yale health care

NEWS FROM THE YALE HEALTH PLAN

VOL. VIII NO. 2 MARCH–APRIL 2005

Much has been written about the fact that Americans are heavier than ever. The causes appear to be many: the incessant marketing of calorically dense and nutritionally poor foods; the increase in portion sizes; the ubiquitousness of fast food eateries; the availability of food—usually junk food—in unlikely retail venues such as gas stations; and a culture where relatively few of us earn our livings doing physical work, where entertainment is often sedentary, and where suburban sprawl means more and more time spent in cars.

In this issue of *yale health care*, we offer some common-sense approaches to the subject of achieving and maintaining a healthy weight. A few main points: (1) while general weight standards exist and are useful, each individual's healthy weight is a product of many factors, including genetics, family and personal health history, and current health indicators; (2) while excess weight can be a health risk factor, being thin does not in and of itself assure good health; (3) working with your clinician is the best way to evaluate your health and improve your well-being.

—Rhea Hirshman, editor *yale health care*

(Particular thanks to YHP nutritionist Linda Bell, MS, RD, CD/N, who researched and put together most of the material for this issue)

Low Fat, Low Carb, Low—?

Linda Bell, MS, RD, CD/N
YHP nutritionist

Nonfat and Loving It
Eat Fat, Be Fat
A Fat-Free Holiday Season

These fictional book titles sum up some of the extreme reactions to the recommendations to lower fat intakes in the 1990s in an effort to curb growing concerns about weight gain. The food pyramid itself relegated fat to the tiny tip of the triangle, placing it in the same category as sweets ("fats, oils, and sweets group"). The result of the low-fat flurry: an explosion in the marketplace of fat free processed foods, such as fat free cakes, muffins, and frozen treats—many of them with little nutritional value and as high in calories (usually because of increased sugar content) as equivalent items containing some fat.

While many people can control their weight by eating a lower fat diet, focusing solely on lowering fat intake did not by any means solve the problem of the American public's expanding waistline.

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Body Mass Index: One Standard for Weight Goals

How can you tell if someone is too heavy for optimal health? This may seem simple enough. Do they look heavy? Do they get out of breath easily? What do they actually weigh? But the question, while simple, does not have a simple answer. Imagine having to develop a standard to indicate who is "too heavy" or "obese," as opposed to those whose weight is "ideal" or "desirable" or even "healthy." The U.S. government has been developing standards to provide a useful weight assessment tool that is also consistent with international consensus.

Some people may remember the Metropolitan Life Insurance Company tables in widespread use before 1980. These were sex-specific weight-for-height tables based on actuarial data, presented as ranges of body weights for each inch of adult height. These "desirable" body weights were associated with minimal mortality among Americans and Canadians at the time they purchased life insurance policies.

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BMI

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The resulting tables were based on statistical findings for a specific group of people (life insurance holders), not on findings related to evaluations of diet, exercise, patterns of weight gain and loss or other health and lifestyle factors.

Since 1980, six editions of the Dietary Guidelines for Americans have been issued jointly by the US Department of Agriculture and the US Department of Health and Human Services. Recommendations concerning healthy weights are reflected by the current body mass index (BMI) categories, found in the sixth edition of the Dietary Guidelines, released in 2005.

Below are steps for evaluating weight (for adults) excerpted from the Dietary Guidelines.

1. Weigh yourself and have your height measured.

   Find your BMI category, either by using a chart or the following formula:

   BMI = [Weight in pounds/(Height in inches)2] x 703

   or

   Metric: BMI = Weight in kilograms/(Height in meters)^2

   Find your BMI category in the chart below

BMI	weight status
below 18.5	underweight
18.5–24.9	healthy range
25.0–29.9	overweight
30.0 and above	obese

2. Measure around your waist, just above your hip bones, while standing. Health risks increase as waist measurement increases, especially if waist is greater than 35 inches for women or 40 inches for men.

3. Use the list below to assess your other risk factors for chronic disease. The more of these risk factors you have, the more you are likely to benefit from weight loss if you are overweight or obese:

   - family history of heart disease
   - male older than 45 or postmenopausal female
   - smoke cigarettes
   - sedentary lifestyle
   - high blood pressure
   - abnormal lipid profile
   - diabetes

BMI is the tool most often recommended to assess weight status in adults and is thought to be a reliable indicator of total body fat. However, the best way to determine if your weight and level of fitness are optimal is to discuss them with your clinician, who will evaluate your BMI, other health indicators and your family history and personal health history.

in touch

IMPORTANT TELEPHONE NUMBERS

Urgent Care	203-432-0123
Open 24 hrs/day, seven days per week	
Toll free out of area	1-877-YHP-CARE
General information	203-432-0246
Pharmacy	203-432-0033
Hours of operation	
Monday, Tuesday, Wednesday, Friday	8:00 AM–6:30 PM
Thursday	8:30 AM–6:30 PM
Saturday	8:30 AM–3:30 PM
Patient Representative	203-432-0109
Medicare/Retiree Coordinator	203-432-8134
Outpatient referrals	203-432-7397
Claims	203-432-0250
Inpatient Care Facility	203-432-0001

For more information

Dietary Guidelines for Americans
6th edition, 2005
www.health.gov/dietaryguidelines/

National Center for Chronic Disease Prevention and Health Promotion
www.cdc.gov/nccdphp/dnpa/bmi/index.htm

American Dietetic Association
www.eatright.org

Note: Body mass index is also used to evaluate weight for children, by comparing the child's BMI to percentiles published by the Centers for Disease Control (CDC).

At the same activity level, men generally have higher caloric needs than women because of men's greater muscle mass. While the average sedentary man requires about 2400–2900 calories to maintain his weight, the average sedentary women requires only around 1600–2200 calories. However, women have the same and often higher needs for vitamins and minerals as men, meaning less room in their caloric "budgets" for the empty calories in items like soda, chips, candy and alcohol.

from the desk of

PAUL GENECIN, MD

DIRECTOR, YALE UNIVERSITY HEALTH SERVICES

Reliance by patients and clinicians on the FDA "seal of approval" has been challenged by numerous recent revelations.

Recent medication recalls—for instance, of the widely prescribed "blockbuster" anti-inflammatory agent, Vioxx—as well as disclosures about the workings of the Food and Drug Administration (FDA), have done little to reassure the public about our federal system of drug approval and monitoring.

Reliance by patients and clinicians on the FDA "seal of approval" has been challenged by numerous recent revelations: that the FDA approval process relies heavily on drug company financing; that FDA scientists feel pressure to approve drugs; that the process for evaluating safety in the post-marketing phase is predicated on voluntary clinician reporting (a rare event) and delegated to the manufacturers themselves; that the financial motivation to market "blockbuster" drugs with unregulated direct-to-consumer advertising creates conflicts of interest for the same companies that must monitor their products; that there are instances where data about unsafe drugs may be suppressed; that in addition to tens of millions of dollars in direct FDA subsidies, the FDA and Congress receive billions in pharmaceutical company lobbying; and that the FDA may be subject to political pressures that influence scientific judgment. In addition, the standard FDA drug approval process relies on preliminary safety and efficacy data compared with placebos, but gives no information about whether a drug offers advantages compared to drugs already approved for the same clinical indication(s).

The issues are complex. The expedited approval process has helped to bring life-saving medications to market—for example, potent anti-HIV and cancer therapies—with minimal delay. However, the inevitable consequence is that these drugs cannot be scrutinized as thoroughly as those subject to the older, more bureaucratic approval system, and the faster a drug is approved, the more likely it is to be recalled. Also, we hear a great deal about drugs that turn out to be unsafe. Examples include: the notorious diet drug combination phen-fen; the lipid-lowering agent Baycol; and now the Cox-2 inhibitors such as Vioxx and Celebrex. We know much less about drugs that are held up in the approval system. In the latter scenario, we risk harming patients who may be denied access to new drugs that could offer life-saving benefits.

While most medicines approved by the FDA are safe and effective, patients and clinicians must not assume that a drug offers a clinical advantage because it is novel or aggressively advertised. In the case of Vioxx and drugs of its class, which can cost dollars per pill, there has never been evidence that these agents offer(ed) clinical advantages over existing medications costing pennies per day.

The drug approval must become independent of pressure and financing from drug companies. Studies of efficacy must be public and independent, with a vigorous system for monitoring before and after approval—and without the current reliance on surveillance by the very manufacturers that may profit by minimizing negative findings. Legislation to address these concerns is likely to be introduced in Congress this year.

What should patients and clinicians do? YHP's Pharmacy and Therapeutics Committee evaluates drug data and makes decisions about our formulary, therapeutic substitutions (recommending existing drugs with a better-established record and which are frequently less costly), and education for clinicians and patients. We do not permit pharmaceutical company "detailers" to market their new drugs to clinicians. We monitor prescribing practices by checking for known drug allergies, alerting patients and clinicians to potential drug interactions, and providing education and monitoring to patients whose conditions require multiple medications.

We must ensure that patients understand potential risks and benefits of medication regimens, that these regimens be as simple as possible and that their effectiveness and safety be carefully monitored. While we should not eschew new medications, we should be wary of "me too" drugs that offer no advantage over existing therapies—and usually cost more. We should avoid using unnecessary medications such as antibiotics for viral infections. We should report adverse reactions and do our part to contribute to the FDA database on drug safety. Talk with your clinician(s) or our pharmacists about any medication questions. Working together, we can keep medication use safe and effective.

National Registry Offers Insights Into Successful Weight Control

Linda Bell, ms, rd, cd/n
yhp nutritionist

Does anyone succeed at long term weight loss, and if so, how? This is the question researchers set out to address when they started the National Weight Control Registry in 1994. The Registry is neither a treatment plan nor a randomized controlled trial; people self-select to participate. It collects and analyzes data from successful weight losers, defined by maintenance of a weight loss of at least 30 pounds (13.6 kg) for at least one year.

There are now 4800 participants enrolled, and the researchers have been studying common characteristics of these "successful losers" in order to identify strategies that can help others and guide the development of more successful weight loss programs.

Most important: the researchers were unable to identify any one diet common to this group. A variety of dietary approaches were reported: restricted intake of certain foods; restricting portion sizes; calorie counting; tracking fat grams or carbohyrate grams; or using exchange systems. Some lost weight on their own, while others used formal programs. Women seemed to prefer formal programs, while men generally preferred to lose weight on their own.

However, the Registry did discover some common strategies used by participants, including:

- The vast majority (89%) used both diet and physical activity to lose weight; only 10% used diet alone, and only 1% used exercise alone.
- Participants tended to eat a low-fat, high carbohydrate diet (from self reported intakes, they consumed 1300-1500 calories per day, of which about 24% came from fat).
- Participants tended to eat breakfast regularly.
- Successful losers monitored their weight regularly—75% weighed themselves at least once a week, and many weighed themselves every day.

- Registry participants reported a high level of physical activity—a caloric expenditure equivalent to about 60 to 90 minutes of moderate intensity physical activity per day. Walking was the most popular form of exercise, with many combining walking with some other form of planned exercise.

From their analysis of the data the researchers offer these comments about our current approach to weight loss:

- We focus too much on diet and not enough on physical activity.
- We focus too much on losing weight and not enough on keeping it off. The "magic bullet" is the hard work of changing your lifestyle to include healthier eating and more exercise.

How can you use these results if you need to lose weight or maintain your current weight?

- Avoid fad diets that you know you can not (and don't want to) maintain for a long period of time.
- Select a dietary approach that seems reasonable for you and incorporates a style and philosophy consistent with your own food preferences.
- Make sure to incorporate a plan for exercise into your efforts, and aim for 60 minutes most days of the week.
- Strive for consistency in behaviors such as eating breakfast and checking your weight, which seem to help keep people on track.
- Don't give up if you don't succeed at first! In fact, 90% of the participants in the Weight Control Registry reported previous attempts at weight loss followed by regain. Few participants successfully lost weight and maintained the weight loss on the first try.

March is National Nutrition Month

National Nutrition Month® is an education and information campaign sponsored annually by the American Dietetic Association (ADA), designed to focus attention on the importance of making informed food choices and developing sound eating and physical activity habits.

This year's theme *Get a Taste for Nutrition,* reinforces the importance of nutrition as a key component of health, along with physical activity:

Be adventurous and expand your horizons. Explore a wide variety of foods based on flavor, textures and colors that are tasty and healthy.

Treat your taste buds. What counts is what you eat over several days, not just at one meal or on one day. So enjoy your favorite foods; eat them in moderation.

Maintain a healthy weight. Managing your weight plays a vital role in achieving and maintaining good health and quality of life.

Balance food choices with your lifestyle. Choosing the right balance of foods helps you get the right combination of nutrients. Balance food choices with your activity level.

Be active. Be creative and enjoy a variety of ways to stay active. Start by making a list of physical activities that fit into your lifestyle and schedule one every day. Some easy examples: Take the stairs instead of the elevator at work. Park your car in a spot that requires you to spend a few minutes walking to your destination. Spend 15 minutes of your lunch hour walking either indoors or outdoors.

For more information: The American Dietetic Association *www.eatright.org*

Low Fat Low Carb

continued from page 1

Now we are more likely to see titles like:

Carb-Free and Loving It
Carbohydrates Were My Downfall
Planning Your Carb-Free Wedding

What is the truth about low fat (or low carbohydrate) diets and weight control?

The short answer is that choosing either a modified lower fat or a modified lower carbohydrate diet can be very effective in long term weight control. However, the extreme low fat or a extreme low carbohydrate diet can be difficult to sustain as a long term strategy, and both extreme eating patterns may be lacking in important nutrients. The key to long term weight control, as we currently understand it, is to balance calorie input with output to maintain weight, or to burn more calories than you take in for weight loss.

What do recent studies have to say? In a study comparing a very low carbohydrate versus a low fat diet, there appeared to be more weight lost at six months on the very low carbohydrate diet than the low fat diet. However, at one year, the total weight loss was the same for both groups.

If you are trying to lose weight, what is the best way to do it? A key component in weight loss is not only finding a dietary approach that results in short term weight loss, but also one that is sustainable over time. The most important changes to make are to exercise regularly (at least 60 minutes most days of the week) and to increase your intake of vegetables. Aim for at least three or more servings of vegetables daily (a serving is half a cup of cooked or one cup of raw vegetables). Minimize your intake of foods with low nutritional value, regardless of marketing claims (such as low carb candy bars that are high in fat, or fat free pound cake which is high in sugar). Scrutinize nutrition labels to avoid falling prey to misleading claims.

Select unprocessed foods whenever possible. Choose 5–8 oz. of lean protein foods daily, two or three portions of fruits, and 1–3 servings of low fat, no sugar added dairy products.

Include at least three servings of whole grains daily and about a tablespoon or two of healthy vegetable oils or about one ounce of nuts.

Want to lean toward a "lower carb" diet? Limit your intake of additional starchy foods (like rice, bread, and pasta) and include an extra serving or two of healthy proteins like fish, poultry or high fat foods (which contain heart healthy fats) like avocado and nuts. Want to stick with the "lower fat" plan? Include 2–4 extra servings of carbohydrate containing foods like fruits and starches instead of extra fats and proteins.

Keeping limits on carbohydrates can help with weight loss, but don't lose sight of the need to control overall caloric intake for effective weight control.

A note about beverages Studies suggest that our bodies do not register liquid calories in the same way as calories from solid food. While there are still some questions about how much of a role sugary drinks have played in the current obesity crisis, indications are that calories from drinks such as soda, sweetened teas, and other sugary beverages overload our bodies' weight control mechanisms. In addition, most of these drinks have virtually no nutritional value. Make water your beverage of choice, or choose seltzer or unadorned coffee or tea. Diet drinks flavored with Nutrasweet™ or Splenda™ are alternatives for those who occasionally prefer a sweeter selection. Check the Nutrition Facts Box for calories (should read zero) to make sure you are not fooled by products such as clear sodas or other misleading options in attractive containers.

Still not convinced? Consider the following:

Comparison of one cup of ice cream products

ice cream product	calories	fat (g)	carb (g)
premium ice cream	480	32	42
ice cream (not premium brand)	280	16	30
low carbohydrate	220	16	18
reduced fat, no sugar added	200	9	30
fat free	200	0	46

As you can see, the no sugar added, low fat, and fat free ice creams have all about the same calories, and all of them are substantially lower in calories than the premium ice cream and offer a reasonable caloric savings from the supermarket-type ice cream. You can decrease the calories by having a half cup, instead of a whole cup of any of these.

Of course, selecting a piece of fresh fruit for dessert (about 80 calories) will provide more fiber and vitamins than any of the selections above, along with a substantial calorie savings!

information

PEDIATRIC PHYSICALS NEEDED FOR SCHOOL, CAMP, DAYCARE

Connecticut schools require a physical exam; most schools will accept a physical exam done any time after January 1 of the year that the child is entering. Daycare and after school programs also require these exams. Many summer camps also require a physical exam within the previous 12 months for a child to enroll, and many sports programs have similar requirements. If you know your child will be attending camp or entering school or day care, please schedule these exams three to four months in advance so we can update all necessary information. Try to avoid the busier months of May, June, August and September. Call the Pediatrics Department at 203-432-0206 for an appointment.

MAKING SPACE, CONTINUED

Renovations continue at 17 Hillhouse Avenue. The latest:

- In March, the Dermatology Department will move to the 3rd floor.
- At around the same time, we will be expanding the Obstetrics & Gynecology clinic space.

BLOOD PRESSURE MONITORING

YUHS conducts monthly blood pressure screenings at various campus locations for YHP members who are not currently being treated for a blood pressure problem. Members who have been diagnosed and are under treatment for hypertension are monitored in the Internal Medicine Department (203-432-0038) by appointment.

2005 U.S. Government Dietary Guidelines

By now you may have heard media reports about the updated Dietary Guidelines, released in January by the Department of Health and Human Services and the Department of Agriculture. This sixth edition of the Dietary Guidelines places more emphasis on reducing calorie consumption and increasing physical activity, stressing the importance of fruits, vegetables and whole grains, which are naturally high in nutrients and low in calories.

You may also have read a variety of commentaries about the latest Dietary Guidelines—including from some of the industries whose food products are being de-emphasized in these latest recommendations. If you would like to formulate your own opinion, they can be viewed at *www.healthierus.gov/dietaryguidelines/index.html*

This web page also provides links to other useful sites, including a site to calculate body mass index and caloric requirements for adults.

You can print out a version of the 70 page document from the web page, or order it by calling the U.S. Government Printing Office toll-free at 866-512-1800. Or you can access the GPO bookstore at *http://bookstore.gpo.gov/* for this and other government publications.

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published by Yale Health Plan

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NEW PA IN INTERNAL MEDICINE

Patricia Loving, MSW, PA-C, joined the YUHS Internal Medicine staff in November 2004. A graduate of Brandeis University where she majored in psychology, Loving received her MSW from the University of Michigan and her physician associate training from the Yale University School of Medicine.

Prior to coming to YUHS, she worked with the inpatient hospitalist service at Yale-New Haven Hospital and has been a primary care clinician at Community Health Care Plan, Hill Health Center and in a private practice in Hamden. In her earlier life Loving was a teacher in a cooperative daycare center, an emergency service medical technician and a psychiatric social worker.

Some Meds, Illnesses Can Cause Weight Gain

Martha Asarisi, RPh
YUHS Pharmacy

For most people at most times in their lives, weight gain and loss is a matter of the balance between energy intake (eating) with energy output (daily activities and exercise). However, under certain conditions this equation can be disturbed and a number of other factors—including food sensitivities, certain medications, thyroid problems and other illnesses—can also cause weight gain.

Food sensitivity reactions can be either very subtle or immediate. (See the January 2005 issue of *yale health care* for an article about food allergies and sensitivities.) Weight gained because of such sensitivities is usually due to fluid retention caused by inflammation; this inflammation can result in bloating and swelling. Also, in sensitive people, the fermentation of certain foods in the intestines can cause gas and an appearance of a swollen belly.

Some prescription drugs can also cause weight gain. Medications like estrogen used in hormone replacement therapy (HRT) and oral contraceptives can cause fluid retention and increased appetite. Other medications that can cause weight gain in some individuals are steroids, nonsteroidal anti-inflammatory drugs or NSAIDS, some antidepressants and diabetic medications.

Hypothyroidism or a deficiency of thyroid hormone can decrease the metabolism of food, causing appetite loss but some weight gain. In this situation, the weight gain is caused by fat and fluid accumulation from protein deposits in the body.

Other medical conditions that can cause weight gain are certain organ diseases of the kidney, heart or liver, all of which can result in fluid retention. This may cause a general puffiness all over the body, especially the ankles and eyes.

In Cushing's Syndrome, a disorder caused by an excess of the hormone cortisol, weight gain is most often visible in the face and upper back. Organ enlargement, such as from an ovarian cyst, can be another medical reason for otherwise unexplained weight gain.

While many of us are concerned about our weights for general health and aesthetic reasons, any sudden weight gain or loss that seems unrelated to eating and exercise patterns should be discussed with your clinician so that possible underlying causes can be determined and addressed.

Note: *While this article focuses on weight gain, other medications and illnesses might cause weight loss. As noted above, consult with your clinician if you experience any unusual changes in weight.*

From the Pharmacy

Drug substitutions

The YUHS Pharmacy may sometimes substitute a different brand or a generic medication equivalent to fill your prescription. The color, shape and/or markings may differ from what you've seen before. Although the appearance may be different, the medication is the clinical equivalent to the drug ordered by your clinician. A substitution may be made because the former medication is no longer available from the manufacturer or the quantity needed to fill your prescription is unavailable. Generic medications may be substituted for these reasons as well, or because the brand name or trade name medication is on back order, or the generic has just been approved by the FDA as equivalent. The YHP Pharmacy substitutes generic equivalent medications as they become available.

If your prescription is filled with an equivalent drug, you will be alerted by a sticker on your prescription package and receipt. The information on such changes is also posted on our website (*www.yale.edu/uhs*). Please contact the Pharmacy staff if you have any questions.

Traveling? Take your meds with you

Are you going away this summer? If you are taking any medications regularly, we strongly recommend that you take with you enough to last for your whole trip. A Pharmacy staff member can help coordinate your medication supply. Please give the Pharmacy at least three business days to complete your order, as we sometimes have to order additional stock to fulfill such requests. Questions? Call the Pharmacy at 203-432-0033.

Where's my clinician's name?

Did you ever wonder why the name of the clinician on the label of your latest prescription refill is different from the name of your primary care clinician who wrote the original prescription?

Here's the reason: This occurs when your request for a refill is either more than a year old or is beyond the number of refills allowed when the prescription was written. In either of these situations, the Pharmacy must contact your clinician to ask permission to continue providing the medication. If your primary care clinician is not available when we make this request (for instance, off that day or on vacation), the permission can be given by another member of the team your clinician works with. This means that you do not have to await your regular clinician's return in order for the matter to be dealt with—one of the many advantages of the team approach. The name of the clinician providing the refill permission will appear on your label.

The Appointed Hour

Alan Greenglass, md
Chief, Internal Medicine

In the past year, Internal Medicine, our largest clinical department, has improved service by adding new staff, a new phone system and early morning and evening appointments. Equally important is our new system for making appointments.

Previously, we often filled all our appointment slots well in advance. This meant a low likelihood (40–50%) of being seen by your own primary care clinician if you needed an immediate appointment. Now we hold open several appointments on each clinician's schedule for same day or next day use—providing a balance among appointments for urgent needs, for previously scheduled appointments, and for physical exams. The result: the likelihood of seeing your own clinician on short notice is now up to 60–70%. Many patients are also happy seeing the primary care team partners if their clinician is not available. If we include those visits, about 70–80% of our adult care is now provided by Internal Medicine clinicians.

Also, we can now book appointments three months in advance, and very often further out (compared to one or two months before). This means being able to set follow-up appointments at the end of the current visit and having more dates available.

The downside to holding open appointment slots is that the wait for routine, non-urgent appointments can sometimes be longer. With your help, we can minimize this problem by reducing "no-shows."

We have always had, compared to community practices, a high percentage of patients who don't keep appointments or who cancel late for routine appointments—an overall rate of about 12%; and about 15% for physicals. This means a big chunk of wasted time on clinician schedules. Since about half of those patients then reschedule, providing care often requires "double time."

The solution is simple: Please let us know as early as possible if you don't plan to keep an appointment. We've made the process easy through our new phone system: dial 203-432-0038 and press 5 to leave a message. Yale Health Online users can e-mail us. You can also let us know if we should contact you for a new appointment.

Remember: If you cancel in advance we will have more slots available for your colleagues, friends and family members—and for you!—and shorter appointment waiting times for all.

...the culmination of four years of intensive planning...

On February 7–9, 2005, Yale University Health Services underwent its first survey by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO.) I am delighted to report that effective February 10th, YUHS will be formally accredited as an ambulatory care facility, skilled nursing care facility and behavioral health facility. This event is the culmination of four years of intensive planning, work process re-design and culture change. Our success...provides affirmation of YUHS's clinical excellence and dedication to performance improvement. It is also a tribute to the exceptional team spirit of our large and diverse staff.

Paul Genecin, md
Director, Yale University Health Services

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Please remember that free parking for YHP members is available both in the lot right next to 17 Hillhouse Avenue and in parking lot 37, just across Trumbull Street.