



Children's National Medical Center Policy Statement: Childhood Obesity

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

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

- ✓ 16 percent of children (more than 9 million) between the ages of 6-19 years are overweight or obese -- a number that has tripled since 1980.¹
- ✓ Over the past three decades, the childhood obesity rate has more than doubled for preschool children aged 2-5 years and adolescents aged 12-19 years, and it has more than tripled for children aged 6-11 years.¹
- ✓ Overweight adolescents have a 70 percent chance of becoming overweight or obese adults. This increases to 80 percent if one or more parent is overweight or obese.²

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Body Mass Index Screening

A. Body Mass Index (BMI) is the most widely used measure of weight-related health risk. Children's National believes BMI measurement is most appropriately carried out in the primary care medical home. Some states, however, have implemented mandatory BMI screening in public schools as a means to assess the weight status of individual students and provide this information to parents with guidance for action. Based on clinical evidence and the lack of proven efficacy⁴, Children's National does not endorse mandatory BMI screening in public schools. Children's National believes school resources are more appropriately directed to

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

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

Poor Reimbursement as a Barrier to Care

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

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

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

Approved by the Children's National Medical Center Board on the 24th day of April 2008.

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

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