

Financial Incentives Spur Patients to Slim Down

BY MARY ELLEN SCHNEIDER
New York Bureau

Everyone knows that money talks. But when it comes to dieting, can money really motivate overweight patients to shed pounds?

Dr. Joseph K. Chemplavil, an endocrinologist in Hampton, Va., thinks it can. He points to his own success in giving patients \$1 for each pound they lose.

Nearly all of Dr. Chemplavil's patients have diabetes, and most are overweight or obese. So when they come into the office he offers them a chance to enroll in his weight-loss program. The plan is simple: he advises them to eat less and exercise more. Then he asks them to sign a contract, which is posted on his Web site (www.dollarsfordieting.com).

Patients pay him \$10 to enroll and then agree that for every pound they gain, they will pay him \$1 in cash at the visit. In exchange, Dr. Chemplavil pledges to pay them \$1 for every pound they lose. He keeps a cookie jar full of dollar bills on his desk to make good on his end of the deal. "Signing the contract is the most important thing," Dr. Chemplavil said.

So far, the program is working. Since it began in 2002, nearly 400 patients have enrolled. Between 70% and 80% of those who have enrolled in the program have lost weight, with the average weight loss at 9 to 12 pounds per person per year.

The remainder of those in the program have gained about 5 to 11 pounds per person per year. Only a small number maintained the same weight throughout, he said.

But it's not really about the amount of money patients



can earn, Dr. Chemplavil said. Simply the act of getting or paying the money is the key. Some patients have even asked him for a crisp dollar bill so they could frame it. "I'm asking the patient: Show me the result; I'll show you the money," he said.

Any physician can do this in his or her office, Dr. Chemplavil advised. The small enrollment fee pays for the program, and he doesn't spend much time counseling on the diet itself since the idea of a healthy diet and exercise isn't news to most patients.

Offering an incentive to patients is definitely appropriate, said Dr. J. Michael Gonzalez-Campoy, an endocrinologist and obesity expert in Egan, Minn., and assistant professor of medicine at the University of Minnesota, though he favors the use of positive incentives alone.

Physicians don't have to use money to achieve results, though, he said. In his practice, he uses encouragement and measurement to motivate patients to lose weight and keep it off. Aside from positive reinforcement, Dr. Gonzalez-Campoy said patients also see a prescription for an obesity medication

as a kind of reward. Those medications can be great tools, and are often underutilized, he said. But physicians aren't the only ones trying to motivate individuals to lose weight, Dr. Gonzalez-Campoy noted. On the national level, there are proposals to decrease health care premiums for individuals with a low body mass index. There are also some workplace initiatives that

offer extra days off for employees who walk a certain number of steps each day, for example. "Financial incentives are powerful," he said. "People will do a lot of things for money."

Financial incentives to lose weight in the workplace are starting to get more attention. Researchers at the University of North Carolina at Chapel Hill and RTI International are currently studying worksite weight loss programs that rely on access to healthy foods, Web-based support, and financial incentives.

Researchers in a pilot study found that people who received payments of \$14 per percentage point of weight loss were able to lose more weight than those receiving \$7 or no money at all (*J. Occup. Environ. Med.* 2007;49:981-9).

"Incentives on average work," said Eric Finkelstein, Ph.D., director of RTI's Public Health Economics Program and the lead author of the pilot study. But the incentives were most effective among a subset of employees for whom the financial incentive gave them the extra boost to really focus on losing weight, he added.

Now that more workplace wellness programs are emerging, there are some questions about whether paying employees to meet certain health targets is legal or ethical, said Dr. Donald Bergman, an endocrinologist in New York City and a past president of the American Association of Clinical Endocrinologists.

Paying people to meet specific clinical targets could be unfair for those who put in the effort but can't meet the targets, he said. Instead, he favors programs that reward individuals for achieving some level of improvement through participation, even if they don't meet the targets. ■



No gain, no pain ... just a crisp dollar bill from your doctor.

COURTESY DR. JOSEPH K. CHEMPLAVIL

Assess 'Global Cardiometabolic Risk' Factors in Patients With Dyslipidemia

BY MIRIAM E. TUCKER
Senior Writer

Lipoprotein management in patients with cardiometabolic risk is the focus of a joint consensus statement from the American Diabetes Association and American College of Cardiology Foundation.

The evidence-based statement, written by a seven-member panel, advises assessing global "cardiometabolic risk" (CMR), followed by a multifactorial risk-reduction strategy targeting individual risk factors with lifestyle and pharmacologic therapy. Specific recommendations are given for management of dyslipidemia in patients by risk level (*Diabetes Care* 2008;31:811-22).

Among the clinical entities considered to increase CMR are type 2 diabetes, familial combined hyperlipidemia, familial hypoalphalipoproteinemia, and polycystic ovary syndrome. All share the characteristics of central obesity, insulin resistance, dyslipoproteinemia, and hypertension. For such patients, the panel recommended statin therapy for the majority of dyslipidemic adult patients with CMR and guiding therapy for patients with CMR on statin therapy, with measurements of apolipoprotein B (apoB) and treatment to apoB goals in addition to LDL-cholesterol and non-HDL-cholesterol assessments.

The panel also recommended treat-

ment goals that address the high lifetime risk of patients with cardiometabolic risk and dyslipidemia:

► For patients with either known cardiovascular disease (CVD) or diabetes plus one or more additional major CVD risk factors, LDL cholesterol should be less than 70 mg/dL, non-HDL cholesterol less than 100 mg/dL, and apoB less than 80 mg/dL.

► For those with no diabetes or known clinical CVD risk factors but who have two or more additional major CVD risk factors or who have diabetes but no other major CVD risk factors, LDL cholesterol should be less than 100 mg/dL, non-HDL cholesterol less than 130 mg/dL, and apoB less than 90 mg/dL.

The panel also recommended clinical trials to determine whether the pharmacologic therapy for achieving very low levels of atherogenic lipoproteins is safe and cost effective. It also advocated for a public health effort focusing on lifestyle modification for reducing those levels.

Two panelists disclosed no conflicts of interest. The other five each disclosed multiple dualities of interest, including four who accepted consulting fees/honoraria from Merck & Co, and Schering-Plough Corp., three from Abbott Laboratories and Pfizer Inc., and two from Astra-Zeneca Pharmaceuticals, Kos Pharmaceuticals, Sanofi-Aventis, and Daiichi-Sankyo. ■

HbA_{1c} May Help Flag Impaired Glucose Tolerance in Children

BY KERRI WACHTER
Senior Writer

PHILADELPHIA — Testing for hemoglobin A_{1c} could be an effective means of screening children not only for type 2 diabetes but also for impaired glucose tolerance, according to the results of a study of 74 children.

"Type 2 diabetes was effectively excluded by hemoglobin A_{1c} [HbA_{1c}] below 6.0%," said Dr. Alisa Schiffman of Children's Hospital of Philadelphia. Using this cut-off, HbA_{1c} was 100% sensitive and 80% specific in identifying children with type 2 diabetes.

In its 2008 position statement on the standards of medical care in diabetes, the American Diabetes Association stated that the fasting plasma glucose test is the preferred means to diagnose diabetes in children and nonpregnant adults. The use of the HbA_{1c} level for the diagnosis of diabetes is not recommended at this time (*Diabetes Care* 2008;31:S12-54).

However, "oral glucose tolerance tests and fasting plasma glucose have logistical challenges in children" because of the overnight fasting requirement and multiple blood draws, Dr. Schiffman said at the annual meeting of the Eastern Society for Pediatric Research. HbA_{1c} testing can be performed with just a finger stick at any

time of day regardless of fasting status.

The researchers performed a retrospective chart review of 74 children (mean age 12 years) who were referred for the evaluation of type 2 diabetes. The children were assigned to one of three groups based on their fasting plasma glucose level and 2-hour plasma glucose level.

There was a significant trend for increasing HbA_{1c} along the continuum from normal glucose tolerance to type 2 diabetes. Mean HbA_{1c} was 5.4% for those with normal glucose tolerance, 6.1% for those with impaired glucose tolerance, and 6.8% for those with type 2 diabetes. A threshold HbA_{1c} of 5.7% was 91% sensitive and 80% specific in identifying children with abnormal glucose tolerance.

"Hemoglobin A_{1c} can be used to screen for type 2 diabetes and even impaired glucose tolerance [in children]," said Dr. Schiffman.

Likewise, there was a significant trend for decreasing mean β-cell function along the continuum from normal glucose tolerance to impaired glucose tolerance to type 2 diabetes.

There were no significant differences between the groups in terms of gender, age, race, or body mass index. HbA_{1c} was adjusted for age, gender, ethnicity, and body mass index. ■