BEST PRACTICE: Blue Distinction Centers Point The Way To Quality Health Care *(page 2)*

CareFirst BlueChoice

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INfOCUS

Best Practice 2
Blue Distinction Centers Point The Way To Quality Health Care

Quality Improvement 5
2007 HMO Performance Reports Released

Technology 6-9
New and Emerging Technology

Disease Management and Disease Prevention 10-11
CareFirst and CareFirst BlueChoice Disease Management Initiatives

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Blue Distinction Centers Point The Way To Quality Health Care

By Curt Matthews

The following is presented to highlight medical "best practice" in the CareFirst and CareFirst BlueChoice service areas and to share with medical professionals throughout the region the innovative approaches being adopted in Maryland, Washington, D.C. and Northern Virginia. The "best practice" approach to patient care not only improves the quality of care, it also helps limit rising costs.

The search for new ideas to improve the quality of health care in the CareFirst and CareFirst BlueChoice service areas is a process that draws upon the combined experience of doctors, nurses, hospitals and medical specialty professionals. The Blue Distinction Program, launched by the Blue Cross Blue Shield Association two years ago, is an example of just such a collaborative effort.

Nine hospitals in Maryland, four in Northern Virginia and two in Washington, D.C. have qualified to participate in the on-going nationwide Blue Distinction program.

The program is designed to "bring transparency to health care," according to Scott P. Serota, president and chief executive officer of the Blue Cross Blue Shield Association.

"Blue Distinction brings to health care a market similar to what consumers expect when purchasing most other goods and services today," Serota said. "It is the cornerstone of an ongoing effort to create a more knowledge-driven national health care system."

Blue Distinction provides members comprehensive health care quality and affordability information that is based on objective, consistent and common standards. A CareFirst team focused on issues related to improving public understanding of the health care process concluded that this information should lead to "confident, cost effective decision-making" that can improve the quality of health care and make it more affordable.

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Peggy Reineking, manager of CareFirst's Provider Performance Program, says that review and assessment of claims information is simply not adequate to support the information needs for true transparency of health care outcomes.

"We meet some resistance by providers regarding this," she said, "but with the Blue Distinction Centers we are entering a whole new era of quality measurement. While case volume is important, the Blue Cross Blue Shield Association is taking the national lead in establishing comprehensive quality metrics for specialized hospital services. You just can't get that kind of information from claims forms."

Driven by quality, collaboration and affordability, Blue Distinction will strengthen consumer engagement and provider partnerships through transparency demonstrations that identify and compare medical costs. It also creates a nationwide hospital measurement and improvement program through new specialty centers offering the best practices and standards of care in bariatric surgery, cardiac care and transplant services.

The Blue Distinction centers in the CareFirst and CareFirst BlueChoice service areas have documented their excellence in quality clinical processes, patient safety and outcomes, based on national standards and compared with hospitals nationwide. This produces information that offers CareFirst and CareFirst BlueChoice members a new, unprecedented consumer tool.

One persistent difficulty in trying to match affordable care and quality outcomes is that so much of health care is not consistently available, objectively assessed or delivered according to national standards. In addition, until recently there have been no consistent sources of data to use when comparing hospitals, although national quality improvement databases are beginning to emerge.

> "Blue Distinction brings to health care a market similar to what consumers expect when purchasing most other goods and services today, Serota said." "It is the cornerstone of an ongoing effort to create a more knowledge-driven national health care system."

The Blue Distinction Centers in Maryland, Washington, D.C. and Northern Virginia address these issues and are meeting rigorous care and treatment standards to qualify as participants in the nationwide program. Each hospital is evaluated to determine that its facilities meet the required criteria and are fully accredited, that the care process is patient oriented, comprehensive and understood by the patients, and that outcomes are objectively monitored and followed over time.

The Blue Distinction centers in CareFirst's service area are endorsed to provide three specific medical procedures: bariatric surgery, cardiac care and select and specified transplants. The experience gained in these areas will be useful in expanding the program to include other types of care in the future.

CareFirst is one of 17 Blue Cross and Blue Shield plans collaborating with local hospitals, physicians and medical groups to test the most effective ways to help health care consumers learn about the true costs of medical services and the relationship between cost and the quality of care.

In the CareFirst and CareFirst BlueChoice service areas, as well as other areas served by Blue Cross and Blue Shield plans throughout the U.S., each Blue Distinction Center's structure, processes and care outcomes are closely monitored and evaluated. For example, the basic criteria for becoming a Blue Distinction Center for Cardiac Care require that a hospital be a "Full-service, accredited, inpatient hospital." In addition, it must have an active cardiac care program performing a required volume of percutaneous coronary interventions and artery bypass graft surgeries. It must also offer a full range of services for cardiac patients, including inpatient care and rehabilitation.

Further requirements include:

- board certification of the cardiac team
- ongoing programs for quality management and improvement
- systematic evaluation and baseline levels for outcomes for acute myocardial infarction, heart failure, percutaneous coronary interventions
- bypass surgery to include evaluation of complications and mortality rates.

Blue Distinction Centers for Cardiac Care must also participate in national cardiac quality improvement and outcomes databases. Similar high performance standards are required for the bariatric surgery and transplant facilities designated as Blue Distinction Centers. Commenting on the centers contribution to the development of improved care in the Mid-Atlantic region, Daniel J. Winn, MD, CareFirst Vice President and Senior Medical Director, said recently, "Blue Distinction Centers put a high value on evidenced-based health outcomes and medical information. The Centers are collecting up to date information and presenting it in a usable and transparent way."

(continued next page)

Blue Distinction Centers Point The Way To Quality Health Care (continued)

Winn added, "These centers show our commitment to working with doctors and hospitals throughout the CareFirst service area to identify the leading care facilities that meet clinically validated quality standards and consistently deliver better outcomes."

Applications to participate as Blue Distinction Center hospitals are currently pending for Johns Hopkins Hospital in Baltimore and Georgetown University Hospital in Washington, D.C.

BCBSA is expanding the Blue Distinction programs. The Association will soon release the names of hospitals that qualify for Blue Distinction Centers for Rare and Complex Cancer. Several CareFirst network hospitals are among those under consideration.

To learn more about Blue Distinction, go to *www.bcbs.com/bluedistinction*. A national provider locator is available to enable Blue members to locate participating bariatric surgery and cardiac care centers.

Blue Distinction Centers in the CareFirst BlueChoice BlueShield Service Area

Hospital	Cardiac Blue Distinction Centers	Bariatric Blue Distinction Centers	Transplant Blue Distinction Centers
Johns Hopkins Bayview		X	
St. Agnes		X	
University of Maryland	X		X (Adult Autologous & Allogeneic Bone Marrow & Adult Simultaneous Pancreas-Kidney; Adult Pancreas & Adult Kidney (in conjunction with SPK)
Sacred Heart	X		
Sinai	X	X	
Johns Hopkins	X		Pending
St. Joseph	X		
Peninsula Regional	X		
Union Memorial	X		
George Washington University	X		
Georgetown University			Pending
Inova Alexandria	X		
Inova Fairfax	X		X (Adult Single or Bi-lateral Lung & Adult Autologous Bone Marrow)
Virginia Hospital Center	X		
Inova Fair Oaks		X	

2007 HMO Performance Reports Released

The Maryland Health Care Commission (MHCC) recently released its Measuring the Quality of Maryland HMOs and POS Plans: 2007/2008 Performance Report, 11th edition which adds new information to the established clinical and member satisfaction respectively, results reported each year.

The new information evaluates both quality of care and cost-effectiveness. Health plans are rated in five categories: behavioral health care, consumer engagement, disease management, prescription management and preventive care. Information in these categories was collected using a tool (eValue8™) developed by the National Business Coalition on Health. The participating health plans are compared against each other as a regional benchmark and against national benchmarks.

Healthcare Effectiveness Data and Information Set (HEDIS 2007) and Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CareFirst BlueChoice demonstrated above-average performance in the following measures:

- Immunization for children
- Controlling high blood pressure
- Cholesterol control in diabetics
- Postpartum care

CareFirst BlueChoice demonstrated opportunities for improvement in the following measures:

- Breast cancer screening
- Persistence of Beta-Blocker treatment after a heart attack
- Antidepressant medication management
- Colorectal cancer screening
- Chlamydia screening
- Getting needed care (CAHPS)
- Getting care quickly (CAHPS)
- Rating of health plan (CAHPS)

CareFirst BlueChoice annually reviews the results, analyzes the causes and implements new programs and processes to improve the care and services provided to its members and to increase members' level of satisfaction. For example, breast cancer screening rates have declined across the country; fewer women are having mammograms. After analyzing the results, CareFirst BlueChoice contracted with a company that uses interactive voice response (IVR) technology to provide reminder calls to women who have not had a mammogram within two years.

The complete 2007/2008 Performance Report is available on the MHCC Web site at: http://mhcc.maryland.gov. To obtain a CD or print copy call the MHCC at 410-764-3460 or toll free at 877-245-1762.

New and Emerging Technology

CareFirst and CareFirst BlueChoice's Technology Assessment Committee – which includes CareFirst and CareFirst BlueChoice physicians and nurses and external consulting physicians – reviews new and developing technologies. The committee relies on current scientific evidence published in peer-reviewed medical literature, local expert consultants and physicians to determine whether those technologies meet CareFirst and CareFirst BlueChoice's criteria for coverage. Coverage policies applicable to national Blue Cross Blue Shield accounts and Federal Employees Benefits Programs may differ from those at the local account level. The review criteria can be found in the Providers & Physicians section of www.carefirst.com by clicking on Medical Policies and opening the Definitions and Interpretive Guidelines in the Introduction section. The Technology Assessment Committee recently made the following determinations:

CT coronary angiography:

Non-invasive imaging of the coronary arteries to assess for areas of stenosis and calcification has continued to advance. 64-slice scanners are now available to provide improved resolution and allow imaging to be done in a shorter time period with reduced breath-holding by the patient.

CareFirst and CareFirst BlueChoice determination:

Studies of feasibility and diagnostic performance have been studied in small groups of selected patients, i.e. those who have already been identified for invasive coronary angiography. Reported values for sensitivity, specificity, and positive and negative predictive values indicate that CT angiography has the potential for clinical utility in the diagnosis and management of patients presenting with signs of coronary artery disease. However, there are no studies that have demonstrated an improvement in health outcomes, and experts in the specialty have noted that studies to identify specific patient groups that would benefit from CT angiography are currently lacking. **CareFirst and CareFirst BlueChoice consider the procedure experimental / investigational.**

Carotid intima-media thickness measurement to assess risk for coronary artery disease:

Numerous risk factors have been identified that are associated with the development of coronary artery disease, but identification of risk factors such as high density and low density lipoproteins, cholesterol and lifestyle risks do not measure the actual pathology that may be present in an individual. Despite the presence of elevated risk, the patient may or may not have significant levels of atherosclerosis. A non-invasive method of identifying atherosclerosis is therefore an area of interest. Ultrasound measurement of the thickness of the intimal and medial layers along the carotid artery is therefore being investigated as such a method.

CareFirst and CareFirst BlueChoice determination:

There have been several studies published in the peer-reviewed literature that have identified carotid intima-media thickness (CIMT) as a surrogate marker of risk for atherosclerosis-related coronary events. However, these studies have focused on feasibility and diagnostic performance rather than clinical utility. No studies have demonstrated an improvement in patient management or disease outcomes through the use of CIMT. In addition, it is unclear as to the standardized values and test procedures for CIMT. Finally, the latest report of the National Cholesterol Education Panel (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults has stated the routine use of CIMT is not currently recommended. **CareFirst and CareFirst Blue Choice consider the test experimental / investigational.**

New and Emerging Technology

Monitoring of regional cerebral blood flow using an implanted thermal perfusion probe:

Assessment of cerebral perfusion is considered an important component of the management of patients with conditions such as head trauma, post-intracranial surgery, stroke and subarachnoid hemorrhage (SAH). Vasospasm in SAH, for example, can be a major contributor to mortality from neurological deterioration. Thus, SAH patients are carefully monitored for vasospasm and treated as appropriate. Bedside assessment can be performed using transcranial doppler ultrasound (TCD), but this technique has limitations. CT scanning, PET scans and radionuclide studies can also be performed to assess cerebral perfusion, but these studies must be scheduled, and cannot be performed at the patient's bedside. The use of an implanted thermal perfusion probe to assess regional cerebral circulation is being investigated. Such a system would have the advantage of providing continuous information on circulation within a region of the patient's brain at the bedside. A probe containing two embedded thermistors is implanted via burr hole in the area of interest, and the probe is connected to a monitor that provides continuous display of perfusion information.

CareFirst and CareFirst BlueChoice determination:
As a diagnostic procedure, the evidence should demonstrate the technical performance of the test, the comparison of the test to the current gold standard, and whether clinical management is influenced by the test in a way that demonstrates an improvement in patient outcomes. Overall there is a scarcity of data regarding diagnostic performance of the cerebral perfusion probe. Furthermore, there have been no studies that have been powered to determine if the regional thermal perfusion probe results in improved medical decision making or improved patient outcomes. CareFirst and CareFirst BlueChoice therefore consider the technology experimental / investigational.

Electrocardiographic body surface mapping:

The 12-lead electrocardiogram (ECG) has long been accepted as the principle diagnostic tool for patients presenting in the emergency room setting complaining of acute chest pain, and its use in identifying acute myocardial ischemia and infarction has been well established. Its limitations are also well known, however, given that only six chest electrodes are used, which covers a relatively small precordial area. Although ECGs with multiple precordial leads potentially can yield more diagnostic information, their use can be technically cumbersome, and data from 80 or more leads difficult to interpret. The development of a system with 80 precordial leads that can be attached to the patient via a vest apparatus, and the data interpreted using the assistance of a computer algorithm, has renewed interest in the "body surface mapping" ECG.

CareFirst and CareFirst BlueChoice determination:
Technical feasibility and diagnostic performance studies are few in number, and have been conducted mainly in small patient groups without formal controls. These studies have suggested that the body surface mapping ECG may have a higher sensitivity than the standard 12-lead ECG, with a slightly reduced specificity. No studies have focused on whether patient outcomes are improved, however, so the body surface mapping ECG's clinical utility has not been established. CareFirst and CareFirst BlueChoice consider the technology experimental / investigational.

Cervical intervertebral disc replacement:

Anterior cervical discectomy with fusion is the standard procedure to relieve pain and neurologic symptoms of advanced cervical degenerative disc disease (DDD). However, removing a disc and fusing the two adjacent vertebrae results in reduced range of motion, and may contribute to degeneration of the adjacent intervertebral spaces. Replacing the diseased cervical disc with a prosthetic replacement has been proposed as an alternative procedure that maintains flexibility of the cervical spine and possibly reduces the likelihood of degeneration of adjacent discs.

CareFirst and CareFirst BlueChoice determination:
A number of studies have been documented to compare anterior cervical disc replacement (ACDR) with anterior diskectomy and fusion (ACDF). In terms of subjective relief of symptoms as the main outcomes measures, the procedures appear to be comparable in short-term follow-up. There are a number of studies, however, that have reported high rates of heterotopic ossification and spontaneous fusion in ACDR patients. Many authors agree that while preliminary outcomes of ACDR are encouraging, longer follow-up periods of at least five years are needed before it can be determined that cervical disc replacement is a viable alternative to ACDF. The advantages to be gained by preserving spinal motion are theoretical, but unproven. CareFirst and CareFirst BlueChoice therefore consider cervical disc replacement experimental / investigational.

New and Emerging Technology

Bronchial thermoplasty for control of asthma:

Serious asthma attacks account for nearly two million emergency room visits per year, and nearly 6,000 deaths. The application of radiofrequency (RF) heat energy is known to reduce smooth muscle tissue mass and reduce contractility. The rationale for bronchial thermoplasty therefore is to apply RF heat energy to the bronchial walls so as to reduce hyper-responsive narrowing of the airway and minimize the severity of the attack. The procedure requires about 30 minutes and is performed via bronchoscopy in the outpatient setting, using light anesthesia. The procedure may be repeated several times if necessary. The Alair® Bronchial Thermoplasty system (Asthmatx, Inc.) is a proprietary medical device designed specifically for bronchoscopic bronchial thermoplasty. The FDA has currently given it an investigational device exemption, which means it may be used in the clinical investigative setting in the United States, but is not authorized for general distribution.

CareFirst and CareFirst BlueChoice determination:

To date, only small, uncontrolled pilot-level feasibility studies have been conducted. Preliminary results are favorable in terms of safety, untoward effects, and control of asthma symptoms in short-term follow-up. As a result, a larger-scale, randomized clinical trial is being organized to further study the technology in terms of safety, efficacy and durability. CareFirst and CareFirst BlueChoice consider bronchial thermoplasty experimental / investigational.

Percutaneous thermal therapies for chronic discogenic low back pain:

Most cases of discogenic low back pain are successfully treated conservatively, using medications, physical therapy, and lifestyle changes. For patients who do not respond to conservative measures, surgical interventions are aimed at removing disc material to relieve pressure. The intervertebral disc annuloplasty techniques have been proposed as minimally invasive procedures designed to shrink the fibrous annulus portion of the disc, closing annular tears and relieving pain. There are two main approaches that have been developed: Intradiscal electrothermal therapy (IDET), also known as intradiscal electrothermal annuloplasty (IDEA), and percutaneous intradiscal radiofrequency thermocoagulation (PIRFT). IDET involves the placement of a trochar directly into the annulus of the disc, and then passing an electrical thermal catheter. The disc is heated to a temperature of 90°C over approximately 15 minutes, and maintaining the heating for four minutes. It is believed IDET works by shrinking the collagen fibers in the annulus and denervating the sinuvertebral nerve endings. PIRFT, although similar in some ways to IDET, involves placing a radiofrequency catheter in the center of the disc. Radiofrequency energy generates heat within the disc to a level of 70°C for 90 seconds.

CareFirst and CareFirst BlueChoice determination:

The IDET procedure initially was met with some enthusiasm as a possible minimally-invasive remedy for discogenic pain in selected patients. However, in randomized, sham-controlled studies, patients in the IDET arm do not report results significantly improved over sham treatment. Retrospective reviews in longer term follow-up suggest that IDET overall did not help patients with their pain, in results that have been described as “disappointing.” There is a paucity of clinical evidence supporting the PIRFT technique. In a small, but randomized, sham-controlled and double-blinded study, PIRFT performed no better than the sham treatment for control of pain and disability. Both procedures have received low evidence ratings in evidence-based practice guidelines. Therefore, CareFirst and CareFirst BlueChoice consider these procedures experimental / investigational.

New and Emerging Technology

Serum biomarker panels for hepatic fibrosis

Biopsy of the liver is the current gold standard used to assess the degree of fibrosis present as a predictor of morbidity and mortality in patients with liver diseases such as hepatitis C (HCV), nonalcoholic steatohepatitis (NASH) or alcoholic liver disease. Serum biomarker combinations are being developed as non-invasive alternatives to liver biopsy, to initially assess patients and to monitor response to therapy. Research into the pathophysiology of fibrosis has led to the identification of several enzymes, proteins, and metabolites involved with the process which has in turn led to development of proprietary algorithms which have been proposed as assessment tools in reducing or eliminating the need for invasive liver biopsy. FibroSure™ (LabCorp) and FibroSPECT® (Prometheus Laboratories, Inc.) are examples of proprietary biomarker panels currently available.

CareFirst and CareFirst BlueChoice determination:

Diagnostic performance studies have been conducted on both of the above test panels. Sensitivities, specificities, positive and negative predictive values, and overall diagnostic performances have been reported. There is disagreement among authors and reviewers over whether the reported performance values are adequate for clinical use. There have been no studies that have demonstrated the clinical utility of either test panel. Both the American Gastroenterological Association and the American Association for the Study of Liver Diseases have stated that neither of the test panels are sufficiently accurate for routine clinical use. CareFirst and CareFirst BlueChoice therefore consider both of the currently available liver fibrosis biomarker panels experimental / investigational.

Dynasplint® carpal tunnel splint

Dynasplint Systems, Inc. of Severna Park, Md., has developed a device specifically designed for treatment of carpal tunnel syndrome. The company claims the device stretches the carpal tunnel ligament, relieving pressure on the median nerve at the carpal tunnel. Because carpal tunnel syndrome is a chronic, painful condition it would be one that would likely be subject to the placebo effect in any new or emerging treatment. Studies to determine the efficaciousness of such a splint should therefore be well-designed so as to minimize bias and account for placebo effects. No such studies have been found in the peer-reviewed literature. Although CareFirst and CareFirst BlueChoice provide benefit coverage for a variety of Dynasplint® products, the Dynasplint® carpal tunnel system is considered experimental / investigational.

Disease Management and Disease Prevention

Recent Literature Related to:

CareFirst and CareFirst BlueChoice Disease Prevention and Management Initiatives

By Richard S. Safeer, MD, Medical Director, Preventive Medicine

CareEssentials: As part of the Disease Management and Disease Prevention components of CareEssentials, the CareFirst and CareFirst BlueChoice multi-faceted care management program that provides you with essential tools for patient care, this article is intended to call your attention to recent literature that may be of interest to you. For more information on how to enroll your patients in one of our disease management programs, please call 800-783-4582.

Disease Management

CORONARY HEART DISEASE	Where to Find it:
There are several risk factors for heart disease which receive a steady stream of attention in the medical literature -- smoking, hypertension and cholesterol to name a few. One risk factor that doesn't receive as much attention is stress. "Job Strain and Risk of Acute Recurrent Coronary Heart Disease Events" is a logical continuation of the work which has shown that job strain increases the risk of first coronary events. Job strain may be defined as "a combination of high psychological demands and low decision latitude." Aboa-Eboule et al. looked at the outcome of about 1,000 Canadians discharged from the hospital after having a first myocardial infarction (MI). Through an interview, job strain was assessed, using a validated tool, six weeks after returning to work and then again at two and six years. Fatal and non-fatal MI, as well as unstable angina, served as negative outcome markers. The results showed, "Chronic job strain was associated with a significantly increased risk of recurrent CHD events from 2.2 years of follow-up and beyond among middle aged patients who returned to work after a first MI. These results were obtained after full adjustment for 26 CHD-risk factors, sociodemographics, lifestyle, and clinical-prognostic and work-environment characteristics." As noted in an accompanying editorial, the researchers did not control for depression. Knowing that job strain (which many might refer to as stress) has a negative impact on health, begs the question: "What do we do about it?" CareFirst and CareFirst BlueChoice incorporate questions about the individuals' social and psychological well being during the intake to our disease management programs. We also have a health risk assessment and connecting stress management program for those members who self report this problem. In your office, a simple "are you under any stress?" is a great place to start.	JAMA 2007; 298 (14):1652-1660.

Disease Management and Disease Prevention

COPD

Where to Find it: Ann Intern Med 2007;147:633-638.

One of the key principles of Disease Management programs is to follow clinical recommendation guidelines. The presumption is that by following these guidelines, clinical outcomes are improved. As such, staying abreast of new recommendations is paramount to the success of our disease management programs. "Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease: A Clinical Practice Guideline from the American College of Physicians" was recently published in the Annals of Internal Medicine.

Six recommendations (mostly strong with moderate–quality evidence) were generated in these guidelines and they are as follows:

1. In patients with respiratory symptoms, particularly dyspnea, spirometry should be performed to diagnose airflow obstruction. Spirometry should not be used to screen for airflow obstruction in asymptomatic individuals.
2. Treatment for stable chronic obstructive pulmonary disease (COPD) should be reserved for patients who have respiratory symptoms and FEV1 less than 60% predicted, as documented by spirometry.
3. Clinicians should prescribe 1 of the following maintenance monotherapies for symptomatic patients with COPD and FEV1 less than 60% predicted: long-acting inhaled _-agonists, long-acting inhaled anticholinergics, or inhaled corticosteroids.
4. Clinicians may consider combination inhaled therapies for symptomatic patients with COPD and FEV1 less than 60% predicted.
5. Clinicians should prescribe oxygen therapy in patients with COPD and resting hypoxemia (Pao2 <55 mm Hg).
6. Clinicians should consider prescribing pulmonary rehabilitation in symptomatic individuals with COPD who have an FEV1 less than 50% predicted.

The recommendations above accompany "Management of Stable Chronic Obstructive Pulmonary Disease: A Systematic Review for a Clinical Practice Guideline" in the same publication. The authors looked at 42 randomized controlled trials and eight meta-analyses to make their conclusions. "Respiratory symptoms are common, clinical examination has poor accuracy for determining airflow obstruction severity (www.ahrq.gov/clinic/tp/spirotp.htm), and few adults have airflow obstruction severe enough that treatments have demonstrated effectiveness. Therefore, adopting a strategy that targets use of long-acting inhaled corticosteroids or bronchodilator as monotherapy to individuals reporting activity – limiting respiratory symptoms would maintain benefits and minimize unnecessary testing or ineffective treatment."

DIABETES

Where to Find it: NEJM 2007;357:1716-1730, 1759-1761.

Inhaled corticosteroids are a mainstay in many asthmatics' maintenance regimens. However, It's no secret that lower HgA1C levels equate to better clinical outcomes. The challenge however, is to figure out how to get to these lower levels. Most type 2 diabetics are started on oral medications and if not controlled, later add insulin. "Large-scale, direct comparisons of various regimens of insulin analogues in combination with oral antidiabetic agents have been lacking." The Treating to Target in Type 2 Diabetes (4-T) study is intended to begin filling this void.

Holman et. al. looked at several hundred type 2 diabetics on maximally tolerated doses of a sulfonylurea and metformin and placed them in to one of three insulin regimens (while continuing their present oral medications): prandial, biphasic and basal. After the first of this three year study, the investigators found that mean HgA1C levels were 7.2% in the prandial group and 7.3% in the biphasic group, both significantly lower than the basal group (7.6%). This translates in to more diabetics in the prandial and biphasic groups meeting their HgA1C goal. Even though the addition of insulin did help, most patients still did not achieve their HgA1C goal.

The authors summarize the adverse events as, "Glucose lowering was achieved at the expense of weight gain and an increased risk of hypoglyciema, particularly with the biphasic and prandial regimens." An accompanying editorial declares "The 4-T study provides clear indication that prandial and biphasic formulations are suboptimal choices for insulin initiation and probably expose patients to an unnecessarily high risk of hypoglycemia without clinically important benefit".

Looking at the bigger picture, diabetologists recommend starting any insulin regimen if the patient is not at goal on two maximally utilized oral medicines for more than a few months. Ask yourself whether your uncontrolled diabetic patients should be on insulin. Also consider encouraging your patients to enroll in our diabetes disease management program because patients who understand their disease are more likely to have better clinical outcomes.

CareFirst and CareFirst BlueChoice asthma disease management nurses can help your patients understand the importance of their medication and how to properly take them. Participation in an asthma disease management program can decrease the chances of your patient ending up in the emergency room. Call 800-783-4582 to refer your patient.

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For current administrative news, look for the most recent edition of BlueLink.

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