Target Interventions to Specific Communities

BY KATE JOHNSON

MONTREAL — Locally designed and delivered lifestyle interventions can result in clinically meaningful improvements in patient health, according to preliminary findings from a statewide initiative aimed at decreasing health disparities.

"The idea behind it is to locally define the interventions, because the people who live and work in those communities know the most about what might work best," said Lauren Whetstone, Ph.D., who presented the findings in a poster at the annual meeting of the North American Primary Care Research Group.

Using a $9.2 million grant from the North Carolina Health and Wellness Trust Fund, 18 local governments and nonprofit organizations developed local interventions targeting obesity, cardiovascular disease, diabetes, and lifestyle issues in the specific communities.

Most of the communities had large African American or Native American populations that were underserved and had poor access to health care, explained Dr. Whetstone of East Carolina University, Greenville, N.C.

Some of the interventions involved health systems implementing home medical visits for diabetic patients. Other interventions involved churches establishing physical exercise and nutrition classes before Bible study, Dr. Whetstone explained in an interview.

In each community, a cohort of participants were followed longitudinally for an average of 19.5 months. Data were collected on biologic and behavioral outcomes such as blood pressure, blood glucose and cholesterol levels, dietary habits, physical activity, and smoking.

Each community had different needs, so the interventions were different and the specific measures for determining outcomes varied. However, a collective analysis of the combined data for 2,504 participants (average age, 53 years) showed a positive impact in several areas.

Among 67 diabetic patients, mean hemoglobin A_{1c} levels dropped from a baseline level of 8.9% to 8.0% by the end of the study period.

Among 203 hypertensive patients, mean systolic blood pressure dropped from a baseline of 141.62 mm Hg to 137.24 mm Hg.

Mean body mass index did not change, but data from the first half of the study period showed significant increases in self-reported daily fruit and vegetable intake (2.34 to 2.88 servings), mean days of physical activity per week (3.22 to 3.56), and mean self-rated health. There was a slight decrease in the number of current smokers (13.9% to 13.2%).

Although the study had significant limitations, including possible selection bias and lack of controls, improvements of this magnitude, if sustained, have been associated with reductions in diabetes and cardiovascular morbidity and mortality, Dr. Whetstone said.

She attributed the success to the fact that the interventions were locally defined and administered. "We've learned a lot about the differences in how organizers work within one population compared to another," she said. For example, within the Native American population, communication and the development of trust were rooted in the tribal circle, where all community organization and business is centered.

"I think going directly to communities is going to be the way we can make the most change," said Dr. Sally P. Weaver, a meeting delegate who commented on the study.

Dr. Weaver, of the McLennan County Medical Education and Research Foundation in Waco, Tex., added that the study's blood pressure results were not clinically significant. However, she said she was particularly impressed by the reported drop in blood glucose levels.

"I was surprised to see that much of a change. It was clinically significant. So whatever they're doing is working," she said. ■

Survey: Physicians Prefer Medicare to Private Plans

BY ERIK GOLDMAN

DENVER — Physicians may not be enamored of Medicare, but they like it better than private insurance plans, according to a survey by the Medical Group Management Association.

In MGMA's Payer Performance Study—covering more than 1,700 group practices—physician groups ranked Medicare Part B well ahead of six large private insurers in terms of overall satisfaction. The survey asked members of MGMA to rank seven of the largest payers (Medicare Part B, UnitedHealthcare, Aetna, Cigna, Humana, Coventry, and Anthem) on payer communications, provider credentialing, contract negotiation, payment processing, systems transparency, and overall satisfaction.

Medicare led the pack with a mean aggregate satisfaction score of 3.59 on a 6-point scale. Aetna took second place with a score of 3.14. The big loser? UnitedHealthcare, with a score of 2.45.

Medicare scored particularly well on the amount of time it takes to respond to questions from physicians or practice managers, the accuracy of its responses, and transparency in disclosing fee schedules and reimbursement policies.

The respondents were much less satisfied with Medicare's provider-credentialing processes. On that measure, Medicare ranked last, with Aetna and Anthem taking first and second place. "The Medicare credentialing process is completely out of synch with that of the private payers, and it is a problem," said Dr. William Jessee, president and chief executive officer of MGMA, which released the data at its annual meeting.

The data show particularly strong member dissatisfaction with the private insurers on contract negotiation. "MGMA members feel there is disproportionate power on the side of the payers," Dr. Jessee said.

The MGMA survey did not ask about satisfaction with actual Medicare reimbursement rates, but Dr. Jessee said he anticipated that Medicare's ranking could drop considerably if the federal government cuts physician fees in the future.

Medical group operating costs have been rising at an average rate of 6.5% per year for the last decade, yet Medicare reimbursement has been flat. That, Dr. Jessee said, is making it difficult for many groups to stay in business. Further fee cuts will likely discourage many doctors from continuing to participate in Medicare. ■

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