Rhode Island KIDS COUNT Findings from Stakeholder Discussions:
Opportunities for Systematic BMI Data Collection & Public Reporting

Important Considerations & Key Takeaways:

- Rhode Island currently has no statewide surveillance of clinical BMI data for children and adolescents.

- Rhode Island KIDS COUNT is researching systems or instruments that could be used for systematic BMI data collection and public reporting. Outlined below are (1) current sources of BMI data (self-reported or clinical) and (2) instruments/organizations that could possibly be utilized to collect additional BMI data in Rhode Island. Benefits and barriers are described, as are emerging national practices and state opportunities.

- An ideal BMI surveillance system in Rhode Island would have the following elements: (a) a large sample size of children of various ages (i.e., toddlers, elementary, middle, and high school students) and (b) clinical BMI data that is recorded by a trained professional. The information would be (c) updated regularly and (d) shared publicly with various stakeholders, including communities, schools, medical professionals, health organizations, policymakers, and funders so that prevention and intervention for at-risk, overweight, and obese children and adolescents can occur early and at all ages.

	Instrument/Organization	Reach	Reporting Parameters	Pros	Barriers
Statewide	KIDSNET RI Department of Health	All RI children born since 1997	Only collects clinical BMI data of children enrolled in WIC	Very large sample; existing interface with providers; successful track record of collecting data; opt-out enrollment; national BMI EHR reporting parameters exist	Administrative capacity and resources; EHR variations and associated funding; legal authority
	CurrentCare RI Quality Institute	43,700 RI children under age 18	Limited clinical BMI data; Not publicly reported	Large sample; growing enrollment; existing interface with providers; adding consumer interface	Limited clinical BMI data currently available; potential non-representative sample; legal authority; administrative capacity; opt-in enrollment
Institutional	FitnessGram, ASPEN (school health record systems)	141,959 RI children enrolled in grades K-12	BMI recorded by relevant staff; Infrequent public reporting	25 states (including CT, MA, & ME) collect data relating to BMI through schools; captive audience; school physical forms with BMI information annually collected; various screening programs occur	Administrative capacity and resources; difficulty with aggregation and reporting; RIDE does not mandate BMI collection; technology platforms vary and may not collect BMI data; legal concerns

	RI Health Center Association	44,255 RI children under age 18	Clinical BMI data; Annually reported on HRSA website but only for all patients	Large sample; annual federal reporting requirement; working toward reporting aggregate child and adolescent clinical BMI data	Potential non-representative sample; not all Health Centers have the same EHR platform; administrative and resource capacity
	Providence Community Health Center	23,000 RI children under age 18 served by PCHC	Clinical BMI data; Reported in 2016 Factbook	Large sample; annual federal reporting requirement; Brown University conducting analysis of data in 2016	One-time data pull; limited time and geographic analysis; administrative and resource capacity; different EHR vendor than other Health Centers
Programmatic	WIC	12,871 RI children ages 2 to 4 (with family incomes <185% FPL)	BMI recorded by WIC staff; Annually reported in Factbook	Annual federal reporting requirement; multiple points in time BMI measurements	Limited and non-representative sample
	Head Start	2,742 RI children ages 3 to 5 (with family incomes <130% FPL)	BMI recorded by Head Start staff; Annually reported in Factbook	Annual federal reporting requirement	Extremely limited and non-representative sample
Surveys	*SurveyWorks!* RI Department of Education	76,505 RI elementary, middle, and high school students	No BMI collection	Large sample; school level data that can be aggregated at many levels; new survey protocol being considered in 2016	Self-reported BMI survey question not included; reliability and validity data concerns if included; survey has a history of collection lapses; no national comparison available
	Youth Risk Behavior Survey RI Department of Health	3,462 RI high school students	Self-reported height and weight; RI Department of Health/CDC performs statewide BMI calculations; Annually reported in Factbook	Collected every other year; long historical trend line; cross cuts by race/ethnicity and age available; national comparisons available	Reliability and validity data concerns due to self-report; statewide analysis only; no community-, district- or school-level data available
Emerging National Trends	States and cities like Colorado (CHORDS), Massachusetts (MPDHnet), and New York City (NYC Macroscope), as well as large networks of children's hospitals have created electronic health record-based surveillance systems that facilitate bi-directional information sharing among various entities that retain institutional ownership/privacy of data by populating public health registries with de-identified aggregate clinical information, including BMI.				
Emerging State Opportunities	In Rhode Island, some primary care practices affiliated with the Care Transformation Collaborative (a statewide Patient-Centered Medical Home initiative) use electronic health-record reporting software called Deep Domain, which does have de-identified aggregate-level reporting capabilities. The State Innovation Model (SIM) grant has appropriated $1.7 million dollars for a Healthcare Quality, Reporting, Measurement and Technology Feedback System that could potentially be used to obtain de-identified aggregate clinical information, including BMI.				