The remaining 417 smokers were enrolled in a phone care intervention designed by the researchers, in addition to their usual health care. The intervention combined telephone counseling (based on the protocol used by the California Smokers’ Helpline) with easy access to cessation medication. The people in this group got a series of 7 phone calls over 2 months from trained counselors and were encouraged to use nicotine replacement or other medications to help them quit. The study physicians gave them prescriptions for the medication in consultation with their primary care physicians as needed.

Participants in the intervention and control groups were similar with regard to their smoking habits. The median duration of smoking was approximately 40 years in both groups, and the median number of cigarettes smoked per day was approximately 26 in both groups. The majority of participants in both groups showed signs of severe nicotine addiction. More than 80% in both groups reported having their first cigarette within 30 minutes of waking up in the morning, and approximately 38% also reported waking in the middle of the night to have a cigarette.

The fact that the people in the study were such heavy smokers makes the results that much more impressive, An said. “There is a kind of notion, true or untrue, that as smoking rates go down, you end up with this hard-core group of smokers who are resistant to treatment, and no one has ever shown that phone counseling would be effective for those smokers,” he said. “We show that phone counseling does work for those smokers.”

People in the phone care group made more quit attempts than those in the regular care group, and they made more use of counseling services (mostly by phone, but also one-on-one and in groups) and medications. Just 18% of the people in the usual care group used both counseling and medication to help them quit, compared with 88% of people in the phone care group.

That’s why the phone care strategy was so successful, An said. “People who used both [medications and counseling] quit at about the same rate,” he explained, “but we had more people using both in the intervention group.”

An said all health services—including the VA—should consider adding a phone care component to their quitting programs. Doing so could not only save lives, but also money, said the American Cancer Society (ACS)’s Tom Glynn, PhD, Senior Director, International Tobacco.

“The CDC estimates that tobacco costs the US economy $157 billion a year from increased health care costs and lost productivity,” he said. “Anything that’s successful not only makes for better health, but it also makes for a better economy.”

But both Glynn and An say phone counseling shouldn’t replace doctors in the cessation equation. “The message for doctors is keep doing what you’re doing—it’s really important to do those things,” An emphasized, “but what a great service to be able to offer your patients. We’re limited in what we can do in the clinic. We’re limited to brief interventions, and one of the best things we can do is get patients hooked up with programs that can give them real support and treatment over time.”

PATIENT NAVIGATOR APPROACH BOOSTS CANCER SCREENING IN LOW-INCOME WOMEN

Low-income women got more of the cancer screening tests they needed when encouraged and assisted by trained “care managers” who contacted them by phone, researchers report in Annals of Internal Medicine (2006;144:563-571). This patient navigator-like approach is a promising strategy for increasing cancer screening among populations whose rates are lagging, they and other experts say.
The study was led by Allen Dietrich, MD, Professor of Community and Family Medicine at Dartmouth Medical School and Associate Director of Population Sciences at Dartmouth’s Norris Cotton Cancer Center, and Jonathan N. Tobin, PhD, President and CEO of Clinical Directors Network, Inc., a clinical research network and clinician education organization.

This randomized study involved 1,413 women who were regular patients at one of 11 community and migrant health centers in New York City. The women were primarily from low-income neighborhoods (more than 78% were enrolled in Medicaid), and more than 60% listed Spanish as their primary language. All were overdue for at least one cancer screening test, including mammograms, Pap tests, or colorectal screening, according to their medical records.

Women randomized to the intervention group received a series of phone calls from trained care managers who motivated them to get the required screening tests, answered questions about cancer screening, and offered assistance like making appointments or arranging transportation. Those randomized to usual care received one phone call advising them to get the tests they needed. All women also received a brochure with information on recommended screening tests.

Over 18 months, screening rates for all 3 cancers went up significantly in the intervention group compared with the control group. Dietrich called the results “very gratifying,” especially considering that baseline screening rates were already quite high for mammograms and Pap tests.

“That surprised me and gave me a little bit of worry that it would be hard to take it a notch up,” he admitted. “But it does speak well of the New York City community health centers that the rates were so good to begin with.”

The mammogram rate increased from 58% at baseline to 68% (P < .001) in the intervention group; the rate actually declined slightly, from 60% to 58%, in the usual care group. The rate of Pap tests in the intervention group went from 71% to 78% (P < .001) while holding steady at 70% in the usual care group.

Rates of colorectal cancer screening also improved. While 39% of women in both groups were on schedule for these tests at baseline, 63% in the intervention group were up-to-date at the end of the study (P < .001), as were 50% in the usual care group. (Dietrich and his colleagues attribute the increase in the usual care group to a colon cancer screening initiative run by the city’s health department at the time of the study.)

There have been a number of studies of telephone interventions as a means of increasing screening rates, noted Richard C. Wender, MD, who is ACS President-Elect and a member of the ACS Board of Directors. He is also Alumni Professor and Chair, Department of Family and Community Medicine at Jefferson Medical College of Thomas Jefferson University. He was not involved with the current study, but is familiar with the prior work of Dietrich and his colleagues.

“This navigator concept for preventive care is a very promising concept because there are a lot of barriers to preventive care and just relying on the clinicians alone to do this is difficult,” Wender said. “If you depend just on the memory of the physician at the time of the visit to remember to order all the things they’re supposed to order, it’s less likely to happen.”

Using care managers helps overcome that problem. Not only did they provide motivation for patients, but they helped women address common barriers to screening, explained Andrea Cassells, MPH, a coauthor of the paper who helped train the care managers.

For instance, women who indicated they couldn’t communicate well with their doctor about screening were mailed a “patient activation card” that listed the screening tests they needed. The women could take this card back
to their doctor to get the ball rolling. The care managers also obtained letters recommending needed screenings from the clinicians of women who said their doctors had never discussed screening with them.

In this study, the care managers were research assistants who had gone through about 7 hours of training, which covered the rationale for cancer screening, screening guidelines issued by the US Preventive Services Task Force, techniques for motivational interviewing, and role playing. However, the curriculum is designed for people at the level of a medical assistant so that primary care practices would not have to rely on registered nurses or physicians’ assistants to act as care managers.

That helps keep the costs of the program down, said Dietrich. He and his colleagues are preparing a cost-benefit analysis of the intervention based on their current data. They are also launching a new study to test this strategy working with Medicaid managed care organizations. Telephone outreach staff from these organizations will be trained as prevention care managers, and Medicaid billing records will be used to determine who needs screening outreach. The new study will target women who are not frequent visitors to the health clinics, as well as those who visit more frequently, like the women in the current study.

That’s an important step in learning just how transferable this intervention is to other settings, Dietrich and Tobin said, though they both think it could be implemented by other health care providers.

“This is ready for translation and dissemination to sites that are committed to providing preventive services and able to respond when women request these services,” said Dietrich. “We’d be doing harm if we encouraged women to get screening and sent them to places that couldn’t respond.”

Funding is also a concern, Tobin said.

“Implementing this method requires the addition of new staff to be prevention care managers, or it means reducing their current workload to create enough time to undertake effectively this new set of responsibilities,” he said. “So while we are really excited and enthusiastic about these findings, the real challenge comes down to a financial one.”

Wender agreed that finding resources to pay for these types of programs is a problem. But it’s one that should be addressed—reforming the reimbursement system is one way, he said—because prevention pays off.

“This could be duplicated in multiple settings and it should be,” he said. “This is the approach we need.”

RALOXIFENE PREVENTS BREAST CANCER IN WOMEN AT INCREASED RISK

The osteoporosis drug raloxifene (Evista) is just as good as tamoxifen in preventing invasive breast cancer in postmenopausal women at increased breast cancer risk and has fewer toxicities, according to initial findings from the Study of Tamoxifen and Raloxifene, known as the STAR trial. However, unlike tamoxifen, raloxifene does not protect against lobular carcinoma in situ (LCIS) and ductal carcinoma in situ (DCIS).

Researchers involved in the STAR trial hailed the results as good news for women concerned about their potential for developing breast cancer.

“Although no drugs are without side effects, tamoxifen and raloxifene are vital options for women who are at increased risk of breast cancer and want to take action,” said Leslie Ford, MD, associate director for clinical research at the National Cancer Institute’s Division of Cancer Prevention. “For many women, raloxifene’s benefits will outweigh its risks in a way that tamoxifen’s benefits do not.”

The National Cancer Institute (NCI) sponsored the trial, which was run by the National Surgical Adjuvant Breast and Bowel Project (NSABP). It involved nearly 20,000 women who