

Module May Yield Rewards

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President Christine Cassel told this newspaper.

Practice improvement modules are self-evaluation tools that internists can use toward credit for maintenance of certification. The conventional modules have a specific focus: on preventive cardiology, diabetes care, hypertension, acute myocardial infarction. These performance assessment tools do not focus on global practice issues, Dr. Cassel said.

The comprehensive care module is an alternative that will address 60 measures of clinical process and outcomes, including heart disease, hypertension, diabetes, pulmonary conditions, and prevention, she said. "We're still making final decisions about some of them. We hope to be able to include a depression management measure, and in addition, a broad look at the infrastructure of the office practice, and patient satisfaction."

Physicians who are interested in BTE's program would choose the ABIM's comprehensive care module and then fill out a series of data fields with information from their practice. "This could be average blood pressure for patients with hypertension or A_{1c} for patients with diabetes," Francois de Brantes, director of

Bridges to Excellence, said in an interview.

The ABIM would score the data, giving the physician a pass/fail grade. BTE, which would see only the passing grades, would forward the data to all plans, employers, and employer coalitions that participate in BTE initiatives. This way, "physicians will only need to report their performance data once," he said. The data also would be used to support the internist's application to BTE's pay-for-performance program.

This arrangement isn't exclusive to BTE, Mr. De Brantes noted. Internists who complete the comprehensive care module could get financial rewards through other employers or plans in their area.

Internists are likely to hear about the program from participating employers or health plans in the BTE program, he said. "They would get a letter saying if they voluntarily met criteria in this performance assessment—they would receive 'x' in rewards for every patient who belongs to our BTE group."

The program is scheduled to begin later this year, after the ABIM has tested the module. The ABIM also plans to conduct actuarial analyses of the performance measures to determine what each mea-

sure is worth to a payer or plan, he said.

BTE has yet to set payment rates for the comprehensive care module. In its only other arrangement with an ABIM module, BTE pays rewards of \$80 per diabetic patient per year for internists who complete the diabetes module, he said. Even \$50 per year per patient can add up, he said. "If you have 200 patients whose employers or health plans are participating, that's \$10,000" annually.

For now, BTE wants to see how the diabetes and comprehensive care modules work to increase physician participation in pay for performance. "Then we can look at some of the [ABIM's] other practice-improvement modules," Mr. De Brantes said.

After learning about the ABIM/BTE arrangement, Dr. William Golden, a professor of medicine and public health at the University of Arkansas, commented that any program that integrates multiple requirements for physicians to maintain their status and practices are welcome.

But to be effective, these programs must be relevant and not burdensome, said Dr. Golden, who has worked on a special liaison panel between the ACP and the ABIM to develop pathways to recertification. "We are in the early stages of these efforts, and they will likely evolve over time to be more targeted and integrated into daily activities. Nevertheless, its designers need to be careful not to micro-

manage the daily lives of the participants."

The hope is the new module will serve as an incentive for internists to recertify and get rewarded for good work, Dr. Cassel said.

Internal medicine is struggling on two fronts: attracting medical students and keeping generalists within its ranks.

In a recent survey of 1,799 board-certified internists conducted by the ABIM and the ACP, 91% of the internists were working in internal medicine. Among general internists, however, 21% were working in other fields (Ann. Intern. Med. 2006;144:29-36).

The finding helped explain why the rate of participation in maintenance of certification was somewhat lower for general internists (77%) than for subspecialists (86%) who were surveyed. ■

TALK BACK

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Low-Fat Diets Not Shown to Cut Cancer Risk in Older Women

BY DEEANNA FRANKLIN
Associate Editor

Eating a low-fat diet did not affect rates of cardiovascular disease, coronary heart disease, stroke, or colorectal cancer in the largest-ever long-term randomized trial of a dietary intervention in postmenopausal women.

The study showed a small reduction in the rate of invasive breast cancer, but even that finding was not statistically significant.

In the 8-year Women's Health Initiative Randomized Controlled Dietary Modification Trial, 19,541 women were randomized into a low-fat diet group and 29,294 women were randomized into a control group.

The low-fat arm of the study included intensive behavior modification with a goal of reducing daily fat intake to 20% of total calories, raising intake of fruits and vegetables to five servings daily, and increasing grain intake to six servings daily. There were 18 nutritionist-led group sessions during the first year, with quarterly sessions thereafter. Weight loss was not a goal in the study.

The women in the control group received a copy of the Dietary Guidelines for Americans, published by the Department of Health and Human Services, and other health-related materials.

All participants ranged in age from 50 to 79 years (mean age 62 years) and consumed 35%-38% of calories from fat before the study. Race and ethnicity were comparable between the intervention group (81.2% white, 10.9% black, and 3.9% Hispanic, 2.2% Asian) and the control group (81.6% white, 10.7% black, and 3.8% Hispanic, 2.3% Asian). The groups had comparable rates of mammography screenings during the study.

In the intervention group, fat intake was 24% of calories at year 1 and 29% of calories at year 6, and most women did not meet the goal of 20% fat intake: 31.5% did so at year 1 and 14.4% did so at year 6. Fat intake was

significantly higher in the control group: 35% of calories at year 1 and 37% at year 6.

During a mean follow-up period of 8 years, 3.35% of women in the intervention group developed invasive breast cancer, compared with 3.66% of women in the control group. (On an annual basis, the rates were 0.42% per year in the intervention group and 0.45% per year in the control group.)

The 9% lower rate of invasive breast cancer in the intervention group (hazard ratio of 0.91) was not statistically significant. "Chance provides an explanation for the modestly lower breast cancer incidence rates in the intervention group," said Ross L. Prentice, Ph.D., and his associates (JAMA 2006;295:629-42).

The study showed that 'total fat is not as important as type of fat' in preventing cardiovascular disease.

DR. HOWARD

that "women with higher baseline percentages of energy from fat show greater evidence for a reduction in breast cancer risk."

The results may prove useful for counseling patients after a diagnosis of cancer, said Dr. Aman U. Buzdar of the University of Texas M.D. Anderson Cancer Center, Houston. "In the future it may also be possible to counsel women about the optimal combined dietary and pharmacological interventions for reducing or eliminating the risk of breast cancer," he wrote in an editorial (JAMA 2006;295:691-2).

In another analysis of the trial data, the low-fat dietary intervention did not reduce the risk of invasive colorectal cancers. The rate of colorectal cancer was 0.13% per year in the intervention group and 0.12% per year in the control group.

"Despite a significant change in fat intake and increases in vegetable, fruit, and grain consumption, the inter-

vention hazard ratio is in the direction of an increased risk," although the difference was not statistically significant, said Shirley A.A. Beresford, Ph.D., professor of epidemiology at the University of Washington, Seattle, and her colleagues (JAMA 2006;295:643-54).

"The current results suggest that changing dietary patterns ... in mid to late life will have limited or no benefit in preventing colorectal cancers in postmenopausal women," Dr. Beresford and her colleagues said.

An analysis of the incidence of major coronary heart disease showed that the dietary intervention had no significant effect: The annual rates were 0.35% in the intervention group and 0.36% in the control group. Similarly, the incidence of stroke was 0.28% in the intervention group and 0.27% in the control group, reported Barbara V. Howard, Ph.D., and her associates (JAMA 2006;295:655-66).

Cheryl A.M. Anderson, Ph.D., and Dr. Lawrence J. Appel, both of Johns Hopkins University Bloomberg School of Public Health, Baltimore, commented in an editorial that despite the findings, "dietary changes can have powerful, beneficial effects on CVD risk factors and outcomes." During the years after the trial was designed, "there has been a major evolution in the thinking about the role of fat intake in reducing risk of CVD, specifically a shift in focus from reducing total fat intake to modifying specific types of fats," such as saturated and trans fatty acids.

Dr. Howard, president of MedStar Research Institute, Hyattsville, Md., said in an interview that the data suggest that if a 20% fat intake level had been achieved by more participants, the reduction in the rate of breast cancer would have been greater.

As for cardiovascular disease, "we were able to validate over an 8-year period the safety of this diet. It helped to maintain weight, the risk factor profile was improved, there were no increases in insulin, glucose, or triglycerides or decreases in HDL, as had been claimed would happen if you lowered fat and raised carbohydrates," she said.

The study also confirmed that "total fat is not as important as type of fat" in preventing cardiovascular disease, according to Dr. Howard. ■

