

## Editors' Comments



Tom Janisse, MD, Editor-in-Chief

### Promoting Physical Activity for Senior HMO Members

Last October, the National Institutes of Health (NIH) Institute on Aging and the National Health Care Financing Administration (HCFA) requested that Kaiser Permanente Northwest (KPNW) and KP Colorado participate with other health care experts from around the country with innovative managed care programs in a conference entitled, "How Managed Health Care Can Help Older Persons Live Well With Chronic Conditions." John Scott, MD, KP Colorado, presented "Co-operative Care Clinics," and representing KPNW, I presented the "HealthClub & SilverSneakers" program.

#### Brief History

In October 1996, KPNW contracted with Healthcare Dimensions, Inc (Arizona) to provide an exercise and fitness health club program for KP Senior Advantage Medicare members. The Health Plan has again approved the program for 1999. This no-charge, exercise and fitness program was approved primarily to enhance the attractiveness of KP to seniors at a time when Medicare premiums were poised to change in the market. KP Colorado also adopted this program in 1997, as did Group Health Cooperative in Seattle in October, 1998.

The program consists of free health club membership in any of 13 health clubs in the Northwest. At each site, a fitness coordinator leads a one hour "SilverSneakers" exercise program three times a week. Participants exercise to music by the Beach Boys, Fleetwood Mac, and Carly Simon, while sitting in a chair and standing behind it. At several points during the hour, their exercise steps approach line dancing. People attend, in part, because they meet others there and exercise in a group. An average-size class includes 40 seniors.

KPNW has 33,000 Medicare-eligible members with 7,000 enrolling in the exercise program. Oregon and national enrollees are approximately the same demographically, having 55% women and 45% men, with an average age of 72 years.

#### Exercise and Health

Physical inactivity is a major cause of premature mortality among Americans. Despite this fact, there is little evidence to support the effectiveness of provider-based interventions aimed at reducing inactivity. People who engage in regular aerobic activity have substantially better health.<sup>1,3</sup> Further, people with lower health risks have less lifetime disability at any given age.<sup>4</sup>

HMOs have sought to reduce health care costs while maintaining or improving quality. However, in a 1996

study, the elderly and poor chronically ill patients had worse physical health outcomes in HMOs than in fee-for-service systems.<sup>5</sup> Exercise programs can enhance health. If the program promotes social activity, this could be an added benefit, perhaps interdependent with exercise in producing enhanced physical and emotional well-being. It has been shown that socially active men were two to three times less likely to die within nine to 12 years than those of a similar age who were isolated. The risk for socially isolated women was one and a half to two times as great. Daily contact with people may help to prolong life<sup>6</sup> and reduce health care needs.<sup>7</sup> Exercise can also create anti-depressive effects among older adults.<sup>8</sup>

#### Member Testimonials

While we await studies to demonstrate significant outcomes, members that participate have offered enthusiastic comments and personal experience of improved health. Several comments are cited so you can "hear" their voices. Of note, several describe improvement in symptoms that often require medical treatment. Thus, exercise benefits can complement clinician treatment plans.

- "We, the undersigned, would like to express our appreciation to Kaiser Permanente for making this program available to us. We feel we have had good results healthwise and hope that the classes will be continued for additional benefits." (11 signatures)
- "I have lost 15 pounds without making any change in eating habits. For some reason, a bad case of heartburn and leg cramps have disappeared."
- "After the first year on this program, my cholesterol and blood pressure have gone down 20 points. Surely this is the best medicine that Kaiser Permanente could prescribe for any of its patients."
- "In just one month, my triglycerides lowered considerably; also cholesterol and glucose were better. I like the increased sense of well-being."
- "My arthritis is 100% better. This program is very good for all people, and everyone should take advantage of these classes."
- "I feel so much better; I don't take my pain medication anymore, and now I can work in my garden again. God bless you Kaiser Permanente."
- "I stopped taking my pills for my back pain two weeks ago."
- "I had a mild stroke four years ago. These classes have helped me with my coordination and strength."

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- “My posture has improved; I can raise my arm above my head, and my balance also improved.”
- “I chipped my uppermost vertebrae years ago and couldn’t move my head comfortably left, right, or back. Since going regularly to the SilverSneakers program, I can move my head comfortably. God bless the program and the instructors.”
- “Our general health has greatly improved, as evidenced by our ability to move better, sleep better, and generally enjoy better mental health. Alan has had problems with vertigo, and he now finds it much easier to maintain his balance. Your medical staff will not be seeing much of us healthy members.”
- “To the person who thought up this SilverSneakers idea. This is the best thing that KP has done for me since I joined.”
- “My patients love this program, and they are doing better medically. It is a great program we have added.”
- “I’m surprised how poor my fitness was.”
- “I have never felt better. I feel more fit and healthier and look forward to every session.”
- “I need this class as discipline.”
- “I’m having fun.”

#### Center for Health Research Study

In January 1999, Mary Durham, PhD, KP’s Director, Center for Health Research, in collaboration with Ed Wagner, MD, of Group Health Cooperative, will evaluate the effectiveness of the HealthClub program. Their study is funded from the Centers for Disease Control and Prevention. The primary question is: “Do registrants report higher levels of physical activity, better health status, and fewer outpatient visits 24 months after registering than those who did not register?” Secondary questions address yearly incidence and prevalence of registrants and users, reduction in hospital days and lower health care costs, and the distance between the member’s residence and the near-

est health club. They argue that the way to determine whether seniors would benefit from exercise is not to compare those who choose it to those who don’t; rather, it is to compare outcomes for “exposed” and “unexposed” people, all of whom would have chosen a health club benefit if it had been offered. The study design is a nonrandomized controlled trial with an intent-to-treat design (that is, members will remain in the study whether or not they use the health clubs). The health club benefit is the intervention. The primary outcomes for this full evaluation include physical activity, health status (SF-36), and outpatient utilization. The secondary outcomes include variables related to use of the health club benefit (for example, incidence and prevalence of registration, prevalence of health club use) as well as hospital use and total health care costs.

#### Conclusion

Clinicians are now thinking beyond just diagnosing and treating conditions in their patients. They are considering how to motivate behavior change. Group activity can be a powerful tool to motivate change. So can having fun. ❖

#### References

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“I have met with but one or two persons in the course of my life who understood the art of taking walks daily, who had a genius, so to speak, for sauntering—not to exercise in the legs or body merely, nor barely to recruit the spirits, but positively to exercise both body and spirit, and to succeed to the highest and worthiest ends by the abandonment of all specific ends.”

*Henry David Thoreau*

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## Clinical Contributions

Arthur L. Klatsky, MD, Associate Editor



### Alternative Medicine and Other Matters

Alternative Medicine is definitely a hot topic these days with prominent articles in lay magazines, newspapers, devotion of an entire issue of *JAMA*, discussion on television/radio, and more. Philip J. Tuso, MD's article in this issue, "The Herbal Medicine Pharmacy: What Kaiser Permanente Providers Need to Know," presents some material which is "alternative," although there is much in herbal therapy which is evidence-based and more that is on the borderline of such. Dr. Tuso points out the obvious need for clinicians to increase their knowledge about this area, including the risks and hazards of unproven or partially proven treatments. Appropriately, he clearly states that his article represents his own opinions. One suspects that, whether articulated or not, all clinicians have opinions—perhaps often highly subjective—about this topic.

There may be a lesson in the fact that "alternative medicine" is difficult to define and, thus, has so many synonyms. Since the words we use are important, it is appropriate to realize that some definitions and terms used in this controversial area carry implicit, emotionally charged overtones. Most of what we practice is variously called: traditional, conventional, official, standard, orthodox, mainstream, regular, Western, allopathic, scientific, evidence-based, or modern. Some synonyms for "alternative" are unconventional, complementary, unorthodox, naturopathic, irregular, unscientific, and not evidence-based.

One major problem in formulating these categorizations is the fact that the boundary is not clear; thus no term is fully satisfactory. It is easy to find instances of this fuzzy boundary in cardiology, this writer's own specialty. An excellent example is the role of antioxidant supplements in prevention of atherosclerotic vascular disease. In 1999, Vitamin E is probably "mainstream" therapy, while ubiquinone (coenzyme Q10) remains "alternative." Q10 could, of course, become "mainstream" in 2000 or 2001. Another cardiologic example of therapeutic programs which straddle the "mainstream-alternative" dichotomy is the Ornish regime. This includes a severe, fat-restricted diet, for which there is solid evidence of benefit in prevention (and, possibly, reduction) of atherosclerosis. It also includes some components, such as meditation, yoga, and group psychotherapy, which many would still consider "alternative" for coronary disease care. Finally, as an example of a still widely used, but almost surely ineffective (and far from innocuous) "alternative" cardiologic "therapy," one could cite chelation therapy.

Another of this issue's articles, Vincent Felitti, MD's "Hemochromatosis: A Common, Rarely Diagnosed Disease," has also received recent prominent lay media attention. *Newsweek* (Nov. 16, 1998: p. 88), published an article entitled "The Iron Albatross," with, as a subheadline, "Never heard of hemochromatosis? Knowing something about it could save your life." In the article, an expert is quoted as calling the condition "the most unrecognized problem in American Medicine." To place a personal face on the disease, Dr. Felitti's authoritative review includes a personal account of the ravages of the disease by Graydon Funke, MD, a retired Kaiser Permanente (KP) physician. We are fortunate to have an accompanying Guest Editorial by David Baer, MD, another KP expert. Dr. Baer deals primarily with the issue of routine screening for the condition, a subject of his own research and of importance for Permanente Medicine.

We have a Perspective piece, with a Commentary by Paul Smith, MD, a KP Oakland surgeon. The Commentary is based on a 1944 (Vol. II: 1-11) *Permanente Foundation Medical Bulletin* article entitled "Perforated Peptic Ulcer," by Leo D. Nannini, MD, a surgeon who left KP practice. The past 55 years have seen a revolution in knowledge about etiology and medical treatment of peptic ulcer disease, with lesser changes in surgical management. Dr. Smith gives us a concise summary of the current status of his topic.

This issue also includes a brief report of a one-person clinical study by Robert Baker, MD, entitled "Incidence of Atopic Dermatitis and Eczema by Ethnic Group Seen Within a General Practice Clinic." Ethnic differences in disease risk have importance as guides for screening and pinpointing areas of needed public health efforts and, often, as clues leading to insight about pathogenesis of disease. As has been said before in this column, we hope to see more such brief clinical reports from KP physicians. ❖



### External Affairs

Scott Rasgon, MD, Associate Editor

In the this issue's External Affairs section, we take a glimpse at the history of Kaiser Permanente (KP). We are featuring three editorials about KP from 1952 and 1953, and it is striking how these same editorials—from the *New England Journal of Medicine*, and *California Medicine*—could have been written today. Some similar themes from these editorials are echoed by experts inside KP, and are included in our roundtable discussion about our current public image. Also, in keeping with our historical “look back,” M. Rudolph Brody, MD, has written an article on 50 years of CME that reviews the SCPMG's long commitment to medical education.

Time has certainly brought change for KP; not only are we no longer perceived as communist, but today's medical societies accept us as mainstream. Our commitment and rich history differentiate us from our competition. I hope you find these articles interesting and informative. I welcome your thoughts and comments. ❖



### Health Systems

Lee Jacobs, MD, Associate Editor

During the past year, the Permanente community has experienced probably more change than at any other time in our past. All this change underscores the importance of understanding and promoting the distinguishing characteristics of the “Permanente Physician,” as well as continuing to define the elements of “Permanente Medicine.” Since our inaugural edition, this has been the objective of the Health Systems section of the *Journal*—to present articles that help define the Permanente person and his or her practice of Permanente Medicine. This issue of *The Permanente Journal* takes us further down the road in our quest. These contributions to the Health Systems section include a description of the Northwest's “Physician Advocate Resource” committee intended to help fellow physicians with emotional or substance abuse problems. The theme is—Permanente cares for its own. I believe that is especially valuable because the program seems to be easily transferred to other groups.

I'm certain that you will enjoy the Spevak, et al article on the Ohio Group's Pain Clinic. A sound multidiscipline approach of a challenge that is all too frequently fragmented within health care systems. It seems to me that we frequently under-value the integrated processes that are possible because of our group model structure.

The remaining articles provide us with additional information that helps in the understanding of the uniqueness of Permanente Medicine. Conrow's and Formanek's article on the Medical Directors' Quality Review is a must read, if you want to understand just how Permanente is different from our competitors. We are clearly setting the standards for others to follow! Also, the Massimino, et al article on faculty development demonstrates how far out on the cutting-edge Permanente really is. Finally, Dr. Crosson describes the competitive world that we work in, and the components of Permanente Medicine that will take us to the next level of performance. I suggest that the Permanente community use Dr. Crosson's comments to have a dialogue in their departments, offices or boards. Such a dialogue can reinforce our values and cause us to reconsider how we work.

As in the past, I would invite your comments on these articles. ❖