

Prevention and the Medicaid/Low-Income Population: What Does the Evidence Tell us About How to Encourage Healthy Lifestyles?

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Introduction

- Aim: evidence base for prevention in low income/Medicaid population
- Topics:
 - Obesity
 - Cholesterol
 - Hypertension
 - Diabetes
 - Tobacco cessation
 - Economic incentives

Obesity

What obesity reduction and prevention strategies are effective with the low-income/Medicaid child and adult population?

Overview: Obesity

- Medicaid/ CHIP will reimburse for most PEDIATRIC obesity related-services, as mandated by EPSDT guidelines
 - Yet many Medicaid providers do not focus on preventative services and state guidelines do not highlight such services
- In 2010, obesity accounted for 17% of American medical expenses.
- Obesity reduction and prevention is often best achieved through multi-level interventions which target both eating behaviors and exercise habits, and are led by wide range of personnel

Evidence Base

- Children and adolescents:
 - School and home based-programs can prevent and/or reduce obesity rates and BMI
 - Special effort should be made to target children/adolescents, when life-long health behaviors and attitudes are being formed
 - Example: El Paso CATCH
- Adults:
 - Successful interventions concentrate on increasing self-efficacy and motivation to exercise and lose weight.
Example: Self-efficacy and pedometers with mothers

Obesity: Diet-specific focus

- Cost-specific barriers exist among the low-income/Medicaid population base
 - Foods high in sugar and fat content are far more affordable than are the recommended "healthful" diets
- Successful interventions focus on engaging whole communities in healthy eating and active living
 - Use of mass-media to reach wider range of population
 - Avoidance of stigmatization

Cholesterol Management

What cholesterol management strategies are effective with the low-income/Medicaid population?

Overview: Cholesterol Management

- Barriers to effective cholesterol management exist at both the patient and provider level
- Patient level:
 - Low health literacy related to cholesterol
 - High rates of low-compliance with prescribed lipid-lowering medications
- Provider level:
 - Lower rates of regular cholesterol screening among Medicaid versus privately-insured patients
- Less than half of patients who qualify for lipid-lowering medications are actually prescribed

Evidence Base

- Successful patient-targeted interventions:
 - Increase patient knowledge and health literacy
 - Emphasize medication compliance

Example: Use of weekly reminders and education provision
- Successful physician- and systems-targeted interventions:
 - Utilize multi-provider collaborations
 - Train clinicians on effective management and outreach techniques

Example: Southeast Cholesterol Study

Hypertension

What anti-hypertensive strategies are effective with the low-income/Medicaid population?

Overview: Hypertension

- Increased length and severity of uncontrolled hypertension leads to increased CVD- related morbidity and mortality
 - Economic burden associated with persistent, uncontrolled hypertension (increased hospitalization, health costs)
- Barriers to treatment fall into three different categories:
 - Patient barriers:
 - Lack of trust
 - Language and culture-related communication problems
 - Provider barriers
 - Insufficient training for minority populations
 - Unable to inspire behavioral change in patient
 - System barriers
 - Poor intra-provider communication
 - Lack of multidisciplinary approach to coordinated care

Evidence

- Successful interventions:
 - Increase patient self-monitoring of blood pressure
 - Increase patient adherence to anti-hypertensive regimen
 - Increase patient education and awareness
 - Capitalize on existing social-support systems
- Supplemental aims should be to create stronger patient-provider relationships to improve communication and trust
- Interventions can also be implemented through diverse range of non-traditional providers
 - Community health workers
 - Home-visitation nurses
 - Clergy members

Ex: Baltimore Church High Blood Pressure Program

Diabetes

What diabetes prevention strategies are effective with the low income/Medicaid population?

Importance of Diabetes Prevention

- Diabetes is a serious health problem
 - Secondary complications include amputations and kidney failure
 - More hospital admissions
 - Longer hospital stays
 - More complications in-hospital
- Diabetes (including complications) is costly
 - \$116 billion in direct costs
 - \$58 billion in indirect costs
- North Carolina ranks in the top 25% of all states in diabetes mortality

Evidence: General Lessons

- Including community health workers is helpful in designing more effective programs
- Social support by health professional is beneficial
- Providing actual cooking demonstrations provides participants with a motivation to attend and actual guidance in cooking healthy
- Removal of barriers
 - Literacy and language barriers found to be a limiting factor in education component of diabetes management programs
 - Increase cultural competency

Example: Horton Hawks Stay Healthy Program

- **Overview**

- Tailored diabetes program for families delivered at elementary school

- **Program**

- 30 minute physical activity
- 30 minute adult and child lectures
- Food preparation sessions

- **Results**

- Weight loss, though not significant
- Increase in leisure time physical activity
- Improvement in healthy behavior

Example: Increasing Exercise

- Overview
 - Community health center aimed to improve access to exercise for low income patients with diabetes
- Program
 - Community health center partnered with YMCA.
 - Free 3 month membership followed by reduced rate fee
 - Free biweekly diabetes exercise classes led by exercise coach
- Results
 - At one year, clinical outcomes of A1C, blood pressure, and LDL level reduction were significantly reduced from baseline measures.
 - 11% renewed and purchased membership

Tobacco Cessation

What tobacco cessation strategies are effective with the low-income/Medicaid population?

Overview

- Tobacco is the leading cause of preventable death in NC
- NC ranks 37th in the U.S. in # of adults who are current smokers
- Interventions fall into three types:
 - Targeting the smoker
 - Targeting the health system
 - Interventions targeting the community

Evidence: Smoker Interventions

- Quitting is tough.
- The problem isn't figuring out “what works”. The problem is ACCESS.
 - Most Medicaid recipients don't know what is available and/or have misconceptions.
 - Physicians perform the first three A's for (ask, assess, advise) for Medicaid recipients, but fail to assist/arrange, i.e. connect patient with quit services.
- Evidence shows that providing these interventions free of charge is beneficial.

Evidence: Pregnant Women

- Pregnant women on Medicaid can and do quit.
 - Example: educational materials and brief counseling yielded 17% quit rate versus 8.3% in control group.
- Methods effective with pregnant women are NOT the same as those which work for the general population
 - Major review stated that there is not yet sufficient evidence that pharmacological aids are effective with pregnant women. Thus, counseling is preferable.
 - Recent review indicates incentives may be *best* way to encourage pregnant women to quit. More on this later.
- Evidence shows substantial concerns that women relapse after delivery.

Evidence: Health Systems

- ✓ 1. Implement tobacco-use identification system
- ✓ 2. Cover tobacco dependence treatment (TDT)
- ✗ 3. Reimburse clinicians for TDT and include it among defined clinician duties
 - Evidence Base: No evidence specifically on fee for service payment for TDT. However, evidence has shown that providers will better document tobacco status if tied to bonuses.
- ✗ 4. Provide education resources and feedback to promote provider participation
 - Evidence Base: evidence has shown that providers will make more cessation efforts when they receive feedback on their performance

Incentives

Do incentives promote preventive behavior in the low-income/Medicaid population?

Overview

- Many types of incentives: cash payments, movie tickets, baby bucks, vouchers for health supplies, access to enhanced health benefits, lotteries
- Important characteristics
 - Simple behaviors versus complex behaviors
 - Carrots versus sticks
 - Outcome-based versus participation-based
 - Psychologically plausible incentives

Evidence: Complex Behaviors

- Mixed results for smoking
 - For general population, the benefit of incentives persists only as long as the rewards persists.
 - A large, recent study has finally succeeded in showing enhanced quit rates at 1 year, using large incentives (up to \$750).
 - For pregnant women, incentives have been linked to very high quit rates (6% versus 24%).
 - Oregon WIC program combined incentives and social support.
 - Alabama Medicaid program provided monetary monthly incentive lottery.

Evidence: Simple Behaviors

- Mixed results: Incentives worked 74% of the time for simple behaviors.
- Examples of interventions which worked
 - \$25, \$50 and \$100 lottery for immunizing parents at public clinic
 - Two \$15 payments to attend STD education
 - Coupons for infant formula for women attending postpartum check
 - Punishment: Must return to WIC offices monthly (instead of bimonthly/quarterly) if child is not immunized
- But there's no obvious rhyme or reason
 - Gerry Cuddlers motivated more postpartum visits. Jewelry did not.
 - Lotteries worked for immunizations—but not for postpartum checks
 - Bus passes for follow-up visits for abnormal Pap smear results