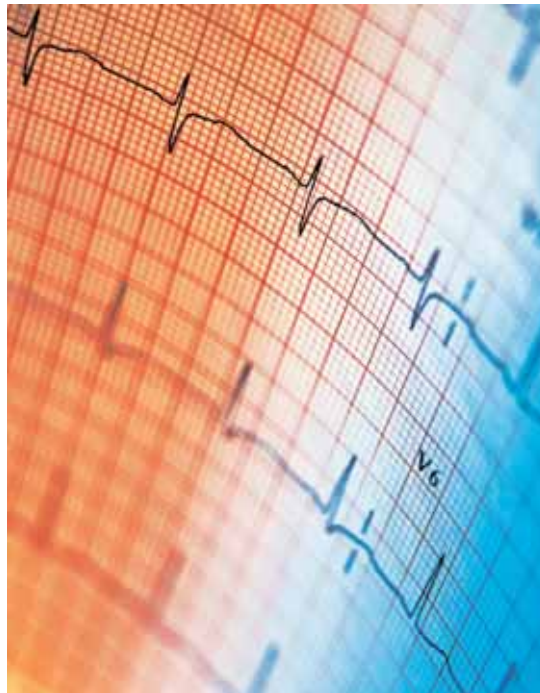


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## Best Practice

# Hand-held prescription software provides clear link for doctor-pharmacist dialog

*InFocus has expanded its Best Practice feature to include all medical professionals – physicians, providers and institutions - and highlight and acknowledge the innovative approaches to patient care that are being adopted by CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice) providers in Maryland, Washington, D.C. and Northern Virginia. Their “best practice” approach to patient care is not only improving the quality of care, but helps contain the rising cost of care.*

A year-long pilot program to familiarize Maryland doctors with the advantages of electronic prescription writing has produced positive results and continues to demonstrate how new technology can improve the health care system and reduce costs. About 500 doctors are currently participating in the program which is sponsored jointly by CareFirst and CareFirst BlueChoice in cooperation with DrFirst, a Rockville, Md. company that focuses on developing innovative technology for the health care industry.

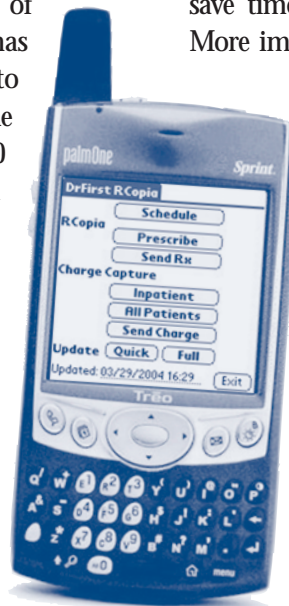
After a modest start in the fall of 2004, the pilot program has gained momentum this year. The most recent review of the program shows that more than 300 active users wrote about 80,000 electronic prescriptions during the June-July period this year. By avoiding the most common errors in administering drugs – non-compliance with established formularies, adverse reactions and mis-filled prescriptions – the program has demonstrated a potential for substantial savings in the first 12 months.

Physicians participating in the program use hand-held personal digital assistance (PDA) and desktop computers to access an electronic prescription writing system called Rcopia. The systems, developed by DrFirst, allows doctors to access the Internet and prescribe medicine with greater knowledge, information and accuracy than ever before possible.

### New Medical Technology

The trend toward greater use of new medical technology at the patient level continues to gain momentum. More and more, physicians are adopting inventive tools – from prosthetic heart valves, to beeper-sized insulin pumps, to spinal neurostimulators that block pain. These patient-oriented medical inventions are complex and often very costly. Others are

considerably less complicated and relatively inexpensive – but save time and money for doctors and patients, nonetheless. More importantly, the very best of the new technology is also saving lives.



Rcopia, one of several prescription writing systems available to doctors and similar in concept to communications tools now widely used in business, construction, transportation and medicine, is changing the way doctors communicate with pharmacists. It is also improving the ease and accuracy of doctor-to-doctor information exchanges, access to patient medical histories and communications with nurses, physician assistants, and front office staff. And, for doctors who use such new technology to take notes and record reminders, the system is a useful aid in organizing the many details of a busy day.

Maislyn Christie, M.D., a pediatric physician in Cheverly, Md., has used Rcopia for nearly a year. “I have put my life in that device right now. I had some experience with electronic prescriptions before Rcopia, and was a little concerned at first if it would work for me,” she says. “I sometimes write four or five prescriptions for a single patient. But, I am very comfortable with it now. It fits right into my practice and patient routine. And my patients like it. It has become a standard of care they look for now.”

Rcopia was developed and brought to market four years ago by DrFirst. The company’s name – DrFirst -- is derived from the purpose of its products: to ease the administrative burdens of modern medicine and let physicians “get back to being a doctor first.”

The pilot program started last fall with doctors in Maryland, Virginia and the Washington D.C. area who were identified as those frequently writing a large number of prescriptions.

Eric R. Baugh, M.D., CareFirst's chief medical officer and senior vice president of Medical Affairs, says that patient safety and cost efficiency were the major factors that prompted the company to develop its pilot project.

"We are engaged in this statewide patient safety and cost reduction initiative because we see a great benefit to our members, our network physicians, the pharmacies they use, and, in fact, the entire health care system in Maryland," Baugh says.

## Patient Safety Comes First

Patient safety clearly tops the list of benefits that result from electronic prescription management. A 1999 study by the Institute of Medicine found that medical errors – including those related to improperly prescribed medications – were the eighth leading cause of death in the United States, ranking ahead of motor vehicle accidents, breast cancer and AIDS.

How does electronic prescribing help? First and foremost, it reduces the potential for error in prescribing medications. The importance of that is found in statistics released by the National Association of Boards of Pharmacy showing that as many as 5 percent of the three billion prescriptions filled each year in the United States are incorrect and may contribute to as many as 7,000 deaths a year.

In addition, physicians who write electronic prescriptions are able to access more than 3,300 drug monographs and formularies to check for proper dosage, look up accurate medication history for the past 10 years, and receive immediate warnings regarding contraindications and adverse drug-to-drug and drug/allergy interactions for both brand and generic drugs. In combination with a home or office Internet connection, a doctor can e-mail a prescription, include specific instructions for its use, check the patient's medical history to avoid adverse effects, get cost information and otherwise remotely manage the entire patient medication procedure from start to finish.

Because the scripts are clear and easily read, electronic prescriptions virtually eliminate calls and faxes between physicians and pharmacists to verify or decipher. And because the electronic process is accessible on almost any hand-held and portable web-enabled device, prescriptions can be written from almost anywhere at any time, giving physicians greater freedom to "be doctors first." For example, Rcopia's e-mail feature allows a physician not only to check a patient's treatment record and medication history, but also to confer with other medical professionals prior to writing a prescription.

In addition, Rcopia offers a number of other features including MultiCheck, a cross referenced database check on multiple drug interactions, and MedMath, a medical calculator that includes a body mass index, creatinine clearance and other measures of importance in prescribing medications. Rcopia software also alerts physicians to avoid potentially dangerous drug interactions. In a recent month, for example, the system intercepted 342 prescriptions that could have resulted in adverse patient reactions.

Other useful features include an integrated Epocrates ID infectious disease treatment guide, a guide to more than 400 alternative (herbal) medicines and their possible interactions with prescription drugs, and an IV compatibility checker.

All this information is literally available at the finger tips of physicians who have adopted electronic prescription writing.

Howard Goldstein, M.D., who practices internal medicine in Annapolis, is one of them. "We are, in our practice, moving to electronic medical records, and this is one aspect, one feature of electronic medical records," he says.

## Apparent Advantages

The advantages of electronic prescription writing become quickly apparent to those who have tried it. Marketing representatives of DrFirst report that the only hurdle they have experienced is reluctance on the part of some physicians to adopt new technology and new routines in their practice. Once that hurdle is cleared, electronic prescriptions quickly become another welcomed tool in their daily practice workflow.

The physicians participating in the program can use the system for all patients, not just those with health insurance coverage from CareFirst or CareFirst BlueChoice.

CareFirst's participation in and support of the electronic prescription pilot program is a reflection of the company's commitment to the advancement of quality health care. As new products and new medical procedures are introduced to improve the quality of care available in the Mid-Atlantic region, CareFirst will continue to step forward to assist in their evaluation and encourage adoption of those that deliver better care and better value consistent with the highest standards of a "best practice" approach to patient care.

*The CareFirst and CareFirst BlueChoice electronic prescription pilot program is currently full. If you would like to learn more about the Rcopia interface, contact DrFirst at 888-271-9898, ext. 147 or visit [www.drfirst.com](http://www.drfirst.com)*

# Quality Improvement

## What's New In Prevention?

The United States Preventive Services Task Force (USPSTF) recommends screening for Abdominal Aortic Aneurysm once between ages 65-75 in men with a history of smoking.

The Task Force last released a statement on screening for abdominal aortic aneurysms (AAA) in 1996. At that time, there was insufficient evidence to support or discourage routine screening of asymptomatic adults (Grade C recommendation). Since then, four randomized, controlled trials addressing the question of AAA screening have been performed. The USPSTF has concluded:

- Men, aged 65-75 years, who have ever smoked, one-time screening for AAA by ultrasonography. Grade B recommendation.
- Men, aged 65-75 years, who have never smoked, no recommendation for AAA screening. Grade C recommendation.
- Women are advised not to be screened for AAA. Grade D recommendation.

Repair of an AAA should not be taken lightly, as about one-third of these surgical patients have significant complications and there is a 4-to-5 percent operative mortality rate. Still, screening in the appropriate population can reduce AAA-related mortality by 42 percent. Do not harbor a false sense of security by palpating for an AAA, as this technique has poor accuracy. Order an abdominal ultrasound which has 95 percent sensitivity and almost 100 percent specificity.

### U.S. Preventive Services Task Force Recommendations and Ratings

Grade	Recommendation
A	The USPSTF strongly recommends that clinicians provide (the service) to eligible patients. The USPSTF found good evidence that (the service) improves important health outcomes and concludes that benefits substantially outweigh harms.
B	The USPSTF recommends that clinicians provide (the service) to eligible patients. The USPSTF found at least fair evidence that (the service) improves important health outcomes and concludes that benefits outweigh harms.
C	The USPSTF makes no recommendation for or against routine provision of (the service). The USPSTF found at least fair evidence that (the service) can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.
D	The USPSTF recommends against routinely providing (the service) to asymptomatic patients. The USPSTF found at least fair evidence that (the service) is ineffective or that harms outweigh benefits.
I	The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing (the service). Evidence that (the service) is effective is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

## New and Emerging Technology

CareFirst and CareFirst BlueChoice's Technology Assessment Committee — which includes CareFirst and CareFirst BlueChoice physicians, nurses and external consulting physicians — reviews new and developing technologies. The committee relies on current 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](http://www.carefirst.com) by clicking on *Medical Policies*. The Technology Assessment Committee recently made the following determinations:

### Total vertebral disc replacement (Charite® lumbar disc prosthesis)

Painful degenerative disc disease is one of the most common ailments that lead to reduced quality of life and varying degrees of disability. Many patients can be treated conservatively with analgesics, physical therapy and lifestyle changes. For those patients whose disease becomes severe or refractory to conservative treatment, surgical intervention may be indicated. Removal of the degenerated intervertebral disc and fusion of the vertebral segments is often performed. Total vertebral disc replacement is a technique that maintains flexibility of the lower spine by replacing the disc with a prosthetic and avoids a fusion of the vertebral segments.

#### *CareFirst and CareFirst BlueChoice determination*

The Charite® disc prosthesis has been used in Europe for 17 years, but is relatively new to the United States, having only recently received approval by the FDA for U.S. distribution. Only a few U.S. studies have been published, generally involving small groups of patients, in case-series type reports. A larger, randomized, multicenter study was undertaken using a non-inferiority type of design, in which patients were randomized to receive either treatment with a Charite prosthesis or by a more conventional discectomy and fusion procedure. The results of these studies show promise, but follow-up periods have generally been reported at one to two years. Longer follow-up is needed to properly determine whether Charite is sufficiently durable as an alternative to fusion surgery. One European study reported on longer term results of 105 patients, but it was not clear as to how patients were selected. The possibility of selection bias limits conclusions based on this report. Based on the data to date, and the cautious interpretation given by expert reviewers, CareFirst and CareFirst BlueChoice determine the procedure to be experimental / investigational.

### Laparoscopic adjustable gastric banding (LAGB) for treatment of morbid obesity

Placement of a silicone banding device about the stomach severely restricts the ability of a patient to take in food, but does not alter the absorption of nutrients as does the more traditional gastric bypass.

#### *CareFirst and CareFirst BlueChoice determination*

This type of device, one example of which is the Lap-Band®, has been FDA approved for use for a number of years, but early outcomes were disappointing in terms of insufficient weight loss and complication rates. Complication rates have decreased during the last two years and loss of excess body weight by percent has improved, owing to changes in the surgical technique, more careful selection of patients for the procedure and improved preoperative preparation and postoperative ongoing support. Furthermore, the procedure has become more widely accepted by the bariatric surgery specialty. As a result, CareFirst and CareFirst BlueChoice now consider the procedure medically necessary as a surgical intervention for patients who meet established criteria for morbid obesity.

### FDG-PET imaging for diagnosis of Alzheimer's disease and dementias

The use of positron emission tomography has developed into a valuable tool for diagnosis and staging of various cancers as well as to assess myocardial perfusion and viability. Less clear has been PET's application to neurodegenerative processes, such as Alzheimer's and other dementias. CareFirst and CareFirst BlueChoice's latest evidence review was prompted by a change in Medicare's coverage policy.

#### *CareFirst and CareFirst BlueChoice determination*

The published evidence continues to indicate that PET is actively involved as a research tool in the study of dementias, to aid in the study of the physical processes involved, the influence of medications on these processes and in the development of potential medical therapies. It is less clear as to the clinical utility of PET as a diagnostic procedure. Evidence has been evaluated by bodies such as the AHRQ and expert panels of the American Academy of Neurology, the American College of Radiology and the Society of Nuclear Medicine. Although recommendations from the expert panels support the coverage decision as framed by Medicare, the panels caution that there is insufficient evidence to support routine clinical use of FDG-PET as a diagnostic tool for dementias. Therefore, CareFirst and CareFirst BlueChoice's current medical policy remains unchanged, and CareFirst and CareFirst BlueChoice continue to regard FDG-PET scans for Alzheimer's disease and dementias as experimental / investigational.

## Pharmacogenomic and serologic markers for selection and therapeutic monitoring of patients with inflammatory bowel disease (IBD) and treatment with azathioprine

Most patients with IBD are managed with steroids or other medications, but some may become steroid resistant or dependant, and may thus be considered for treatment with azathioprine (AZA). Studies have shown that metabolism of AZA to its therapeutic metabolite 6-thioguanine (6-TG) is genetically determined, with 10 percent of the population having insufficient activity of the enzyme TPMT to properly metabolize AZA. These patients may be susceptible to myelosuppression at lower doses of AZA than for normal patients, and may be candidates for lowered initial dosing or the use of AZA may be contraindicated. Genetic testing for traits related to TPMT activity is now available to identify these patients. There is also a test available to monitor levels of 6-TG present in serum, which has been proposed as a therapeutic monitoring test to maintain IBD patients above a certain threshold to theoretically prolong periods of remission.

### *CareFirst and CareFirst BlueChoice determination*

Validation studies have shown that TPMT activity can be determined using the established molecular DNA identification procedures. CareFirst and CareFirst BlueChoice have determined that the genetic test may be considered medically necessary for patients whose physician has determined that there may be risk for myelosuppression related to AZA, where a margin of safety is necessary. This test is available within the CareFirst and CareFirst BlueChoice network.

6-TG therapeutic monitoring is a part of the Pro-Predict™ laboratory test product offered by Prometheus Laboratories®, and is available from them exclusively. Clinical studies have attempted to establish a therapeutic level for 6-TG. However, results are conflicting in that patients below the suggested therapeutic level have shown sustained periods of remission of IBD in response to AZA therapy, and others have not sustained their remissions even though their 6-TG levels have been kept above the suggested threshold. Therefore, expert reviewers have called for additional studies, particularly large-scale dose response studies, before routine use of such therapeutic monitoring can be recommended. Furthermore, the use of 6-TG monitoring does not reduce or eliminate the need for laboratory monitoring for myelosuppression or hepatotoxicity. Therefore, as the clinical utility of this test has not yet been established, CareFirst and CareFirst BlueChoice considers the test to be experimental / investigational.

## Posterior tibial nerve (PTN) stimulation for voiding dysfunctions

Electrical stimulation of the sacral nerve plexus has been used in treating non-neurogenic voiding dysfunctions (urge incontinence, stress incontinence, frequency-urgency syndrome, “overactive bladder”) that have not responded to more conservative treatments such as pelvic muscle retraining. The procedure entails surgical implantation of a pulse generator and electrodes. Experimentally, researchers have shown that the sacral nerve plexus can be stimulated by stimulation of the posterior tibial nerve. Treatments are typically 30 minutes weekly, for a course of eight to 12 weeks.

### *CareFirst and CareFirst BlueChoice determination*

Although study groups have been small, there is evidence that PTN stimulation helps control symptoms in terms of incontinent episodes in patients who have not responded to treatment with medication and pelvic muscle exercise. The level of improvement, measured as a percentage of reduction of voiding episodes and pad counts, appears to be close to those achieved by pelvic muscle retraining. PTN stimulation is regarded as an intermediate therapy between pelvic muscle exercise and surgical sacral nerve stimulator implantation. The procedure is well tolerated, even by children, and no untoward effects have been documented. CareFirst and CareFirst BlueChoice considers PTN stimulation medically necessary for non-neurogenic voiding dysfunctions, and experimental / investigational for neurogenic bladder dysfunctions secondary to multiple sclerosis, Parkinson’s disease, traumatic injury or stroke, since evidence for PTN stimulation for neurogenic bladder dysfunctions has not been published in the peer-reviewed literature.

## CareFirst Commitment

**T**hrough its CareFirst Commitment initiative and other public mission activities, CareFirst BlueCross BlueShield (CareFirst) supports efforts to increase the accessibility, affordability and quality of health care throughout its market areas.

CareFirst is helping to bridge the gap in health disparities among minority groups by funding a \$360,000 diabetes care management over three years at *La Clinica del Pueblo*, a free, nonprofit health clinic in Washington, D.C., that serves mostly uninsured and underinsured Latinos.

Diabetes affects almost twice as many Latinos as caucasians. Many Latinos can't afford the care and don't have the knowledge required to manage diabetes. Therefore, they suffer more complications, which leads to lower quality of life for them and higher health care costs for all of us.

With CareFirst's support, the program will use national guidelines to improve the care of persons with diabetes and make better use of doctors' time so that more patients with diabetes can be treated.

### The program has three parts:

**1** CareFirst is funding computer equipment that links the scheduling system to national guidelines for the treatment of diabetes. Doctors and nurse practitioners provide health care services while Patient Care Coordinators offer one-on-one case management and follow-up. The health care teams can track services and evaluate treatment at all times. This means that patients receive more efficient care from the moment they enter the clinic.

**2** A health educator who is sensitive to the Latino culture teaches patients to manage diabetes. This will take place both in individual and group sessions. The health educator also informs patients about community resources and outreach and treatment services.

**3** The home education visit program is an innovative approach using trained peer health educators, or promotores. The promotores visit patients in their homes to teach them to self-manage their diabetes.

CareFirst's support of *La Clinica del Pueblo's* diabetes program will pave the way for better diabetes care that will meet the needs of our Latino members.



# Disease Management

## Recent Literature Related to:

## CareFirst and CareFirst BlueChoice Disease Management Initiatives

By Richard S. Safer, MD, Medical Director, Health Promotion and Disease Prevention



### CareEssentials: Disease Management

As part of the Disease Management component of CareEssentials, CareFirst's and CareFirst BlueChoice's 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.

#### CONGESTIVE HEART FAILURE • *What's Available:*

Vitamin supplementation is a common practice among our patients. Since vitamin E is an antioxidant, theoretically it can serve to prevent oxidation of LDL, a step in the process of atherosclerosis. Some have also touted its potential benefit in preventing cancer. Although there are epidemiologic studies to support the effect of vitamin E in preventing cardiovascular disease and a few observational studies as well, there have been no good randomized controlled trials to state the same. The authors of Effects of Long-term Vitamin E Supplementation on Cardiovascular Events and Cancer studied patients over an average of seven years. "The major finding of the HOPE trial... is the lack of benefit for vitamin E in preventing cancer or major cardiovascular events after a prolonged period of treatment and observation. Furthermore, our study raises concerns about an increased risk of heart failure related to vitamin E." In addition, there was no significant difference between the incidence of cancers between the vitamin E group and a placebo. This study confirms the earlier findings of the Heart Protection Study, which failed to show any benefits of vitamin E after five years, and raises awareness of the potential detrimental affects of vitamin E on heart health. The CareFirst Congestive Heart Failure disease management program includes education about a proper diet.

#### Where to Find It:

*Journal of the American Medical Association 2005; 293(11)1338-1347*

#### CORONARY ARTERY DISEASE • *What's Available:*

It's been more than 15 years since the launch of the landmark Scandinavian Simvastatin Survival Study. Since then, physicians have been on steady ground to employ statins as a means of not only lowering cholesterol levels, but of improving clinical cardiac outcomes. The medical community is still striving to optimize the use of statins. Findings from the study, Intensive Lipid Lowering with Atorvastatin in Patients with Stable Coronary Artery Disease, continue to push the envelop of LDL-lowering goals. Previously, it had been shown that lowering LDL goals below 100 mg/dL was clinically beneficial in patients with acute coronary syndromes. In this study, patients with LDL less than 130 mg/dL and clinically evident CHD were randomized between 10 mg or 80 mg of atorvastatin and followed for almost five years. "As compared with the group given 10 mg of atorvastatin, the group given 80 mg had a 22 percent relative reduction in the primary composite efficacy outcome of death from CHD...Patients given 80 mg of atorvastatin also had significant reductions in the risk of a major coronary event, any coronary event, a cerebrovascular event, hospitalization with a primary diagnosis of congestive heart failure, and any cardiovascular event." Although these results are encouraging because they demonstrate the potential to further reduce our patients' risk of a poor outcome, the medical community's biggest obstacle to maintaining our CHD patients' health may in fact be compliance of the medication, not the dose. As many as 50 percent of our patients stop taking their statin medication within the first year of starting. Our coronary artery disease management program can work with your patients to improve adherence to medication.

#### Where to Find It:

*New England Journal of Medicine 2005; 352:1425-35*

#### LOWER LDL GOALS • *What's Available:*

There is increasing evidence to support lower LDL goals in those patients at highest risk for heart disease. In fact, in 2004, the National Heart, Lung and Blood Institute issued an update to the National Cholesterol Education Program (NCEP). In this update, they recommended that those patients at highest risk for heart disease strive for an LDL level less than 70 mg/dL. You can go to [www.nhlbi.nih.gov](http://www.nhlbi.nih.gov) for more information. C-reactive protein has also become a frequently discussed and studied topic since the release of NCEP III occurred in 2001. The authors of C-Reactive Protein Levels and Outcomes after Statin Therapy were trying to understand whether lowering C-reactive protein in patients with acute coronary syndrome altered the clinical outcome. They found that in this high-risk population, regardless of the resultant LDL level, those patients with the lowest CRP levels had better clinical outcomes than those with higher CRP levels. "Given that the participants had recently had a myocardial infarction or had high-risk unstable angina and thus had a clear indication for long-term statin therapy, we believe our findings should not be generalized beyond situations involving secondary prevention...whether statin therapy should be used for primary prevention among persons with elevated levels of CRP who do not have hyperlipidemia remains highly controversial and is the subject of an ongoing multinational trial." The NCEP has not yet made a recommendation to screen risk of heart disease with CRP levels.

#### Where to Find It:

*New England Journal of Medicine 2005; 352:20-8*

# Disease Management

## CORONARY ARTERY BYPASS GRAFTING VS. STENT IMPLANTATION \* • *What's Available:*

The researchers of Long-Term Outcomes of Coronary-Artery Bypass Grafting versus Stent Implantation observed the outcomes of almost 60,000 patients entered in the New York cardiac registry. They compared three year survival and revascularization rates of patients undergoing the aforementioned revascularization procedures. "After adjustment for severity of illness before revascularization, CABG was associated with a significantly higher likelihood of survival in all anatomical groups..." These anatomical groups were comprised of either two - or three - vessel disease, with or without an ejection fraction less than 40 percent, and considered the subpopulation of diabetics. Furthermore, "The overall rates of revascularization were significantly lower in the CABG group than in the stenting group." The accompanying editorial adds "Multiple trials of coronary revascularization in multivessel disease have suggested that survival is not compromised by an initial strategy of Percutaneous Coronary Intervention, except in patients with diabetes. Therefore, the implications of this study are profound and suggest that things are not as clear-cut as originally thought." Still, the decision of which revascularization procedure to pursue is influenced by "the patient's and physician's appreciation of periprocedural morbidity and mortality, a realistic perception of the effect of procedural outcomes on the quality of life, the effect of coexisting conditions, and the magnitude of the benefit of one procedure over another." The observed data occurred between 1997 and 2000 and, since then, there has been an increased use of drug-eluting stents and off-pump coronary bypass, just two of the several changes in performing these procedures. The question of which revascularization procedure is superior must be continuously reevaluated to keep up with current technology.

## Where to Find It:

*New England Journal of Medicine* 2005; 352:2174-83

## DIABETES • *What's Available:*

Diabetes Prevention Program (DPP) compared behavioral and lifestyle interventions in delaying the onset, or preventing diabetes in nondiabetic adults with impaired glucose tolerance and fasting glucose levels between 95mg/dL and 125 mg/dL. It showed that both lifestyle modification (weight loss and increased physical activity) and use of metformin delayed the onset and reduced the cumulative incidence of type 2 diabetes. In The Cost-Effectiveness of Lifestyle Modification or Metformin in Preventing Type 2 Diabetes in Adults with Impaired Glucose Tolerance, the authors compare the costs, cost-effectiveness and quality-adjusted life-years (QALYs) of these two interventions, versus placebo, over a lifetime. The lifestyle intervention costs approximately \$1,100 per QALY and the metformin intervention costs \$31,300 when compared to placebo. Because of the lower cost and better outcomes, lifestyle intervention is clearly the preferred option. "The lifestyle intervention was cost-effective in all age groups. The metformin intervention did not represent good use of resources for persons older than 65 years of age." The DPP shows us that it is possible to delay the onset of diabetes in some high-risk patients and prevent the disease in others. For those of your patients who do develop diabetes, consider enrolling them in our diabetes disease management program. Our nurses will help your patients adhere to a healthy lifestyle and improve their medication compliance.

## Where to Find It:

*Annals of Internal Medicine* 2005; 142:323-332

## OTHER ITEMS OF INTEREST • *What's Available:*

It's fairly common to have a patient ask you about which type of diet they should start. Although most people in the medical community believe a balanced diet with the appropriate calorie intake balanced by exercise is the most favored approach, many patients want a plan that can ensure quick weight loss. The Comparison of the Atkins, Ornish, Weight Watchers and Zone Diets for Weight Loss and Heart Disease Risk Reduction study set out to determine whether any of these diet plans was superior to the others. The Atkins diet emphasizes restriction of carbohydrate intake without regard to fat, whereas the Ornish diet strives for a vegetarian diet, where only about 10 percent of calories come from fat. The Zone diet aims to reduce glycemic load while balancing macronutrient intake from protein, carbohydrate and fat. Finally, Weight Watchers emphasizes portion size and calorie control. Compliance with the diets was poor across the board. Those who did comply (as self-reported), however, did show a small but significant weight loss, with all programs producing roughly the same results. There was a reduction in LDL cholesterol levels seen, but not in blood pressure or glucose levels. This study assigned individuals to a particular diet, whereas self selection of the diet plan may increase adherence. The authors conclude, "Sustained adherence to a diet rather than diet type was the key predictor of weight loss and cardiac risk factor reduction in our study." CareFirst and CareFirst BlueChoice members are eligible for enrollment in the Weight Watchers program at a reduced cost. Your CareFirst and CareFirst BlueChoice patients can sign up through our web site, [www.carefirst.com](http://www.carefirst.com).

## Where to Find It:

*Journal of the American Medical Association* 2005; 293:43-53

Although uncommon, patients infected by varicella can die. The varicella vaccine was made available in 1995 and since 1999 mortality rates from varicella infection have declined. The greatest decline in mortality occurred in the one to four years of age group. In the Decline in Mortality Due to Varicella after Implementation of Varicella Vaccination in the United States, the authors conclude, "Our analysis clearly documents the dramatic national decline in varicella-related mortality for all ages, race, and ethnic groups after the increased use of vaccine." Please be certain that your patients who are older than one year have received a varicella vaccine. Patients who are not immune and older than 13 years need two doses; at least four weeks apart.

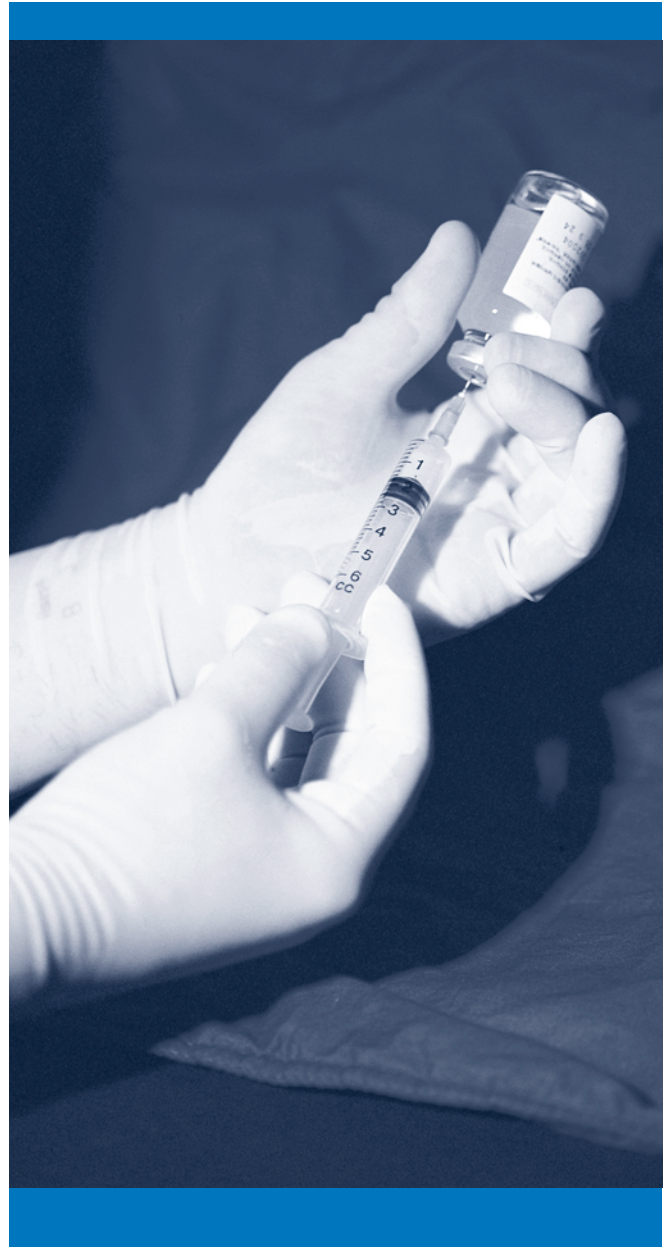
*New England Journal of Medicine* 2005; 352:450-8

## Influenza Vaccine Reminder

**L**ast year's influenza season started off with some concern over a projected short supply and finished with excess vaccine being wasted. This year's supply and distribution will hopefully be smoother. The optimal time for administering the vaccine is in October and November, but patients can still yield some benefit if the vaccine is administered later. Remember, patients allergic to eggs should not be given the vaccine and must resort to prophylactic use of antiviral agents.

The following is a list of those patient populations recommended by the Center for Disease Control to be immunized.

- Patients 65 years of age and older
- Children 6 -23 months of age
- Health workers
- House-hold members of persons at high risk
- Residents of nursing homes and chronic care facilities
- Adults and children with asthma and other chronic pulmonary or cardiovascular disorders
- Adults and children with diabetes, renal dysfunction and other disorders which suppress the immune system (such as HIV)
- Pregnant women in their second or third trimester during influenza season
- Persons age 50-65 because of their increased association with chronic illnesses



For more information on influenza and the vaccine to prevent the illness, visit the Center for Disease Control at [www.cdc.gov](http://www.cdc.gov).



**W**e represent a philosophy of health care that emphasizes active partnerships between patients and their physicians. We believe that comprehensive health care is best provided by networks of health care professionals who are willing to be held accountable for the satisfaction of their patients and the quality of their services. We are committed to high standards of quality and professional ethics and to the principle that patients come first.

We believe that patients should have the right care, at the right time and in the right setting. This includes preventive care, as well as comprehensive care for acute and chronic illness — at home, at the doctor's office and in the hospital.

We believe that all health care professionals should be held accountable for the quality of the services they provide and for the satisfaction of their patients.

We believe that patients should have a choice within their health plans of physicians who meet high standards of professional training and

experience, and that informed choice and the freedom to change physicians are essential to building active partnerships between patients and doctors.

We believe that health care decisions should be the shared responsibility of patients, their families and health care

professionals, and we encourage physicians to share information with patients on their treatment options, medical conditions and health status.

We believe that consumers have a right to information about health plans and how they work. We believe that working with people to keep them healthy is as important as making them well.

We value prevention as a key component of comprehensive care, reducing the risks of illness and helping to treat small problems before they can become more severe.

We believe that access to comprehensive, affordable care gives

consumers the value they expect and contributes to the peace of mind that is essential to good health.

## CareFirst's Mission

The mission of CareFirst BlueCross BlueShield is to provide health benefit services of value to customers across the region comprised of Maryland, Delaware, and the National Capital Area. To fulfill this mission, CareFirst BlueCross BlueShield commits to:

- Offer a broad array of quality, innovative insurance plans and administrative services that are affordable and accessible to our customers
- Fairly address the needs of customers in each jurisdiction in which we operate
- Conduct business responsibly as a non-profit health service plan, to ensure the plan's long-term financial viability and growth
- Collaborate with the community to advance health care effectiveness and quality
- Support public and private efforts to meet needs of persons lacking health insurance
- Foster health systems integration and health care cost containment to benefit the people in areas we serve, and
- Promote respect, fairness and opportunity for our associates.

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



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