Call to order
The meeting was called to order at 6:15 pm.

Reading and approval of the minutes
Minutes from the last meeting will be approved at the next meeting.

Old business

New business
Diabetes Disease Management population-based intervention. The following indicators were presented and discussed:

1. Underutilization of Angiotensin Modulating (ACE-inhibitor or Angiotensin Receptor Blocker [ARB]) Therapy ;n=297
   Rationale: Clinical studies have shown that ACE-inhibitors and certain angiotensin receptor blockers (ARB) (specifically losartan and irbesartan) decrease or stabilize albuminuria in incipient nephropathy and slow the rate of progression to advanced nephropathy. They should be utilized in all patients with diabetes and hypertension who do not have a contraindication to receiving them.
   Candidates: Patients who have hypertension and diabetes and are not taking an angiotensin modulating agent are potential candidates for either ACE-inhibitor or ARB therapy.
   Criteria: Patients with a diagnosis of diabetes (ICD-9 code or inferred from drug therapy) and hypertension (submitted ICD-9 code diagnosis required) who are receiving antihypertensive drug treatment and who do not have a documented contraindication or relative contraindication to angiotensin modulating therapy (i.e., anuric renal failure, renal artery stenosis, pregnancy or a history of angioneurotic edema) and who are not receiving angiotensin-modulating agents (either an ACE-inhibitor or an ARB).
2. Underutilization of Antilipemic Therapy; n=1,572
   Rationale: The National Cholesterol Education Program Adult Treatment Panel III (NCEP ATP III) identified diabetes as a CHD risk equivalent. The onset of CHD in patients with diabetes carries a poor prognosis, both at the time of an acute CHD event and in the post-event period. The NCEP and the American Diabetes Association (ADA) recommend that patients with a history of diabetes maintain LDL cholesterol < 100 mg/dl. In high risk patients with diabetes and overt cardiovascular disease, a lower LDL cholesterol goal of <70 mg/dl, is an option.
   Candidates: Patients with diabetes not receiving antilipemic therapy and without a contraindication to such therapy.
   Criteria: Patients 20-80 years of age with diabetes (submitted ICD-9 diagnosis or inferred diagnosis from drug therapy) who do not have a diagnosis of hepatic impairment, myopathy, rhabdomyolysis or pregnancy and who are not currently on antilipemic therapy.
   Paragraph: Cites NCEP and ADA guidelines and asks providers to please review their records to determine if a lipid panel has been checked in the past year and evaluate the potential need for lipid lowering therapy (diet and pharmacological).

DUR Board: yes, as presented.

3. Potential Drug-Drug Interactions Involving Diabetes Medications; n=0.
   Rationale: Patients with potential drug-drug interactions are at increased risk of having an adverse drug event. There may be coordination of care issues if more than one prescriber is involved.
   Candidates: Patients taking alpha glucosidase inhibitors and who are also taking a prescription medication with a potential drug interaction with a severity level of 1 per First Data Bank.

DUR Board: yes, as presented.

4. Increased Risk of Adverse Drug Events (ADE) With Oral Diabetes Medication; n=1,681.
   Rationale: Certain medical conditions may predispose patients receiving antidiabetic agents to adverse drug events.
   Candidates: Patients receiving diabetes medications who are at increased risk for adverse drug events due to predisposing medical conditions will be identified.
   2007 additions to ADE include:
   • thiazolidinediones and heart failure disease (n=94)
   • thiazolidinediones and liver disease (n=101)
   • thiazolidinediones and macular edema (n=864)

DUR Board: yes, as presented.
5. Compliance with Maintenance Medications (Diabetes, Hypertension, Dyslipidemia); n = 804
   **Rationale:** Compliance with prescribed maintenance drug regimens is paramount to
   successful patient outcomes. More than $100 billion is spent annually for problems related
to noncompliance. Over half of written prescriptions are taken incorrectly. Because of the
various complications associated with diabetes, such as dyslipidemia and hypertension,
many diabetic patients are receiving multiple medications, thus increasing the risk of
noncompliance.
   **Candidates:** This indicator identifies patients taking maintenance diabetes, antihypertensive
   and antilipemic medications who have received less than 66% of the cumulative amount
   prescribed.
   **Criteria:** Patients with diabetes receiving chronic oral antidiabetic,
antihypertensive and/or antilipemic drug therapy who have received < a 60-day
   supply of the medication during the most recent 90-day period.

   DUR Board: yes, as presented after discussion of the less than 66% cumulative amount.

6. Duplicate Therapy With Diabetes Medications; n = 3.
   **Rationale:** Combination therapy with diabetes medications with complementary
   mechanisms of action is often required for adequate glycemic control. However, duplicate
   within-class drug therapy has not been shown to increase efficacy and may increase the risk
   of adverse drug events, particularly if coordination of care issues play a role.
   **Candidates:** Patients prescribed multiple antidiabetic medications.
   **Criteria:** Candidates receiving multiple sulfonylureas, multiple
   thiazolidinediones, multiple meglitinides, or multiple alpha-glucosidase
   inhibitors.

   DUR Board: yes, as presented.

7. Underutilization of Metformin; n = 1,445.
   **Rationale:** A consensus statement from the American Diabetes Association (ADA) and the
   European Association for the Study of Diabetes recommends early intervention with
   metformin in combination with lifestyle changes. This recommendation is based upon
   metformin’s effect on glycemia, absence of weight gain or hypoglycemia, generally low
   level of side effects, high level of acceptance, and relatively low cost. Furthermore, the
   UKPDS demonstrated a beneficial effect of metformin therapy on cardiovascular disease.
   **Candidates:**Patients with type 2 diabetes who are not receiving metformin therapy who do
   not have a contraindication to such therapy. Patients who have been treated exclusively
   with insulins for the past year will be excluded.
   **Criteria:** Adult patients with type 2 diabetes without contraindications to
   metformin and who have 1) not received metformin in the past year (n=915), 2)
discontinued metformin in the past 90 days (n=29), or 3) received a dose <1700
   mg/day on the most recent prescription (n=501).

   DUR Board: yes, with recommendation to remove the following wording and corresponding
   reference from education paragraphs: “furthermore, the UKPDS demonstrated a beneficial
effect of metformin therapy on cardiovascular disease”.
Lastly, the DUR Board recommended that a new indicator be created addressing the benefits of daily low dose enteric-coated aspirin in patients, forty-one years of age or greater, in whom aspirin therapy is not contraindicated and who are not currently taking aspirin (any strength, any dose), clopidogrel (Plavix®), or Aggrenox® (aspirin and dipyridamole).

The DUR Board agreed with sample intervention letter presented with the change of adding the Daily Aspirin Use indicator.

There was no public comment. The next meeting will be Wednesday, February 13, 2008.