007



OVERALL PREVALENCE AND RANK ¹ :	CA	National	Change in California since 2003 ²
Percentage of children ages 10- 17 years who are overweight or obese	30.5%	31.6%	↑
State Rank for overweight or obese children (1 is best)	24		Rank in 2003: 27
RISK FACTORS			
Percentage of children ages 6-17 years who participate in 4 or more days of vigorous physical activity per week	62.3%	64.3%	↑
Percentage of children ages 1-5 who engage in 4 or more hours of screen time per weekday (includes TV, videos, etc.)	8.3%	12.8%	
Percentage of children ages 6-17 who engage in 4 or more hours of screen time per weekday (includes TV, videos, video games, etc.)	8.0%	10.8%	↑
DISPARITIES—ACROSS AND WITHIN STATES			
% Overweight or Obese by Family Income			
<100% Federal Poverty Level ³	44.3%	44.8%	↑
>400% FPL	21.2%	22.2%	↓
State Rank on Income Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 35 is worst) ⁴	24		
% Overweight or Obese by Type of Insurance			
Public Insurance	40.6%	43.2%	↑
Private Insurance	29.5%	27.3%	↑
State Rank on Insurance Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 50 is worst)	18		
% Overweight or Obese by Race			
Black, non-Hispanic	NA ⁵	41.1%	NA
White, non-Hispanic	NA	26.8%	NA
State rank on Race Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 22 is worst)	NA		
% Overweight or Obese by Hispanic Origin			
Hispanic (<i>footnote on definition</i>) ⁶	39.9%	41.0%	↑
Non-Hispanic	21.7%	29.6%	↑
State Rank on Hispanic Origin Disparity Ratio (This figure represents calculated disparity ratios and ranks these ratios – A rank of 1 is best, 19 is worst)	14		

What is CALIFORNIA doing about obesity?

KEY POLICY and GRANT INITIATIVES available in CALIFORNIA:

- California currently receives 6 grants from the Robert Wood Johnson Foundation's Healthy Kids, Healthy Communities Fund to battle overweight and obesity in children.
- California is one of only 2 states with menu labeling laws.
- Santa Clara and South San Mateo Counties, CA currently receives a *Pioneering Healthier Communities* grant through the YMCA Activate America Initiative.

The table below is derived from the 2009 edition of *F as in Fat*, published by Trust for America's Health. The summary below is intended for comparing a state's activities as of 2008 with others and provides information on state-specific policies as well as the number of states implementing a particular policy. For more information on recommended policy strategies, go to: www.reversechildhoodobesity.org.

ECONOMIC INDICATORS	CA	National
Estimated adult obesity-attributable medical expenditures, 1998-2000 (in 2003 dollars)	\$7,675 M	\$75 Billion
OBESITY-RELATED STATE INITIATIVES		
Snack and/or soda tax	YES	29 states + DC
Menu labeling law	YES	2 states
<i>Complete the Streets</i> policy	YES	9 states
OBESITY-RELATED SCHOOL STANDARDS		
Nutritional standards for school meals and snacks that go beyond existing USDA requirements.	YES	19 states
Nutritional standards for competitive food products sold a la carte, in vending machines, school stores or at bake sales	YES	27 states
Limited access to competitive food	YES	28 states
BMI or health information collected	YES	21 states
CHILD CARE CENTER LICENSING REGULATIONS		
Meals and snacks should follow meal requirements	YES	29 states
Meals and snacks should be consistent with Dietary Guidelines for Americans	NO	2 states
Have policy prohibiting or limiting foods of low nutritional value	NO	12 states
Have policy on vending machines	NO	4 states
Require vigorous or moderate physical activity	NO	8 states

TECHNICAL NOTES

The 2007 National Survey of Children's Health (NSCH) provides parent-reported information on the health and well-being of children in each state and nationwide. Overweight and obesity are calculated from the child's height and weight as reported by the parent or guardian. Children with BMI between the 85th and 95th percentiles are classified as overweight; those with a BMI at or above the 95th percentile are classified as obese. For more information on survey methods and analysis, visit:

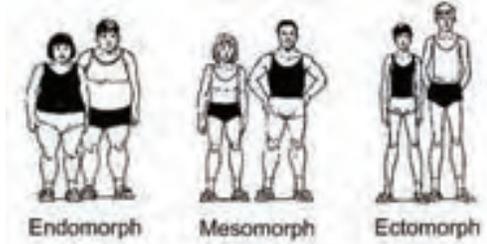
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slais/nsch07/2_Methodology_Report/NSCH_Design_and_Operations_052109.pdf

1. Data Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. <http://www.childhealthdata.org/>
2. Compares data, where available, between 2003 and 2007. This column does not take into account the significance of the change since 2003.
3. Federal Poverty level is defined by 2007 data according to HHS poverty guidelines. The 2007 definition defines 100% of poverty as \$20,650 per year for a family of four.
4. Disparity Ratios estimate the magnitude of differences between rates of overweight/obesity for any two groups of children within each state. They are calculated by dividing the rate for the more vulnerable/minority group by the rate for the less vulnerable/majority group. States are ranked by lowest to highest disparity ratios, such that a lower number ranking indicates a lower level of disparity between the groups in that state.
5. NA – Not Available. Estimates with a relative standard error greater than 30%, or based on an un-weighted sample of fewer than 25 children, are considered unreliable and are not reported. State rankings on disparity ratios include only those states with reliable estimates for both groups.
6. Hispanic here is defined as ethnicity and compares those who self-identify as Hispanic with all individuals who do not self-identify as Hispanic

Getting to Know How You Feel about You!

(Elementary ages, gender neutral)

Circle the Body shape that looks almost like yours.



Circle the number beside the question according to how you think and feel about the question.

I Feel Sad	I Feel OK	I Feel Happy	
1	2	3	
1	2	3	1. When I look in the mirror.
1	2	3	2. When my family mention my looks.
1	2	3	3. When I compare my looks with what I see on TV and in magazines.
1	2	3	4. When I compare my looks to my friends.
1	2	3	5. When I try on new clothes.
1	2	3	6. About how boys or girls talk about my looks.
1	2	3	7. About the size and shape of my body.
1	2	3	8. How much food I eat.
1	2	3	9. How I talk about my looks and body.
1	2	3	10. How often I exercise.

What do you want to say?

(continue on back)

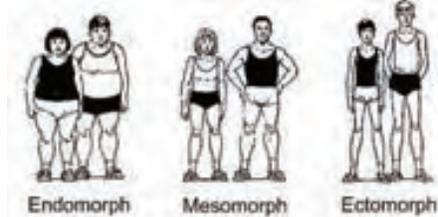
Remember: How you feel about yourself is important to your health!



Getting to Know How You Feel about You!

(Middle to High school ages, gender neutral)

Circle the Body type that most closely resembles your shape:



Answer these simple but important questions about what you think and feel about your self-image. Circle the number beside the question according to how you think and feel about the question.

I Feel Unhappy 1	I Feel Discouraged 2	I Feel OK 3	I Feel Good 4	
1	2	3	4	1. When I look in the mirror before putting on clothes.
1	2	3	4	2. When others talk about my appearance.
1	2	3	4	3. When I compare my looks with what I see on TV and in magazines.
1	2	3	4	4. When I compare my looks to my peers.
1	2	3	4	5. When I go shopping for clothes.
1	2	3	4	6. About how the opposite sex talks about my looks.
1	2	3	4	7. About the size and shape of my body.
1	2	3	4	8. How my family talks about my looks/body.
1	2	3	4	9. How I communicate about my looks.
1	2	3	4	10. The way I eat and exercise.

What do you want to say?

(continue on back)

Remember: You take you wherever you go!!!

Practitioner Assessment Guide:

Based on the Self-worth, self-esteem Assessment Tool, a participant may be experiencing body image issues affecting food and exercise choices in the following manner:

Assessment Scale:	Advisory Recommendation
10 – 18	Immediately refer adolescent for support services to seek counseling that may include social or psychological services as well as enrolled nutrition and fitness program. Engage family on the appropriate level.
19 – 29	Adolescent is at a pivotal point in their development of positive or negative body image, possibly establishing an unhealthy perception of self-image. Should be immediately referred to services highlighted by assessment self-disclosure. Peer edutainment programs, self-esteem building programs, would be very advisable. Family awareness and advisement.
30 – 40	Play close attention to the questions answered in the negative to see exactly where the adolescent is expressing concern and give pointed suggestions for proper attention. Praise and encourage the positive self-image issues raised. Give specific fitness regiment warranted according to diagnosis.

Note to Health Care Provider:

The Practitioner Assessment Guide when used in tandem with the Self-worth/Self-esteem Assessment Tool provides a basic evaluation of the impact of self esteem and self worth (comparative worth) on physical and emotional/mental health. The assessment is two-layered:

- I. Self-identified feelings from patient concerning their self-worth/esteem
- II. Comparative analysis of assessment and physician diagnosis and checklist

Resources for Teen Health Care Providers Regarding Obesity

Adolescent Health Working Group's Body Basics Tool Kit

www.ahwg.net/knowledgebase/nodates.php?pid=79&tpid=2

American Medical Association Boy's Guide to Becoming a Teen

Paw Prints, 2008.

Ethnic Differences in Weight Control Practices Among U.S. Adolescents from 1995 to 2005

Y. May Chao, Emily M. Pisetsky, Lisa C. Dierker, Faith-Anne Dohm, Francine Rosselli, Alexis M. May, Ruth H. Striegel-Moore, International Journal of Eating Disorders, (DOI: 10.1002/eat.20479).

Body Image and Self-Esteem

KidsHealth - the Web's most visited site about children's health.

http://kidshealth.org/teen/your_mind/body_image/body_image.html

Eating Disorders in Adolescents

Science Daily: News & Articles in Science, Health, Environment & Technology.

<http://www.sciencedaily.com/releases/2007/11/071119113857.htm>

Teens' Self-Image Shaped by Friends, Family, TV

MarketingCharts: Charts & Data for Marketers Online.
<http://www.marketingcharts.com/television/teens-self-image-shaped-by-friends-family-tv-3967/otx-teen-happiness-things-that-influence-how-feel-about-yourselfjpg/>

My Overweight Teen | Weight Loss for Kids.

www.overweightteen.com

Research: What Girls Say: Body Image

Girl Scouts of the U.S.A. Web.

http://www.girlscouts.org/research/what_girls_say/body_image.asp

Report of the APA Task Force on the Sexualization of Girls

American Psychological Association (APA).

<http://www.apa.org/pi/women/programs/girls/report.aspx>

Teen Self Image - Troubled Teen

Troubled Teen - Issues, Suicide, Depression, Pregnancy.

<http://www.troubledteen101.com/articles60.html>

Teens and Self-esteem

Palo Alto Medical Foundation.

<http://www.pamf.org/teen/life/depression/selfesteem.html>

Teen Obesity

Palo Alto Medical Foundation.

www.pamf.org/teen/health/diseases/obesity.html

Obesity in Children and Teens

American Academy of Child & Adolescent Psychiatry.

http://www.aacap.org/cs/root/facts_for_families/obesity_in_children_and_teens

The Seven Habits of Highly Effective Teens. Sean Covey.com - Inspiring Greatness in Youth

http://www.seancovey.com/books_7habits.html

The Teen Health Book: A Parents' Guide to Adolescent Health and Well-being.

Lopez, Ralph I., and Kate Kelly. New York: W.W. Norton & Co., 2003.



California Health Plan Interpreter Services Directory - June 2011

Plan Name	Phone
Aetna Health of California, Inc.	Customer Service: 800-756-7039 TTY/TDD number: 877-688-9891
Alameda Alliance for Health	In-person: (510) 747-4567 - 3 days in advance TTY/TDD (510) 747-4501 By Telephone: 877-263-0939 during appointment
Anthem Blue Cross Partnership Plan	In-person: (800) 407-4627 -3 days in advance TTY/TDD (888) 757-6034 By Telephone: 800-407-4627 during appointment After Hours: 800-224-0336
Blue Shield of California	In-person: (800) 424-6521 - 5 days in advance TTY/TDD 800-241-1823 By telephone: 800-424-6521 during appointment
CalOptima	In-Person: (888) 587-8088 - 3 days in advance TTY/TDD (714) 246-8523 By Telephone: Cal Optima Kids Plan call: 800-530-2899 during appointment
Care 1st Partner Plan, LLC	In-person: (800) 605-2556 - 5 days in advance TTY/TDD (800) 735-2929 By Telephone: 800-605-2556 during appointment
Care1st Health Plan	In-person: 800-847-1222 - 5 days in advance By Telephone: 800-847-1222 during appointment
Central California Alliance for Health	In-person: (800) 700-3874 ext. 5505 (4877) - 4 days in advance TTY/TDD (877) 548-0857 By Telephone: 800-523-1786 during appointment



Plan Name	Phone
CenCal Health	In-person: (877) 814-1861 TTY/TDD (805) 685-4131
Chinese Community Health Plan	Customer service: 415-834-2118 or 1-866-HMO-CCHP TTY/TDD number: 877-681-8898
CIGNA HMO	Customer service: 1-888-992-4462 TTY/TDD number: 711 (state relay service)
Community Health Group Partnership Plan	In-person: (800) 224-7766 - 2 days in advance TTY/TDD (800) 735-2929 By Telephone: 800-224-7766 during appointment
Contra Costa Health Plan	In-person: (877) 661-6230 - 2 days in advance TTY/TDD (800) 735-2929 By Telephone: 877-661-6230 during appointment
Family Mosaic Project (No Website)	In-person: (415) 206-7600 - 1 week in advance By Telephone: (415) 206-7600 1 week in advance
Health Net Community Solutions, Inc.	In-person: (800) 675-6110 - 1 day in advance TTY/TDD (800) 431-0964 By Telephone: 800-675-6110 during appointment
Health Plan of San Joaquin	In-person: (888) 936-7526 - 1 week in advance TTY/TDD (209) 942-6306 By Telephone: 800-874-9426 during appointment
Health Plan of San Mateo	In-person: (650) 616-0050 or (800) 750-4776 - 10 days in advance TTY/TDD (650) 616-8037 By Telephone: 800-750-4776 during appointment
Inland Empire Health Plan	In-person: (800) 440-4347 - 5 days in advance TTY/TDD (800) 718-4347 By Telephone: 800-440-4347 during appointment



Plan Name	Phone
Kaiser Permanente	In-person: 877-886-3885 helpful to call ahead but not necessary (800) 464-4000 English (800) 788-0616 Spanish (800) 757-7585 Chinese Dialects TTY/TDD (800) 777-1370 By Telephone: 877-866-3885 during appointment
Kern Family Health Care	In-person: (800) 391-2000 - 1 day in advance TTY/TDD (800) 735-2929 By Telephone: 800-391-2000 during appointment
L. A. Care Health Plan	In-person: (888) 839-9909 OR 213-694-1250 - 3 days in advance TTY/TDD (866) 522-2731 By Telephone: 800-259-4521 during appointment
Molina Healthcare of California Partner Plan, Inc.	In-person: (888) 665-4621 - 5 days in advance TTY/TDD (800) 479-3310 By Telephone: 888-665-4621 during appointment
PacifiCare of California	Customer service: 800-624-8822 TTY/TDD number: 800-442-8833
Partnership Health Plan of California	In-person: Solano or Napa County call: 707-863-4120 - 2 days in advance Yolo County call: (800) 863-4155 - 2 days in advance TTY/TDD (800) 226-2140 By Telephone: 800-874-9426 during appointment
Premier Access	By Telephone: 888-584-5830 during appointment
San Francisco Health Plan	In-person: (800) 288-5555 before appointment date TTY/TDD (888) 833-7347 By Telephone: 800-288-5000 during appointment
Santa Clara Family Health Plan	In-person: (800) 260-2055 - 2 days in advance TTY/TDD (800) 735-2929 By Telephone: 800-324-8033 during appointment



Plan Name	Phone
Sharp Health Plan	In-person: 800-359-2002 - 1 week in advance By Telephone: 800-359-2002 during appointment
Universal Care Medical & Dental	In-person: 800-635-6668 - 5 days in advance By Telephone: 800-635-6668 during appointment
Ventura County Healthcare Plan	In-person: 800-600-8247 OR 805-677-8787 - 2 days in advance By Telephone: 800-600-8247 OR 805-677-8787 during appointment
Western Health Advantage	In-person: 916-734-2321 when you schedule appointment By Telephone: 916-734-2321 during appointment
Delta Dental	In-person: 877-580-1042 - 2 days in advance By Telephone: 877-580-1042 during appointment
Safeguard Dental Plan	By Telephone: 800-880-3080 during appointment
Healthy Families Vision Program/VSP	In-person: 800-877-7239 - 1 day in advance By Telephone: 800-877-7239 - 1 day in advance



PROMOTING CULTURAL and LINGUISTIC COMPETENCY Self-Assessment Checklist for Personnel Providing Primary Health Care Services

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently, or statement applies to me to a great degree

B = Things I do occasionally, or statement applies to me to a moderate degree

C = Things I do rarely or never, or statement applies to me to minimal degree or not at all

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

- _____ 1. I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

- _____ 2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures and languages of individuals and families served by my program or agency.

- _____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the culture and ethnic backgrounds of individuals and families served by my program or agency.

- _____ 4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.



COMMUNICATION STYLES

5. When interacting with individuals and families who have limited English proficiency I always keep in mind that:
- _____ *
- _____ *
- _____ *
- _____ 6. I use bilingual/bicultural or multilingual/multicultural staff, and/or personnel and volunteers who are skilled or certified in the provision of medical interpretation services during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.
- _____ 7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words so that I am better able to communicate with them during assessment, treatment or other interventions.
- _____ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment, health promotion and education or other interventions.
- _____ 9. For those who request or need this service, I ensure that all notices and communiqués to individuals and families are written in their language of origin.
- _____ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.
- _____ 11. I understand the principles and practices of linguistic competency and:
- _____ *
- _____ *
- _____ 12. I understand the implications of health literacy within the context of my roles and responsibilities.
- _____ 13. I use alternative formats and varied approaches to communicate and share information with individuals and/or their family members who experience disability.

VALUES & ATTITUDES

- _____ 14. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
- _____ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.
- _____ 16. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that show cultural insensitivity, racial biases, and prejudice.
- _____ 17. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
- _____ 18. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).
- _____ 19. I accept and respect that male-female roles may vary significantly among different cultures (e.g. who makes major decisions for the family).
- _____ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).
- _____ 21. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.
- _____ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.
- _____ 23. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.
- _____ 24. I understand that the perception of health, wellness, and preventive health services have different meanings to different cultural groups.
- _____ 25. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.
- _____ 26. I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.



VALUES & ATTITUDES (CON'T)

- _____ 27. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.
- _____ 28. I understand that grief and bereavement are influenced by culture.
- _____ 29. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
- _____ 30. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.
- _____ 31. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally diverse groups served by my program or agency.
- _____ 32. I keep abreast of the major health and mental health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.
- _____ 33. I am aware of specific health and mental health disparities and their prevalence within the communities served by my program or agency.
- _____ 34. I am aware of the socio-economic and environmental risk factors that contribute to health and mental health disparities or other major health problems of culturally and linguistically diverse populations served by my program or agency.
- _____ 35. I am well versed in the most current and proven practices, treatments, and interventions for the delivery of health and mental health care to specific racial, ethnic, cultural and linguistic groups within the geographic locale served by my agency or program.
- _____ 36. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, and linguistically diverse groups.
- _____ 37. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

How to use this checklist

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic competence in health, mental health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health and mental health care delivery programs.



Healthy Lifestyle Questionnaire

Patient Name _____ Date _____

Health Care Provider Name _____

How many hours of television does your child watch each day?

0 - 2 3 - 5 more than 5

How many hours does your child spend playing video or computer games each day?

0 - 2 3 - 5 more than 5

How often does your child play outside?

Daily Sometimes Rarely Never

Is it safe for your child to play outside?

Yes No

How often does your family do something active together?

Daily Sometimes Rarely Never

Examples of activity _____

How often do you play actively with your child?

Daily Sometimes Rarely Never

What does your family eat in a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Does your child eat breakfast every day?

Yes No

When eating at home, does your family routinely eat while watching TV?

Yes No

How often does your family eat out each week?

Daily Sometimes Rarely Never

How often are fruits and vegetables included as part of your meals?

Daily Sometimes Rarely Never

How many sodas or sweetened beverages does your child drink each day?

0 1 - 3 more than 3



CARE PLANNING GUIDE FOR OVERWEIGHT CHILDREN AND ADOLESCENTS

Name _____ Birthdate _____ Date _____

BMI AND EXPECTED GROWTH PATTERN

1. Height _____ in or _____ cm (without shoes) Weight _____ lb or _____ kg
2. Height for age % ile ____ Is height below the 3rd % ile for age? No Yes
3. Calculate body mass index (BMI = kg/m²) = _____ BMI % ile _____
Is the BMI above 85th % ile? No Yes Is the BMI above the 95th % ile? No Yes
4. Tanner stage- Females: Breast I II III IV V Pubic Hair I II III IV V Age at menses onset _____
5. Tanner stage- Males: Genitals I II III IV V Pubic Hair I II III IV V Is puberty delayed? N Y
6. Weight history, pattern of weight gain _____
7. Is body size and shape similar to parents or grandparents? No Yes _____

DOES THE WEIGHT FIT WITH THE EXPECTED GROWTH FOR THAT CHILD? No Yes

NOTES _____

MEDICAL RISK

CHILD'S MEDICAL HISTORY	CURRENT OR PAST HISTORY?		NOTES
	NO	YES	
1. Asthma/reactive airway disease	<input type="radio"/>	<input type="radio"/>	_____
2. Diabetes Mellitus or hyperglycemia	<input type="radio"/>	<input type="radio"/>	_____
3. Eating disorder	<input type="radio"/>	<input type="radio"/>	_____
4. High blood pressure (BP ≥ 95 th percentile) Current BP _____/_____	<input type="radio"/>	<input type="radio"/>	_____
5. High total plasma cholesterol	<input type="radio"/>	<input type="radio"/>	_____
6. Low HDL cholesterol level	<input type="radio"/>	<input type="radio"/>	_____
7. Irregular menses	<input type="radio"/>	<input type="radio"/>	_____
8. Orthopedic problems	<input type="radio"/>	<input type="radio"/>	_____
9. Cardiac or Pulmonary problems	<input type="radio"/>	<input type="radio"/>	_____
10. Sleep problems	<input type="radio"/>	<input type="radio"/>	_____
11. Thyroid problems	<input type="radio"/>	<input type="radio"/>	_____
12. Current Medications: _____			

★ Quick Tip

Patients and their families may have socioeconomic reasons for not adhering to a particular lifestyle.

They may have limited access to healthy food choices, have unreliable transportation, limited finances, or live in an unsafe neighborhood preventing outdoor physical activity.

Be Sure to Follow Up and Ask!



FAMILY HISTORY	NO	YES	FAMILY MEMBER(S)
Diabetes (takes insulin <input type="radio"/> No <input type="radio"/> Yes)	<input type="radio"/>	<input type="radio"/>	

Eating disorder or frequent dieting	<input type="radio"/>	<input type="radio"/>	_____
Heart attack/stroke (age _____)	<input type="radio"/>	<input type="radio"/>	_____
High blood pressure	<input type="radio"/>	<input type="radio"/>	_____
High blood cholesterol	<input type="radio"/>	<input type="radio"/>	_____
Overweight	<input type="radio"/>	<input type="radio"/>	_____

MEDICAL RISK? **LOW** **MEDIUM** **HIGH**
NOTES _____

DIET AND ACTIVITY RISK

- DIETING HISTORY: Past dieting or weight management efforts? No Yes

- FOOD CHOICES: High fat/high sugar foods or beverages? _____
 Food at school? _____
 Snacks/meals eaten out? _____
 Nutritional adequacy issues: 3 servings daily? _____
 5 servings fruits and vegetables? _____
- FOOD PATTERN: # Meals and snacks/day? _____ Meal skipping? _____
 Dieting, fasting, or diet pill use? _____ Family meals? _____
- HUNGER AND SATIETY CUES: Normal hunger and fullness sensations? _____
 Eating when not hungry? _____
- PHYSICAL ACTIVITY: # days/week? _____ Type of sports or activities? _____
 Family exercise? _____ If no, reasons? _____
- SEDENTARY ACTIVITY: # hours/day of TV, computer and video games? _____
 Limits on TV/computer time? _____

DIET AND ACTIVITY RISK? **LOW** **MEDIUM** **HIGH**
NOTES _____

★ Quick Tip

Ask about traditional foods that are consumed by the patient's family.



PSYCHOSOCIAL ASSESSMENT

1. BODY IMAGE _____ Extreme body dissatisfaction? _____
2. DEPRESSION? _____
3. DIVISION OF RESPONSIBILITIES AROUND EATING: Does parent provide a variety of Nutritious foods and limit high fat, high sugar foods? _____
Does parent allow child to eat until satisfied? _____
Does parent restrict food? _____
4. EMOTIONS AND EATING: Overeat when feeling sad or angry? _____
Feeling of not being able to stop eating? _____
Guilty about overeating? _____
Vomiting or laxatives to feel better after eating? _____
5. FAMILY AND FRIENDS: Friends or someone to talk to? _____
Serious teasing or criticism about weight? _____
Isolation or withdrawal from activities? _____
Good communication with all family members? _____
Family stress or dysfunction? _____
6. SCHOOL: Attendance? _____ Grades or change in grades? _____
7. STRESSFUL LIFE EVENTS: Move? _____ School? _____ Divorce? _____
Serious illness or death? _____
8. WEIGHT-RELATED EXPECTATIONS: Goals made? _____
Appropriate? _____ Changes made? _____

PSYCHOSOCIAL RISK? LOW MEDIUM HIGH

NOTES _____

GOALS AND CARE PLAN

★ Quick Tip

Adolescents use alcohol to varying degrees, depending on the culture of their peer groups or families, or as a coping mechanism. Sensitive inquiry about alcohol use - both as part of the psychosocial assessment and to identify a potential source of extra calories.



This assessment tool was adapted from the SHAPEDOWN program.





Contract for _____ Healthy Lifestyle

1. _____

2. _____

3. _____

Patient's Signature

Date



Self-Administered Food Security Survey Module for Children Ages 12 Years and Older¹

1. Did the food that your family bought run out and there wasn't enough money to buy more?
 A LOT
 SOMETIMES
 NEVER
2. Did your meals only include a few kinds of cheap foods because your family was running out of money to buy food?
 A LOT
 SOMETIMES
 NEVER
3. How often were you not able to eat a balanced meal because your family didn't have enough money?
 A LOT
 SOMETIMES
 NEVER
4. Did you have to eat less because your family didn't have enough money to buy food?
 A LOT
 SOMETIMES
 NEVER
5. Has the size of your meals been cut because your family didn't have enough money for food?
 A LOT
 SOMETIMES
 NEVER
6. Did you have to skip a meal because your family didn't have enough money for food?
 A LOT
 SOMETIMES
 NEVER
7. Were you hungry but didn't eat because your family didn't have enough food?
 A LOT
 SOMETIMES
 NEVER
8. Did you not eat for a whole day because your family didn't have enough money for food?
 A LOT
 SOMETIMES
 NEVER

U.S. Household Food Security Survey Module: Six-Item Short Form²

1. "The food that we bought just didn't last, and we didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last 12 months?
 Often true
 Sometimes true
 Never true
 Don't know or Refused

2. "We couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 12 months?
 Often true
 Sometimes true
 Never true
 Don't know or Refused

3. In the last 12 months, since last (name of current month), did you or other members in your household, ever cut the size of your meals or skip meals because there wasn't enough money for food?
 Yes
 No
 Don't know

4. [IF YES ABOVE] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?
 Almost every month
 Some months but not every month
 Only 1 or 2 months
 Don't know

5. In the last 12 months, did your family ever eat less than you felt you should because there wasn't enough money for food?
 Yes
 No
 Don't know

6. In the last 12 months, was your family ever hungry but didn't eat because there wasn't enough money for food?
 Yes
 No
 Don't know

¹ Connell, C., Nord, M., Lofton, K., and Yadrick, K. "Food Security of Older Children Can Be Assessed Using a Standardized Survey Instrument," *The Journal of Nutrition* 134:2566-72. (2004)

² Bickel, G., Cook, J., Hamilton, W., Nord, M., Price, C. "Guide to Measuring Household Food Security, Revised 2000." *U.S. Department of Agriculture, Food and Nutrition Service*. (2000).

USDA Dietary Guidelines (2011)

Make Half Your Plate Fruits and Vegetables

How much fruit is needed daily?

The amount of fruit you need to eat depends on age, sex, and level of physical activity. Recommended amounts are shown in the table below.

Daily recommendation*		
Children	2-3 years old	1 cup
	4-8 years old	1 to 1 ½ cups
Girls	9-13 years old	1 ½ cups
	14-18 years old	1 ½ cups
Boys	9-13 years old	1 ½ cups
	14-18 years old	2 cups



These amounts are appropriate for individuals who get less than 30 minutes per day of moderate physical activity, beyond normal daily activities. Those who are more physically active may be able to consume more while staying within calorie needs.

How many vegetables are needed daily or weekly?



The amount of vegetables you need to eat depends on your age, sex, and level of physical activity. Recommended total daily amounts are shown in the first chart. Recommended weekly amounts from each vegetable subgroup are shown in the second chart.

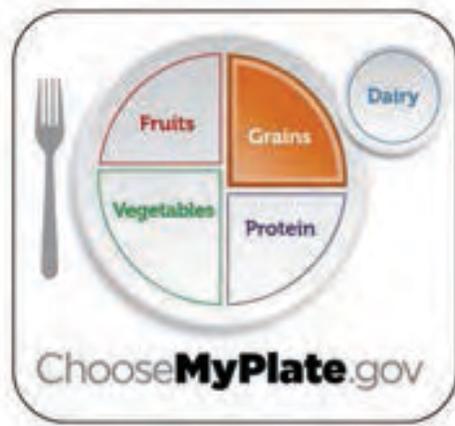
Daily recommendation*		
Children	2-3 years old	1 cup
	4-8 years old	1½ cups
Girls	9-13 years old	2 cups
	14-18 years old	2½ cups
Boys	9-13 years old	2½ cups
	14-18 years old	3 cups

Vegetable subgroup recommendations are given as amounts to eat WEEKLY. It is not necessary to eat vegetables from each subgroup daily. However, over a week, try to consume the amounts listed from each subgroup as a way to reach your daily intake recommendation.

		Dark green vegetables	Red and orange vegetables	Beans and peas	Starchy vegetables	Other vegetables
AMOUNT PER WEEK**						
Children	2-3 yrs old	½ cup	2½ cups	½ cup	2 cups	1½ cups
	4-8 yrs old	1 cup	3 cups	½ cup	3½ cups	2½ cups
Girls	9-13 yrs old	1½ cups	4 cups	1 cup	4 cups	3½ cups
	14-18 yrs old	1½ cups	5½ cups	1½ cups	5 cups	4 cups
Boys	9-13 yrs old	1½ cups	5½ cups	1½ cups	5 cups	4 cups
	14-18 yrs old	2 cups	6 cups	2 cups	6 cups	5 cups

These amounts are appropriate for individuals who get less than 30 minutes per day of moderate physical activity, beyond normal daily activities. Those who are more physically active may be able to consume more while staying within calorie needs.

The Grain Group – ¼ of Your Plate



Any food made from wheat, rice, oats, cornmeal, barley or another cereal grain is a grain product. Bread, pasta, oatmeal, breakfast cereals, tortillas, and grits are examples of grain products.

Grains are divided into 2 subgroups, **whole grains** and **refined grains**.

Whole grains contain the entire grain kernel — the bran, germ, and endosperm. Examples include:

- whole-wheat flour
- bulgur (cracked wheat)
- oatmeal
- whole cornmeal
- brown rice

Refined grains have been milled, a process that removes the bran and germ. This is done to give grains a finer texture and improve their shelf life, but it also removes dietary fiber, iron, and many B vitamins. Some examples of refined grain products are:

- white flour
- degermed cornmeal
- white bread
- white rice

Most refined grains are enriched. This means certain B vitamins (thiamin, riboflavin, niacin, folic acid) and iron are added back after processing. Fiber is not added back to enriched grains. Check the ingredient list on refined grain products to make sure that the word “enriched” is included in the grain name. Some food products are made from mixtures of whole grains and refined grains.

How many grain foods are needed daily?

The amount of grains you need to eat depends on your age, sex, and level of physical activity. Recommended daily amounts are listed in the chart. Most Americans consume enough grains, but few are whole grains. **At least half of all the grains eaten should be whole grains.**

		Daily recommendation*	Daily minimum amount of whole grains
Children	2-3 years old	3 ounce equivalents	1 ½ ounce equivalents
	4-8 years old	5 ounce equivalents	2 ½ ounce equivalents
Girls	9-13 years old	5 ounce equivalents	3 ounce equivalents
	14-18 years old	6 ounce equivalents	3 ounce equivalents
Boys	9-13 years old	6 ounce equivalents	3 ounce equivalents
	14-18 years old	8 ounce equivalents	4 ounce equivalents

The Protein Group – ¼ of Your Plate



All foods made from meat, poultry, seafood, beans and peas, eggs, processed soy products, nuts, and seeds are considered part of the Protein Foods Group. Beans and peas are also part of the Vegetable Group

Select a variety of protein foods to improve nutrient intake and health benefits, including at least 8 ounces of cooked seafood per week. Young children need less, depending on their age and calories needs. The advice to consume seafood does not apply to vegetarians. Vegetarian options in the Protein Foods Group include beans and peas, processed soy products, and nuts and seeds. Meat and poultry choices should be lean or low-fat.

How much food from the Protein Foods Group is needed daily?

The amount of food from the Protein Foods Group you need to eat depends on age, sex, and level of physical activity. Most Americans eat enough food from this group, but need to make leaner and more varied selections of these foods. Recommended daily amounts are shown in the chart.

Vegetarians get enough protein from this group as long as the variety and amounts of foods selected are adequate. Protein sources from the Protein Foods Group for vegetarians include eggs (for ovo-vegetarians), beans and peas, nuts, nut butters, and soy products (tofu, tempeh, veggie burgers).

The Dairy Group - Switch to fat-free or low-fat (1%) milk.



All fluid milk products and many foods made from milk are considered part of this food group. Most Dairy Group choices should be fat-free or low-fat. Foods made from milk that retain their calcium content are part of the group. Foods made from milk that have little to no calcium, such as cream cheese, cream, and butter, are not. Calcium-fortified soymilk (soy beverage) is also part of the Dairy Group.

How much food from the Dairy Group is needed daily?

The amount of food from the Dairy Group you need to eat depends on age. Recommended daily amounts are shown in the chart below.

Choose fat-free or low-fat milk, yogurt, and cheese. If sweetened milk products are chosen (flavored milk, yogurt, drinkable yogurt, desserts), the added sugars also count against your maximum limit for "empty calories" (calories from solid fats and added sugars with few or no nutritional value).

Daily recommendation		
Children	2-3 years old	2 cups
	4-8 years old	2 ½ cups
Girls	9-13 years old	3 cups
	14-18 years old	3 cups
Boys	9-13 years old	3 cups
	14-18 years old	3 cups

Childhood Obesity

Multicultural Patient Communications Vignette

Patient Overview

Juan is a 12 year old male referred to your office for ER follow-up after presenting with chest pain. He had a negative cardiac workup in the ER and elevated random blood sugar of 196 mg/dl. He was born in San Diego. Both of his parents are of Mexican descent. English is the primary language spoken at home.

Juan's father is morbidly obese and has type 2 diabetes and hypertension. Juan is obese with a height of 65 inches, weight of 190 pounds. He has acanthosis nigricans and labs consistent with pre-diabetes. Juan also has no health insurance.

What are possible challenges to successful multicultural communications?

Health Access Needs

- In your communication with Juan, be aware that there may be some reluctance to get health insurance due to the citizenship process or repayment concerns. Lack of insurance is likely why Juan and his family went to the emergency room for care. The family will need assistance in finding health care coverage and the best ways to utilize the health care system.

Perception of Healthcare Providers

- Direct disagreement with a healthcare provider is very uncommon. The more usual response to a decision with which the patient or family disagrees is silence and noncompliance. Reinforcing verbally, writing down instructions and asking open-ended questions as to their understanding is important. For example, is there anything you see as a barrier for you to doing "this action."

Cultural Perception of Illness

- Within the Latino community, there may be a fatalistic sense of health – "Fatalismo". This reflects a belief that individuals can do little to alter fate. The patient may delay in seeking medical treatment. Be aware of this to have a dialogue with the patient about treatment and proposed interventions.

Traditional & Folk Remedies

- Among Latinos it is not uncommon for traditional and folk remedies not to be shared with the patient's healthcare provider as well as the use of herbs and other alternative healing methods. You should ask about alternative remedies.

Utilize the patient communication mnemonic, LEARN, in your discussion with Juan.

L

- Listen with sympathy and understanding to Juan's perception of his obesity.

E

- Explain your perceptions of this situation and your strategy for initiating treatment options.

A

- Acknowledge and discuss with Juan the differences and similarities between yours and his perception of his obesity and its health impacts.

R

- Recommend treatment to Juan and his family while remembering his cultural parameters.

N

- Negotiate agreement for the solution and steps Juan can take to reduce his weight and lower his BMI.





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