Study finds payment for pediatric obesity services now can save money later

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Pediatric obesity ends up costing $3 billion annually in the U.S., but a significant amount of that could be saved by streamlining medical coverage to address health issues affecting young obese patients now rather than waiting to treat conditions they develop as they get older, according UCLA researchers and colleagues.

For morbidly obese children, access to multidisciplinary services can lead to successful outcomes. But because clinicians lack a universal set of guidelines to follow, health insurers and hospitals often evaluate insurance coverage for obesity services on a case-by-case basis. This creates a critical barrier between patients and providers.

In an effort to guide medical providers, patients and payers in better serving obese children and enabling the best health outcomes possible, a UCLA-led work group from the FOCUS on a Fitter Future collaboration of the National Association of Children's Hospitals and Related Institutions reviewed existing successful programs to evaluate what works best.

They found that stage 3 comprehensive, multidisciplinary intervention programs should include a health care team with a medical provider, a registered dietitian, a physical activity specialist, a mental health specialist and a coordinator. The team should provide a total of at least 26 to 75 hours of service to overweight and obese children.

While some may argue that up to 75 hours of service is a lot of time, the

group determined that the investment of services would be recovered in 6.5 years for the privately insured patient and 3.5 years for the patient insured by Medicaid.

"With pediatric obesity, the focus has been on the related diseases that usually come later, such as diabetes, heart disease and hypertension," said lead author Dr. Wendy Slusser, medical director of the UCLA Fit for Healthy Weight program at Mattel Children's Hospital UCLA. "However, what we see now is that the obese child or adolescent may suffer from gastrointestinal disorders, mental health issues and musculoskeletal problems such as backaches or knee problems. By investing in the health issues of today, we can improve the health conditions of tomorrow and ultimately impact the future costs."

According to the Centers for Disease Control and Prevention, 17 percent of children between the ages of 2 and 19 are now considered overweight or obese — a number that has tripled since 1980. Adolescents who are overweight have a 70 percent chance of becoming overweight or obese adults.

"Why can an obese adolescent get coverage for bariatric surgery to lose weight but not all the services that could help that child avoid surgery in the first place?" asked co-author Dr. Daniel De Ugarte, surgical director of UCLA's Fit for Healthy Weight program. "Scientific evidence supports practice recommendations for the stage 3 level of care, and it is time to address the payment for the delivery of this care."

For the study, researchers interviewed 15 children's hospitals participating in the FOCUS on a Fitter Future collaborative and one non-participating hospital. They used the interview transcripts to identify five financially sustainable stage 3 programs, each funded differently.

The programs examined in the study ranged from the newly launched to

those operating for more than 20 years. All had multidisciplinary teams delivering services via one of three institutional structures: 60 percent freestanding, 7 percent specialty and 33 percent hospital-within-a-hospital. One-third had one to two funding sources, and 67 percent had three or more.

The authors concluded that the programs they reviewed shared some common strategies for achieving financial stability and followed key strategies of the chronic-care model.

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