



Healthy Kids, Healthy Michigan

Advocates of Healthy Weight in Children

Healthy Weight, Overweight & Obesity Clinical Decision Support Tools for
Children Ages 2-18

Prepared for use with the Michigan Care Improvement
Registry Body Mass Index Surveillance Tool

*Materials developed by members of Healthy Kids, Healthy Michigan,
Health, Family and Child Care Services Policy Action Team,
Family & Provider Resources Task Force*

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Contact Healthy Kids, Healthy Michigan at healthykidshealthymi@gmail.com for more information.

Preface

With funding from the National Governor's Association, the Michigan Department of Community Health convened a statewide coalition, now known as Healthy Kids, Healthy Michigan Coalition, to identify top policy priorities for the state's efforts in childhood obesity prevention and treatment. Creation of a body mass index (BMI) surveillance system was selected by the Coalition as one of six policy priorities to pursue in the Coalition's first year, 2009. With one of the most advanced immunization information systems in the nation, the coalition recommended that BMI surveillance be added to the Michigan Care Improvement Registry (MCIR). Virtually every health care provider in the state already has access to the MCIR and many use it daily, to track and guide care in selected areas such as immunizations and lead screening.

The team planning the surveillance system recognized that Michigan's health care providers needed streamlined tools to apply expert guidelines to the screening, diagnosis and treatment of childhood obesity, and that the surveillance system presented an opportunity to bring such tools into the care setting. With internal funding from its Childhood Obesity Prevention Mission Project, staff from the Altarum Institute conducted a focus group with providers in the state to further specify provider needs that might be addressed through the new surveillance system.

With support from the American Heart Association, and under the auspices of the Healthy Kids, Healthy Michigan's (HKHM) Health, Family and Child Care Services Policy Action Team (HPAT), Ms. Sarah Poole convened the Family and Provider Resources Task Force which developed the tools presented in this report. Tailored for the age, gender, and weight status of children, the tools are designed to help providers efficiently assess children's risk for obesity, guide their investigation of co-morbidities, and streamline healthy weight and physical activity counseling.

The tools are consistent with the "Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Childhood and Adolescent Overweight and Obesity: Summary Report" (Barlow, 2007) and with the recommendations of the U.S. Preventive Services Task Force that all children be screened for obesity, and that children age six and above receive counseling to achieve a healthy weight (USPSTF, 2010).

The tools were developed after a review of similar tools developed by other organizations and institutions, especially *Nemours Health & Prevention Services* and the Maine Center for Public Health.

Authors of this document would like to thank Dr. Tom Peterson, Co-Chair (along with Dr. Susan Woolford) of the Health, Family and Child Care Services Policy Action Team; current and former staff of the Michigan Department of Community Health, especially Ms. Shannon Carney Oleksyk; and each of our institutions for supporting our time to produce these documents.

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Instructions for use of the Clinical Decision Support Tools

These tools are designed to be used in conjunction with the Michigan Care Improvement Registry's body mass index (BMI) surveillance system, but may also be used independently based on a limited set of information about each child including the child's weight status as determined by BMI percentile. MCIR will calculate the BMI based on the child's measured height and weight, determine the BMI percentile in relation to a standard reference population, and then assign a weight status based on standard classifications of:

WEIGHT STATUS	BMI Percentile
Normal weight	5 th – 84 th
Overweight	85 th – 94 th
Obese	>95 th

The tools consist of several components, each tailored for the specific age group (2-5, 6-11 and 12-18) and weight status as shown above:

- A survey tool for providers to determine a child's behavioral and family history risk factors
- A four part clinical form which includes:
 - assessment of specific medical risks for that child
 - assessment of behavioral risks and readiness to change
 - counseling tailored according to whether or not the child has medical risks posed by obesity
 - assessment and plan including a summary of referrals provided and behavior change goals identified

The survey and clinical guidance documents are designed to be incorporated into the existing flow of a provider office. The short survey tool can be completed by the caregiver and/or child while sitting in the waiting room prior to the visit, or, with minor modifications, it can be administered orally by a clinician during the visit.

While the survey questions are very similar on all tools, they vary slightly according to a child's age. For example, questions relating to portion size and quantity vary. It is also assumed that a caregiver will be responding for children ages 2-5 while older children will answer on their own.

The clinical decision support tools are tailored by weight status category (healthy weight, overweight, obese) and age group (2-5, 6-11, 12-18). Once a child's age and weight status category is determined using BMI percentile, the appropriate decision support tool can be selected and used to guide the clinician through appropriate assessment and counseling. The Overweight and Obese category decision support tools offer guidance on how to assess for specific health risks related to weight status and encourage the clinician to use the completed survey in identifying current behavior and attitude practices which may contribute to risk. Finally, based on the findings of the physical exam and the review of current behavior practices, the clinician is provided with a recommended course of treatment and referral, when appropriate.

The clinical decision support tools are also designed to be interactive and to become a part of the patient chart. They guide the provider through an age-appropriate review of systems and medical exam, provide space to fill out what was communicated with the patient and family, as well as space to outline the next steps for follow up. In addition to guiding providers through weight assessment and treatment, each of the clinical decision support tools offers clinicians resources for further information and education and as well as recommendations for possible billing codes and guidance.

HEALTHY WEIGHT TOOLS

Weight Status: This child's BMI percentile puts her/him in the **Healthy Weight** category (BMI 5th to 84th percentile)

AAP MANAGEMENT/TREATMENT RECOMMENDATIONS BASED ON BMI PERCENTILE

This child falls within the category of Healthy Weight. The American Academy of Pediatrics recommends that all children receive prevention messaging. Consider use of the attached Patient/Parent Survey to promote overweight and obesity prevention.

The American Academy of Pediatrics recommends the following elements be incorporated into overweight and obesity prevention messaging:

1. Limit consumption of sugar-sweetened beverages.
2. Encourage consumption of diets with recommended quantities of fruits and vegetables.
3. Limit television and other screen time (the AAP recommends no television viewing before 2 years of age and thereafter no more than 2 hours of television viewing per day)
4. Eat breakfast daily.
5. Limit eating out at restaurants, particularly fast food restaurants.
6. Encourage family meals during which parents and children eat together.
7. Allow child to self-regulate his or her food.
 - Find ways to reward good behavior other than with food.
 - Parents say "what & when", children say "how much".

Resources & References

- "Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Childhood and Adolescent Overweight and Obesity: Summary Report" Barlow, Sarah E. & the Expert Committee. *Pediatrics* 2007; 120; S164-S192.
- Blue Cross Blue Shield of Michigan Pediatric Healthy Weight Toolkit - http://www.bcbsm.com/pdf/pediatric_healthy_weight_toolkit.pdf
- American Academy of Pediatrics. *What Families Can Do* featuring the 5210 message. <http://www.aap.org/obesity/families.html?technology=1>
- Recommended daily intake amounts of fruits and vegetables based on age and sex can be found at www.mypyramid.gov ; choosemyplate.gov
- Blue Cross Blue Shield of Michigan Good Health Club Physician Toolkit - <http://www.bcbs.com/innovations/childhood-obesity-prevention/good-health-club-physician.html>

Survey - Ages 2-5 years old

Name: _____

Age: _____ Date: _____

In our office, we are interested in discussing the aspects of a healthy lifestyle with all of our families. Please answer the following questions. We realize how busy parents are and how difficult it is to do all the right things! The questions below will give you and us a snapshot of the health habits of your child. Thank you.

Please circle Yes or No.

- | | | |
|---|-----|----|
| 1. My child eats fruits and vegetables 5 times a day on 4 days a week or more. | Yes | No |
| 2. My child eats breakfast every day (examples: fruit, milk, cereal, sandwich). | Yes | No |
| 3. My child usually eats dinner at the table with other family members. | Yes | No |
| 4. My child eats take out, fast food, or other restaurant food two times a week or less. | Yes | No |
| 5. My family has the things needed to cook at home (examples: working stove, refrigerator) | Yes | No |
| 6. My family can drive to a grocery store at least once a month (examples: Kroger, Walmart, Meijer). | Yes | No |
| 7. It is easy for my family to get fresh fruits and vegetables. | Yes | No |
| 8. My child has access to healthy meals and snacks when school is not in session. | Yes | No |
| 9. My child spends more than 2 hours a day in front of the TV or computer. | Yes | No |
| 10. My child has electronic devices in his/her bedroom or where he/she sleeps (examples: TV, game consoles, computer, phone). | Yes | No |
| 11. My child does some kind of physical activity (examples: general play, sports, dancing, biking) for at least 1 hour each day. | Yes | No |
| 12. My child drinks fat free (skim) or 1% milk, not 2% or whole milk. | Yes | No |
| 13. My child drinks less than 1 ½ cups (1 ½ cups = 1 soda can) of 100% fruit juice every day. | Yes | No |
| 14. My child has sugary drinks (examples: punch, fruit drinks, sports drinks, soda, ices, slurpees, Arizona teas, Kool-Aid, Capri Sun) on 4 or more days of the week. | Yes | No |

My child has (circle the correct answer):

A parent or sister/brother who is overweight or obese.

Yes No Don't Know

A parent, grandparent, aunt, uncle, sister or brother with:

Diabetes Type 2 Yes No Don't Know

High blood pressure Yes No Don't Know

High cholesterol Yes No Don't Know

Heart attack before age 55 Yes No Don't Know

Stroke before age 55 Yes No Don't Know

Circle the number which best reflects where you are at, how you feel or think.

How concerned/worried are you about your child's diet and physical activity habits?

Not concerned/worried Very concerned/worried

1 2 3 4 5 6 7 8 9 10

How ready are you to make changes?

Not ready Very ready

1 2 3 4 5 6 7 8 9 10

How sure are you that you can make changes?

Not sure Very sure

1 2 3 4 5 6 7 8 9 10

Weight Status: This child's BMI percentile puts her/him in the **Healthy Weight** category (BMI 5th to 84th percentile)

AAP MANAGEMENT/TREATMENT RECOMMENDATIONS BASED ON BMI PERCENTILE

This child falls within the category of Healthy Weight. The American Academy of Pediatrics recommends that all children receive prevention messaging. Consider use of the attached Patient/Parent Survey to promote overweight and obesity prevention.

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1. Limit consumption of sugar-sweetened beverages.
2. Encourage consumption of diets with recommended quantities of fruits and vegetables.
3. Limit television and other screen time (the AAP recommends no television viewing before 2 years of age and thereafter no more than 2 hours of television viewing per day)
4. Eat breakfast daily.
5. Limit eating out at restaurants, particularly fast food restaurants.
6. Encourage family meals during which parents and children eat together.
7. Allow child to self-regulate his or her food.
 - Find ways to reward good behavior other than with food.
 - Parents say "what & when", children say "how much".

Resources & References

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- American Academy of Pediatrics. *What Families Can Do* featuring the 5210 message. <http://www.aap.org/obesity/families.html?technology=1>
- Recommended daily intake amounts of fruits and vegetables based on age and sex can be found at www.mypyramid.gov ; choosemyplate.gov
- Blue Cross Blue Shield of Michigan Good Health Club Physician Toolkit - <http://www.bcbs.com/innovations/childhood-obesity-prevention/good-health-club-physician.html>

Survey - Ages 6-11 Years Old

Name: _____

Age: _____ Date: _____

In our office, we are interested in discussing the aspects of a healthy lifestyle. Please answer the following questions. We realize how busy families and kids are and how difficult it is to do all the right things! The questions below give you and us a snapshot of your health habits. Thank you.

	Please circle Yes or No.	
	Yes	No
1. My child eats fruits and vegetables 5 times a day on 4 days a week or more.	Yes	No
2. My child eats food every day before school (examples: fruit, milk, cereal, sandwich)	Yes	No
3. My child usually eats dinner at the table with other family members.	Yes	No
4. My child eats take out, fast food, or other restaurant food two times a week or less.	Yes	No
5. My family has the things needed to cook at home (examples: working stove, refrigerator)	Yes	No
6. My family can drive to a grocery store at least once a month (examples: Kroger, Walmart, Meijer).	Yes	No
7. It is easy for my family to get fresh fruits and vegetables.	Yes	No
8. My child has access to healthy meals and snacks when school is not in session.	Yes	No
9. My child spends more than 2 hours a day in front of the TV or computer.	Yes	No
10. My child has electronic devices in his/her bedroom or where he/she sleeps (examples: TV, game consoles, computer, phone).	Yes	No
11. My child does some kind of physical activity (he/she is up and moving) for at least 1 hour each day (examples: general play, sports, dancing, biking)	Yes	No
12. My child drinks fat free (skim) or 1% milk, not 2% or whole milk.	Yes	No
13. My child drinks less than 1 ½ cups (1 ½ cups = 1 soda can) of 100% fruit juice every day.	Yes	No
14. My child has sugary drinks (examples: punch, fruit drinks, sports drinks, soda, icees, slurpees, Arizona teas, Kool-Aid, Capri Sun) on 4 or more days of the week.	Yes	No

My child has (circle the correct answer):

A parent or sister/brother who is overweight or obese.
 Yes No Don't Know

A parent, grandparent, aunt, uncle, sister or brother with:

Diabetes Type 2	Yes	No	Don't Know
High blood pressure	Yes	No	Don't Know
High cholesterol	Yes	No	Don't Know
Heart attack before age 55	Yes	No	Don't Know
Stroke before age 55	Yes	No	Don't Know

Circle the number which best reflects where you are at, how you feel or think.

How concerned/worried are you about your child's diet and physical activity habits?
 Not concerned/worried Very concerned/worried

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How ready are you to make changes?
 Not ready Very ready

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How sure are you that you can make changes?
 Not sure Very sure

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

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Weight Status: This child's BMI percentile puts her/him in the **Healthy Weight** category (BMI 5th to 84th percentile)

AAP MANAGEMENT/TREATMENT RECOMMENDATIONS BASED ON BMI PERCENTILE

This child falls within the category of Healthy Weight. The American Academy of Pediatrics recommends that all children receive prevention messaging. Consider use of the attached Patient/Parent Survey to promote overweight and obesity prevention.

The American Academy of Pediatrics recommends the following elements be incorporated into overweight and obesity prevention messaging:

1. Limit consumption of sugar-sweetened beverages.
2. Encourage consumption of diets with recommended quantities of fruits and vegetables.
3. Limit television and other screen time (the AAP recommends no television viewing before 2 years of age and thereafter no more than 2 hours of television viewing per day)
4. Eat breakfast daily.
5. Limit eating out at restaurants, particularly fast food restaurants.
6. Encourage family meals during which parents and children eat together.
7. Allow child to self-regulate his or her food.
 - Find ways to reward good behavior other than with food.
 - Parents say "what & when", children say "how much".

Resources & References

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- Blue Cross Blue Shield of Michigan Pediatric Healthy Weight Toolkit - http://www.bcbsm.com/pdf/pediatric_healthy_weight_toolkit.pdf
- American Academy of Pediatrics. *What Families Can Do* featuring the 5210 message. <http://www.aap.org/obesity/families.html?technology=1>
- Recommended daily intake amounts of fruits and vegetables based on age and sex can be found at www.mypyramid.gov ; choosemyplate.gov
- Blue Cross Blue Shield of Michigan Good Health Club Physician Toolkit - <http://www.bcbs.com/innovations/childhood-obesity-prevention/good-health-club-physician.html>

Survey - Ages 12-18 Years Old

Name: _____

Age: _____ Date: _____

In our office, we are interested in discussing the aspects of a healthy lifestyle. Please answer the following questions. We realize how busy families and kids are and how difficult it is to do all the right things! The questions below give you and us a snapshot of your health habits. Thank you.

	Please circle Yes or No.	
1. I eat fruits and vegetables 5 times a day on 4 days a week or more.	Yes	No
2. I eat food every day before school (examples: fruit, milk, cereal, or sandwich).	Yes	No
3. I usually eat dinner at the table with other family members.	Yes	No
4. I eat take out, fast food, or other restaurant food two times a week or less.	Yes	No
5. My family has the things needed to cook at home (examples: working stove, refrigerator)	Yes	No
6. My family can drive to a grocery store at least once a month (examples: Kroger, Walmart, Meijer).	Yes	No
7. It is easy for my family to get fresh fruits and vegetables.	Yes	No
8. I have access to healthy meals and snacks when school is not in session.	Yes	No
9. I watch more than 2 hours of TV a day or play video or computer games more than 2 hours a day.	Yes	No
10. I have electronic devices in my bedroom or where I sleep (examples: TV, game consoles, computer, phone).	Yes	No
11. I do some kind of physical activity (examples: housework, sports, dancing, biking) for at least 1 hour each day.	Yes	No
12. I drink fat free (skim) or 1% milk, not 2% or whole milk.	Yes	No
13. I drink less than 1 ½ cups (1 ½ cups = 1 soda can) of 100% fruit juice every day.	Yes	No
14. I have sugary drinks (examples: punch, fruit drinks, sports drinks, soda, icees, slurpees, Arizona teas, Kool-Aid, Capri Sun) on 4 or more days of the week.	Yes	No

My parent or sister/brother is overweight or obese.
 Yes No Don't Know

I have parents, grandparents, aunts, uncles, sisters or brothers with:

Diabetes Type 2	Yes	No	Don't Know
High blood pressure	Yes	No	Don't Know
High cholesterol	Yes	No	Don't Know
Heart attack before age 55	Yes	No	Don't Know
Stroke before age 55	Yes	No	Don't Know

Circle the number which best reflects where you are at, how you feel or think.

How concerned/worried are you about your diet and physical activity habits?

Not concerned/worried Very concerned/worried

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How ready are you to make changes?

Not ready Very ready

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How sure are you that you can make changes?

Not sure Very sure

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

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STEP 2: REVIEW BEHAVIOR TARGETS & FAMILY READINESS FOR CHANGE

a. Reinforce positive behaviors noted on survey tool and note risky behaviors below.

- | | |
|---|--|
| <input type="checkbox"/> Eats <5 svgs fruit & veggies every day. | <input type="checkbox"/> Physical activity less than 1 hr per day. |
| <input type="checkbox"/> Does not eat a healthy breakfast every day. | <input type="checkbox"/> Drinks > 1 sugar sweetened beverage per day |
| <input type="checkbox"/> Does not Usually eat meals at the table with family. | <input type="checkbox"/> Drinks 2% or greater milk. |
| <input type="checkbox"/> Eats take out or fast food $\geq 2x$ per week. | <input type="checkbox"/> Drinks > 6 oz 100% fruit juice per day. |
| <input type="checkbox"/> Spends >2 hours TV &/or computer time per day. | <input type="checkbox"/> TV in bedroom. |

b. Assess readiness for change – Record number from survey tool

- Concern about child's diet & physical activity habits? Ready to make changes? Confidence in ability to make changes?
0-3=Not Ready 4-6=Unsure 7-10=Ready

STEP 3: TAILOR APPROACH TO FAMILY/PATIENT

	3a. OVERWEIGHT WITH <u>NO</u> MEDICAL RISK FACTORS (PREVENTION)	3b. OVERWEIGHT <u>WITH</u> MEDICAL RISK FACTORS (STAGE 1: PREVENTION PLUS)
GOAL	Weight velocity maintenance.	Weight maintenance or slow weight gain. * Review weight for age curve. If weight percentile is stable over time (ie weight velocity is stable) consider continued weight velocity maintenance.
RECOMMENDATIONS	<ul style="list-style-type: none"> Provide basic education specific to weight classifications and review the medical risks associated with obesity. Target problem behaviors identified in Step 2. Review prevention messages (e.g. 5210) Praise current practice when appropriate. 	<ul style="list-style-type: none"> Counsel and guide parents through goals they set themselves using Step 2. If low parental concern (i.e. pre-contemplation, 0 to 3) attempt to motivate by educating family regarding medical risk factors associated with obesity. Refer or order appropriate follow-up testing for co-morbidities.
LABS	Obtain fasting lipid profile. Repeat every 3-5 years if normal.	Obtain fasting lipid profile. Repeat every 3-5 years if normal.
FOLLOW UP	<i>Yearly for health maintenance.</i> Consider more frequently to confirm weight percentile is stable especially if history is unknown).	<i>Monthly ideally.</i> If no progress in 6 months, advance to Stage 2 (Structured Weight Management).

STEP 4: ASSESSMENT & PLAN

Labs (check those obtained during visit)	Recommended Follow Up	Referrals: <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)
<input type="checkbox"/> Fasting lipid profile	<input type="checkbox"/> Weeks	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Months	_____
	<input type="checkbox"/> Year	_____
Counseling occurred for _____ minutes and comprised 50% or more of visit.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Topics addressed: <input type="checkbox"/> weight counseling <input type="checkbox"/> physical activity counseling		<input type="checkbox"/> nutrition counseling
Agreed upon goals from target behaviors in 2a (above).		OTHER NOTES: _____
_____		_____
_____		_____
_____		_____
Provider Signature: _____		Date: _____

Billing Information - This section is for information only and cannot be taken as a guarantee of payment for services. Check with the patient's health plan directly to determine eligibility and billing requirements.

Hypertension	401.9	Obesity	278.00	BMI 85 th to < 95 th %tile	V85.53	BMI, \geq 95 th %tile	V85.54	Type 2 DM	250.00
Hyperlipidemia	272.0	Obstructive sleep ap	780.57	Primary Cushing syndrome	255.0	Excessive wt gain	783.1	GERD	530.81
Sleep disturb.	780.50	Inappropriate diet	V69.1	Physical activity counseling	V65.41	Nutrition counseling	V65.3	PCOS	256.4
Anxiety	300.0	Lack of exercise	V69.0	Acanthosis nigricans acquired	701.2	Hypertriglyceridemia	272.1	Asthma	493.9
Gallstones	574.20	Depression	311.0	Nonalcoholic fatty liver dis	571.8	Hypothyroidism	244.9	Constipation	564.0
Fam hx of type 2 DM	V18.0	Elevated BP	796.2	Fam hx of cardiovascular dis	V17.3	Fam hx of type 2 DM	V18.0		

For more information and clarification on billing for pediatric obesity prevention, assessment and treatment services for patients on straight Medicaid, access a Medicaid 'L Letter' at http://www.michigan.gov/documents/mdch/L-09-15-Obesity_Outreach_281184_7.pdf

Resources & References

- "Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Childhood and Adolescent Overweight and Obesity: Summary Report" Barlow, Sarah E. & the Expert Committee. *Pediatrics* 2007; 120; S164-S192.
- Blue Cross Blue Shield of Michigan Pediatric Healthy Weight Toolkit - http://www.bcbsm.com/pdf/pediatric_healthy_weight_toolkit.pdf
- American Academy of Pediatrics. *What Families Can Do* featuring the 5210 message. <http://www.aap.org/obesity/families.html?technology=1>

Survey - Ages 2-5 years old

Name: _____

Age: _____ Date: _____

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	Please circle Yes or No.	
	Yes	No
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2. My child eats breakfast every day (examples: fruit, milk, cereal, sandwich).		
3. My child usually eats dinner at the table with other family members.		
4. My child eats take out, fast food, or other restaurant food two times a week or less.		
5. My family has the things needed to cook at home (examples: working stove, refrigerator)		
6. My family can drive to a grocery store at least once a month (examples: Kroger, Walmart, Meijer).		
7. It is easy for my family to get fresh fruits and vegetables.		
8. My child has access to healthy meals and snacks when school is not in session.		
9. My child spends more than 2 hours a day in front of the TV or computer.		
10. My child has electronic devices in his/her bedroom or where he/she sleeps (examples: TV, game consoles, computer, phone).		
11. My child does some kind of physical activity (examples: general play, sports, dancing, biking) for at least 1 hour each day.		
12. My child drinks fat free (skim) or 1% milk, not 2% or whole milk.		
13. My child drinks less than 1 ½ cups (1 ½ cups = 1 soda can) of 100% fruit juice every day.		
14. My child has sugary drinks (examples: punch, fruit drinks, sports drinks, soda, icees, slurpees, Arizona teas, Kool-Aid, Capri Sun) on 4 or more days of the week.		

My child has (circle the correct answer):

A parent or sister/brother who is overweight or obese.
 Yes No Don't Know

A parent, grandparent, aunt, uncle, sister or brother with:

Diabetes Type 2	Yes	No	Don't Know
High blood pressure	Yes	No	Don't Know
High cholesterol	Yes	No	Don't Know
Heart attack before age 55	Yes	No	Don't Know
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Circle the number which best reflects where you are at, how you feel or think.

How concerned/worried are you about your child's diet and physical activity habits?
 Not concerned/worried Very concerned/worried

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How ready are you to make changes?
 Not ready Very ready

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How sure are you that you can make changes?
 Not sure Very sure

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Weight Status: This 6-11 year old's BMI percentile puts her/him in the **overweight** category.
(BMI 85th to 95th percentile)

STEP 1: ASSESS THE CURRENT AND FUTURE WEIGHT-RELATED DISEASE BURDEN.

a. Assess Vitals: Is the patient hypertensive?

⇒ N Y

Blood Pressure Table for GIRLS by Age and Height Percentile

Age	BP %	Systolic BP (mmHg) ←Percentile of Height→							Diastolic BP (mmHg) ←Percentile of Height→							
		95th	5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
		6		108	109	110	111	111	113	114	115	72	72	73	74	74
7		110	111	112	113	113	115	116	116	73	74	74	75	76	76	77
8		112	112	114	115	115	116	118	118	75	75	75	76	77	78	78
9		114	114	115	117	117	118	119	120	76	76	76	77	78	79	79
10		116	116	117	119	120	121	122	122	77	77	77	78	79	80	80
11		118	118	119	121	122	123	124	124	78	78	78	79	80	81	81

Blood Pressure Table for BOYS by Age and Height Percentile

Age	BP %	Systolic BP (mmHg) ←Percentile of Height→							Diastolic BP (mmHg) ←Percentile of Height→							
		95th	5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
		6		109	110	112	114	115	117	117	72	72	73	74	75	76
7		110	111	113	115	117	118	119	74	74	75	76	77	78	78	
8		111	112	114	116	118	119	120	75	76	77	78	79	79	80	
9		113	114	116	118	119	121	121	76	77	78	79	80	81	81	
10		115	116	117	119	121	122	123	77	78	79	80	81	81	82	
11		117	118	119	121	123	124	125	78	78	79	80	81	82	82	

b. Is the child taking any of these obesogenic medications?

⇒ N Y

Antipsychotics ___ Mood Stabilizers ___ TCA ___ Anticonvulsants ___ Prednisone ___ SSRI ___

c. Laboratory Assessment - Are any levels above borderline or higher?

⇒ N Y

Total Cholesterol ≥ 170 ___ LDL ≥ 110 ___ Triglycerides > 110 ___ HDL < 40 ___
For ages ≥10 also obtain: ALT or AST >60 on two occasions ___
Fasting glucose >100 (impaired glucose tolerance) ___ OR >126 (diabetes) ___

d. Assess Comorbidities and ROS – Is there presence of comorbidites from the ROS?

⇒ N Y

___ Anxiety, school avoidance, social isolation (Depression) ___ Polyuria, polydipsia, wt loss (DM)
___ Daytime sleepiness (Sleep apnea, hypoventilation syndrome, depression) ___ Hip/knee pain (SCFE, limping)
___ Night breathing problems (Sleep apnea, hypoventilation syndrome, asthma) ___ Headaches (Pseudotumor cerebri)
___ Shortness of breath, exercise intolerance (Asthma, lack of physical conditioning) ___ Nocturnal Enuresis (Obstructive sleep apnea)
___ Abdominal pain (GERD, constipation, gallbladder disease, NAFLD)

e. Physical Exam – Are comorbidities noted on the physical exam?

⇒ N Y

Potential Causes of Obesity

___ Violaceous striae (Cushing's syndrome) ___ Undescended testicle (Prader-Willi syndrome)
___ Poor linear growth (Hypothyroidism, Cushing's, Prader-Willi) ___ Dysmorphic features (Genetic disorders)
___ Goiter (hypothyroidism)

Potential Comorbidities/Complications of Obesity

___ Acanthosis nigricans (NIDDM, insulin resistance) ___ Lower leg bowing (Blount's disease)
___ Hepatomegaly (Nonalcoholic fatty liver disease) ___ Papilledema, cranial nerve VI paralysis (Pseudotumor cerebri)
___ Wheezing (Asthma) ___ Tonsillar hypertrophy (Sleep apnea)
___ Abdominal tenderness (Gall bladder disease, GERD, NAFLD)
___ Limited hip range of motion (Slipped capital femoral epiphysis)
___ Advanced Tanner Stage (Premature puberty in 7 yo white girls, 6 yo black girls, 9 yo boys)

f. Review assessment tool – is family history positive for any of the following?

⇒ N Y

Family Hx: Obesity ___ HTN ___ Type 2 DM ___ Hyperlipidemia ___ Early MI ___ Early Stroke ___

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If any above medical risks are noted "Yes" in Step 1 use tailored approach Step 3b.

STEP 2: REVIEW BEHAVIOR TARGETS & FAMILY READINESS FOR CHANGE

a. Reinforce positive behaviors noted on survey tool and note risky behaviors below.

- | | |
|---|--|
| <input type="checkbox"/> Eats <5 svgs fruit & veggies every day. | <input type="checkbox"/> Physical activity less than 1 hr per day. |
| <input type="checkbox"/> Does not eat a healthy breakfast every day. | <input type="checkbox"/> Drinks > 1 sugar sweetened beverage per day |
| <input type="checkbox"/> Does not usually eat meals at the table with family. | <input type="checkbox"/> Drinks 2% or greater milk. |
| <input type="checkbox"/> Eats take out or fast food $\geq 2x$ per week. | <input type="checkbox"/> Drinks > 6 oz 100% fruit juice per day. |
| <input type="checkbox"/> Spends >2 hours TV &/or computer time per day. | <input type="checkbox"/> TV in bedroom. |

b. Assess readiness for change – Record number from survey tool

- Concern about child's diet & physical activity habits? Ready to make changes? Confidence in ability to make changes?
- 0-3=Not Ready 4-6=Unsure 7-10=Ready**

STEP 3: TAILOR APPROACH TO FAMILY AND PATIENT

	3a. OVERWEIGHT WITH <u>NO</u> MEDICAL RISK FACTORS (PREVENTION)	3b. OVERWEIGHT <u>WITH</u> MEDICAL RISK FACTORS (STAGE 1 - PREVENTION PLUS)
GOAL	Weight velocity maintenance.	Weight maintenance or slow weight gain.
RECOMMENDATIONS	<ul style="list-style-type: none"> Provide basic education specific to weight classifications and review the medical risks associated with obesity. Target problem behaviors identified in Step 2. Review prevention messages (e.g. 5210) Praise current practice when appropriate. 	<ul style="list-style-type: none"> Counsel and guide parents & patients (if appropriate) through goals they set themselves based on problem behaviors identified in Step 2a . If low parental / patient concern (i.e. pre-contemplation, 1-3 in Step 2b) attempt to motivate by educating family regarding medical risk factors associated with obesity. Refer or order appropriate follow-up testing for co-morbidities.
LABS	Obtain fasting lipid profile. Repeat every 3-5 years if normal.	Obtain fasting lipid profile. Obtain fasting glucose & ALT/AST for 10 yo & greater. Repeat every 3-5 years if normal.

FOLLOW UP	Yearly for health maintenance. Consider more frequently to confirm weight percentile is stable, especially if history is unknown.	Monthly ideally. If no progress is made in 3-6 months, Stage 2 (Structured Weight Management) should be considered.
------------------	---	---

STEP 4: ASSESSMENT & PLAN

Labs (check those obtained during visit) **Recommended Follow Up** **Referrals:** None Yes (list below)

Fasting lipid profile _____ Weeks _____

Fasting glucose (≥ 10 yo) _____ Months _____

ALT / AST (≥ 10 yo) _____ Year _____

Other _____

Counseling occurred for _____ minutes and comprised 50% or more of visit. Yes No

Topics addressed: weight counseling physical activity counseling nutrition counseling

Agreed upon goals for target behaviors from 2a:

OTHER NOTES: _____

Provider Signature: _____

Date: _____

Billing Information - This section is for information only and cannot be taken as a guarantee of payment for services. Check with the patient's health plan directly to determine eligibility and billing requirements.

Hypertension	401.9	Obesity	278.00	BMI 85 th to < 95 th %tile	V85.53	BMI, $\geq 95^{\text{th}}$ %tile	V85.54	Type 2 DM	250.00
Hyperlipidemia	272.0	Obstructive sleep ap	780.57	Primary Cushing syndrome	255.0	Excessive wt gain	783.1	GERD	530.81
Sleep disturb.	780.50	Inappropriate diet	V69.1	Physical activity counseling	V65.41	Nutrition counseling	V65.3	PCOS	256.4
Anxiety	300.0	Lack of exercise	V69.0	Acanthosis nigricans acquired	701.2	Hypertriglyceridemia	272.1	Asthma	493.9
Gallstones	574.20	Depression	311.0	Nonalcoholic fatty liver dis	571.8	Hypothyroidism	244.9	Constipation	564.0
Fam hx of type 2 DM	V18.0	Elevated BP	796.2	Fam hx of cardiovascular dis	V17.3	Fam hx of type 2 DM	V18.0		

For more information and clarification on billing for pediatric obesity prevention, assessment and treatment services for patients on straight Medicaid, access a Medicaid ' L Letter' at http://www.michigan.gov/documents/mdch/L-09-15-Obesity_Outreach_281184_7.pdf

Resources & References

- "Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Childhood and Adolescent Overweight and Obesity: Summary Report" Barlow, Sarah E. & the Expert Committee. *Pediatrics* 2007; 120; S164-S192.
- Blue Cross Blue Shield of Michigan Pediatric Healthy Weight Toolkit - http://www.bcbsm.com/pdf/pediatric_healthy_weight_toolkit.pdf
- American Academy of Pediatrics. *What Families Can Do* featuring the 5210 message. <http://www.aap.org/obesity/families.html?technology=1>

Survey - Ages 6-11 Years Old

Name: _____

Age: _____ Date: _____

In our office, we are interested in discussing the aspects of a healthy lifestyle. Please answer the following questions. We realize how busy families and kids are and how difficult it is to do all the right things! The questions below give you and us a snapshot of your health habits. Thank you.

	Please circle Yes or No.	
1. My child eats fruits and vegetables 5 times a day on 4 days a week or more.	Yes	No
2. My child eats food every day before school (examples: fruit, milk, cereal, sandwich)	Yes	No
3. My child usually eats dinner at the table with other family members.	Yes	No
4. My child eats take out, fast food, or other restaurant food two times a week or less.	Yes	No
5. My family has the things needed to cook at home (examples: working stove, refrigerator)	Yes	No
6. My family can drive to a grocery store at least once a month (examples: Kroger, Walmart, Meijer).	Yes	No
7. It is easy for my family to get fresh fruits and vegetables.	Yes	No
8. My child has access to healthy meals and snacks when school is not in session.	Yes	No
9. My child spends more than 2 hours a day in front of the TV or computer.	Yes	No
10. My child has electronic devices in his/her bedroom or where he/she sleeps (examples: TV, game consoles, computer, phone).	Yes	No
11. My child does some kind of physical activity (he/she is up and moving) for at least 1 hour each day (examples: general play, sports, dancing, biking)	Yes	No
12. My child drinks fat free (skim) or 1% milk, not 2% or whole milk.	Yes	No
13. My child drinks less than 1 ½ cups (1 ½ cups = 1 soda can) of 100% fruit juice every day.	Yes	No
14. My child has sugary drinks (examples: punch, fruit drinks, sports drinks, soda, icees, slurpees, Arizona teas, Kool-Aid, Capri Sun) on 4 or more days of the week.	Yes	No

My child has (circle the correct answer):

A parent or sister/brother who is overweight or obese.
 Yes No Don't Know

A parent, grandparent, aunt, uncle, sister or brother with:

Diabetes Type 2	Yes	No	Don't Know
High blood pressure	Yes	No	Don't Know
High cholesterol	Yes	No	Don't Know
Heart attack before age 55	Yes	No	Don't Know
Stroke before age 55	Yes	No	Don't Know

Circle the number which best reflects where you are at, how you feel or think.

How concerned/worried are you about your child's diet and physical activity habits?
 Not concerned/worried Very concerned/worried

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How ready are you to make changes?
 Not ready Very ready

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How sure are you that you can make changes?
 Not sure Very sure

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Weight Status: This 12-18 year old's BMI percentile puts her/him in the **overweight category (BMI 85th to 95th percentile).**

STEP 1: ASSESS THE CURRENT AND FUTURE WEIGHT-RELATED DISEASE BURDEN.

a. Assess Vitals: Is the patient hypertensive?

N Y

Age	BP % 95	Systolic BP (mmHg) ← Percentile of Height →						Diastolic BP (mmHg) ← Percentile of Height →							
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
		12	119	120	121	123	124	125	126	79	79	79	80	81	82
13	121	122	123	124	126	127	128	80	80	80	81	82	83	83	
14	123	123	125	126	127	129	129	81	81	81	82	84	84	84	
15	124	125	126	127	129	130	131	82	82	82	83	84	85	85	
16	125	126	127	128	130	131	132	82	82	83	84	85	85	86	
17	125	126	127	129	130	131	132	82	83	83	84	85	85	86	

Age	BP % 95	Systolic BP (mmHg) ← Percentile of Height →						Diastolic BP (mmHg) ← Percentile of Height →							
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
		12	119	120	122	123	125	127	127	78	79	80	81	82	82
13	121	122	124	126	128	129	130	79	79	80	81	82	83	83	
14	124	125	127	128	130	132	132	80	80	81	82	83	84	84	
15	126	127	129	131	133	134	135	81	81	82	83	84	85	85	
16	129	130	132	134	135	137	137	82	83	83	84	85	86	87	
17	131	132	134	136	138	139	140	84	85	86	87	88	88	89	

b. Is the child taking any of these obesogenic medications?

N Y

Antipsychotics ___ Mood Stabilizers ___ TCA ___ Anticonvulsants ___ Prednisone ___ SSRI ___

c. Laboratory Assessment - Are any levels above borderline or higher?

N Y

Total Cholesterol \geq 170 ___ LDL \geq 110 ___ Triglycerides $>$ 110 ___ HDL $<$ 40 ___
 ALT or AST $>$ 60 on two occasions ___
 Fasting glucose $>$ 100 (impaired glucose tolerance) OR $>$ 126 (diabetes)

d. Assess Comorbidities and ROS – Is there presence of comorbidites from the ROS?

N Y

- | | |
|--|---|
| <input type="checkbox"/> Anxiety, school avoidance, social isolation (Depression) | <input type="checkbox"/> Polyuria, polydipsia, wt loss (DM) |
| <input type="checkbox"/> Abdominal pain (GERD, Gall bladder disease, constipation) | <input type="checkbox"/> Hip/knee pain (SCFE) |
| <input type="checkbox"/> Daytime sleepiness (Sleep apnea, hypoventilation syndrome, depression) | <input type="checkbox"/> Headaches (Pseudotumor cerebri) |
| <input type="checkbox"/> Night breathing problems (Sleep apnea, hypoventilation syndrome, asthma) | <input type="checkbox"/> Nocturnal Enuresis (Obstructive sleep apnea) |
| <input type="checkbox"/> Shortness of breath, exercise intolerance (Asthma, lack of physical conditioning) | |
| <input type="checkbox"/> Hirsutism, excessive acne, irregular menses - $<$ 9 cycles per yr (Polycystic ovarian syndrome) | |
| <input type="checkbox"/> Tobacco use (Increased cardiovascular risk) | |

e. Physical Exam – Are comorbidities noted on the physical exam?

N Y

Potential Causes of Obesity

- Violaceous striae (Cushing's syndrome) Undescended testicle (Prader-Willi syndrome) Poor linear growth (Hypothyroidism, Cushing's, Prader-Willi) Dysmorphic features (Genetic disorders)
 Goiter (hypothyroidism)

Potential Comorbidities/Complications of Obesity

- Acanthosis nigricans (NIDDM, insulin resistance) Lower leg bowing (Blount's disease)
 Hepatomegaly (Nonalcoholic fatty liver disease) Papilledema, cranial nerve VI paralysis (Pseudotumor cerebri)
 Wheezing (Asthma) Tonsillar hypertrophy (Sleep apnea)
 Abdominal tenderness (Gall bladder disease, GERD, NAFLD) Limited hip range of motion (Slipped capital femoral epiphysis)
 Excessive acne, hirsutism (Polycystic ovarian syndrome)

f. Review assessment tool – is family history positive for any of the following?

N Y

Family Hx: Obesity ___ HTN ___ Type 2 DM ___ Hyperlipidemia ___ Early MI ___ Early Stroke ___

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If any above medical risks are noted "Yes" in Step 1 use tailored approach Step 3b.

STEP 2: REVIEW BEHAVIOR TARGETS & PATIENT READINESS FOR CHANGE

a. Reinforce positive behaviors noted on survey tool and note risky behaviors below.

- | | |
|---|---|
| <input type="checkbox"/> Eats <5 svgs fruit & veggies every day.
<input type="checkbox"/> Does not eat a healthy breakfast every day.
<input type="checkbox"/> Does not usually eat meals at the table with family.
<input type="checkbox"/> Eats take out or fast food $\geq 2x$ per week.
<input type="checkbox"/> Spends >2 hours TV &/or computer time per day. | <input type="checkbox"/> Physical activity less than 1 hr per day.
<input type="checkbox"/> Drinks > 1 sugar sweetened beverage per day
<input type="checkbox"/> Drinks 2% or greater milk.
<input type="checkbox"/> Drinks > 12 oz 100% fruit juice per day.
<input type="checkbox"/> TV in bedroom. |
|---|---|

b. Assess readiness for change – Record number from survey tool

- Concern about child's diet & physical activity habits?
 Ready to make changes?
 Confidence in ability to make changes?
0-3=Not Ready
 4-6=Unsure
 7-10=Ready

STEP 3: TAILOR APPROACH TO PATIENT/FAMILY

	3a. OVERWEIGHT WITH <u>NO</u> MEDICAL RISK FACTORS (PREVENTION)	3b. OVERWEIGHT <u>WITH</u> MEDICAL RISK FACTORS (STAGE 1: PREVENTION PLUS)
GOAL	Weight velocity maintenance.	Weight maintenance or slow weight gain.
RECOMMEN-DATIONS	<ul style="list-style-type: none"> Provide basic education specific to weight classifications and review the medical risks associated with obesity. Target problem behaviors identified in Step 2. Review prevention messages (e.g. 5210) Praise current practice when appropriate. 	<ul style="list-style-type: none"> Counsel and guide patients & parents (as appropriate) through goals they set themselves based on behaviors in Step 2a. If low patient/parental concern (i.e. pre-contemplation, 0 to 3 in Step 2b) attempt to motivate by educating patient/parents regarding medical risk factors associated with obesity. Refer or order appropriate follow-up testing for co-morbidities.
LABS	Obtain fasting lipid profile Repeat every 3-5 years if normal.	Obtain fasting lipid profile, fasting glucose, & ALT/AST Repeat every 2 years if normal.

FOLLOW UP	<i>Yearly for health maintenance.</i> Consider more frequently to confirm weight percentile is stable, especially if history is unknown.	<i>Monthly ideally.</i> If no progress in 3-6 months, Stage 2 (Structured Weight Management) should be considered.
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STEP 4: ASSESSMENT & PLAN

Labs (check those obtained during visit) <input type="checkbox"/> Fasting lipid profile <input type="checkbox"/> Fasting glucose <input type="checkbox"/> ALT / AST <input type="checkbox"/> Other _____	Recommended Follow Up <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Year	Referrals: <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ _____
Counseling occurred for _____ minutes and comprised 50% or more of visit. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Topics addressed: <input type="checkbox"/> weight counseling <input type="checkbox"/> physical activity counseling <input type="checkbox"/> nutrition counseling		
Agreed upon goals for target behaviors from 2a: _____ _____ _____		
OTHER NOTES: _____ _____ _____		
Provider Signature: _____		Date: _____

Billing Information - This section is for information only and cannot be taken as a guarantee of payment for services. Check with the patient's health plan directly to determine eligibility and billing requirements.

Hypertension	401.9	Obesity	278.00	BMI 85 th to < 95 th %tile	V85.53	BMI, $\geq 95^{\text{th}}$ %tile	V85.54	Type 2 DM	250.00
Hyperlipidemia	272.0	Obstructive sleep ap	780.57	Primary Cushing syndrome	255.0	Excessive wt gain	783.1	GERD	530.81
Sleep disturb.	780.50	Inappropriate diet	V69.1	Physical activity counseling	V65.41	Nutrition counseling	V65.3	PCOS	256.4
Anxiety	300.0	Lack of exercise	V69.0	Acanthosis nigricans acquired	701.2	Hypertriglyceridemia	272.1	Asthma	493.9
Gallstones	574.20	Depression	311.0	Nonalcoholic fatty liver dis	571.8	Hypothyroidism	244.9	Constipation	564.0
Fam hx of type 2 DM	V18.0	Elevated BP	796.2	Fam hx of cardiovascular dis	V17.3	Fam hx of type 2 DM	V18.0		

For more information and clarification on billing for pediatric obesity prevention, assessment and treatment services for patients on straight Medicaid, access a Medicaid 'L Letter' at http://www.michigan.gov/documents/mdch/L-09-15-Obesity_Outreach_281184_7.pdf

Resources & References

- "Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Childhood and Adolescent Overweight and Obesity: Summary Report" Barlow, Sarah E. & the Expert Committee. *Pediatrics* 2007; 120; S164-S192.
- Blue Cross Blue Shield of Michigan Pediatric Healthy Weight Toolkit - http://www.bcbsm.com/pdf/pediatric_healthy_weight_toolkit.pdf
- American Academy of Pediatrics. *What Families Can Do* featuring the 5210 message. <http://www.aap.org/obesity/families.html?technology=1>

Survey - Ages 12-18 Years Old

Name: _____

Age: _____ Date: _____

In our office, we are interested in discussing the aspects of a healthy lifestyle. Please answer the following questions. We realize how busy families and kids are and how difficult it is to do all the right things! The questions below give you and us a snapshot of your health habits. Thank you.

	Please circle Yes or No.	
1. I eat fruits and vegetables 5 times a day on 4 days a week or more.	Yes	No
2. I eat food every day before school (examples: fruit, milk, cereal, sandwich).	Yes	No
3. I usually eat dinner at the table with other family members.	Yes	No
4. I eat take out, fast food, or other restaurant food two times a week or less.	Yes	No
5. My family has the things needed to cook at home (examples: working stove, refrigerator)	Yes	No
6. My family can drive to a grocery store at least once a month (examples: Kroger, Walmart, Meijer).	Yes	No
7. It is easy for my family to get fresh fruits and vegetables.	Yes	No
8. I have access to healthy meals and snacks when school is not in session.	Yes	No
9. I watch more than 2 hours of TV a day or play video or computer games more than 2 hours a day.	Yes	No
10. I have electronic devices in my bedroom or where I sleep (examples: TV, game consoles, computer, phone).	Yes	No
11. I do some kind of physical activity (examples: housework, sports, dancing, biking) for at least 1 hour each day.	Yes	No
12. I drink fat free (skim) or 1% milk, not 2% or whole milk.	Yes	No
13. I drink less than 1 ½ cups (1 ½ cups = 1 soda can) of 100% fruit juice every day.	Yes	No
14. I have sugary drinks (examples: punch, fruit drinks, sports drinks, soda, icees, slurpees, Arizona teas, Kool-Aid, Capri Sun) on 4 or more days of the week.	Yes	No

My parent or sister/brother is overweight or obese.
 Yes No Don't Know

I have parents, grandparents, aunts, uncles, sisters or brothers with:

Diabetes Type 2	Yes	No	Don't Know
High blood pressure	Yes	No	Don't Know
High cholesterol	Yes	No	Don't Know
Heart attack before age 55	Yes	No	Don't Know
Stroke before age 55	Yes	No	Don't Know

Circle the number which best reflects where you are at, how you feel or think.

How concerned/worried are you about your diet and physical activity habits?

Not concerned/worried Very concerned/worried

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How ready are you to make changes?

Not ready Very ready

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How sure are you that you can make changes?

Not sure Very sure

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

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Weight Status: This 2-5 year old's BMI percentile puts her/him in the **obese category (BMI ≥95th percentile)**

STEP 1: ASSESS THE CURRENT AND FUTURE WEIGHT-RELATED DISEASE BURDEN.

a. Assess Vitals: Is the patient hypertensive?

N Y

Blood Pressure Table for GIRLS by Age and Height Percentile

Age	BP %	Systolic BP (mmHg) ←Percentile of Height→							Diastolic BP (mmHg) ←Percentile of Height→						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
2	95 th	102	103	104	105	107	108	109	57	58	58	59	60	616	61
3	95 th	104	104	105	107	108	109	110	65	66	66	67	68	68	69
	95 th	105	106	107	108	110	111	112	68	68	69	70	71	71	72

Blood Pressure Table for BOYS by Age and Height Percentile

Age	BP %	Systolic BP (mmHg) ←Percentile of Height→							Diastolic BP (mmHg) ←Percentile of Height→						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
2	95 th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
3	95 th	104	105	107	109	110	112	113	63	63	64	65	66	67	67
4	95 th	106	107	109	111	112	114	115	66	67	68	69	70	71	71
5	95 th	108	109	110	112	114	115	116	69	70	71	72	73	74	74

b. Is the child taking any of these obesogenic medications?

N Y

Antipsychotics ___ Mood Stabilizers ___ TCA ___ Anticonvulsants ___ Prednisone ___ SSRI ___

c. Laboratory Assessment - Are any levels above borderline or higher?

N Y

≥ 170 ___ LDL ≥ 110 ___ Triglycerides > 110 ___ HDL < 40 ___

d. Assess Comorbidities and ROS – Is there presence of comorbidites from the ROS?

N Y

___ Anxiety, school avoidance, social isolation (Depression) ___ Polyuria, polydipsia, wt loss (DM)
 ___ Abdominal pain (GERD, Gall bladder disease, constipation) ___ Hip/knee pain (SCFE)
 ___ Daytime sleepiness (Sleep apnea, hypoventilation syndrome, depression) ___ Headaches (Pseudotumor cerebri)
 ___ Night breathing problems (Sleep apnea, hypoventilation syndrome, asthma)

e. Physical Exam – Are comorbidities noted on the physical exam?

N Y

Potential Causes of Obesity

___ Violaceous striae (Cushing's syndrome)
 ___ Undescended testicle (Prader-Willi syndrome)
 ___ Dysmorphic features (Genetic disorders)
 ___ Poor linear growth (Hypothyroidism, Cushing's, Prader-Willi)

Potential Complications of Obesity

___ Papilledema, cranial nerve VI paralysis (Pseudotumor cerebri)
 ___ Tonsillar hypertrophy (Sleep apnea)
 ___ Abdominal tenderness (Gall bladder disease, GERD, NAFLD)
 ___ Acanthosis nigricans (NIDDM, insulin resistance)
 ___ Lower leg bowing (Blount's disease)
 ___ Hepatomegaly (Nonalcoholic fatty liver disease (NAFLD))
 ___ Limited hip range of motion (Slipped capital femoral epiphysis)

f. Review assessment tool – is family history positive for any of the following?

N Y

Family Hx: Obesity ___ HTN ___ Type 2 DM ___ Hyperlipidemia ___ Early MI ___ Early Stroke ___

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If any above medical risks are noted refer as appropriate.

STEP 2: REVIEW BEHAVIOR TARGETS & FAMILY READINESS FOR CHANGE

a. Reinforce positive behaviors noted on survey tool and note risky behaviors below.

- | | |
|---|--|
| <input type="checkbox"/> Eats <5 svgs fruit & veggies every day.
<input type="checkbox"/> Does not eat a healthy breakfast every day.
<input type="checkbox"/> Does not usually eat meals at the table with family.
<input type="checkbox"/> Eats take out or fast food $\geq 2x$ per week.
<input type="checkbox"/> Spends >2 hours TV &/or computer time per day. | <input type="checkbox"/> Physical activity less than 1 hr per day.
<input type="checkbox"/> Drinks > 1 sugar sweetened beverage per day
<input type="checkbox"/> Drinks 2% or greater milk.
<input type="checkbox"/> Drinks > 6 oz 100% fruit juice per day.
<input type="checkbox"/> TV in bedroom. |
|---|--|

b. Assess readiness for change – Record numbers from survey tool

Concern about child's diet & physical activity habits?
 Ready to make changes?
 Confidence in ability to make changes?
0-3=Not Ready
 4-6=Unsure
 7-10=Ready

STEP 3: TAILOR APPROACH TO FAMILY/PATIENT START WITH STAGE 1 (PREVENTION PLUS) AND PROGRESS AS NOTED TO STAGES 2,3 OR 4

	Stage 1: Prevention Plus	Stage 2: Structured Weight Management
GOAL	Weight maintenance (weight loss of up to 1 lb/mo may be acceptable if BMI is >21 or 22kg/m2).	Weight maintenance (weight loss of up to 1 lb/mo may be acceptable if BMI is >21 or 22kg/m2).
RECOMMEN-DATIONS	<ul style="list-style-type: none"> Counsel and guide parents through goals they set themselves. If low parental concern (i.e. pre-contemplation) attempt to motivate by educating family regarding medical risk factors associated with obesity. Refer or order appropriate follow-up testing for co-morbidities. 	<ul style="list-style-type: none"> A structured meal plan developed by a dietician (refer as needed) or clinician who has received additional training in developing this kind of eating plan for children. Reduction of sedentary screen time ≤ 1 hour per day. Supervised physical activity or active play totaling 60 minutes per day. Monitor above behavior through use of logs. Planned reinforcement for achieving targeted behaviors. <p><i>*As needed, refer for help to dietician, behavioral counselor, physical therapist, personal trainer.</i></p>
LABS	Obtain fasting lipid profile. Repeat every 2 years if normal.	Obtain fasting lipid profile. Repeat every 2 years if normal.
FOLLOW UP	<i>Monthly ideally.</i> If no progress is made in 6 months, advance to Stage 2 (Structured Weight Management) if family is ready.	<i>Monthly ideally.</i> If no progress is made in 6 months progress to Stage 3 (Comprehensive Multidisciplinary Intervention) if family is ready.

STEP 4: ASSESSMENT & PLAN

Labs (check those obtained during visit)

Fasting lipid profile
 Other _____

Recommended Follow Up

_____ Weeks
 _____ Months

Referrals: None Dietician

Physical Therapist Personal Trainer
 Behavioral Counselor
 Other _____

Counseling occurred for _____ minutes and comprised 50% or more of visit. Yes No

Topics addressed: weight counseling physical activity counseling nutrition counseling

Agreed upon goals for target behaviors from 2a:

OTHER NOTES: _____

Provider Signature: _____

Date: _____

Billing Information

This section is for information only and cannot be taken as a guarantee of payment for services. Check with the patient's health plan directly to determine eligibility and billing requirements.

Hypertension	401.9	Obesity	278.00	BMI 85 th to < 95 th %tile	V85.53	BMI, $\geq 95^{\text{th}}$ %tile	V85.54	Type 2 DM	250.00
Hyperlipidemia	272.0	Obstructive sleep ap	780.57	Primary Cushing syndrome	255.0	Excessive wt gain	783.1	GERD	530.81
Sleep disturb.	780.50	Inappropriate diet	V69.1	Physical activity counseling	V65.41	Nutrition counseling	V65.3	PCOS	256.4
Anxiety	300.0	Lack of exercise	V69.0	Acanthosis nigricans acquired	701.2	Hypertriglyceridemia	272.1	Asthma	493.9
Gallstones	574.20	Depression	311.0	Nonalcoholic fatty liver dis	571.8	Hypothyroidism	244.9	Constipation	564.0
Fam hx of type 2 DM	V18.0	Elevated BP	796.2	Fam hx of cardiovascular dis	V17.3	Fam hx of type 2 DM	V18.0		

For more information and clarification on billing for pediatric obesity prevention, assessment and treatment services for patients on straight Medicaid, access a Medicaid 'L Letter' at http://www.michigan.gov/documents/mdch/L-09-15-Obesity_Outreach_281184_7.pdf

Resources & References

- "Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Childhood and Adolescent Overweight and Obesity: Summary Report" Barlow, Sarah E. & the Expert Committee. *Pediatrics* 2007; 120; S164-S192.
- Blue Cross Blue Shield of Michigan Pediatric Healthy Weight Toolkit - http://www.bcbsm.com/pdf/pediatric_healthy_weight_toolkit.pdf
- American Academy of Pediatrics. *What Families Can Do* featuring the 5210 message. <http://www.aap.org/obesity/families.html?technology=1>

Survey - Ages 2-5 years old

Name: _____

Age: _____ Date: _____

In our office, we are interested in discussing the aspects of a healthy lifestyle with all of our families. Please answer the following questions. We realize how busy parents are and how difficult it is to do all the right things! The questions below will give you and us a snapshot of the health habits of your child. Thank you.

- | | | |
|--|-----|----|
| 1. My child eats fruits and vegetables 5 times a day on 4 days a week or more. | Yes | No |
| 2. My child eats breakfast every day (examples: fruit, milk, cereal, sandwich). | Yes | No |
| 3. My child usually eats dinner at the table with other family members. | Yes | No |
| 4. My child eats take out, fast food, or other restaurant food two times a week or less. | Yes | No |
| 5. My family has the things needed to cook at home (examples: working stove, refrigerator) | Yes | No |
| 6. My family can drive to a grocery store at least once a month (examples: Kroger, Walmart, Meijer). | Yes | No |
| 7. It is easy for my family to get fresh fruits and vegetables. | Yes | No |
| 8. My child has access to healthy meals and snacks when school is not in session. | Yes | No |
| 9. My child spends more than 2 hours a day in front of the TV or computer. | Yes | No |
| 10. My child has electronic devices in his/her bedroom or where he/she sleeps (examples: TV, game consoles, computer, phone). | Yes | No |
| 11. My child does some kind of physical activity (examples: general play, sports, dancing, biking) for at least 1 hour each day. | Yes | No |
| 12. My child drinks fat free (skim) or 1% milk, not 2% or whole milk. | Yes | No |
| 13. My child drinks less than 1 ½ cups (1 ½ cups = 1 soda can) of 100% fruit juice every day. | Yes | No |
| 14. My child has sugary drinks (examples: punch, fruit drinks, sports drinks, soda, icees, slurpees, Arizona teas, Kool-Aid, Capri Sun) on 4 or more days of the week. | Yes | No |

My child has (circle the correct answer):

A parent or sister/brother who is overweight or obese.

Yes No Don't Know

A parent, grandparent, aunt, uncle, sister or brother with:

Diabetes Type 2 Yes No Don't Know

High blood pressure Yes No Don't Know

High cholesterol Yes No Don't Know

Heart attack before age 55 Yes No Don't Know

Stroke before age 55 Yes No Don't Know

Circle the number which best reflects where you are at, how you feel or think.

How concerned/worried are you about your child's diet and physical activity habits?

Not concerned/worried Very concerned/worried



How ready are you to make changes?

Not ready Very ready



How sure are you that you can make changes?

Not sure Very sure



Weight Status: This 6-11 year old's BMI percentile puts her/him in the **obese** category (BMI $\geq 95^{\text{th}}$ percentile)

STEP 1: ASSESS THE CURRENT AND FUTURE WEIGHT-RELATED DISEASE BURDEN.

a. Assess Vitals: Is the patient hypertensive?

⇒ N Y

Blood Pressure Table for GIRLS by Age and Height Percentile

Age	BP %	Systolic BP (mmHg) ←Percentile of Height→							Diastolic BP (mmHg) ←Percentile of Height→							
		95th	5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
		6		108	109	110	111	111	113	114	115	72	72	73	74	74
7		110	111	112	113	113	115	116	116	73	74	74	75	76	76	77
8		112	112	114	115	115	116	118	118	75	75	75	76	77	78	78
9		114	114	115	117	117	118	119	120	76	76	76	77	78	79	79
10		116	116	117	119	119	120	121	122	77	77	77	78	79	80	80
11		118	118	119	121	121	122	123	124	78	78	78	79	80	81	81

Blood Pressure Table for BOYS by Age and Height Percentile

Age	BP %	Systolic BP (mmHg) ←Percentile of Height→							Diastolic BP (mmHg) ←Percentile of Height→							
		95th	5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
		6		109	110	112	114	115	117	117	72	72	73	74	75	76
7		110	111	113	115	117	118	119	74	74	75	76	77	78	78	
8		111	112	114	116	118	119	120	75	76	77	78	79	79	80	
9		113	114	116	118	119	121	121	76	77	78	79	80	81	81	
10		115	116	117	119	121	122	123	77	78	79	80	81	81	82	
11		117	118	119	121	123	124	125	78	78	79	80	81	82	82	

b. Is the child taking any of these obesogenic medications?

⇒ N Y

Antipsychotics ___ Mood Stabilizers ___ TCA ___ Anticonvulsants ___ Prednisone ___ SSRI ___

c. Laboratory Assessment - Are any levels above borderline or higher?

⇒ N Y

Total Cholesterol ≥ 170 ___ LDL ≥ 110 ___ Triglycerides > 110 ___ HDL < 40 ___
 For ages ≥ 10 also obtain: ALT or AST > 60 on two occasions ___
 Fasting glucose > 100 (impaired glucose tolerance) ___ OR > 126 (diabetes) ___

d. Assess Comorbidities and ROS – Is there presence of comorbidites from the ROS?

⇒ N Y

- | | |
|---|--|
| ___ Anxiety, school avoidance, social isolation (Depression) | ___ Polyuria, polydipsia, wt loss (DM) |
| ___ Daytime sleepiness (Sleep apnea, hypoventilation syndrome, depression) | ___ Hip/knee pain (SCFE, limping) |
| ___ Night breathing problems (Sleep apnea, hypoventilation syndrome, asthma) | ___ Headaches (Pseudotumor cerebri) |
| ___ Shortness of breath, exercise intolerance (Asthma, lack of physical conditioning) | ___ Nocturnal Enuresis (Obstructive sleep apnea) |
| ___ Abdominal pain (GERD, constipation, gallbladder disease, NAFLD) | |

e. Physical Exam – Are comorbidities noted on the physical exam?

⇒ N Y

- | | |
|--|--|
| ___ Violaceous striae (Cushing's syndrome) | ___ Undescended testicle (Prader-Willi syndrome) |
| ___ Poor linear growth (Hypothyroidism, Cushing's, Prader-Willi) | ___ Dysmorphic features (Genetic disorders) |
| ___ Goiter (hypothyroidism) | |
- Potential Comorbidities/Complications of Obesity**
- | | |
|---|---|
| ___ Acanthosis nigricans (NIDDM, insulin resistance) | ___ Lower leg bowing (Blount's disease) |
| ___ Hepatomegaly (Nonalcoholic fatty liver disease) | ___ Papilledema, cranial nerve VI paralysis (Pseudotumor cerebri) |
| ___ Wheezing (Asthma) | ___ Tonsillar hypertrophy (Sleep apnea) |
| ___ Abdominal tenderness (Gall bladder disease, GERD, NAFLD) | |
| ___ Limited hip range of motion (Slipped capital femoral epiphysis) | |
| ___ Advanced Tanner Stage (Premature puberty in 7 yo white girls, 6 yo black girls, 9 yo boys) | |

f. Review assessment tool – is family history positive for any of the following?

⇒ N Y

Family Hx: Obesity ___ HTN ___ Type 2 DM ___ Hyperlipidemia ___ Early MI ___ Early Stroke ___

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If any above medical risks are noted refer as appropriate.

STEP 2: REVIEW BEHAVIOR TARGETS & FAMILY READINESS FOR CHANGE

a. Reinforce positive behaviors noted on survey tool and note risky behaviors below.

- | | |
|---|--|
| <input type="checkbox"/> Eats <5 svgs fruit & veggies every day. | <input type="checkbox"/> Physical activity less than 1 hr per day. |
| <input type="checkbox"/> Does not eat a healthy breakfast every day. | <input type="checkbox"/> Drinks > 1 sugar sweetened beverage per day |
| <input type="checkbox"/> Does not usually eat meals at the table with family. | <input type="checkbox"/> Drinks 2% or greater milk. |
| <input type="checkbox"/> Eats take out or fast food $\geq 2x$ per week. | <input type="checkbox"/> Drinks > 6 oz 100% fruit juice per day. |
| <input type="checkbox"/> Spends >2 hours TV &/or computer time per day. | <input type="checkbox"/> TV in bedroom. |

b. Assess readiness for change – Record number from survey tool

- Concern about child's diet & physical activity habits? Ready to make changes? Confidence in ability to make changes?
- 0-3=Not Ready 4-6=Unsure 7-10=Ready**

STEP 3: TAILOR APPROACH TO FAMILY/PATIENT

START WITH STAGE 1 (PREVENTION PULUS) AND PROGRESS AS NOTED TO STAGE 2, 3 OR 4

	STAGE 1: PREVENTION PLUS	STAGE 2: STRUCTURED WEIGHT MANAGEMENT
GOAL	BMI 95th-99th percentile – Gradual weight loss (1 lb/mo or 0.5 kg/mo) BMI >99th percentile – Weight loss (max is 2 lb/wk)	BMI 95th-99th percentile – Gradual weight loss (1 lb/mo or 0.5 kg/mo) BMI >99th percentile – Weight loss (max is 2 lb/wk)
RECOMMENDATIONS	<ul style="list-style-type: none"> Counsel and guide parents & patients (if appropriate) through goals they set themselves based on problem behaviors identified in Step 2a. If low parental / patient concern (i.e. pre-contemplation, 1-3 in Step 2b) attempt to motivate by educating family regarding medical risk factors associated with obesity. Refer or order appropriate follow-up testing for comorbidities. 	<ul style="list-style-type: none"> A structured meal plan developed by a dietician or clinician (refer as needed) who has received additional training in developing this kind of eating plan for children. Reduction of sedentary screen time ≤ 1 hour per day. Supervised physical activity or active play totaling 60 minutes per day. Monitor above behavior through use of activity logs. Planned reinforcement for achieving targeted behaviors. <p><i>*As needed, refer for help to dietician, behavioral counselor, physical therapist, personal trainer.</i></p>
LABS	Obtain fasting lipid profile. Obtain fasting glucose & ALT/AST for 10 yo & greater. Repeat every 2 years, if normal.	Obtain fasting lipid profile. Obtain fasting glucose & ALT/AST for 10 yo & greater. Repeat every 2 years, if normal.
FOLLOW UP	<i>Monthly ideally.</i> If no progress in 3-6 months advance to Stage 2 (Structured Weight Management) if family is ready. BMI >99th percentile – Stage 2 or 3 should be considered instead of Stage 1 if patient and family are motivated.	<i>Monthly ideally.</i> If no progress in 3-6 months advance to Stage 3 (Comprehensive Multidisciplinary Intervention) if family is ready. For BMI >99th percentile consider referral to Stage 4 (Tertiary Care Intervention).

STEP 4: ASSESSMENT & PLAN

Labs (check those obtained during visit)	Recommended Follow Up	Referrals: <input type="checkbox"/> None <input type="checkbox"/> Dietician
<input type="checkbox"/> Fasting lipid profile	<input type="checkbox"/> Weeks	<input type="checkbox"/> Physical Therapist <input type="checkbox"/> Personal Trainer
<input type="checkbox"/> Fasting glucose (≥ 10 yo)	<input type="checkbox"/> Months	<input type="checkbox"/> Behavioral Counselor
<input type="checkbox"/> ALT / AST (≥ 10 yo)		<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____		

Counseling occurred for _____ minutes and comprised 50% or more of visit. Yes No

Topics addressed: weight counseling physical activity counseling nutrition counseling

Agreed upon goals for target behaviors from 2a above: **OTHER NOTES:** _____

Provider Signature: _____ **Date:** _____

Billing Information - This section is for information only and cannot be taken as a guarantee of payment for services. Check with the patient's health plan directly to determine eligibility and billing requirements.

Hypertension	401.9	Obesity	278.00	BMI 85 th to < 95 th %tile	V85.53	BMI, $\geq 95^{\text{th}}$ %tile	V85.54	Type 2 DM	250.00
Hyperlipidemia	272.0	Obstructive sleep ap	780.57	Primary Cushing syndrome	255.0	Excessive wt gain	783.1	GERD	530.81
Sleep disturb.	780.50	Inappropriate diet	V69.1	Physical activity counseling	V65.41	Nutrition counseling	V65.3	PCOS	256.4
Anxiety	300.0	Lack of exercise	V69.0	Acanthosis nigricans acquired	701.2	Hypertriglyceridemia	272.1	Asthma	493.9
Gallstones	574.20	Depression	311.0	Nonalcoholic fatty liver dis	571.8	Hypothyroidism	244.9	Constipation	564.0
Fam hx of type 2 DM	V18.0	Elevated BP	796.2	Fam hx of cardiovascular dis	V17.3	Fam hx of type 2 DM	V18.0		

For more information and clarification on billing for pediatric obesity prevention, assessment and treatment services for patients on straight Medicaid, access a Medicaid 'L Letter' at http://www.michigan.gov/documents/mdch/L-09-15-Obesity_Outreach_281184_7.pdf

Resources & References

- “Expert Committee Recommendations Regarding the Prevention, Assessment and Treatment of Childhood and Adolescent Overweight and Obesity: Summary Report” Barlow, Sarah E. & the Expert Committee. *Pediatrics* 2007; 120; S164-S192.
- Blue Cross Blue Shield of Michigan Pediatric Healthy Weight Toolkit - http://www.bcbsm.com/pdf/pediatric_healthy_weight_toolkit.pdf
- American Academy of Pediatrics. *What Families Can Do* featuring the 5210 message. <http://www.aap.org/obesity/families.html?technology=1>

Survey - Ages 6-11 Years Old

Name: _____

Age: _____

Date: _____

In our office, we are interested in discussing the aspects of a healthy lifestyle. Please answer the following questions. We realize how busy families and kids are and how difficult it is to do all the right things! The questions below give you and us a snapshot of your health habits. Thank you.

	Please circle Yes or No.	
1. My child eats fruits and vegetables 5 times a day on 4 days a week or more.	Yes	No
2. My child eats food every day before school (examples: fruit, milk, cereal, sandwich)	Yes	No
3. My child usually eats dinner at the table with other family members.	Yes	No
4. My child eats take out, fast food, or other restaurant food two times a week or less.	Yes	No
5. My family has the things needed to cook at home (examples: working stove, refrigerator)	Yes	No
6. My family can drive to a grocery store at least once a month (examples: Kroger, Walmart, Meijer).	Yes	No
7. It is easy for my family to get fresh fruits and vegetables.	Yes	No
8. My child has access to healthy meals and snacks when school is not in session.	Yes	No
9. My child spends more than 2 hours a day in front of the TV or computer.	Yes	No
10. My child has electronic devices in his/her bedroom or where he/she sleeps (examples: TV, game consoles, computer, phone).	Yes	No
11. My child does some kind of physical activity (he/she is up and moving) for at least 1 hour each day (examples: general play, sports, dancing, biking)	Yes	No
12. My child drinks fat free (skim) or 1% milk, not 2% or whole milk.	Yes	No
13. My child drinks less than 1 ½ cups (1 ½ cups = 1 soda can) of 100% fruit juice every day	Yes	No
14. My child has sugary drinks (examples: punch, fruit drinks, sports drinks, soda, icees, slurpees, Arizona teas, Kool-Aid, Capri Sun) on 4 or more days of the week.	Yes	No

My child has (circle the correct answer):

A parent or sister/brother who is overweight or obese.
 Yes No Don't Know

A parent, grandparent, aunt, uncle, sister or brother with:

Diabetes Type 2	Yes	No	Don't Know
High blood pressure	Yes	No	Don't Know
High cholesterol	Yes	No	Don't Know
Heart attack before age 55	Yes	No	Don't Know
Stroke before age 55	Yes	No	Don't Know

Circle the number which best reflects where you are at, how you feel or think.

How concerned/worried are you about your child's diet and physical activity habits?
 Not concerned/worried Very concerned/worried

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How ready are you to make changes?
 Not ready Very ready

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

How sure are you that you can make changes?
 Not sure Very sure

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Weight Status: This 12-18 year old's BMI percentile puts her/him in the **obese** category (BMI $\geq 95^{\text{th}}$ Percentile)

STEP 1: ASSESS THE CURRENT AND FUTURE WEIGHT-RELATED DISEASE BURDEN.

a. Assess Vitals: Is the patient hypertensive?

N Y

Blood Pressure Table for GIRLS by Age and Height Percentile															
Age	BP % 95	Systolic BP (mmHg) ←Percentile of Height→							Diastolic BP (mmHg) ←Percentile of Height→						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
		12	119	120	121	123	124	125	126	79	79	79	80	81	82
13	121	122	123	124	126	127	128	80	80	80	81	82	83	83	
14	123	123	125	126	127	129	129	81	81	81	82	84	84	84	
15	124	125	126	127	129	130	131	82	82	82	83	84	85	85	
16	125	126	127	128	130	131	132	82	82	83	84	85	85	86	
17	125	126	127	129	130	131	132	82	83	83	84	85	85	86	
18															

Blood Pressure Table for BOYS by Age and Height Percentile															
Age	BP % 95	Systolic BP (mmHg) ←Percentile of Height→							Diastolic BP (mmHg) ←Percentile of Height→						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
		12	119	120	122	123	125	127	127	78	79	80	81	82	82
13	121	122	124	126	128	129	130	79	79	80	81	82	83	83	
14	124	125	127	128	130	132	132	80	80	81	82	83	84	84	
15	126	127	129	131	133	134	135	81	81	82	83	84	85	85	
16	129	130	132	134	135	137	137	82	83	83	84	85	86	87	
17	131	132	134	136	138	139	140	84	85	86	87	88	88	89	
18															

b. Is the child taking any of these obesogenic medications?

N Y

Antipsychotics ___ Mood Stabilizers ___ TCA ___ Anticonvulsants ___ Prednisone ___ SSRI ___

c. Laboratory Assessment - Are any levels above borderline or higher?

N Y

Total Cholesterol ≥ 170 ___ LDL ≥ 110 ___ Triglycerides > 110 ___ HDL < 40 ___
 ALT or AST > 60 on two occasions ___
 Fasting glucose > 100 (impaired glucose tolerance) ___ OR > 126 (diabetes) ___

d. Assess Comorbidities and ROS – Is there presence of comorbidites from the ROS?

N Y

- | | |
|--|---|
| <input type="checkbox"/> Anxiety, school avoidance, social isolation (Depression) | <input type="checkbox"/> Polyuria, polydipsia, wt loss (DM) |
| <input type="checkbox"/> Abdominal pain (GERD, Gall bladder disease, constipation) | <input type="checkbox"/> Hip/knee pain (SCFE) |
| <input type="checkbox"/> Daytime sleepiness (Sleep apnea, hypoventilation syndrome, depression) | <input type="checkbox"/> Headaches (Pseudotumor cerebri) |
| <input type="checkbox"/> Night breathing problems (Sleep apnea, hypoventilation syndrome, asthma) | <input type="checkbox"/> Nocturnal Enuresis (Obstructive sleep apnea) |
| <input type="checkbox"/> Shortness of breath, exercise intolerance (Asthma, lack of physical conditioning) | <input type="checkbox"/> Tobacco use (Increased cardiovascular risk) |
| <input type="checkbox"/> Hirsutism, excessive acne, irregular menses - < 9 cycles per yr (Polycystic ovarian syndrome) | |

e. Physical Exam – Are comorbidities noted on the physical exam?

N Y

Potential Causes of Obesity

- | | |
|---|---|
| <input type="checkbox"/> Violaceous striae (Cushing's syndrome) | <input type="checkbox"/> Undescended testicle (Prader-Willi syndrome) |
| <input type="checkbox"/> Poor linear growth (Hypothyroidism, Cushing's, Prader-Willi) | <input type="checkbox"/> Dysmorphic features (Genetic disorders) |
| <input type="checkbox"/> Goiter (hypothyroidism) | |

Potential Comorbidities/Complications of Obesity

- | | |
|---|--|
| <input type="checkbox"/> Acanthosis nigricans (NIDDM, insulin resistance) | <input type="checkbox"/> Lower leg bowing (Blount's disease) |
| <input type="checkbox"/> Hepatomegaly (Nonalcoholic fatty liver disease) | <input type="checkbox"/> Papilledema, cranial nerve VI paralysis (Pseudotumor cerebri) |
| <input type="checkbox"/> Wheezing (Asthma) | <input type="checkbox"/> Tonsillar hypertrophy (Sleep apnea) |
| <input type="checkbox"/> Abdominal tenderness (Gall bladder disease, GERD, NAFLD) | <input type="checkbox"/> Limited hip range of motion (Slipped capital femoral epiphysis) |
| <input type="checkbox"/> Excessive acne, hirsutism (Polycystic ovarian syndrome) | |

f. Review assessment tool – is family history positive for any of the following?

N Y

Family Hx: Obesity ___ HTN ___ Type 2 DM ___ Hyperlipidemia ___ Early MI ___ Early Stroke ___

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If any above medical risks are noted refer as appropriate.

Survey - Ages 12-18 Years Old

Name: _____

Age: _____ Date: _____

In our office, we are interested in discussing the aspects of a healthy lifestyle. Please answer the following questions. We realize how busy families and kids are and how difficult it is to do all the right things! The questions below give you and us a snapshot of your health habits. Thank you.

	Please circle Yes or No.	
1. I eat fruits and vegetables 5 times a day on 4 days a week or more.	Yes	No
2. I eat food every day before school (examples: fruit, milk, cereal, or sandwich).	Yes	No
3. I usually eat dinner at the table with other family members.	Yes	No
4. I eat take out, fast food, or other restaurant food two times a week or less.	Yes	No
5. My family has the things needed to cook at home (examples: working stove, refrigerator).	Yes	No
6. My family can drive to a grocery store at least once a month (examples: Kroger, Walmart, Meijer).	Yes	No
7. It is easy for my family to get fresh fruits and vegetables.	Yes	No
8. I have access to healthy meals and snacks when school is not in session.	Yes	No
9. I watch more than 2 hours of TV a day or play video or computer games more than 2 hours a day.	Yes	No
10. I have electronic devices in my bedroom or where I sleep (examples: TV, game consoles, computer, phone).	Yes	No
11. I do some kind of physical activity (examples: housework, sports, dancing, biking) for at least 1 hour each day.	Yes	No
12. I drink fat free (skim) or 1% milk, not 2% or whole milk.	Yes	No
13. I drink less than 1 ½ cups (1 ½ cups = 1 soda can) of 100% fruit juice every day.	Yes	No
14. I have sugary drinks (examples: punch, fruit drinks, sports drinks, soda, icees, slurpees, Arizona teas, Kool-Aid, Capri Sun) on 4 or more days of the week.	Yes	No

My parent or sister/brother is overweight or obese.
Yes No Don't Know

I have parents, grandparents, aunts, uncles, sisters or brothers with:

Diabetes Type 2	Yes	No	Don't Know
High blood pressure	Yes	No	Don't Know
High cholesterol	Yes	No	Don't Know
Heart attack before age 55	Yes	No	Don't Know
Stroke before age 55	Yes	No	Don't Know

Circle the number which best reflects where you are at, how you feel or think.

How concerned/worried are you about your diet and physical activity habits?

Not concerned/worried Very concerned/worried

1	2	3	4	5	6	7	8	9	10
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How ready are you to make changes?

Not ready Very ready

1	2	3	4	5	6	7	8	9	10
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How sure are you that you can make changes?

Not sure Very sure

1	2	3	4	5	6	7	8	9	10
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