| Suggestion | Expansion | Limitations | Previous or ongoing related interventions | Moving the dial? |
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| Asthma and Inhaled Steroids | The latest guideline expanded the potential role of inhaled steroids as opposed to the combination products like Advair. A sample for an intervention could be drawn from folks with multiple steroid bursts, frequent albuterol (getting more expensive) users, etc. | Not able to get diagnostic info for COPD etc from SeniorCare and Managed Care patients. | Previously conducted intervention for patienst using too many inhaled beta agoinsts or having ER/hospitalization for asthma without preventive medications | Can we get precribers to utilizes Advair/Symbicort correctly through a " light touch" intervention? |
| Singulair with no asthma diagnosis | Large utilization of Singulair for allergic rhinitis even when the literature says it's no better than loratadine, etc. | Same isssues with diagnosis | Based on concerns by the PDL committee, we had previously looked at trying to detremine how mnay patients were using Singulair as a first line drug for allergic rhinitis without having failed other therapy. | About 13% of the leukotriene RXs were suspected of being first line agents. Conversion of these scripts to some other therapy would be estimated to save roughly $100,000 annually. |
| Rosiglitazone | Potentially contact prescribers of rosiglitazone who have prescribed it in patients with cardiac risk factors. | Diagnosis issues. Could use drugs as proxy for cardiac disease. Newer data makes first findings not as definitive | Reviewed policy for state. Analyzed original article. | Utilization of Rosi has fallen since the issue has been raised. |
| Diabetics with No Metformin | New international guidelines say that everyone should be started on metformin at diagnosis. Perhaps we could look at newly diagnosed people or all diabetics. It's a cost effective med that may limit the need of other, more expensive products. | Diagnosis issues. Could use drugs as proxy for diabetes. | No previous intervention. | Don't know |
| Erythropoesis Stimulating Agents | What is the coverage criteria for ESA'swith respect to the new dosing recommendations/warnings? | Access to lab values would be useful. | No previous intervention. | Should we identify target prescribers to send information? Should we develop PA guidelines that require the reporting of hemoglobin values? |
| Femara (letrozole) for induction of ovulation | The Rx's can easily be found by looking at quantities and days supplies that don't equal; the typical cancer prevention dose is once daily. To stimulate ovulation, it's usually 2.5mg to 5mg daily for 5 days; basically look for tablet multiples of 5 that aren't 30. | By policy, Medicaid does not pay for infertility. | No previous intervention. | Policy/fraud issue? |
| Overuse of sedative/hypnotics | Higher dose sedative hypnotics, e.g., zolpidem 20mg and ramelteon 16mg | Not many | We do have selected retrospective interventions for high dose, specifically for elderly? | How prevalent is it? A previous analysis indiacted most people taking sleepers take them nightly for extended periods of time. |
| Medication adherence on atypicals | Studies show that even a 10 day variance in refills can have a negative impact on hospitalizations. | Few | Prospective DUR has an alert that sets for late refill for atypical antipstchotics. Allan has designed a tool which can look at this in conjunction with other services. | Detection of problem is after the fact. Can we move the dial? |
| Drug review post-MI and post-stent placement | Beta-blockers, antiplatelet drugs, ACE's and statins. Also use of beta-blockers for patients with CHF. | Need good mechanism to get data on MI or stent placement in a timely fashion. Data not avaialble for SeniorCare or HMO. | Previously did a small intervention for CHF. Sample size was ultimately very small | Can we intervene in a timely fashion? |
| Use of prophylaxis therapy for migraine | Could use frequent ER visit as a marker. | Diagnosis issues | Currently have an active retrospective DUR alert for this. | Should evaluate current criteria results for effectiveness. |
| Adherence to HIV meds | Data shows adherence rates of less than 90 or 95% leads to resistance with the HIV antivirals | Detection may be done after the fact | Have not done | What is our non-compliance rate? Is it too late once we detect it? Should this be a targeted intervention? |
| Use of insulin without claims for glucometer test strips | Are these patients testing their blood glucose on a regular basis? | Test strips may be paid by Medicare or MCO | | |
| Use of meds without appropriate labs (see NCQA HEDIS measure) | Examples - ACE-I without Cr and Potassium, digoxin without digoxin level | Lab tests paid by another vendor | Currently evaluating our data | Once we detect a problem with the HEDIS measure, we would need to design an intervention. |
| Edits for allowing more 100 days supply dispening | | Determination of the list has been done. EDS needs to design system to allow. | Ready to go as soon as EDS is ready. | Current low compliance by pharmacies. We believe we can move the dial somewhat. Reimbursement for this service cannot exceed savings realized through implementation |
| Appropriate use of antibiotics | HEDIS measures "appropriate treatment for children with URI" and "avoidance of antibiotic treatment in adults with acute bronchitis". | This needs to occur "in the office." | Have not done | Not sure how to move the dial? Target high utilizers for educational intervention? |