

that neither the taping process nor the tapes themselves significantly impacted measured outcomes of patient satisfaction or quality of life, although the majority rated the intervention positively. The tapes helped patients perceive themselves as being better informed, particularly with regard to treatment side effects. It is not clear if patients sought other sources of information (eg, second opinions, Web-based resources) that may have negated any true benefit of audiotapes. As well, it is possible that the instruments used did not capture other subjective benefits of the tapes that may account for the overall positive rating by patients. Finally, it is worth noting that the tapes had essentially no negative impact on patients and are relatively inexpensive communication aids.

### **Applications for Clinical Practice**

Audiotapes are easy and practical tools that can enhance physician-patient communication. Audiotapes help some patients with cancer feel more informed but do not appear to impact quality of life.

—Review by David R. Spigel, MD

### **References**

1. Lee SJ, Back AL, Block SD, Stewart SK. Enhancing physician-patient communication. *Hematology (Am Soc Hematol Educ Program)* 2002;464–83.
2. Smith TJ. Tell it like it is. *J Clin Oncol* 2003;21(9 Suppl):12–6.

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## **Impact of Nonphysician Coaching on Cardiovascular Risk Factors in Patients with Coronary Heart Disease**

Vale MJ, Jelinek MV, Best JD, et al. Coaching patients On Achieving Cardiovascular Health (COACH): a multicenter randomized trial in patients with coronary heart disease. *Arch Intern Med* 2003;163:2775–83.

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### **Study Overview**

**Objective.** To determine if frequent communication with dietitian or nurse coaches who did not prescribe medication led to reductions in cardiovascular risk factors among adults with coronary artery disease (CAD).

**Design.** Randomized controlled trial.

**Setting and participants.** Adults from 6 medical centers in Melbourne, Australia, with CAD were recruited during hospitalizations for coronary artery bypass surgery, percutaneous coronary intervention, acute myocardial infarction, or coronary angiography with planned revascularization. Patients who could not be reached by phone, did not speak English, did not have a fasting blood sample done in the first 24 hours of hospitalization, were participating in another study, could not return to the hospital for follow-up, or were judged too ill to participate were excluded.

**Intervention.** Patients were randomized to receive a coaching intervention or usual care. The intervention consisted of information on their in-hospital cardiac risk factors, a list of risk factor targets, and a series of telephone calls and written follow-up from the coaches. The goal of coaching was to encourage patients to go to their regular physicians to obtain

measurements of cardiac risk factors and negotiate a plan for reaching risk factor targets (ie, total cholesterol < 155 mg/dL, smoking cessation, fasting glucose < 110 mg/dL, body mass index < 25 kg/m<sup>2</sup>, saturated fat intake of < 10% of total energy intake, and at least 30 minutes of moderate-intensity physical activity on most days of the week). Patients received 4 coaching telephone calls at 6-week intervals and were mailed printed reports after the phone conversations.

**Main outcome measures.** Outcomes were measured after 6 months. The primary outcome was change in fasting serum total cholesterol. Secondary outcomes included change in triglycerides, high-density lipoprotein cholesterol, and low-density lipoprotein (LDL) cholesterol; systolic and diastolic blood pressure; body weight; body mass index; fasting glucose; dietary intake of saturated fat, cholesterol, and fiber (using a food frequency questionnaire); smoking (using serum cotinine level); and depression and anxiety (using validated scales).

**Main results.** Total cholesterol was 14 mg/dL lower in the intervention group (95% confidence interval, 8–20 mg/dL). The intervention group also had significantly better results for LDL cholesterol (13 mg/dL), body weight (0.9 kg), and blood pressure (4.4/2.4 mm Hg) (all  $P \leq 0.005$ ). Self-reported anxiety, saturated fat intake, dyspnea, and chest pain also

were lower in the intervention group ( $P \leq 0.03$  for all comparisons). More patients in the intervention group reported starting a regular walking program since discharge compared with the usual care group (69% versus 44%;  $P < 0.001$ ). Smoking cessation rates were similar in both groups.

**Conclusions.** Having a nurse or dietitian coach patients using repeated telephone calls followed by written reports led to significant improvement in several cardiovascular risk factors following hospital discharge among patients with CAD.

**Commentary**

Poor control of cardiovascular risk factors is still a major problem for many patients with established CAD. Additional systematic approaches beyond routine clinical care are needed to ensure that all eligible patients benefit from existing therapies. The best approach to this problem has not been established. As the authors of this study point out, several studies of disease management programs have been attempted with varying success. In general, interventions that use nonphysician clinical personnel with the power to prescribe lipid-lowering medication have been more successful than interventions that use other providers who cannot prescribe medication. Vale et al's findings are important because they show that clinical personnel outside the usual system of care can have a positive impact on patients' pursuit of risk factor control and on lifestyle improvements.

Programs like the one used in this study may become increasingly relevant for health care in the United States. As the quality of care received by individuals at different refer-

ral centers or health plans comes under closer scrutiny by purchasers and consumers, centers that perform cardiac procedures or health insurers who are interested in demonstrating high quality care may seek ways to improve cardiovascular risk factor reduction.

A limitation of this study is that it does not report the total time and effort required on behalf of the coaches to deliver the interventions. Widespread adoption of any disease management activity is likely to depend on its cost. Also the coaches were affiliated with the medical center where patients had their cardiac hospitalization and may have been more effective at motivating patients than coaches affiliated with a third party would be. Last, it should be acknowledged that while patients in the intervention group did have clinically meaningful improvements in several cardiac risk factors compared with the control group, even the intervention group had a mean total cholesterol level that was above the target at the end of the study.

**Applications for Clinical Practice**

Having nurse or nutritionist coaches contact patients at 6-week intervals following hospital discharge can improve the control of cardiac risk factors and motivate patients to seek more intensive care from their regular doctors for hypercholesterolemia in the short term. Health care systems should consider implementing this type of program. Even with this intervention, however, many patients did not achieve target cholesterol levels at 6 months.

—Review by Stephen D. Persell, MD, MPH

**Prescribing Exercise for Weight Loss: Less Is Not More, but It's Not Bad**

Slentz CA, Duscha BD, Johnson JL, et al. Effects of the amount of exercise on body weight, body composition, and measures of central obesity: STRRIDE—a randomized controlled study. *Arch Intern Med* 2004;164:31–9.

**Study Overview**

**Objective.** To determine the effects of different durations and intensities of physical activity on body weight, body composition, and waist circumference.

**Design.** Randomized controlled trial with an intention-to-treat analysis.

**Setting and participants.** Patients were recruited from Dur-

ham, NC, and the surrounding areas. Inclusion criteria included age 40 to 65 years; sedentary lifestyle (defined as engaging in exercise less than once weekly); overweight or mildly obese (defined as a body mass index of 25–35 kg/m<sup>2</sup>); no prior diagnosis of diabetes or hypertension; and mild to moderate lipid abnormalities (defined as low-density lipoprotein cholesterol of 130–190 mg/dL or high-density lipoprotein cholesterol < 40 mg/dL for men and < 45 mg/dL for women). Exclusion criteria included current dieting or intent to diet, any

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