Policy Development and Analysis

Health Policy Issues and Description of Policy Change

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**Health Policy Issue: what specific health policy do you want to change?**

Due to the incidence of overweight and obesity in school age children and their families, in the state of Texas, we are proposing a Houston area-wide pilot program for extending the Coordinated School Health Program (CSHP), being implemented in Texas schools, into the community. We propose taking major steps to include the children of Houston, as well as their families as a whole, into a program for a healthy lifestyle that addresses the problem of childhood obesity, as well as the obesity epidemic in Houston in general. This proposed policy change would challenge each individual community in the Houston area to make a commitment to changing the eating habits and exercise habits of families with school age children, as well as the community as a whole. It could be called Houston Area School and Community Health Initiative (HASCHI).

Presently, the policy, called Coordinated School Health Program (CSHP): Texas Education Code, Title 2, Chapter 38, sub-section 38.013., addresses the food, nutrition, and physical activity level of students while at school, with parental involvement as a lesser component. While Texas school districts have these programs in place, most of them only address the issues of eating healthy and getting a certain amount of physical activity so that energy out (physical activity) is at least equal to energy in (intake) so that the child does not gain weight, during school hours. The problem is this policy is only effective while the child is at school and does not address inactivity and poor diet while at home. We believe that the school-based program is being made ineffective by the fact that once school ends and private life begins, these children are going home eating unhealthy foods and living a sedentary lifestyle. This unhealthy lifestyle is placing the children of Houston and the surrounding area at risk for metabolic syndrome and premature death, as well as a whole host of health problems. Not only are children being affected by the obesity epidemic, but their families are being affected as well. A community-based program, aimed at changing the habits of the community as a whole (including more parental and community involvement) could decrease body mass index’s (BMI's) in the children and the community as a whole, leading Houston to becoming one of the state’s leanest cities, instead of the fattest.

**Health Policy Issue: what is your proposed change?**

Our proposed policy changes are as follows:

A. Promote healthier foods at school:

1. Healthier school menus: reduce the amount of fat and calories in school lunch menus to no more than one third of the daily recommended allowances for age group.

B. Restrict competitive food offerings at school to healthy ones:

1. Only sugar free or low sugar beverages offered in vending machines (diet soda, water, vitamin water, flavored water).

2. Only healthy choices of foods offered in vending machines (trail mix, granola bars, fruit, nutri-grain bars, etc).

3. Food alternatives in the cafeterias to include only healthy choices such as deli style sandwiches, smoothies, and salad bars.

C. Healthier food choices while away from school:

1. Expanding WIC food offerings to include healthy foods such as fruit and vegetables.

2. Promote healthy eating through public awareness campaigns.

3. Offer community-based classes to help parents with healthy food selection, healthy food preparation, healthy food menus, portion control and healthy foods to substitute for unhealthy ones.

4. Increase access to fresh vegetables by organizing farmer's markets in low income areas.

5. Increase access to supermarkets by giving incentives to companies such as HEB, Randall's, Kroger and Wal-Mart to build stores in low income areas.

6. Place local sin tax on sodas and candy to help pay for program components.

D. Encourage More P.E. at school:

1. Require additional physical education (P.E.) hours in all grade levels of school, particularly at the elementary level.

E. Encourage more physical activity in the community:

1. Give incentives to gym companies and the YMCA to build facilities in low income areas.

2. Supplement gym fees for low income families.

3. Public awareness campaigns (TV & radio ads, billboards, etc.).

F. School Accountability and Reward:

1. Hold schools accountable for poor performance.

2. Reward schools with top performance.

3. Reward communities with top performance.

G. Community Involvement (aside from things already mentioned)

1. Hold community outreach activities such as health fairs, including weigh-ins, BMI measuring, weight management strategies and counseling, healthy eating education, cooking demonstrations, fitness equipment stations, etc.; and, organize activities such as 5-K runs/walks.

2. Fund more parks with jogging trails and gym equipment in low income areas.

A proposal for the inclusion of Advanced Practice Nurses (APNs) into this policy change is as follows:

A. ANPs as Coordinators:

1. APNs would be coordinators by using a care model (this would be theory-based and evidence-based practice). For example, the use of the “Family-centered collaborative negotiation model”, a model for facilitating behavior change in primary care”, is one specific model that was developed for screening and prevention of childhood obesity and its complications (Robinson, 2010, p. 272).

2. APNs would coordinate the interdisciplinary team (i.e. social workers, counselors, dietitians etc.) for children and their families who enter this new program (Robinson, 2010).

3. Since APNs would coordinate care for preventing childhood obesity, children and their families would not receive fragmented or episodic information and care.

4. Who better than APNs to use a family-based effective approach for children who enter this new community-based program.

In order to facilitate the effective use of APNs with this new program, specific, detailed policy changes would need to be made (Robinson, 2010, p. 272). For example, the use of information technology and electronic medical records (EMR) would be an essential element for the interdisciplinary team, to aid in coordination of care and the maintenance of an up-to-date patient records database.

**Background of health policy development**

**What is the historical development of the policy and related health issue?**

Since the early 1800s, schools have been providing health services to school-aged children. School health programs have changed to reflect the needs of students, parents, and the community at large. Today’s school health programs have evolved through the interrelationship of three major professions: education, nursing, and medicine (CSHP, 2008). Good health is necessary for academic success. Like adults at work, students at school have difficulty being successful if they are depressed, tired, bullied, stressed, sick, alcohol or other drugs abused, hungry, or abused. In 1987, the CDC first proposed the concept of a coordinated school health program (CSHP). CSHP is a systemic approach of advancing student academic performance by promoting, practicing, and coordinating school health education and services for the benefit and well-being of students in establishing healthy behaviors designed to last their lifetime (CSHP, 2008). True CSHP consist of eight separate but interconnected components including health education; physical education; health services; family/community involvement; school counselors, psychologists, and social workers; nutrition services; and healthy school environment.

**Were there any socio-economic factors related to development of the policy?**

Childhood obesity is one of the greatest health problems facing the nation today. It is associated with the greatest public health, social, and psychological problems such as discrimination and poor self-esteem. The essential cause of increase in overweight is excess caloric intake, less calorie expenditure, unhealthy eating choices and not getting enough physical activity. The comfortable living conditions of today, including air conditioning, television, video games, and increase availability of rich food has pushed the country into this epidemic. In 2008, overall medical care costs related to obesity for U.S. adults were estimated to be as high as $147 billion. People who were obese had medical costs that were $1,429 higher than the cost for people of normal body weight; and US medical expenditures were estimated to be about $73 billion for 2003 (CDC, 2009). "As [overweight](http://www.cbsnews.com/2100-204_162-507774.html) children become overweight adults, the diseases associated with obesity and health care costs are likely to increase even more," indicated from a report from the Centers for Disease Control and Prevention, (Collins, 2009). Obesity is a multifaceted problem with significant health, social, and economic consequences. Policy interventions that make healthy dietary and activity choices easier are likely to achieve the greatest benefits, (Friedman et. al. 2010). A new policy is an essential initiative that is necessary towards decreasing childhood obesity, producing healthy people, establishing safe, healthy schools and communities. Differential access to healthy foods in low-income communities is a major contributor to health disparities in diet-related chronic diseases and obesity, (Story, Hamm, & Wallinga, 2009). These socio economic factors lead the legislature to think about and consider various policy approaches to facilitate opportunities for a healthier diet and more exercise in childhood. The CDC came up with the Coordinated School Health Program (CSHP) integrating various components that would strongly influence student health. CSHP is a systematic approach to promote student health. Schools can effectively implement these strategies and play a strong role in improving the lives of young people.

Food shortage is another socio-economic problem that has been the main risk to a child’s being and has changed the eating behavior and feeding practices that exist in family homes today with the economy being a key factor. Children from families with low-socioeconomic status and from racial and ethnic minority groups are particularly disadvantaged, (Chaffee, 2012). Families that are food insecure may purchase cheaper foods that are more energy dense and have less nutritional quality but more calories, (TLIOC, 2009). There are many health consequences associated with obesity which in the long run continues into adulthood. Current research indicates that by addressing children’s health, schools can improve student performance; and, while discrepancies exist between what research indicates is needed for healthy development and what society delivers, policy and environmental approaches that make healthy choices available, affordable, and easy to obtain can be used to extend the reach of strategies designed to raise awareness and support individuals who would like to make healthy lifestyle changes (Chaffee, 2012).

**Were there any legal factors, including relevant state and federal legislation and case law that contributed to development of the policy?**

When considering new policy and changes to existing policies, it is vitally important to keep in mind legal considerations. The most significant legal concern when considering amendments to Texas Education Code, Title 2, Chapter 38, sub-section 38.013 is ensuring proposals do not infringe upon parental rights to raise children as the parent(s) see fit. This right was supported in the U.S. Supreme Court case Santosky v. Kramer in which the courts held that “The fundamental liberty interest of natural parents in the care, custody, and management of their child is protected by the Fourteenth Amendment… (Santosky v. Kramer, 1982).” Changes presented in this paper simply provide resources, options, and education that allow students to make better choices in school and parents to make healthier choices for their families at home. The key legal component to our propositions is that they all still allow parents to make choices. None of our proposals force parents or children to participate in any activity or program that they deem disagreeable or against their value system thus ensuring freedom of choice.

Another legal implication that also includes serious ethical concerns is in regards to the definition of child abuse and the line between parental rights to raise their children as they see fit. Federal Law states that child abuse is at minimum, “any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm…or an act or failure to act which presents an imminent risk of serious harm” (Child Welfare Information Gateway, 2008). The State of Texas defines child abuse as “an act or omission that endangers or impairs a child’s physical, mental or emotional health and development. Child abuse may take the form of…physical neglect [and / or] medical neglect…” (Attorney General of Texas, 2010). With no clear guide lines on what all is or could be encompassed by these definitions, the legal and ethical question is at what point is childhood obesity considered abuse? Should childhood obesity, for some, fall into the abuse category of neglect?

Parental rights and the fuzziness of legal definitions of child abuse must be taken into consideration when deciding on programs for schools and communities. As health care professionals it is our duty to protect these children for which we are providing programs. This means not only being aware of the issues, but being an active, hands on member of the solution and assessment / evaluation of program effectiveness.

**Were there any ethical issues related to development of the policy?**

Recent studies show that it can be expensive to maintain a healthy diet and is definitely more expensive to eat healthy than it is to eat processed foods. “Based on a standard 2000-calorie diet…researchers found a diet consisting primarily of calorie-dense foods costs $3.52 a day, but a diet consisting primarily of low-calorie food costs $36.32 a day” (Kish, 2009). So if you have a single mother of three, working two jobs to ensure shelter and minimal clothing for her children and thus can’t afford to purchase healthy foods for the home, should it be considered neglect that her children are obese and starting have health problems related to obesity? “"If you have $3 to feed yourself, your choices gravitate toward foods which give you the most calories per dollar…”(Kish, 2009).” Parents have the ethical responsibility to do no harm and enabling childhood obesity could be argued as harmful (Perryman, 2011). The amendments we have proposed here provide ethical solutions, including parental education and community involvement, that all parents to make better choices for their children.

Childhood obesity and chronic disease rates have reached epidemic proportions with the city of Houston being named “America’s fattest city”, (TM Daily Post, 2012). A report to the Texas Legislature from the Interagency Obesity Council reported the CDC’s 2009 Youth Risk Behavior Survey of Texas found that approximately 29.2 percent of adolescents in grades 9-12 was overweight or obese, (CDC, 2008). Additionally, in 2008, 30 percent of low-income children (ages 2-5) enrolled in Texas’ Women Infants and Children (WIC) Program was already overweight or obese, (Texas Department of Health Services, 2008). The lack of practical solutions is adding fuel to the fire in this growing “war or battle” of the bulge as some have coined the phrase. Unless communities become more involved, and address the obesity dilemma with seriousness, a reversal movement will not take place. It is imperative and of the extreme importance that children, parents, school administrators, mentors, citizens, public health providers, marketing investors, and communities’ partner together to bring about change in childhood obesity. In addressing the above mentioned ethical issues this calls for a paradigm shift that is needed to reverse this epidemic.

**C. Effect of existing policy (and new policy change) on nursing practice, healthcare delivery, and healthcare consumers (now and in the future). How does this exiting policy affect nursing practice, the delivery of healthcare and consumers of healthcare; and, how will this policy change affect nursing practice, the delivery of healthcare and consumers of healthcare (now and in the future)?**

The existing model for coordinated school health (CSH) programs is comprised of a multidisciplinary approach with contributions from school administrators, community leaders, and school nurses among others. By addressing health related issues, schools hope to establish healthy behaviors that last a lifetime, not just the hours that children are in school. A study by Kubik, Story, and Davey (2007) discussed the possibility that because school nurses provide most school health services, it seemed likely that nurses will assume responsibility for oversight of obesity prevention services (p. 506). The study advocated nursing support for obesity prevention that included a community guided process inclusive of school officials, parents, and students (Kubik, Story, & Davey, 2007, p. 506). This study concluded with the statement that “nurses are vital, but underutilized participants in a nationwide effort that aims to lower childhood obesity rates” (Kubik, Story, & Davey, 2007, p. 507).Initiating and maintaining a relationship with other providers in a community based setting would provide the support system that nurses need to deliver obesity-related care effectively, as maximum results for obesity-related initiatives are better achieved with the support of an interdisciplinary team (Moyers, Bugle, & Jackson, 2005, p. 93).

Results from a study of pediatric healthcare practitioners including pediatric nurse practitioners showed a desire to address childhood obesity, but listed many barriers to doing so (Barlow & Dietz, 2002, p. 236). The top barriers mentioned were lack of motivation by parents and lack of access to tertiary care providers (Barlow & Dietz, 2002, p. 237). The proposed changes to the current policy circumvents both of these barriers by offering expanded WIC benefits and community based classes to help parents with healthy food selection and access APNs to address the need for tertiary care.

The role of APNs in the battle against childhood obesity is a crucial one. APNs have the ability to influence children’s eating habits, physical activity, and knowledge of healthy choices. Larson et al (2006) list implications for nursing practice, more specifically advanced nursing practice (p. 77). Nurse practitioners are encouraged to use BMI to screen for overweight and obesity as well as to include the measurement in well child exams (Larson et al, 2006, p. 77). Another recommendation is for NPs be proactive in advocating childhood obesity prevention programs in their communities (Larson et al, 2006, p.77). NPs can assist schools in implementing programs that promote physical activity and nutrition and can encourage insurance companies to provide reimbursement for childhood obesity prevention strategies (Larson et al, 2006, p.77). How does this policy change affect nursing? This policy change could affect nursing in two ways. The first affect would be to solidify school nursing’s role in childhood obesity prevention; and the second affect would be in the Advanced Practice Nursing role in childhood obesity prevention.

To expand on the how school nurse’s roles will be solidified by this policy change let us look at some background history. The Robert Wood Johnson Foundation (RWJF) describes the last 35 years of school nursing as increasing in medical complexity (Robert Wood Johnson Foundation, 2010). However, the irony to this is that as the complexity and medical needs for school children have increased, the funding and support has decreased greatly ("Robert Wood Johnson Foundation," 2010). To add a little perspective to this problem, school nurses are providing episodic care on top of attempting to provide preventative care ("Robert Wood Johnson Foundation," 2010). Can we imagine the demands that school nurses face on a daily basis, much less trying to fit in time for childhood obesity? Currently, school nurses provide complex care for children with medical devices, chronic health conditions, emergencies, as well as prevention measures to children during school hours. In addition to this growing concern, “half the nation’s schools lack a full-time registered nurse” (Robert Wood Johnson Foundation, 2010, p. 1).

Given the epidemic of childhood obesity in Texas, school nurses roles would be dramatically increased with the proposed policy change. For example, a report by Susan Combs, the Texas State Comptroller, describes how children spend a great deal of their lives at school, and that schools are already becoming increasingly more involved in the prevention of childhood obesity (Susan Combs, Texas Comptroller of Public Accountants, 2011). In this report, it describes some of the legislation enacted, such as State Bill 530 regarding required physical education; the Texas Department of Agriculture’s nutrition policies on fatty foods in schools; and, the Texas Fitness now program aimed at middle school children ("Susan Combs, Texas Comptroller of Public Accountants," 2011). The point is that with all of this legislation and effort aimed at prevention of childhood obesity, the role of school nurses is paramount to support these programs. To support this statement, a study published in Preventative Medicine concluded that school nurses roles are “vital” but” underutilized” at lowering obesity (Kubik, Story, & Davey, 2007, p. 507).

The policy change that we propose would increase the scope of childhood obesity prevention to a community wide program, but school-based prevention would remain vital part of this larger program; and, increased funding to support the increased school nursing role, would be a critical component for the successful implementation of the proposed policy change. One proposed avenue for funding the proposed program as a whole would be to initiate a local sin tax on the sale of soda and candy.

How would Advance Practice Nurses (APNs) be involved in this policy change? In the proposed policy change that would expand childhood obesity prevention to a community wide program, APNs would serve as care coordinators who practice childhood obesity prevention with a theory-based family centered approach. APNs are trained to provide holistic care by assessing client, family and environment while using evidenced- based data (Reinke & Hammer, 2011). Reinke and Hammer describe how Advanced Practice Nurses are trained to be leaders and are naturally in the right position to manage client care (Reinke & Hammer, 2011). APNs, of course, already exist in the community and provide primary care for children, but APNs in this community wide program would serve as care coordinators who can collaborate with other team members. In their review of the literature, Reinke & Hammer (2011) reported “the effects of inter-professional interventions suggest that practice-based inter-professional collaboration can improve health care processes and outcomes” (Reinke & Hammer, 2011, p. 864). The goal of this collaboration would be to prevent fragmentation of healthcare services and improve the transfer of information to facilitate communication among key players and stakeholders in this city-wide program. The development and implementation of an information database would be essential to the ability of the facilitators of the program (the multidisciplinary team) and the participant in the program (school children and their parents) to access and input data concerning individual health status; to track, evaluate the health-related data; and, to formulate statistics on the data.

What is Care Coordination? To quote a succinct definition: “Nursing Care Coordination models emphasize patient education and the engagement of patients and families in prevention, self-care, and adoption of health information technology to improve access to information” (Robinson, 2010, p. 266). The role for APNs in this new policy change would seem to be a perfect fit. For a pragmatic example, it would seem that an APN in this new community wide program for childhood obesity prevention would be able to assess clients and client family needs, engage them, place them with the right resources, and provide the follow up.

With Care Coordination in place, APNs would use a family-centered model to engage the client and family. The family-centered collaborative negotiation model uses family interaction with specific parent-to-child negotiations to address childhood obesity (Tyler & Horner, 2008). The authors explain how traditional methods in primary care are usually “passive” when it comes to health promotion and not usually effective (Tyler & Horner, 2008, p. 195). They suggest that family involvement is paramount because this is where health practices are learned and carried out (Tyler & Horner, 2008). The collaborative negotiation model utilizes a “Touchpoints framework” and the “motivational interview” approach to engage families and assist in behavioral changes for childhood obesity (Tyler & Horner, 2008, p. 196).

Where would APNs be used as care coordinators in this new policy change? In Houston, Texas there are community based programs, already in place that are working to reduce childhood obesity. One of these was called CAN DO Houston. CAN DO Houston promoted exercise, nutrition and healthy attitudes to reduce childhood obesity in the city (Post-Correa et al., 2010). This was a pilot program that had positive feedback and involved local schools, parks, local physicians, and many others in 2008 (Post-Correa et al., 2010). The program appeared to be successful, but funding apparently was limited. The authors of this case study described how if funding were available CAN DO Houston could have become larger and involve more services (Post-Correa et al., 2010). It would seem that with funding and further support of policymakers this would be a perfect example of how APNs could partner with a local program such as this or incorporate some of the successful features of this program into the proposed policy change, to successfully effect change in the current childhood obesity epidemic in the city and surrounding communities.

In order to reinforce the need for integration of APNs and a family-centered approach to assist in preventing childhood obesity, the use of supportive data is necessary. We turned to evidenced based literature, specifically meta-analysis. We selected a meta-analysis of randomized controlled trials that looked at the effectiveness of lifestyle and family-based behavioral interventions in children. Overall 64 studies (n=3806) in this analysis showed a reduction in weight by using lifestyle and behavioral methods (Luttikhuis et al., 2009). The analysis looked at two main groups, ages twelve years and younger and a second group of ages twelve years to eighteen years old (Luttikhuis et al., 2009). The behavior and lifestyle interventions were compared the controlled group with standard care (Luttikhuis et al., 2009). The measurement of BMI-SDS was used for comparison, and both age groups showed decreased BMI-SDS with the over twelve year old group showing the greatest decreases (Luttikhuis et al., 2009). The author concluded that further research was needed, to look at pychosocial determinants and cost-effectiveness (Luttikhuis et al., 2009).

On the subject of funding a community based program that incorporated Advanced Practice Nurses, it may be helpful to look at recommendations from Susan Comb’s, Texas State Comptroller, report on the obesity crisis in Texas ("Susan Combs, Texas Comptroller of Public Accountants," 2011). The report mentions recommendations from the comptroller to award competitive type grants to “proven intervention and prevention programs” that target childhood obesity in geographically identified areas of Texas ("Susan Combs, Texas Comptroller of Public Accountants," 2011, p. 4). This may be one option for obtaining funding for a pilot program that would include APNs in a community wide childhood obesity prevention program.

How will this policy affect health care consumers? This policy will affect health care consumers in the long run, by lowering their personal health care costs. This will really help families and their budgets, since medical care and costs can be quite expensive, even with insurance. Children hospitalizations related to obesity have increased, and the cost to care for an obese child is more expensive than a child with a normal body mass index. Studies have also shown that an obese child’s hospital stay is longer than a child with a normal weight. In addition, this policy can increase a student’s academic achievement, since studies have shown that obese children have lower test scores on the Texas Assessment of Knowledge and Skills exam, as well as in their courses. Another benefit of implementing these changes to this policy is that studies have shown that children within normal weight limits have higher self-esteem than obese children. Increasing a child’s health will increase their happiness and positive feelings about themselves (Arons, 2011). This policy will not only require the community and school involvement, but the continuity in the home setting will help as well. Guardians should try to participate and take accountability so that the child doesn’t get confused regarding their diet and physical activity regime. Continuing aspects of this policy in the home setting as well will in return increase the guardians’ health. Also utilizing Advanced Practice Nurses will increase continuity of care and access to medical care/advice for health care consumers.

**Summary/conclusion**

**Brief summary of rationale for changing the existing policy**

Obesity in the Houston area is at an all-time high and its incidence in children is at epidemic proportions. Extending the CSHP empowers individuals and communities with the resources necessary to eradicate obesity and promote healthy eating and living habits. The proposed changes to the existing policy are aimed at students as well as parents with the goal of producing healthy children, adults and families which lead to healthy communities.

Broadening the scope of the current CSHP provides students as well as their families with consistent access to qualified healthcare professionals including APNs who are able to offer un-fragmented care to the population they serve. Being in an interconnected multidisciplinary field, APNs have the ability and resources to consult with and refer clients to specialized services as needed allowing for more specialized and individualized care for the children Houston.

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