

Q&A with Dr. Thompson, Surgeon General of Arkansas and Director of the Arkansas Center for Health Improvement:

Q: Is the Arkansas program primarily "screening" or "surveillance" in nature?

A: It is both. For parents, the BMI assessment provides an important health screening when they receive results for their child via the confidential child health report. In addition, our office does an analysis of the BMI data to provide a surveillance tool on school, school district, county and statewide levels. The results of this analysis are presented in report form via the ACHI website at www.achi.net.

Q: How has Arkansas addressed screening in large school systems - is every child measured and does every child's parents receive a report of their child? If so, who is doing all this work?

A: For the first four years, all public school students were screened. Last year (2007-2008) the periodicity of screening was changed. BMI screening is still done each year, but only for children in even number grades – K, 2, 4, 6, 8 and 10. This is handled much like other screenings, such as vision and hearing. Every child's parent receives a confidential child health report. School nurses are primarily responsible for conducting the screenings, often assisted by other school personnel. The child's height, weight, date of assessment, date of birth and gender are input into a web-based system that calculates the child's BMI percentile and generates the child health report.

Q: Who collects the data? Is it school nurses?

A: School nurses are primarily responsible for conducting measurements and inputting data. ACHI uses the data to generate child health reports, school, school district, county and statewide reports.

Q: What software does Arkansas use to collect the data, send reports to parents, and for the analysis/reporting?

A: A web-based program was built specifically for our purposes.

Q: How long did it take for legislation to pass to collect BMI data in Arkansas?

A: This legislation was passed in 2003, following a childhood obesity policy summit held in 2002 to explore recommendations for addressing the epidemic in our state.

Q: How long did it take Arkansas to implement the initial BMI screening process and what follow up was provided for children overweight?

A: The initial BMI screening process was implemented during the 2003-2004 school year. For the first year, assessments were done on paper. The next year a web-based system was developed, piloted during year three and available for all assessments by year four. Parents of all students assessed are advised of the BMI results for their child via a confidential child health report. The report offers suggestions for healthy food options and increasing physical activity. It also recommends follow up with the child's physician.

Q: Were local physicians informed that the BMI screening was beginning at the schools? Were they supportive of the efforts?

A: Yes they were informed. Yes, they were generally supportive.

Q: Many parents and doctors are not very good at helping their children lose weight and can be very destructive in the process. What steps did you take to increase the likelihood that health care practitioner interaction with parents over their children's body weight would be high quality and positive and that there would be sufficient community resources to serve these children and their families?

A: A continuing medical education program was developed for physicians and made available through the ACHI website: <http://www.achi.net/ChildObDocs/provider.asp>. In addition, clinicians were provided with a statewide list of registered dietitians and health educators that could be referred to parents.

Q: When you gave parents the reports on the BMI status of their children, what did you do to address medical services resources for families without health insurance?

A: Arkansas already had the ARKids First Medicaid program in place. As a result, approximately 90 percent of Arkansas children have health insurance.

Q: Is the BMI improvement rate in Arkansas consistent across social economic, ethnic, and gender groupings?

A: While we have seen a halting in the progression of childhood obesity in Arkansas, we have not yet seen a reversal, or improvement. As indicated in the annual BMI assessment reports available on ACHI's website at www.achi.net, the obesity epidemic is more prevalent among Hispanic boys and African American girls. Results are reported by grade, gender and ethnicity.

Q: You mentioned that a legislative outcome of the statewide BMI assessment was that Physical Activity in schools was eliminated for all but grades K- 5. What was the thinking there?

A: This happened during the 2006-2007 legislative session, via Act 719 of 2007; an Act to increase academic instruction time by limiting physical activity requirements. This was predicated by the stretching of school resources to meet federal academic requirements like "No Child Left Behind."

Q: How are you reporting your data to the public and making the information available to practitioners such as administrators, teacher, physicians, etc in a useful way?

A: Information is available on ACHI's website at www.achi.net. In addition, many presentations are given to various stakeholder and other interested groups.

Q: How do you know that the surveillance has made a difference in the Childhood Obesity problem in your state? Could the leveling off of the weight increase be due to something else?

A: Of course it is possible that the leveling off is due to something else. However, we know via an evaluation report conducted annually by the UAMS College of Public Health that efforts related to Act 1220, including the BMI assessment program, have increased awareness of childhood obesity in our state and that parents are taking a more active role in limiting "junk food" and screen time and increasing physical activity in their homes.

Q: How many parents have opted out of this program?

A: For year five (2007-2008), 4.13 percent of parents opted out.

Q&A with Therese Hoyle, Public Health Consultant:

Q: Do you know how WIC was able to share data on childhood immunizations since WIC has strict confidentiality rules?

A: The WIC program has or will create a document that a responsible party will sign to give permission for BMI data to be shared with the Registry. In 1998 WIC sent letters to all their clients and for permission to send Immunization data to the registry. Very few parents opted out.

Q: For MI, SD and Maine, is any data collected from children who aren't seen by a medical provider?

A: It would be a program decision at MDCH if BMI data will be collected outside the medical community. The MCIR application is being utilized in all schools and child care centers in Michigan.

Q: Do any of the presenters know of school districts using CDC's EpiInfo to track BMI screening of their students?

A: I am not aware of Epi Info being used in Michigan Schools. Most of the school districts in MI have invested in applications that are student centered to collect information on the personal health of the child.

Q: How do you define a migrant school and population?

A: Definition for Migrant Health Centers: An individual or family whose principal employment [51% of time] is in agriculture on a seasonal basis, who has been so employed within the last twenty four months. A "migrant student" is defined as a student who is, or whose parent/guardian is, a migratory fisher, dairy worker, or agricultural worker, AND who in the preceding 36 months has moved from one school district to another in order for the worker to obtain temporary or seasonal employment in agricultural or fishing work.

Q&A with Dr. Deb Galuska, Associate Director of Science, Division of Nutrition, Physical Activity, and Obesity Prevention, Centers for Disease Control and Prevention:

Q: Why the change in labeling recently between obesity and overweight and at-risk of obesity? It seems uncomfortable labeling kids as "obese".

A: The new labels are based on the recommendations of an expert panel convened by AMA. A summary of the rationale for the recommendation can be found in the following citation. *Barlow SE and the Expert Committee. Expert Committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. Pediatrics 2007; 120:S164-S192.*

The panel recognized the potential for stigmatization with the terminology. As such, they recommended "the use of the clinical terms overweight and obesity for documentation and risk

assessment but the use of different terms in the clinician's office to avoid an inference of judgment or repugnance."

Q: Any suggestions for resources for community based interventions?

A: Resources for school based interventions in the community can be found at CDC's Division of Adolescent and School Health website:

<http://www.cdc.gov/HealthyYouth/keystrategies/index.htm>

The IOM report *Progress in Preventing Childhood Obesity: How Do We Measure Up?* contains a chapter on communities. Topics address in the chapter include: key elements of community-based strategies and examples of community based programs and initiatives.

Q: What are we doing to alert children, parents, and others realize that size diversity in the population is normal and that some children who fall above the 85th percentile are achieving weights that are normal and healthy for them?

A: There is no agreed-upon definition of excess body fat for children. BMI is a measure of weight adjusted for height. As such, it does not directly measure fat. However, it is correlated with amounts of fat-- that is those with a higher BMI for age and sex tend to have more fat than those with lower BMI's.

Children who have a BMI \geq the 85th percentile, however, do not necessarily have excess fat and are not necessarily at increased health risk. This is why the new AMA Expert Panel recommended that BMI measurement should not be used exclusively to determine risk but should be followed by a medical assessment to evaluate health risks.

Q: Do any of the presenters know of school districts using CDC's EpiInfo to track BMI screening of their students?

A. I do not know.

Q: What is the advantage of using BMI versus only height and age or are any of them just as good when charting?

A: BMI is a measure of weight that accounts for a child's height. This is important as height and weight are correlated. For example, a 10 year boy who weighted 90 pounds and is four feet 6 inches in height would be classified as overweight. However, if that boy had the same weight but was five feet tall he would be classified as normal weight.

Because children's height changes across time, it is important to take both height and weight into account when monitoring whether a child's weight puts them at risk for health problems.

Q: Is there a best practice for assessing overweight/obesity among high school football players? BMI may show increased risk for overweight - but it may actually be muscle instead of fat?

A: To my knowledge there is not a protocol unique to athletes. The definitions for overweight and obese discussed in the seminar are based on BMI for age and sex percentiles. BMI is a measure of weight adjusted for height. As such, adolescents with a high BMI for age and sex may not necessarily have excess fat.

To determine whether there are health risks associated with the high BMI, additional medical assessments are needed.

Q: Can any of our speakers address obesity prevention in the early years (birth to three)?

A: One obesity prevention strategy in the early years of life is breastfeeding. The following link includes a document that summarizes the evidence for the association between breastfeeding and pediatric weight status:

http://www.cdc.gov/nccdphp/dnpa/nutrition/health_professionals/practice/