Mountain-Pacific Quality Health

DUR PROGRAM NEWS

SUMMER 2021

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The Drug Utilization Review (DUR) Program, administered by Mountain-Pacific through a contract with the Allied Health Services Bureau of the Montana Department of Public Health and Human Services, is the quality assurance body seeking to assure the quality of pharmaceutical care and to help provide rational, cost-effective medication therapy for Montana Healthcare Programs members.

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A Prospective Assessment of the Medicaid Web Portal for Admission Medication Reconciliation at a Community Hospital in Montana[1]

Drug Use Review (DUR) Board pharmacist member Ian McGrane, PharmD, and his colleagues Lauren Parks, PharmD, and Jayme Hartzell, PharmD, recently completed and published a study utilizing the Medicaid Web Portal for their medication reconciliation procedures for patients identified having Montana Medicaid. Their study has been published in the American Journal of Health-System Pharmacy.

During the study, non-obstetric admissions were reviewed for the previous 24 hours to identify current Medicaid members. Over 25 days, 100 members were identified, and the Montana Medicaid Web portal was utilized after the facility's standard medication reconciliation (MR) procedure had been completed, unless extenuating circumstances prevailed. The standard MR included review of the patient's medical record, electronic pharmaceutical claims data (EPCD), the Montana Prescription Drug Registry and an interview from the patient and/or family. If differences were identified between data from the standard MR method and the additional search of the Medicaid portal, they were corrected in real time to improve patient care.

The study identified 46 discrepancies within the medication lists reconciled after use of the Medicaid portal, including one in four total patients having inconsistencies. Of those identified, 46 percent of the discrepancies were due to a drug omission, 33 percent had a wrong dose listed, 17 percent listed the wrong formulation, and four percent had the wrong frequency. There were also six variances for high-risk medications, including anticoagulants, antidiabetics and opioids. Thirty-six percent of the medication lists were inaccurate in the commercially contracted EPCD information and showed the Montana Medicaid Portal was more accurate.

Further, many of the patients within the study were admitted to the neurobehavioral/psychiatric and intensive care units (34% and 19%). Incorrect medication reconciliation for these populations can complicate effective treatment, as these patients often do not have the ability to give an accurate medication history. When examining the additional time demands for this additional task, the study estimated 10 to 30 minutes were needed to identify and correct the variances, but also noted it would be possible to reduce this time if using the web portal during the standard MR procedures. Finally, the study noted the limited ability in some states for health care providers to access a state Medicaid web portal.

There are plans for a larger study using a similar protocol.

[1]Lauren K Parks, PharmD, Ian R McGrane, PharmD, BCPS, BCPP, Jayme L Hartzell, PharmD, MS, BCPS, A prospective assessment of the Medicaid Web portal for admission medication reconciliation at a community hospital in Montana, American Journal of Health-System Pharmacy, 2021;, zxab108, https://doi.org/10.1093/ajhp/zxab108.

Montana Healthcare Pharmacy Programs Link
(Current Montana Healthcare Programs Preferred Drug List, Provider Notices, DUR Board/Meeting Information, Resources)
http://medicaidprovider.mt.gov/19

2021 Update to 2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment[2]

The American College of Cardiology (ACC) released the 2021 update to the 2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment. The purpose of this update was to address new therapies and developments that have emerged since the publication of the 2017 guidelines and to continue to provide practical guidance for managing patients with chronic heart failure with reduced ejection fraction HFrEF (LVEF ≤40%).

Guideline-Directed Medical Therapy (GDMT) for HFrEF Stage C Treatment Summary:

- **Beta-blocker*:** Initiate an evidenced-based beta-blocker (bisoprolol, carvedilol, metoprolol succinate). Consider increasing dose every two weeks until maximum tolerated or target dose achieved.
- **Renin-angiotensin antagonist (Angiotensin receptor-neprilysin inhibitor [ARNI]/Angiotensin-converting enzyme inhibitor [ACEI]/Angiotensin receptor blocker [ARB])*:** ARNIs are the preferred agent. If previously on ACEI, discontinue for 36 hours prior to initiation of ARNI. For patients in whom ARNI administration not possible, initiate ACEI or ARB.
  - ARNI: Increase dose to target of 97/103mg twice daily if possible/indicated.
  - ACEI or ARB: Consider increasing dose every two weeks until maximum tolerated or target dose achieved.
- **Diuretics*:** (New York Heart Association [NYHA] class II-IV) Initate loop diuretic as needed for patients with persistent volume overload. Titrate dose over days to weeks to achieve relief of congestion.
- **Aldosterone antagonist*:** (NYHA class II-IV) Aldosterone antagonist, unless contraindicated, is added as part of therapy for patients with symptomatic chronic HFrEF already receiving a beta-blocker and ARNI/ACEI/ARB. (For patients with eGFR ≥30 ml/min/1.73m2 or creatinine ≤ 2.5mg/dL in males or ≤ 2.0 mg/dL in females & K+ ≤ 5 mEq/L)
- **Sodium-glucose cotransporter-2 (SGLT2) inhibitor*:** (NYHA class II-IV) New clinical trial data supports the use of SGLT2 Inhibitors to reduce risk of cardiovascular death and hospitalization in HFrEF patients with or without diabetes. SGLT2 inhibitors, unless contraindicated, may be added as part of therapy for patients who meet eGFR criteria and are receiving a beta-blocker, ARNI/ACEI/ARB and aldosterone antagonist.

Guideline-Directed Medical Therapy (GDMT) For Specific Cohorts:

- **Hydralazine + Isosorbide Dinitrate*(individual or fixed-dose combination):** (NYHA class III-IV) For Black patients who are persistently symptomatic despite guideline-directed medical therapy (GDMT) (Beta-blocker/ARNI/aldosterone antagonist/SGLT2 inhibitor). Consider titrating every two weeks until maximum tolerated or target dose achieved.
- **Ivabradine**:** (NYHA class II-III) Can be added to lower heart rate. Ivabradine is indicated in patients with EF≤35, in sinus rhythm whose resting heart rate remains ≥ 70 beats per minute and is on maximally tolerated beta-blocker or target dose.

[2]Maddox TM, Januzzi JL Jr., Allen LA, Breathett K, Butler J, Davis LL, Fonarow GC, Ibrahim NE, Lindenfeld J, Masoudi FA, Motiwala SR, Oliveros E, Patterson JH, Walsh MN, Wasserman A, Yancy CW, Youmans QR. 2021 update to the 2017 ACC expert consensus decision pathway for optimization of heart failure treatment: answers to 10 pivotal issues about heart failure with reduced ejection fraction: a report of the American College of Cardiology Solution Set Oversight Committee. J Am Coll Cardiol 2021;77:772–810.

*(Level of evidence Class I)
**(Level of evidence Class II)

Important Dates:

Wednesday, September 22 Drug Use Review Board (DURB) Meeting

DURB meeting agendas and minutes can be found at https://medicaidprovider.mt.gov/19dur.

The DURB met in March, April and May to discuss the preferred drug list. Find the list at https://medicaidprovider.mt.gov/19.

Prior authorization criteria for outpatient medications: https://www.mpqhf.org/corporate/montanans-with-medicaid/pharmacy/

Prior authorization criteria for physician-administered drug (PAD: https://medicaidprovider.mt.gov/priorauthorization

Opioid Prescribing Practices in Montana, 2014 - 2019

The Montana Department of Public Health and Human Services (DPHHS) recently published a report outlining the changes of opioid prescribing utilizing information from the Montana Prescription Drug Registry (MPDR). A copy of this report and be found at https://dphhs.mt.gov/assets/publichealth/EMSTS/opioids/PDMPBurdenreport2014to2019.pdf.

The results of the data analysis showed an overall decline in the number of opioid prescriptions (excluding buprenorphine) as well as a decrease in the daily morphine milliequivalent (MME) for all populations regardless of age or gender. Outside of a slight increase in 2017, overall opioid prescriptions decreased 20.9 percent from 2014 to 2019. Montanans age 18 to 44 saw the largest decrease in prescription rates with a 26.8 percent reduction during the studied years. Additionally, female patients showed an 11.7 percent decline in prescription rate compared to three percent for males.

Hydrocodone remains the most prescribed opioid, but decreased from 54 percent of the prescribed opioids in 2014 to 41 percent in 2019. Oxycodone prescribing remained consistent throughout the study period, as did morphine. However, tramadol prescribing rates increased from five percent in 2014 to 18 percent in 2019.

	Year					
Rank	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)	2019 (%)
1	Hydrocodone (54)	Hydrocodone (46)	Hydrocodone (50)	Hydrocodone (43)	Hydrocodone (43)	Hydrocodone (41)
2	Oxycodone (23)	Oxycodone (24)	Oxycodone (26)	Oxycodone (24)	Oxycodone (24)	Oxycodone (24)
3	Morphine (6)	Tramadol (11)	Morphine (7)	Tramadol (15)	Tramadol (16)	Tramadol (18)
4	Tramadol (5)	Morphine (7)	Tramadol (4)	Morphine (6)	Morphine (6)	Morphine (6)

*Buprenorphine excluded

Figure to left: Most frequently prescribed opioids by proportion of all opioids* prescribed per year *Montana Prescription Drug Registry 2014 - 2019*

Daily MME also deceased during the five-year period, with an overall decrease from 58.3 MME to 41.7 MME. Males continue to have a higher daily MME, but both genders saw significant declines with a 32 percent decrease for males and a 27 percent decrease for females. Patients on high daily MME (90+) decreased by 56.7 percent, and patients on very high MME (180+) decreased 78.5 percent.

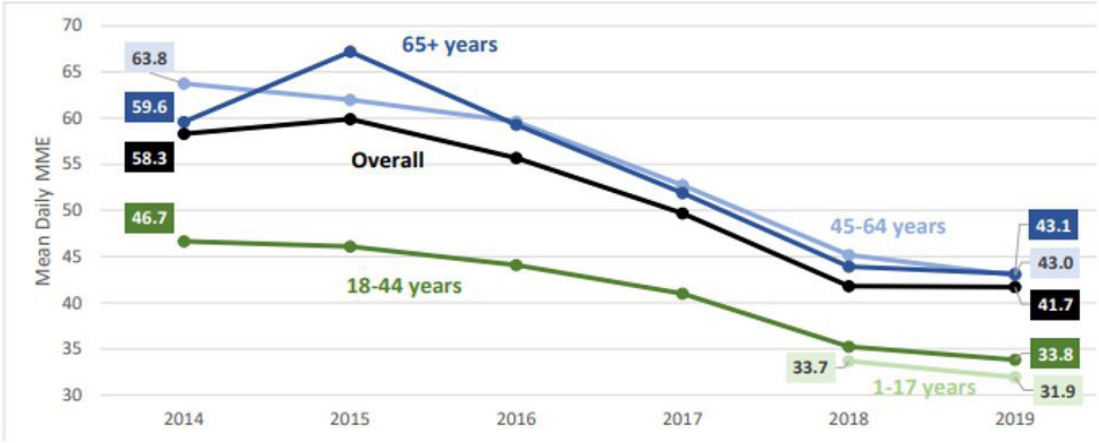

Figure to left: Mean daily MME by age *Montana Prescription Drug Registry 2014 - 2019*

The report also referenced the Montana Board of Pharmacy's new software and its combination with RxCheck that will assist with integration into electronic health records. Finally, the report references Montana's Substance Use Disorder Task Force Strategic Plan located at https://dphhs.mt.gov/assets/SUDStrategicPlan1.pdf.