

**Ohio Department of Job and Family Services (ODJFS)  
Drug Utilization Review (DUR) Board  
Quarterly Meeting  
May 8, 2012**

The quarterly meeting of the ODJFS DUR Board was called to order at 12:00 PM in Room West B and C, 31st floor of the Riffe Building, 77 S. High St. Columbus, Ohio. David Brookover, RPh presided. The following Board members were present:

David Brookover, RPh, Chair  
Michael Farrell, MD  
Thomas Gretter, MD  
Robert Kubasak, RPh  
Kevin Mitchell, RPh  
J. Layne Moore, MD  
Lenard Presutti, DO  
Donald Sullivan, RPh, PhD

Also present were Margaret Scott, RPh, DUR Administrator; Jill Griffith, RPh, DUR Director; Pam Heaton RPh, PhD, and Bob Cluxton, RPh, PhD from the University of Cincinnati College of Pharmacy; and Mina Chang, PhD, ODJFS Bureau of Health Services Research; Brad DeCamp, MPA, Ohio Department of Alcohol and Drug Addiction Services (ODADAS). Approximately ten observers were present representing pharmaceutical manufacturers.

Reading, Correction & Approval of Previous Minutes:

The February 21st, 2012, DUR Board minutes were approved. (1st T. Gretter, 2nd M. Farrell).

New Business:

Brad DeCamp from ODADAS gave a presentation regarding his department's development of a low-dose protocol for buprenorphine used to treat opiate addiction. ODADAS is concerned with diversion of buprenorphine when patients are prescribed up to 32mg or more per day. The goal of the protocol is to engage medical professionals to standardize buprenorphine medication assisted treatment (MAT) and improve care. Without MAT, the relapse rate is about 80% to 90%. The protocol uses the Clinical Opiate Withdrawal Scale (COWS) and is based on studies demonstrating that opiate receptors are about 92% saturated with buprenorphine at the 12-16 mg level. Induction occurs over a period of two to four days. After induction, the patient continues buprenorphine at 8 to 12mg per day (up to a 16 mg max dose) for 18-24 months while participating in counseling and maintaining abstinence from other opiates as shown by clean urine screens. Medication tapering is considered after 24 months of therapy. ODADAS plans to use this protocol in opiate treatment centers to determine efficacy.

K. Mitchell asked if 18-24 months is the total time. B. DeCamp said that this is the "best case," but therapy may be a lifetime. K. Mitchell also asked about the days supply for prescriptions. B. DeCamp said that ODADAS-certified facilities are allowed to prescribe up to 30 days supply at a time.

Ms. Scott reviewed current ODJFS PA criteria for MAT with buprenorphine:

1. Patient has diagnosis of opioid addiction (NOT approvable for pain)
2. Prescribing physician has a DATA 2000 waiver ID ("X-DEA" number)
3. Patient has been referred counseling for addiction treatment (re-authorizations should indicate how often the patient is receiving counseling)
4. Maximum dose 24mg per day (16mg is target, no patient should receive more than 32mg)
5. Prescriber has reviewed Ohio Automated Rx Reporting System (OARRS) for opioid prescription use
6. Periodic drug screens are addressed in treatment plan (will be performed by prescriber or by counseling team)
7. For reauthorizations – the dose has been reduced in the previous 6 months, or the patient has been evaluated for a dose reduction and the prescriber and patient agree that a dose reduction would not be beneficial/may be harmful

The DUR Board agrees with a buprenorphine prior authorization for doses above 16 mg daily.

Mina Chang, PhD, gave a presentation about Ohio Medicaid work on reducing non-emergency care in the emergency department. See attached slides.

#### Health Plan Policy:

M. Scott gave the Health Plan Policy report. Beginning January 1<sup>st</sup>, 2013, five managed care plans (two existing, three new) will manage Ohio Medicaid patients. Some of the health plans that were not selected have filed appeals. 37,000 children are moving out to managed care.

The state is working on an integrated managed care delivery system for 188,000 Medicare/Medicaid dually eligible consumers. A demonstration project with CMS is under way.

The new Medicaid Information Technology System (MITS) went live on August 2, 2011. Since then, ODJFS has been unable to share data with the University of Cincinnati, so DUR reviews cannot be completed.

#### DUR Committee Report:

J. Griffith gave the DUR Committee report. The March DUR Committee was a planning meeting to prioritize interventions upon resolution of our data challenges. There were no committee meetings in April or May.

#### Unfinished Business:

DUR Board members R. Kubasak and M. Farrell, who were not present at the February meeting, signed the Conflict of Interest statement for 2012.

P. Heaton presented a descriptive report about pharmacy utilization patterns for patients in the Ohio Medicaid waiver programs. See attached slides.

D. Sullivan noted that benzodiazepines are appropriate therapy in the elderly, and are preferable to diphenhydramine.

P. Heaton compared two methods of using pharmacy claims data to evaluate medication adherence, proportion of days covered (PDC) and medication possession ratio (MPR). See attached slides.

J. Griffith announced that the DUR annual report for FFY 2011 is nearly completed.

J. Griffith announced that the 2012 DUR review calendar is on hold pending resolution of data challenges and the successful completion of the MITS RETRODUR system testing. A possible educational mailer to the top prescribers of antibiotics in the state with a cough and cold drug list and educational piece about the updated sinusitis guidelines is planned. M. Farrell noted the contraindication of these products for children under age 6 and the potential for acetaminophen overdose. D. Sullivan suggested education should be sent to pharmacists on billing of cough and cold products.

Announcements:

The third and fourth quarter DUR Board meetings are scheduled for noon on Tuesday, September 11th and Tuesday, November 13<sup>th</sup>, location to be announced.

Adjournment:

David Brookover, RPh adjourned the meeting at 1:26 PM.

Respectfully submitted:

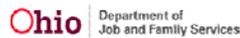
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Jill RK Griffith BS, PharmD, DUR Program Director



## Addressing Avoidable Medicaid ER Overuse Through Rapid Cycle Quality Interventions

Mina Chang, Ph.D., Chief  
 Health Services Research and Program Development Section  
 Bureau of Health Services Research  
 Ohio Department of Job & Family Services



## IHI Framework With Timelines

Setting Aims (Goals)	Establishing Measures	Selecting Changes (Interventions)	Testing Changes	Implementing Changes
<p>What are we trying to accomplish?</p> <p>Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.</p>	<p>How will we know that a change is an improvement?</p> <p>Teams use quantitative measures to determine if a specific change actually leads to an improvement.</p>	<p>What changes can we make that will result in improvement?</p> <p>All improvement requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.</p>	<p>The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.</p>	<p>After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale—for example, for an entire pilot population or on an entire unit.</p>

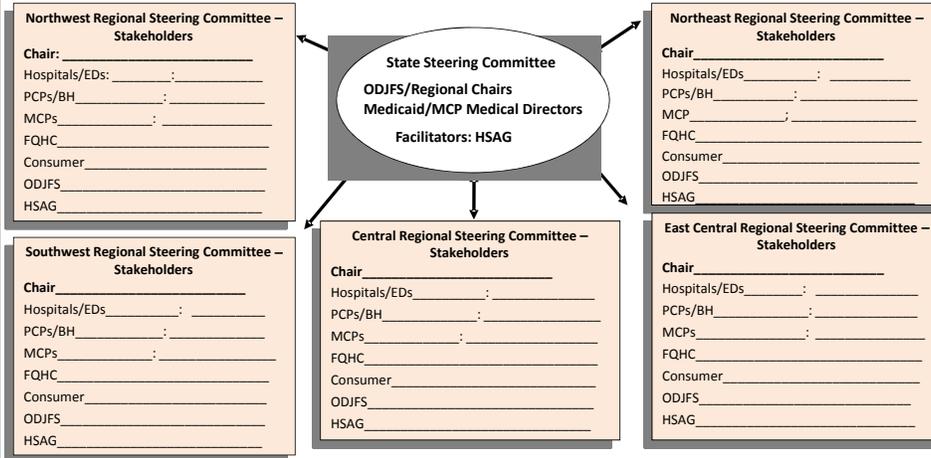


### Spreading Changes—Future Step

After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other organizations.

IHI: Institute for Healthcare Improvement

# Collaborative Leadership & Structure



MCP: Managed Care Plan

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# Patient Populations Ohio Regions

Patient Populations	Region(s)
<ul style="list-style-type: none"> <li>Integrated Care Team – Ultra Utilizers - Adults                             <ul style="list-style-type: none"> <li>✓ Severe Mental Illness</li> <li>✓ Non-Mental Health Conditions</li> <li>✓ Chronic Back Pain</li> </ul> </li> </ul>	East Central Northeast Northwest
<ul style="list-style-type: none"> <li>Dental Conditions – Adults</li> </ul>	Southwest
<ul style="list-style-type: none"> <li>Upper Respiratory Infection (URI)                             <ul style="list-style-type: none"> <li>✓ Children</li> <li>✓ Adults</li> </ul> </li> </ul>	Statewide Central

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## Ultra Utilizers Deciding Factors to Seek ED Care

### Severe Mental Illness

- Patients first experienced symptoms within 48 hours before seeking ED care
- Patients were sent to ED by community mental health center (CMHC), PCP or family due to “crisis”
- An immediate appointment with patient's psychiatrist was unavailable while the patient was experiencing psychiatric symptoms

### Non-Mental Health Conditions

- Pain
- Patients perceived lack of PCP
- Patients did not want to wait for PCP appointment
- Some experienced symptoms longer than 1 month prior seeking ED care

### Chronic Back Pain

- Unbearable pain
- Patients perceived that PCP or urgent care would be unavailable or unable to help
- Long term back problems, some already being seen at pain clinic
- Convenience of ED; Unwilling or unable to wait for a PCP appointment

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## Integrated Care Team Test Intervention

### Test Intervention

- With medical/clinical leadership oversight, interdisciplinary teams (managed care and community provider care/case managers) develop care treatment plans to establish a coordinated care approach.
  - The teams continually outreach sample members, address their social and medical needs, and coordinate care to reduce avoidable ED visits
- A current patient treatment plan summary is accessible by the EDs
- Samples are flagged at participating EDs or identified by ED census
- If a member in the sample accesses the ED, the attending ED physician will:
  - Reference the care plan summary, and
  - Notify the interdisciplinary team contact person that a sample member has accessed the ED

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## Integrated Care Team Key Findings

- ✓ Improved care coordination for patients
- ✓ Increased success of patient adherence with care plan and medications
- ✓ Early intervention when patient experienced problems
- ✓ Improved health outcomes
- ✓ Reduction in ER and inpatient admissions for 77% of the members in the sample.
- ✓ Improved patient awareness of available services and ability to access and use needed services
- ✓ Reduction in “no-show” visits
- ✓ Improved patient and provider satisfaction

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## Dental Deciding Factors to Seek Care at ED

- Tooth pain
- Patients experienced symptoms more than a week before seeking ED care and had dental problems for a long time
- Patient perceived getting a dentist appointment was inconvenient, or did not have dentist
- Convenience of ED
- Perceived a need for antibiotics
- Not aware of dental benefits



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## Fast Track Dental Appointments

### Business Hours

- Medicaid managed care members presenting with dental conditions are identified at the ED
- EDs call participating dental providers and secure a fast-tracked dental appointment for the patient
- EDs forward the identifying information of sample patients to the appropriate MCP
- MCPs follow-up with the member

### After-Hours

- ED staff distribute a card listing the MCP contact information and instruct the patient to call the MCP during business hours for a fast-tracked dental appointment

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## Fast Track Dental Appointments

### DENTAL PROVIDERS



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## Fast Track Dental Appointments Key Findings

- ✓ Patient's dental needs met in a timely fashion and may prevent future ED visits related to dental problems.
- ✓ Intervention provided a useful resource for EDs to make fast-tracked dental appointments for Medicaid members who accessed the ED for dental conditions.
- ✓ Real-time appointment scheduling was successful.
- ✓ High level of satisfaction from patients and ED Drs.
- ✓ Despite the low volume of sample patients, intervention created a shift of consciousness in the community.

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## URI Deciding Factors to Seek Care at ED

- Child experienced symptoms for a week or longer prior to seeking ED care
- Parents worried about child's symptoms (high fever, cough, breathing)
- No improvement after over the counter medicine or PCP visit
- Parents did not want to wait for an appointment
- Parents preferred ED care over PCP or urgent care



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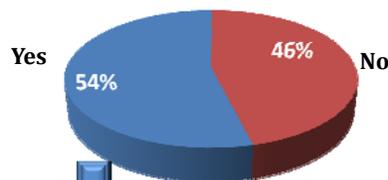
## URI Children Test Intervention Ohio Statewide

1. Sample members receive a kit for colds which promotes the managed care plans' (MCP) 24-Hour Nurse Advice Line with a "call early, call often theme".
  - ✓ Most sample patients receive the kits through the mail with a letter from their primary care physician (PCP) or their health plan's medical director. In the real-time test interventions, kits are distributed at the ED.
2. MCP 24-Hour Nurse Advice Lines triage sample members and bridge services the MCP has to offer with follow-up PCP care.
3. PCP office provides next day/same day appointment scheduling for sample members.
4. An MCP Health Coach to assess the effectiveness of tool kit, awareness of 24/7 nurse line, and conduct any follow up care members may need

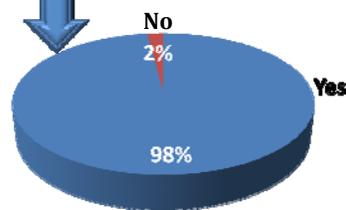
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## URI Children Test Intervention Statewide Data – Member Follow-Up

**Respondents' Use of the  
Nurse Advice Line**



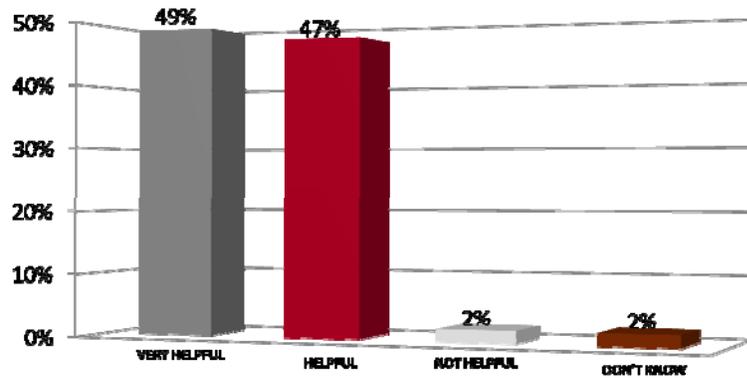
**Likelihood Respondents'  
Will Call the Nurse Advice  
Line Again**



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## URI Children Test Intervention Statewide Data – Member Follow-Up

### Respondents' Assessment of the Helpfulness of the 24-Hour Nurse Advice Line



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## Spread Team – Next Steps

### Scalability/ Sustainability

- ✓ Does the intervention process need to be modified in your organization?
- ✓ Should the criteria for the targeted patient group stay the same?
- ✓ What is a reasonable number of target patients that can benefit from the intervention?
- ✓ What additional staff can be involved?

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# Descriptive Report for Patients in Waiver Programs in the Ohio Medicaid Program



## Objectives

- To describe patients who received different Medicaid Waiver Programs;
- To describe patients' clinical characteristics, such as mental health conditions;
- To describe patients' pharmacy utilization patterns, especially focusing on drug classes such as typical and atypical antipsychotics.



## Waiver Programs

- Ohio Home Care – 12%
- Transitions MRDD – 3.4%
- Transitions Aging Carve Out – 2.5%
- Level One – 12%
- Individual Options 19.4%
- Assisted Living – 4.5%
- Choices – 1%
- PASSPORT – 45.2%



## Highlights

- Number of patients enrolled in at least one of the waiver programs- 87,279
- Patients with schizophrenia or bipolar disorder - 12,983
- Patients with other mental health disorders excluding schizophrenia or bipolar disorder - 23,741
- Patients with dementia only - 5,475
- Patients with autism only - 2,953



## Highlights

- Patient population
  - Average age was 58 years
  - Female (62%)
  - White (76%)
  - Received aid for disabled (57%)
- Mental health diagnoses included
  - Neurotic disorder (n=13,657)
  - Depressive disorder (n=13,141)
  - Bipolar disorder (n=10,665) and
  - Dementia (n=6,462)

## Highlights

- Greatest amount of drug spending (\$) was for:
  - Atypical antipsychotics, dopamine & serotonin - \$15.8 million
  - D2 partial agonist - \$7.5 million
- Most frequently prescribed prescriptions were anti-anxiety drugs

## Highlights

- Major expenditures were for:
  - Medical services - \$2.3 billion
  - Outpatient visits - \$192 million
  - Hospitalizations - \$148 million and
  - Prescription drugs - \$138 million

## PASSPORT Patients with No Mental Illness

- 373 patients received 2184 prescriptions for sedative hypnotics
- 2620 patients received 14,004 prescriptions for antianxiety drugs
- 18 patients received 70 prescriptions for typical antipsychotics
- 53 patients received 354 prescriptions for atypical antipsychotics

## Patients with No Mental Illness Receiving Antianxiety RXs

- Ohio Home Care – 849 patients/5745 RXs
- Transitions MRDD – 175 patients/1103 RXs
- Transitions Aging Carve Out – 152 patients/928 RXs
- Level One – 244 patients/950 RXs
- Individual Option – 621 patients/3,169 RXs
- Assisted Living – 287 patients/2278 RXs
- Choices – 53 patients/417 RXs
- PASSPORT – 2,620 patients/14,004 RXs

# Proportion of Days Covered and Medication Possession Ratio

Pam Heaton, Ph.D.

Pharmacy Practice and Administrative  
Sciences

Winkle College of Pharmacy



## Background

- Adherence definition:  
*“the extent to which patients take medications as prescribed by their healthcare providers”*
- Tremendous problem in United States
  - Annual cost of patients not taking their medications as prescribed is \$290 billion
  - Approximately 125,000 Americans die annually (342 people every day) due to poor medication adherence
  - 10 to 25 percent of hospital and nursing home admissions are caused by the inability of patients to take their medications as prescribed and directed



## Measuring Adherence

- Pharmacy Quality Alliance (PQA) has developed, tested and endorsed numerous measures of medication-use quality
- Claims-based methods for measuring adherence:
  - Medication Possession Ratio (most commonly used)
  - Proportion of Days Covered (newer method)

## Medication Possession Ratio (MPR)

- In general, the summation of the “days’ supply” of medication refills across an interval
- Numerator: sum the days supply for the fills of medication
- Denominator: the time between the first fill and last fill of a medication
- If receive extra prescription, overestimates adherence

## Proportion of Days Covered (PDC)

- PDC calculation based on fill dates and days supply for each fill of a prescription
- Denominator: Number of days between the first fill of the medication during the measurement period and the end of the measurement period
  - E.g. calendar year 365 days is measurement period, patient's first fill of the medication is on day 10 of the year, then the denominator period is 355 days ( $365 - 10 = 355$ )
- Numerator: The number of days covered by the prescription fills during the denominator period, corrects for extra fills

## Comparison

- PDC will provide a more conservative estimate of adherence because it accounts for prescriptions which overlap.
- We examined patients receiving Atripla for HIV. Adherence measured with PDC was lower than with MPR.

## Example 1

### Fill History

- 1/1/11: 30 DS
- 2/3/11: 30 DS
- 2/28/11: 30 DS
- 4/1/11: 30 DS

### • Medication Possession Ratio

- Measured 1/1/11 – 4/30/11
- 120 days supply/120 days
- MPR = 1

### • Proportion of Days Covered

- Measured 1/1/11 – 6/30/11
- 120 days supply/180 days
- PDC = 0.67



## Example 2

### Fill History

- 1/1/11: 30 DS
- 2/3/11: 30 DS
- 2/28/11: 30 DS
- 5/30/11: 30 DS

### • Medication Possession Ratio

- Measured 1/1/11 – 6/29/11
- 120 days supply/179 days
- MPR = .67

### • Proportion of Days Covered

- Measured 1/1/11 – 6/30/11
- 120 days supply/180 days
- PDC = 0.67

