Idaho Drug Utilization Review Program

DUR BOARD MEETING MINUTES

July 17, 2003 9:00am
Len B Jordan Bldg, Room 302
Boise, Idaho

Board Members Attending: K. Jensen, N. Mann, J. Steiner, R. Ting, M. Olson-Fisher and K. Clifford
DUR Staff: V. Culbertson, R. Force, B. Novak, C. Owens and T. Pettinger
Medicaid Representatives: T. Edie, T. Young, S. Kittridge
Excused: G. Wilburn, D. Smith and P. Cady

	Subject	Discussion	Action/Follow up
1.	**Approval of meeting minutes** - R. Ting	N. Mann moved to approve the minutes of the June meeting. Motion seconded by K. Jensen.	Minutes approved
2.	**Quarterly report** - V. Culbertson	Please see Quarterly Report on staff action since the last meeting.	No action was taken
3.	**First quarter intervention evaluation**	**Asthma module: Beta agonist (short and long-acting) overuse without inhaled corticosteroid** – B. Novak The asthma intervention performed last quarter identified patients receiving excess quantities of short-acting beta agonists or any long-acting beta agonist without a concomitant inhaled anti-inflammatory. A retrospective query evaluated the success of these interventions. Since the conclusion of the intervention in April 2003: • Two out of the 31 patients involved in the physicians' short-acting beta agonist responses have received inhaled corticosteroids. • One out of the 20 patients involved in the pharmacists' short-acting beta agonist responses have received inhaled corticosteroids. • Two out of the 20 patients involved in the physicians' long-acting beta agonist responses have received inhaled corticosteroids. • Two out of the 17 patients involved in the pharmacists' long-acting beta agonist responses have received inhaled corticosteroids.	In the future, this intervention should be conducted in coordination with Disease State Management. Recurrence cases may be candidates for Nurse Case Management. Patients may be targeted in the future with this educational intervention. To make future educational material more effective, information on lawsuits arising from asthma mismanagement should be included. Also, statistics regarding increased incidence of Emergency Room visits in poorly controlled asthmatics should be included.

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		<u>Hormone Replacement Therapy</u> – B. Novak This intervention identified patients on hormone replacement therapy for over 2 years. Of the 182 patients involved in the original intervention, 18 patients have undergone a change in therapy since the completion of the intervention. It is important to note that this issue is probably not addressed more than once a year by a physician, so final results are not truly reflective of the success of this intervention for at least a year post-intervention. **<u>ACE Inhibitor Use in Diabetic Patients</u>** – V. Culbertson ACE inhibitors have well-documented benefits in patients with diabetes. This intervention identified patients with diabetes according to drug therapy. Patients were then classified according to the presence of blood pressure lowering therapy and the antihypertensive used. Those patients who did not receive an ACE inhibitor were identified (n=437). A post-intervention follow-up revealed that currently 247 patients in the above group are still not receiving an ACE inhibitor, demonstrating a positive change in therapy for 190 patients.	In the future, this intervention should be expanded to include all women's health issues. The board found the educational leaflet very useful, this handout should be used again. .
4.	**Intervention responses** -	**<u>Acetaminophen Overdoses</u>** —B. Novak	

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		This intervention identified patients receiving an average of 5 grams or greater of acetaminophen over a 90-day period. Patients with documented liver dysfunction or alcoholism were identified if they exceeded a 2-gram limit. Letters were sent to physicians and pharmacists involved; patient profiles were included in the letter to inform doctors and pharmacists about providers of acetaminophen in addition to themselves. A cost comparison of acetaminophen-containing opioid medications was provided in the education leaflet. **Physician Responses** Physician letters sent: 90 Physicians responding: 70 Patients involved: 129 Patients involved: 77 **Pharmacist Responses** Pharmacy letters sent: 70 Pharmacies responding: 42 Unique pt-MD combos: 162 Patients involved: 70 **<u>Inappropriate Prescribing of Antibiotics for Sinusitis</u>** ---B. Novak This intervention identified physicians who frequently prescribe antibiotics for sinusitis. The database was queried for patients with a prescription for an antibiotic filled within two days of a diagnosis of sinusitis. Doctors were targeted if they were identified as the prescriber of seven or more of these prescriptions within the last year. Letters were sent only to these physicians. The questionnaire assessed the diagnostic criteria used by the prescribing physicians and the amount of patient pressure they experienced regarding these antibiotic prescriptions. **Physician Responses** Physician letters: 76 Physicians responding: 38 **<u>Statin Compliance</u>**—R. Force	Repeat intervention in one year. The board discussed sending a general letter to practitioners reminding them that our interventions do not imply personal wrongdoing but should be regarded as educational in nature and are an attempt to improve overall care of the Medicaid population. In addition, practitioners should be thanked for their responses and encouraged to participate in the questionnaires. Repeat in one year. The board suggests narrowing the

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		This intervention identified patients on statin therapy failing to get a refill for 3 months. Due to the stringent criteria used, identified compliance was actually a higher than expected. **Physician Responses** Physician letters: 160 Physicians responding: 47	query for this intervention in the future. Discussion occurred regarding pharmacist inclusion in this intervention to encourage them to institute a refill reminder service.
5.	**Future interventions**	**<u>Statin Under-utilization</u>** – V. Culbertson At least three major trials demonstrating the survival benefits of statin drug therapy in secondary prevention have been published (4S, CARE, and LIPID). Despite this evidence, many patients go without therapy. It has been shown that less than half of high-risk persons who qualify for lipid-lowering therapy receive it, and only half of patients who do begin therapy and still taking it six months later. This intervention will identify high-risk patients and provide educational materials for both physicians and patients to encourage and promote compliance. **<u>Metformin and thiazolidinedione safety</u>** ---T. Pettinger Despite the proven benefits and overall tolerability and safety of metformin and thiazolidinediones (TZDs) in the management of type 2 diabetes, these medications require vigilant monitoring to maximize benefit, minimize complications, and ensure that these medications remain available in the marketplace. Current evidence suggests that metformin and TZD contraindications have not been routinely followed in medical practice. This intervention will identify patients receiving metformin and/or	The board suggests targeting specialist in primary care, cardiology and neurology. They also thought it may be useful to target teaching facilities and report to the directors the appropriateness of their residents' prescribing habits. Patient educational materials should be offered in the questionnaire. Educational information that should be included in the leaflet include perceived problems with statin therapy that need to be addressed with patients, appropriate monitoring criteria, the difference between rhabdomyolysis and myopathy, and a general chart reviewing pertinent literature. Criteria in this intervention need to be scrutinized more closely potentially addressing recent monitoring of BMP, CMP, and/or LFTs, identification of. CHF by drugs (loop diuretics, digoxin, spironolactone, and/or Coreg), hospitalization for CHF

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		TZD's who have contraindications to their use (based on renal or liver function and CHF). Educational materials regarding proper patient selection and monitoring will be provided.	Items to be included in educational leaflet: Equation to calculate creatinine clearance (and link to MedMath), discussion of age difference of creatinine clearances (use chart already compiled in ACE intervention), recent JAMA article on CHF, percent occurrence of adverse effects and appropriate monitoring criteria. M.D.s should be surveyed regarding their current method of calculating creatinine clearance.
		<u>Ace Inhibitor Dosing in CHF</u>---C. Owens Large clinical trials have demonstrated the benefits of ACE inhibitor therapy in patients with CHF. When prescribing these medications, clinicians often use lower doses in an attempt to minimize complications, however, clinical trials such as the ATLAS study demonstrate that higher doses of ACE inhibitors are more effective in reducing hospitalization rates than lower doses. As a result, dosage increases are now recommended in CHF patients to achieve doses similar to those used in clinical trials. Tolerability, adverse effects, and other patient-specific parameters should also be addressed while making dosage titrations. This intervention will identify patients with CHF currently being treated with an ACE inhibitor who may benefit from a dose increase. Additionally, educational materials will be provided to physicians and pharmacists on the role of ACE inhibitors in CHF and dosing strategies to optimize therapy.	Educational materials to be included: better definition of hypotension to assist in titration of dose, ACE inhibitor cost table (was in last newsletter), rates of decreased mortality associated with ACE and the number needed to treat from the trials, target doses of ARBs. Care should be taken to conduct an up-to-date literature search.

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6.	**Bylaws** - T. Eide	A clear conflict of interest statement will be included. After discussion, it was agreed that attendance must exceed 50% to maintain one's position on the Board.	
7.	**Medicaid Update** - T. Eide	New administrator David Rogers from Florida Medicaid and Pfizer disease state management in Florida. P and T committee now fully functional. All formulary decisions are being based on research conducted by Oregon Health Sciences University Evidence Based Medicine Center. These reports are available at oregonrx.org. A new automated enhanced prior authorization program (Smart P.A.) will be initiated on August 22, 2003. The computer will be able to search claims for approval criteria and will only required paper P.A. for patients not qualifying. The pharmacist will be responsible for contacting the physician, but the pharmacist can call in the criteria if available for immediate approval. Another P.A. will be required for all medications that are not on formulary. In August, the PA program will be started on PPIs and COX-2. The next expected medications are statins and triptans. K. Jensen expressed concern for the increasing pharmacist workload handed down from Medicaid. The prior authorizations for stimulants will be discontinued for children and will be loosened for PPIs. Mark England in the Burrow of Care Management is now responsible for physician and pharmacist lock-ins. Pharmacy Consultation Services is being implemented to provide case management and handle Heritage queries. A hard edit requiring that the pharmacist bill other insurance providers prior to billing Medicaid will be reinstituted August 1, 2003. The prescriber ID entry will become a hard edit in October 2003. A	T. Eide will keep the Board informed of any future changes regarding this information.

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		temporary number will be acceptable to dispense the prescription, but the pharmacist will be responsible for resubmitting with the appropriate prescriber number prior to reimbursement. Medicaid will ask for the Board's assistance in analyzing outcomes and costs associated with the new prior authorization programs and preferred drug lists (pre and post-initiation). The board will provide further detail when available.	
8.	**Meeting Dates**	October 16, 2003 in Boise January 15, 2004 in Pocatello	No action taken.

Adjourned at 12:25 p.m.