



## **Medicaid Coverage of Childhood Obesity**

### *Clarify Medicaid policies to improve clinical care and coverage*

#### **ISSUE:**

Recognition of overweight in children is a crucial first step in prevention, treatment, and medical management of obesity. Too often, families and even providers do not recognize that children are at risk for health problems due to excess weight. Professional guidelines<sup>1</sup> and the U.S. Preventive Services Task Force<sup>2</sup> recommend that children be screened annually for Body Mass Index (BMI). Indeed, annual BMI assessment; and weight, physical activity and nutrition counseling are a new Healthcare Effectiveness Data and Information Set (HEDIS) indication of health care quality<sup>3</sup>. In national surveys, providers indicated that they are reluctant to undertake obesity screening and treatment because they are unaware of how to obtain reimbursement or fear that reimbursement claims will be denied<sup>4</sup>. The Michigan Department of Community Health's Medicaid Division issued an "L" Letter to providers indicating circumstances in which they will cover obesity diagnostic, prevention and treatment services<sup>5</sup>. However, additional work is needed to increase provider awareness of coverage. Statewide rates of claim submission and denials should be assessed to monitor progress.

#### **PROPOSED ACTIONS:**

- Assess provider awareness of reimbursement opportunities for obesity screening, prevention and treatment services.
- Assess rates of claims submissions and denials. Determine whether claims rates mirror trends in BMI counseling as reported to the BMI Module being deployed in the Michigan Care Improvement Registry (MCIR).
- Coordinate with external efforts to offer provider training around obesity screening and treatment.
- Expand promotion of the childhood obesity policy clarification published by Medicaid to further disseminate information on coding and reimbursement related to pediatric overweight.
- Establish incentives for health plans and providers to screen for pediatric obesity.
- Establish a system of Best Practices in Childhood Obesity Prevention to bundle obesity-related Medicaid services, and to disseminate and monitor clinical practices.

#### **RATIONALE:**

There is currently a belief in the provider community that obesity prevention and management services are not reimbursed by Medicaid. Consequently, pediatric providers do not routinely provide or request reimbursement for these services. While the policy clarification distributed by the MDCH's Medicaid Division is easily understood and applied, additional promotional efforts may be needed to ensure widespread awareness. In addition, its effectiveness should be assessed through examination of screening and reimbursement rates. Tools will be deployed as part of the MCIR that will support provider screening efforts, and also provide a means to track the frequency of provider screening and counseling. Analyses could be undertaken at the provider and health plan level to track whether BMI screening rates are increasing. Comparisons with Medicaid claims data could also be undertaken to see whether trends observed through MCIR are mirrored on the Medicaid side.

#### References:

1. Barlow, S. E., & the Expert Committee. (2007). Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report. *Pediatrics*, 120(Supplement 4), S164-92.
2. U.S. Preventive Services Task Force. (2010). Screening for Obesity in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement. *Pediatrics*, peds.2009-2037. doi:10.1542/peds.2009-2037
3. National Committee for Quality Assurance. (2009). *HEDIS 2010, Volume 2*. Retrieved from [http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2010/2010\\_Measures.pdf](http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2010/2010_Measures.pdf)
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5. Michigan Department of Community Health. (2009, June). 2009 Medicaid Provider L Letter 09-15: Support of Healthy Kids, Healthy Michigan: Advocates for Healthy Weight in Children. Retrieved from [http://www.michigan.gov/documents/mdch/L-09-15-Obesity\\_Outreach\\_281184\\_7.pdf](http://www.michigan.gov/documents/mdch/L-09-15-Obesity_Outreach_281184_7.pdf)



## **HEALTH AND PHYSICAL EDUCATION**

*Increase quantity and quality of school offerings*

### ***ISSUE:***

Michigan's Revised School Code requires health education and physical education, but presents them as one indistinct aspect of education, and is silent on important details governing their quantity and quality.

Physical activity and health literacy are correlated with healthy behaviors and educational achievement. Establishing healthy behaviors early in life, through education and practice, can produce sustained health benefits for individuals and economic benefits for families, schools, and other businesses and units of government. Despite these benefits, there is a long-term trend in the reduction of efforts and resources committed to physical education and health education programs in schools. Quality health education and physical education promote lifelong skills required for healthy lifestyles. Extra-curricular activities may be physical activities, but they are not a substitute for education.

### ***PROPOSED ACTIONS:***

- Amend the Michigan Revised School Code to separate, and improve expectations for, physical education and health education.
- Require a minimum amount of time to be spent in health education and physical education courses at grade levels K through 8.
- Disallow the application of extra-curricular activities towards physical education requirements.

### ***RATIONALE:***

Because schools and school districts are not required to report on educational outcomes of health education and physical education courses, there is a continuing trend to reduce the time and effort students spend learning these academic subjects. Adding specificity to the Michigan Revised School Code pertaining to the quantity and quality of these instructional areas will ensure regular student physical activity and the instruction of health skills required for a lifetime of health and activity.



## **Coordinated School Health Programs**

*Require the formation of district level Coordinated School Health Councils*

### **ISSUE:**

The academic success of Michigan's youth is strongly linked with their health. Research has found that when a student is hungry, physically or emotionally abused, or suffering from chronic illness, poor school performance can follow. Risky health behaviors such as substance abuse, violence, and physical inactivity often affect school attendance, grades, test scores, and the ability to pay attention in class, leading to academic failure. It follows then, that academic success is an excellent indicator of overall well-being for youth and a primary predictor and determinant of adult health outcomes<sup>1</sup>.

In 2003, the Michigan State Board of Education recognized these facts and recommended that school districts, and individual schools, form Coordinated School Health Councils. While the policy was one of the first in the nation, no guidance was given on the recommended make-up, function, or accountability of these teams. National data indicate Michigan children continue to be less 'health literate,' and less healthy, than their peers in other states.

### **PROPOSED ACTION:**

- Amend the Revised School Code to require the existence of District Coordinated School Health Councils.
- Allow the Michigan Department of Education the ability to establish mechanisms for the development, review, update and reporting of annual school health action plans.

### **RATIONALE:**

About half of Michigan elementary schools (49%) have a team that offers guidance on school health policies and coordinates school health activities. Sixty-one percent (61%) of secondary schools have such a team<sup>2</sup>. However, there is a great deal of variety in their approaches and overall effectiveness. Standardizing the constituency of these Councils and their purpose, and establishing assessment options and reporting requirements, along with technical assistance, will allow for more strategic and effective efforts to improve the health and academic outcomes of Michigan students.

Coordinated School Health Councils provide a framework for school districts to leverage community partners and resources to meet the needs of students and families. Through this model, schools are better able to eliminate duplication of efforts, and increase the effectiveness of programs and services.

The States of Arkansas and Texas, which have both mandated the creation of School Health Councils, have seen a halt or decline of childhood obesity in sizeable proportions of their student populations. Reducing childhood obesity prevalence is an important public health goal that can have significant impact on the long-term financial health of the state.

#### References:

1. [www.cc.gov/healthyyouth](http://www.cc.gov/healthyyouth)
2. 2010 Michigan School Health Profiles



## State Nutrition Standards for the School Campus *Statewide Adoption of Michigan's Nutrition Standards*

### **ISSUE:**

Research shows that nutrition is closely linked with academic success and behavior.<sup>1,2</sup> Impacting the nutrition environment in schools complements the educational process and addresses childhood obesity. Foods and beverages are available throughout the school district campus in a number of venues including: school meals, vending machines, school stores, a la carte and snack lines, parties and celebrations, extracurricular events, and as an incentive or reward for academic achievement or good behavior. Since students often spend the majority of their day at school, a significant amount of their food intake occurs at school. The food and beverages available to students should therefore be nutrient rich and enhance their ability to succeed academically.

### **PROPOSED ACTIONS:**

- Legislation to ensure that all Michigan school districts adhere to *Michigan's Nutrition Standards: Michigan Department of Education Recommendations for All Foods and Beverages Available in Michigan Schools*.
- Utilize social media to mobilize support for *Michigan's Nutrition Standards*.
- Incorporate the 54321Go! message into *Michigan's Nutrition Standards* media and marketing.
- Promote regional trainings, the toolkit, and other resources available for all Michigan school districts on implementation of *Michigan's Nutrition Standards*.

### **RATIONALE:**

Michigan's State Board of Education recognized and acknowledged, through its Model Local Wellness Policy adopted in October 2005, that "schools should provide a campus-wide environment where students are taught healthy eating and physical activity knowledge, skills, and values. In addition, the campus-wide environment should provide ample opportunity to practice these skills on a daily basis." In October 2010, the Michigan State Board of Education adopted *Michigan's Nutrition Standards* in order to provide a consistent message and ensure students are provided with healthy foods and beverages campus-wide. This policy recommends, but does not require, that school districts follow *Michigan's Nutrition Standards*.

By using schools as a conduit for policy and legislation, a large number of students will be impacted. Approximately 1.6 million students were enrolled in Michigan schools during the 2009-2010 academic year.<sup>3</sup> Research has shown that having policies in place to improve the food and beverages offered and sold in schools positively affects student dietary intake.<sup>4,5</sup> Childhood obesity continues to be an issue with 30.6% of Michigan children being classified as overweight or obese in 2009.<sup>6</sup> Legislation requiring that schools follow the standards is necessary in order to ensure that Michigan students will consistently be provided and sold nutrient-rich food and beverages in all venues on the school campus.

### References:

1. Kleinman RE, Hall S, Green H, Korzec-Ramirez D, Patton K, Pagano ME, Murphy JM. Diet, breakfast and academic performance in children. *Ann Nutr Metab* 2002;46( Suppl 1):24-30.
2. Rampersaud GC, Pereira MA, Girard BL, Adams J, Metz JD. Breakfast habits, nutritional status, body weight and academic performance in children and adolescents. *J Am Diet Assoc.* 2005;105(5):743-60
3. [www.michigan.gov/mde](http://www.michigan.gov/mde)
4. Briefel RR, Grepinsek MK, Cabili C, Wilson A, Gleason PM. School food environments and practices affect dietary behaviors of US public school children. *J Am Diet Assoc.* 2009;109(2 Suppl):S91-107
5. Woodward-Lopez, G., Gosliner W., Samuels, S., Craypo, L., Kao, J., Crawford, PB. Lessons learned from evaluations of California's statewide school nutrition standards. *Am J Public Health* 2010; Sept 23
6. National Survey of Children's Health, 2007. Overweight and Physical Activity Among Children: A Portrait of States and the Nation 2009, Health Resources and Services Administration, Maternal and Child Health Bureau.



## **BMI Surveillance:**

### *Monitoring, Evaluating, and Prioritizing Childhood Obesity Prevention Efforts*

#### **ISSUE:**

Leading policy, academic, and advocacy groups have highlighted the urgent need for high quality surveillance data to permit understanding childhood obesity prevalence and trends at the local level and for populations at highest risk. Such information is needed to determine the effectiveness of community-level interventions and identify where additional resources should be focused. Michigan's addition of a Body Mass Index (BMI) surveillance module to its immunization registry could be a model for other states seeking cost-effective ways to monitor obesity. When fully populated, this data will ultimately allow for the evaluation of state and local policies, childhood obesity prevention programs, and the prioritization and effective design of future obesity prevention efforts. To address provider needs, the module also offers tools to help providers screen all children for obesity, those at risk of obesity and under weight, identify weight-related health risks, and focus prevention and treatment counseling on patient-driven goals.

The Michigan Care Improvement Registry (MCIR) has been created and refined by the Michigan Legislature to monitor and improve the Michigan Department of Community Health's (MDCH) response to other challenging public health threats. Operational oversight of the MCIR is provided by the MDCH's Division of Immunization. The MCIR has proved an effective tool for childhood health promotion and offers strategic advantages for BMI surveillance efforts in Michigan.

#### **PROPOSED ACTIONS:**

- Complete programming of the MCIR's BMI screening and surveillance tools and develop reports to be used at the provider, clinic, health plan, region and state level.
- Modify governing statutes and regulations to facilitate providers reporting of children's data for BMI surveillance.
- Prepare communication strategies to roll the system out statewide to health care providers and MCIR users.
- Once MCIR BMI surveillance data are entered, assess data quality and produce reports for surveillance purposes and assessment of obesity-related care quality.

#### **RATIONALE:**

The MCIR is a robust and established public health surveillance tool currently used to monitor immunization status and other child health issues. A vast majority (85-90%) of physicians in the state already use this system to track the immunization and lead screening status of their pediatric patients. Adding BMI-related data fields to the MCIR will provide for improvements in evidence-based community and policy interventions, and medical and public health practices. With better data, policy and program interventions can be evaluated over time, and scarce resources will be more efficiently allocated to improve prevention and clinical management efforts.



## **Improving Nutrition in Child Care Centers** *Changing the intake of juice, milk, and water*

### **ISSUE:**

More than 1 in 4 of Michigan's preschoolers aged 2-4 were obese or overweight in 2007<sup>1</sup>. Nationwide, over 62% of preschoolers with working mothers are in some form of child care<sup>2</sup>, with those aged 3-6 spending an average of 24.8 hours per week in child care centers<sup>3</sup>. In Michigan, there are 4,620 licensed child care centers (capacity=296,823); 5,650 family child care homes (capacity=33,585); 2,716+ group child care homes (capacity=32,473) and 31,000 unregistered home facilities (capacity unknown)<sup>4</sup>. Therefore, child care centers are an appropriate setting in which to combat childhood obesity in the area of improved beverage regulations. The current licensing rules for child care centers do not contain specific rules addressing the provision of healthy beverages. The Child and Adult Care Food Program (CACFP) does have nutrition regulations, however, licensed child care centers that do not participate in the CACFP are currently not required to follow their nutrition regulations. The proposed actions listed below will allow all Michigan licensed child care centers to consistently provide healthy beverages and be in compliance with CACFP federal regulations.

**PROPOSED ACTIONS:** Establish state standards through licensing of child care centers to ensure that:

- Children ages 1-2 are served whole milk.
- Children older than two years are served skim milk or 1%.
- Clean, sanitary, self-serve drinking water is available throughout the day, and
- 100% fruit juice intake is limited to one age-appropriate serving per day.

### **RATIONALE:**

Beverage intake is a major source of calories for young children. Contemporary dietary patterns suggest that milk intakes have declined while sugared beverage intakes (e.g., 100% juice, juice drinks, soda pop) have increased<sup>5</sup>. Milk is an important source of calcium and Vitamin D and provides key nutrients for children's growth and development. It is recommended that children up to age 2 drink whole milk (which provides fats essential for brain development) and skim milk or 1% (with the same nutritional benefits of whole milk) recommended for children older than two<sup>6</sup>.

#### References:

1. Michigan Department of Community Health (MDCH), 2009: Overweight and Obesity in Michigan-Surveillance Report
2. Capizzano J, Main R. *Snapshots of America's Families*. Urban Institute; 2005. Many Young Children Spend Long Hours in Child Care.
3. Iruka, I.U., & Carer, P.R. Initial Results from the 2005 NEHS Early Childhood Program Participation Survey. U.S. Department of Education, 2006. NCES 2006075.
4. Michigan Department of Human Services: Bureau of Children and Adult Licensing
- 5 American Academy of Pediatrics (2001). Committee on nutrition: The use and misuse of fruit juices in pediatrics. PEDIATRICS (May 2001) Vol. 107(5).
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# Healthy Kids, Healthy Michigan

*Advocates for Healthy Weight in Children*

## **Increased Physical Activity in Child Care Centers** *Require a minimum of 60 minutes of physical activity*

### **ISSUE:**

More than 1 in 4 of Michigan's preschoolers aged 2-4 were obese or overweight in 2007<sup>1</sup>. Nationwide, over 62% of preschoolers with working mothers are in some form of child care<sup>2</sup>, with those aged 3-6 spending an average of 24.8 hours per week in child care centers<sup>3</sup>. In Michigan, there are 4,620 licensed child care centers (capacity of 296, 823); 5,650 family child care homes (capacity of 33,585); 2,716+ group child care home (capacity of 32, 473) and 31,000 unregistered home facilities (capacity unknown)<sup>4</sup>. Therefore, child care centers are an appropriate setting in which to combat childhood obesity in the area of improved physical activity standards. The current licensing rules for licensed child care centers do not specify a daily minute-amount of required physical activity for any age group; do not make provisions for infants to be physically active or for child care providers to receive required training in physical activity education.

**PROPOSED ACTION:** Establish state standards through licensing of child care centers to ensure that:

- Children ages 12 months or older attending a full-day program are provided 60 minutes of physical activity per day, a combination of both teacher lead and free play.
- Children attending less than a full day program shall be scheduled to participate in a proportionate amount of physical activity.
- Children with special needs are provided opportunities for active play.
- Children are not seated for more than 30 minutes at a time unless when eating or sleeping.
- While awake, infants cannot spend more than 30 minutes at a time in confining equipment.
- Physical activity education is offered to child care providers at least one time per year.

### **RATIONALE:**

Increased physical activity is a key factor in reducing childhood obesity. Research indicates that regular physical activity seems to help protect against obesity during the preschool-age period<sup>5</sup>. The National Association for Sports and Physical Activity recommends that all children from birth to age 5 should engage daily in physical activity that promotes movement skillfulness and foundations of health-related fitness<sup>6</sup>. Child care centers provide an opportunity for safe physical activity that includes both free play and structured teacher-led or teacher-assisted activities. Research studies have shown that on average, children in child care settings are spending very little time in physical activity that can be classified as moderate or vigorous. One study, for example, found that up to 80% of time spent at daycare can be sedentary, with only 2-3% of physical activity classified as moderate or vigorous<sup>7</sup>. Physical activity does not have to be outdoor or indoor play – it can be done in any environment. The education and training of child care facility workers on the importance and implementation of 60 minutes of physical activity per day is a critical support necessary for successful implementation.

#### References:

1. Michigan Department of Community Health (MDCH), 2009: Overweight and Obesity in Michigan-Surveillance Report
2. Capizzano J, Main R. *Snapshots of America's Families*. Urban Institute; 2005. Many Young Children Spend Long Hours in Child Care.
3. Iruka, I.U., & Carer, P.R. Initial Results from the 2005 NEHS Early Childhood Program Participation Survey. U.S. Department of Education, 2006. NCES 2006075.
4. Michigan Department of Human Services: Bureau of Children and Adult Licensing.
5. Reilly JJ. (2008). Physical activity, sedentary behaviour and energy balance in the preschool child: opportunities for early obesity prevention. *Proceedings of the Nutrition Society*. 2008;67(3): 317-325
6. National Association for Sport and Physical Education. Active Start: a statement of physical activity guidelines for children birth to five years. NASPE Publications; Reston (VA): 2002.
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# Healthy Kids, Healthy Michigan

*Advocates for Healthy Weight in Children*

## Limiting Screen Time in Child Care Centers

*Require limits on television, video, and computer viewing*

### **ISSUE:**

More than 1 in 4 of Michigan's preschoolers aged 2-4 were obese or overweight in 2007<sup>1</sup>. Nationwide, over 62% of preschoolers with working mothers are in some form of child care<sup>2</sup>, with those aged 3-6 spending an average of 24.8 hours per week in child care centers<sup>3</sup>. In Michigan, there are 4,620 licensed child care centers (capacity=296, 823); 5,650 family child care homes (capacity=33,585); 2,716+ group child care homes (capacity=32,473) and 31,000 unregistered home facilities (capacity unknown)<sup>4</sup>. Therefore, child care centers are an appropriate setting in which to combat childhood obesity in the area of limiting screen time. The current licensing rules for child care centers do not specify the number of minutes children can spend in front of a screen nor do they specify an age where screen time is prohibited.

**PROPOSED ACTIONS:** Establish state standards through licensing of child care centers to ensure that:

- Television, DVD, video cassette, electronic games and computer viewing are prohibited for children younger than two years of age.
- Children ages 2 and older in a full-day program are limited to 60 minutes per day of educational programs or programs that actively engage child movement. Each screen time session shall be limited to a maximum of 30 minutes.
- Children attending less than a full day program shall be limited to a proportionate amount of screen time.
- Computer use is limited to educational programming, has protections from exposure to inappropriate websites and supervised by a staff member.

### **RATIONALE:**

Young children in the United States watch an astonishing amount of television, spending more time in front of a screen than any other single activity except sleeping<sup>5,6</sup>. One study indicates that over 31% of preschool children exceed the recommended limit for television viewing/screen time<sup>7</sup>. Screen time can be described as the viewing of TV/video, computer, electronic games, hand-held devices or other visual devices. The American Academy of Pediatrics recommends no TV viewing before age 2 and that children over age 2 accumulate no more than 2 hours per day of television and video time<sup>8</sup>. Establishing state standards on screen time through licensed child care centers would provide limits on the number of minutes children spend sedentary in front of a screen and hopefully help facilitate more children meeting the American Academy of Pediatrics recommendations.

#### References:

1. Michigan Department of Community Health (MDCH), 2009: Overweight and Obesity in Michigan-Surveillance Report
2. Capizzano J, Main R. *Snapshots of America's Families*. Urban Institute; 2005. Many Young Children Spend Long Hours in Child Care.
3. Iruka, I.U., & Carer, P.R. Initial Results from the 2005 NEHS Early Childhood Program Participation Survey. U.S. Department of Education, 2006. NCES 2006075.
4. Michigan Department of Human Services: Bureau of Children and Adult Licensing
5. Christakis D., Ebel B., Rivara F., Zimmerman F. Television, video, and computer game usage in children under 11 years of age. *J Pediatrics*. 2004;145:652-656
6. Rideout VJ, Vandewater EA, Wartella EA. *Zero to Six: Electronic Media in the Lives of Infants, Toddlers, and Preschoolers*. Menlo Park, CA: Kaiser Family Foundation; 2003
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8. American Academy of Pediatrics: Prevention of pediatric overweight and obesity: policy statement. *Pediatrics* 2003,112:4



# Healthy Kids, Healthy Michigan

*Advocates for Healthy Weight in Children*

## **Complete Streets and Safe Routes to School**

*Supporting state and local Complete Streets policy change, and encouraging active transportation throughout school transportation and facility management decisions*

### **ISSUE:**

Obesity rates among children have skyrocketed in recent years. One of the factors contributing to childhood obesity is physical inactivity. Obese children generally become obese adults and suffer from chronic, and often preventable, diseases such as cardiovascular disease, diabetes, and several types of cancer. One of the strategies used to combat obesity is to create safe places for families and children to participate in physical activity.

By being active and choosing healthy foods, individuals can decrease their risk of developing chronic diseases. Children should get at least 60 minutes of physical activity every day. Often the built environment makes it difficult to integrate physical activity into a daily routine by walking or biking to work, school, grocery stores or other points of interest. In order to encourage children and families to be physically active, our built environments need to offer opportunities for active transportation and physical activity.

There are many ways a community creates built environments that support physical activity, including but not limited to:

- *Complete Streets* efforts that recognize the importance of planning, designing, constructing, and maintaining roadways to accommodate safe access for all users.
- *School transportation and infrastructure management* which can encourage the consideration of active transportation throughout decisions regarding the siting, closure, and consolidation of school facilities for providing safe and efficient connections for students, staff, and the community.

### **PROPOSED ACTIONS:**

- Continue to support Complete Streets policy initiatives at the state and local levels through training and resources and assist the Complete Streets Advisory Council.
- Research policy options and determine policy direction that enables school districts and local communities to consider active transportation when making school transportation and infrastructure management decisions such as siting, closure, and consolidation of school facilities.

### **RATIONALE:**

It is difficult for children and families to make physical activity a part of their daily lives when the built environment in which they live does not support healthy behaviors. By supporting Complete Streets policy changes at the state and local level, and strategically targeting specific policies affecting school facility management decisions we can change the fabric of our communities and create built environments that support physical activity.