NEIL ABERCROMBIE
GOVERNOR OF HAWAII

GARY L. GILL
ACTING DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

SENATE COMMITTEE ON HEALTH

SB2351, RELATING TO CHILDHOOD OBESITY

Testimony of Gary L. Gill
Acting Director of Health

January 28, 2014

Department's Position: The Department of Health (DOH) supports the intent of Senate Bill 2351.

Fiscal Implications: There would be substantial operational and personnel cost to develop and maintain an electronic system for data collection, analysis, and reporting from electronic health records (EHRs) received from individual physicians and pediatricians.

Purpose and Justification: The purpose of Senate Bill 2351 is to require primary care physicians and pediatricians to administer an annually screen the body mass index (BMI) of children, beginning at the age of two years old, and report the data to the Department of Health (DOH). The bill also proposes mandatory coverage for assessing the BMI for insured patients from two to eighteen years of age.

The Department recognizes the need to encourage physicians and pediatricians to screen children for obesity as well as the need for statewide BMI data for public health surveillance purposes. At present, the DOH does not have an information system ready to receive, analyze, and create annual reports from EHRs from individual physicians. Although the Department supports the intent of the bill we find the costs of developing the electronic system to be prohibitive and may be redundant to the efforts of the Hawaii Health Information Exchange (HHIE). The Department respectfully suggests that the data may best be collected through the HHIE. The one-time transmission of the data by physicians

to the HHIE then the transfer of the de-identified data to the DOH would provide a more efficient method for all parties, and reduce redundant resource development.

The Department appreciates the intent of SB 2351 to increase the availability of BMI data and takes the opportunity to mention House Bill (HB) 1776 and SB 2235 which would ensure that children are receiving their well child exams at kindergarten, sixth, and ninth grade by requiring an exam prior to entry into public school. Due to the Affordable Care Act, annual well child examinations are a required covered benefit in all health plans and includes BMI screening services. These measures through increasing the physical exam requirements also provides an opportunity for collecting statewide BMI data.

Thank you for the opportunity to provide testimony.

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: leolinda@resqconsultants.com
Subject: Submitted testimony for SB2351 on Jan 28, 2014 08:30AM
Date: Monday, January 27, 2014 9:36:11 AM
Attachments: SB2351-Childhood Obesity Reporting HLT-CPC.pdf

SB2351

Submitted on: 1/27/2014
Testimony for HTH/CPN on Jan 28, 2014 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Leolinda Parlin	Family Voices of HI	Comments Only	Yes

Comments: On behalf of Family Voices of Hawai`i, I offer comments related to SB 2351 which seeks to require Requires primary care physicians and pediatricians to provide an annual body mass index measurement to patients from age two to eighteen years. Requires primary care physicians and pediatricians to annually report anonymous age and body mass index statistics to the department of health. Requires health plans to cover expenses related to body mass index measurement. There may be other ways to achieve the potential desired outcome without adding undue labor to the primary care providers and Department of Health (DOH) as the current bill mandates. In addition, the bill falls short on the desired outcome, is the objective to have more children screened or to have primary care providers take action on their findings? Also, the bill would benefit from including non-physician primary care providers as part of the catchment. On the neighbor island, many children and youth are served by nurse practitioners and physician assistants. 1. Consider shifting the reporting requirement to the health plans Health plans are in a position to capture this data already through HEDIS reporting and or consistent diagnostic coding for childhood BMI. The tracking and enforcement of provider specific data reporting would be extremely cumbersome especially in light that this bill does not have an appropriation. 2. Assess if the mandate for BMI calculation that already exists is adequate The Affordable Care Act already mandates American Academy of Pediatrics guidelines for the Well Child Examination, which in effect is Bright Futures, which calls for a BMI annually (Attachment A). How are the health plans supporting their non-pediatric primary care providers in meeting these requirements? What has the HEDIS experience to date demonstrated on the actual implementation of BMI for children 2 and older? Thank you for your time and consideration.

FAMILY VOICES OF HAWAI'I

HILO PA'A
Family to Family Health Information Center

Date: January 27, 2014

To: COMMITTEE ON HEALTH
Senator Josh Green, Chair
Senator Rosalyn H. Baker, Vice Chair

To: COMMITTEE ON CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Brian T. Taniguichi, Vice Chair

Fr: Leolinda Parlin, State Coordinator for Family Voices of Hawai'i

Re: **Provide comments** – SB 2351 – RELATING TO HEALTH

On behalf of Family Voices of Hawai`i, I offer comments related to SB 2351 which seeks to require Requires primary care physicians and pediatricians to provide an annual body mass index measurement to patients from age two to eighteen years. Requires primary care physicians and pediatricians to annually report anonymous age and body mass index statistics to the department of health. Requires health plans to cover expenses related to body mass index measurement.

There may be other ways to achieve the potential desired outcome without adding undue labor to the primary care providers and Department of Health (DOH) as the current bill mandates. In addition, the bill falls short on the desired outcome, is the objective to have more children screened or to have primary care providers take action on their findings? Also, the bill would benefit from including non-physician primary care providers as part of the catchment. On the neighbor island, many children and youth are served by nurse practitioners and physician assistants.

1. Consider shifting the reporting requirement to the health plans

Health plans are in a position to capture this data already through HEDIS reporting and or consistent diagnostic coding for childhood BMI. The tracking and enforcement of provider specific data reporting would be extremely cumbersome especially in light that this bill does not have an appropriation.

2. Assess if the mandate for BMI calculation that already exists is adequate

The Affordable Care Act already mandates American Academy of Pediatrics guidelines for the Well Child Examination, which in effect is Bright Futures, which calls for a BMI annually (Attachment A). How are the health plans supporting their non-pediatric primary care providers in meeting these requirements? What has the HEDIS experience to date demonstrated on the actual implementation of BMI for children 2 and older? Thank you for your time and consideration.

1319 Punahou St., Suite 792 Honolulu, HI 96826 **voice (808)791-3467 fax (808)665-3595**

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care.**

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	PRENATAL[2]	NEWBORN[3]	3–5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 m	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[5]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision		★	★	★	★	★	★	★	★	★	★	★	★	●[6]	●	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing		●[7]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																															
Developmental Screening[8]								●			●		●																		
Autism Screening[9]											●	●																			
Developmental Surveillance[8]		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment																						★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAMINATION[10]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[11]																															
Newborn Metabolic/Hemoglobin Screening[12]		◄	●	►																											
Immunization[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[14]						★			●		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[15]							★	★	●or★[15]		★	●or★[15]		★	★	★	★														
Tuberculin Test[17]				★			★		★		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[18]												★			★		★		★		★	★	★	★	★	★	★	★	◄	●	►
STI Screening[19]																						★	★	★	★	★	★	★	★	★	★	★
Cervical Dysplasia Screening[20]																						★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH[21]							★	★	●or★[21]		●or★[21]	●or★[21]	●or★[21]	●[22]			●[22]															
ANTICIPATORY GUIDANCE[23]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (2001) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/6/1456].
3. Every infant should have a newborn evaluation after birth, breastfeeding encouraged, and instruction and support offered.
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/2/496]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement "Hospital Stay for Healthy Term Newborns" (2004) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434].
5. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
6. If the patient is uncooperative, rescreen within 6 months per the AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (2007) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/4/902].
7. All newborns should be screened per AAP statement "Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs " (2000) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/798]. Joint Committee on Infant Hearing. Year 2007 position statement: principles and guidelines for early hearing detection and intervention programs. *Pediatrics.* 2007;120:898–921.
8. AAP Council on Children With Disabilities, AAP Section on Developmental Behavioral Pediatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics.* 2006;118:405–420 [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405].
9. Gupta VB, Hyman SL, Johnson CP, et al. Identifying children with autism early? *Pediatrics.* 2007;119:152–153 [URL: http://pediatrics.aappublications.org/cgi/content/full/119/1/152].
10. At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
11. These may be modified, depending on entry point into schedule and individual need.
12. Newborn metabolic and hemoglobinopathy screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.
13. Schedules per the Committee on Infectious Diseases, published annually in the January issue of *Pediatrics.* Every visit should be an opportunity to update and complete a child's immunizations.
14. See AAP *Pediatric Nutrition Handbook,* 5th Edition (2003) for a discussion of universal and selective screening options. See also Recommendations to prevent and control iron deficiency in the United States. *MMWR.* 1998;47(RR-3):1–36.
15. For children at risk of lead exposure, consult the AAP statement "Lead Exposure in Children: Prevention, Detection, and Management" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/4/1036]. Additionally, screening should be done in accordance with state law where applicable.
16. Perform risk assessments or screens as appropriate, based on universal screening requirements for patients with Medicaid or high prevalence areas.
17. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases.* Testing should be done on recognition of high-risk factors.
18. "Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report" (2002) [URL: http://circ.ahajournals.org/cgi/content/full/106/25/3143] and "The Expert Committee Recommendations on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity." Supplement to *Pediatrics.* In press.
19. All sexually active patients should be screened for sexually transmitted infections (STIs).
20. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first).
21. Referral to dental home, if available. Otherwise, administer oral health risk assessment. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
22. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
23. Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.)

KEY

●= to be performed ★= risk assessment to be performed, with appropriate action to follow, if positive ◄—●—► = range during which a service may be provided, with the symbol indicating the preferred age

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: teresa.parsons@hawaii.edu
Subject: Submitted testimony for SB2351 on Jan 28, 2014 08:30AM
Date: Tuesday, January 28, 2014 1:10:16 PM

SB2351
Submitted on: 1/28/2014
Testimony for HTH/CPN on Jan 28, 2014 08:30AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Teresa Parsons	Individual	Support	No

Comments: As a Nurse Practitioner who is concerned about the health of our kekei and understand the epidemic of obesity (and the multitude of health problems related to obesity), I urge you to support this bill to gather "hard data" concerning the prevalence of obesity, so we, as health care providers can begin to address specific issues to improve the health and well-being of the children of Hawai'i. Mahalo for your support of this important legislation.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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