

Evaluating the benefits of and barriers to pediatric obesity programs

August 28 2024, by Mallory Locklear



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Obesity now affects more than one in five children in the United States, and while there are effective, recommended interventions, availability is limited for most children. In two new studies, Yale researchers assessed

the cost-effectiveness of one intervention and factors that have hindered and facilitated implementation of another to uncover strategies for improving access to effective pediatric obesity treatment.

The publications are timely as Yale experts, working as members of national medical organizations, have supported a proposal under consideration by the Centers for Medicare and Medicaid Services for a new billing code that could allow facilities to be reimbursed by [health insurance](#) for intensive health behavior and lifestyle treatment interventions for childhood [obesity](#). Such a change would thereby encourage implementation of these programs and improve access to them, the researchers say.

The studies were published in the journal *Obesity*.

Previous research has shown that interventions that provide comprehensive, family-centered nutrition and behavioral education, and at least 26 contact hours with families over 3 to 12 months, are effective at treating childhood obesity. These types of programs have been recommended by both the U.S. Preventative Service Task Force and the American Academy of Pediatrics.

"We have [treatment options](#) that work," said Mona Sharifi, an author of both studies and an associate professor of pediatrics at Yale School of Medicine. "But we have these systematic barriers to access that we need to address rapidly."

Cost is a perennial concern affecting health care programs, obesity treatments included. In the first new study, Sharifi and her colleagues evaluated the costs—from both a health care and a societal perspective—associated with implementing the Healthy Weight Clinic intervention in federally qualified health centers.

The Healthy Weight Clinic is a program that delivers intensive health behavior and lifestyle treatment for children and adolescents with obesity or overweight that is consistent with guidelines from the American Academy of Pediatrics. The treatment model brings together teams of pediatricians, dieticians, and community health workers within primary care settings where families are already likely to be engaged.

For [the first new study](#), the researchers looked at federally qualified health centers specifically, as they provide services in underserved communities.

"This was purposeful to access communities that are disproportionately affected by obesity disparities," said Sharifi.

In their analysis, the researchers broke down the intervention to its smallest pieces—personnel, materials, etc.—and determined their costs. They also estimated costs incurred by families in the form of time, transportation, and childcare expenses associated with participating in a Healthy Weight Clinic. They then entered those costs into a model that simulated a sample of patients over a 10-year period, some of whom entered a Healthy Weight Clinic intervention.

"We were able to extrapolate those calculations out and ask, if we were able to spread this intervention to all eligible federally qualified health centers in the U.S., what would the scene look like in 10 years?" said Sharifi. "How many cases of obesity would we prevent? How much would it cost and how much might we save by improving the health of children reached by the intervention?"

They found that if Healthy Weight Clinics were made available in all federally qualified health centers over 10 years, the intervention would reach 888,000 children with obesity or overweight and prevent 12,100 cases of obesity and 7,080 cases of severe obesity.

Costs were estimated at \$667 per child reached—with \$456 paid by the health care sector and \$211 incurred by families. Over the same time, however, the reduction in obesity cases would save approximately \$14.6 million dollars in [health care costs](#).

"It's a relatively low-cost intervention that our study team previously found to be effective," said Sharifi. "And given the populations federally qualified health centers serve, our findings also project that scaling up this intervention could mitigate health inequities affecting underserved populations."

In [the second study](#), the researchers evaluated another [intervention](#), by studying the dissemination of a curriculum called Smart Moves that came out of a Yale-developed program named Bright Bodies. Previous research from Sharifi, Mary Savoye (the founder of Smart Moves), and their colleagues has shown Bright Bodies to be both [effective at improving health outcomes](#) in children with obesity and overweight, and compared with usual clinical care, [cost-saving](#).

From 2003 to 2018, the SmartMoves curriculum was disseminated to over 30 U.S.-based sites. The new study collected experiences from staff that worked at those sites to identify what factors facilitated the program's implementation and what barriers exist to its success.

Two of the strongest facilitators of SmartMoves implementation were local partnerships with schools and exercise facilities that helped provide resources and demand for programming from families.

The biggest barrier to sustainability was funding insecurity; more often than not, this barrier resulted in failed efforts to implement or sustain new programs.

"When a child breaks their arm, the family seeks care, and the clinic or

hospital bills their insurance company to cover the cost of treatment. This model of funding doesn't work as well for health behavior and lifestyle treatment programs," said Sharifi. "For example, Bright Bodies involves group visits with families and is run by a dietician, an exercise physiologist, and a social worker. So you typically can't get reimbursement from insurance companies even though Bright Bodies appears to be more effective and cost saving compared with usual clinical care. These programs often rely on grants, but grants run out and programs disappear, leaving communities lacking access to standard of care treatment."

To pave the way for effective programs like Bright Bodies and Healthy Weight Clinic to receive reimbursement, several organizations including the American Academy of Pediatrics, the American Academy of Family Physicians, and the U.S. Centers for Disease Control and Prevention, submitted an application that would establish a new billing code. The proposal will be deliberated over the next few months by the Centers for Medicare and Medicaid Services.

"If approved, I think it would open the door to funding the most efficient and appropriate way to deliver this treatment and give families more options for interventions," said Sharifi. "This kind of thing—treatment that is standard of care not being reimbursed—would never happen in a field like surgery. But it happens in pediatrics because children often get neglected in U.S. health care policy and pediatricians often get shortchanged in billing."

Policy change, she said, is needed to ensure this first-line treatment is accessible to families throughout the country.

"Expanding access is an urgent need," said Sharifi. "And not providing equitable access to effective, low-cost [treatment](#) for children is unethical."

More information: Mona Sharifi et al, Cost-effectiveness of a primary care-based Healthy Weight Clinic compared with usual care, *Obesity* (2024). [DOI: 10.1002/oby.24111](https://doi.org/10.1002/oby.24111)

Emily Benjamin Finn et al, Improving access to first-line treatment for pediatric obesity: Lessons from the dissemination of SmartMoves, *Obesity* (2024). [DOI: 10.1002/oby.24107](https://doi.org/10.1002/oby.24107)

Provided by Yale University

Citation: Evaluating the benefits of and barriers to pediatric obesity programs (2024, August 28) retrieved 3 September 2024 from <https://medicalxpress.com/news/2024-08-benefits-barriers-pediatric-obesity.html>

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