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Drug Utilization Review (DUR) for Oklahoma Medicaid

Medication Errors

Most health care professionals have heard the unfortunate medical stories of human error and its consequences. In 1995, for example, a patient was admitted to the University Community Hospital in Tampa, Florida, for the amputation of a foot; after surgery, the surgeons discovered that the wrong foot had been removed. In 1997, three Colorado nurses were indicted on criminal charges after an infant died due to a medication error. Although extreme cases such as these are infrequent and rare, medical errors do occur on a daily basis and result in the deaths of 44,000-98,000 Americans yearly, according to a report by the U.S. Institute of Medicine released in November 1999. This same report cited a study indicating that medication errors (medical errors related to medication use) alone result in 7,000 deaths annually. Other studies have estimated these errors to occur in 2 out of every 100 hospital admissions and cost on average \$4,700 each. Extrapolated nation-wide, inpatient costs resulting from medication errors are estimated to be about \$2 billion.

With today's health care marketplace becoming more competitive, professionals are expected to push themselves longer and harder to keep up with the demand. In this environment, professionals are expected to maintain their core services at the same time they also perform other duties arising from technological advances which have enabled the lay person to become a much more informed and concerned health care consumer. Not only have the media begun focusing on medical er-



rors, but politicians also are now becoming more directly involved. President Clinton has announced complete support for the IOM recommendations and has instructed federal agencies and health care organizations to adopt feasible techniques for reducing medical errors. Currently there are several bills sponsored by both major political parties being considered in U.S. Senate committees. These range from improving channels of voluntary reporting to establishing a national center for patient safety in the Department of Health and Human Services'

Agency for Healthcare Research and Quality.

Although the most catastrophic medical errors are not likely to arise in the daily practice of most health care professionals, a number of common yet significant errors occur with surprising frequency. The Institute for Safe Medication Practices and the US Pharmacopoeial Convention suggest that roughly one out of every four reported medication errors are related to look-alike or sound-alike drug names. Table 1 on the following page provides a list of some of the most commonly confused medication names based on the look- and/or sound-a like problem. Although far from complete, the list demonstrates the potential for disaster for the patient.

As already mentioned, today's work environment does not allow health care professionals to thoroughly review every questionable situation that arises. Time is of the essence in today's fast paced world, and health care providers are constantly trying to streamline the delivery of care so more work can be accomplished

Table 1. Commonly Confused Medication Names

Altace	Alteplase
Amiodarone	Amrinone
Brethine	Banthine
Cisplatin	Carboplatin
Celebrex	Cerebyx
Dynacin	Dynacirc
Klonopin	Clonidine
Lamictal	Lamisil
Quinidine	Quinine
Retrovir	Ritonavir
Trimox	Tylox
Vioxx	Zyvox

with the same or even improved results. With this time crunch, what can health care professionals do to reduce the occurrence of medication errors?

The National Coordinating Council for Medication Error Reporting and Prevention has recommended some simple criteria to be followed by those health care providers who write prescriptions:

1. All prescriptions must be legible. Since handwriting has always created problems of legibility,

prescribers should move to a direct, computerized order entry system.

2. Prescription orders should include a brief notation of the medication's purpose unless considered inappropriate by the prescriber.
3. All prescription orders should be written in the metric system except for therapies that use standard units such as insulin, vitamins, etc. The term "units" should be spelled out rather than written as the letter "U."
4. The medication order should always include drug name, exact metric weight or concentration, and dosage form.
5. A leading zero should always precede a decimal expression of less than one. A terminal or trailing zero should never be used after a decimal. "Lead, Don't Trail!"
6. Prescribers should avoid the use of abbreviations, including those for drug names and Latin directions for use. The abbreviations in Table 2 below have been declared dangerous and should be avoided.

These suggestions will not only aid the pharmacist in dispensing the medication, but they will also cut down on the number of phone calls prescribers will receive asking for clarification.

Table 2. Dangerous Abbreviations

Abbreviation	Intended Meaning	Common Error
U	Units	Mistaken as a zero (0) or a four (4), resulting in overdose. Also mistaken for "cc" when poorly written.
µg	Micrograms	Mistaken for "mg," resulting in a 10-fold overdose
Q.D.	Latin abbreviation for "every day"	Period after the "Q" has sometimes been mistaken for an "I" and interpreted as four times a day.
QOD	Latin abbreviation for "every other day"	Mistaken as "QD" (daily) or "QID" (four times a day) when poorly written.
SC or SQ	Subcutaneous	Mistaken as SL (sublingual)
T I W	Three times a week	Mistaken as "TID" (three times a day) or "twice a week"
D/C	Discharge, discontinue	Patient's medications have been prematurely discontinued when D/C was misinterpreted as "discontinue meds."
HS	Half strength	Misinterpreted as the Latin abbreviation "HS" (hour of sleep)
AU, AS, AD	Latin abbreviation for "both ears," "left ear," "right ear"	Misinterpreted as the Latin abbreviation "OU" (both eyes), "OS" (left eye), or "OD" (right eye)

Pharmacists have a professional responsibility to offer medication knowledge to the customer by counseling them. Computers and technology have advanced so greatly over the years that pharmacists no longer need to be tied to the counter performing traditional dispensing activities of counting and pouring. Pharmacists should now be taking the initiative to actively talk to their customers, ensuring they understand the medications they are taking. In doing so, pharmacists are not only improving the customer's understanding of the prescription, but they are also becoming more involved in managing the patient's therapy.

Pharmacists are the final gatekeepers for the health care delivery system before the customer goes home. In that role, they must use whatever means available to prevent errors and to catch those that do occur before harm comes to the patient. One particular retail pharmacy chain acknowledges the importance of medication error prevention to the point that it has adopted four simple questions the pharmacist should ask every customer, regardless of whether the prescription is new for the patient or a refill.

Question 1: What did the doctor tell you the medication was for?

This question allows the pharmacist to eliminate many errors resulting from the misinterpretation of orders. This also gives the pharmacist the chance to assess the patient's understanding of the purpose of the medication, including an understanding of the disease state and the place of the medication in the entire therapeutic picture.

Question 2: How did the doctor tell you to take the medication?

This simple question could eliminate misunderstandings of dose, frequency, or route of administration, that result in over- or undermedicating the patient or providing the wrong form of a medication.

Question 3: What side effects did the doctor tell you to expect?

Again, clarifying the patient's understanding of the medication can prevent overt errors. Moreover, asking the patient about side effects gives the pharmacist an opportunity to prepare the patient to deal appropriately with adverse reactions if they do occur.

Question 4: What questions do you have for me?

Opening the door for the patient to ask questions of the pharmacist allows the customer to mention any additional concerns they may have about the medication or the disease being treated.

Although this method of counseling the patient may seem elementary and time consuming to practicing pharmacists, it can be very beneficial in identifying errors at the last minute before they walk out the door. In today's competitive market place, customer retention is very important; and it is becoming increasingly difficult when one considers that cost is no longer a concern for many patients. Because out-of-pocket expense to the consumer—the pharmacy copayment (or "copay")—is uniform regardless of which pharmacy the patient patronizes, personal attention, not the cheapest price, is more likely to gain the customer's trust and loyalty.

The legal ramifications of medical and medication errors have conditioned health care professionals to shy away from self-reporting of mistakes as they occur. It seems that practitioners try to avoid liability by overlooking errors or at least by not reporting them to anyone else, especially any professional governing board. If, however, a non-threatening environment can be created in which medical and medication errors can be reported and analyzed, then we can begin developing processes designed to prevent common errors. In short, we can learn from each other if we start talking about our errors. The optimal approach to this problem must focus not on laying blame for medical errors but rather finding ways to prevent future ones.

Update on Oklahoma Medicaid Antihistamine Coverage

Adult Medicaid recipients are required to attain medication authorization when prescribed non-sedating antihistamines. The guidelines are as follows:

- The diagnosis must be a chronic allergic condition, insomnia, or extrapyramidal side effects.
- Notation of a previous OTC trial of adequate dose and duration must be on the petition. Failure of diphenhydramine due to drowsiness is not an acceptable trial unless other, less sedating antihistamines have been tried as well.

- An OTC trial is not required in the following conditions:
 - Asthma or COPD.
 - Insomnia (for diphenhydramine 50mg).
 - Extrapyrmidal side effects (diphenhydramine 50mg).
 - Closed-angle glaucoma (for second generation antihistamines).
 - Bladder/urethral obstruction (for second generation antihistamines).
 - Seizures (for second generation antihistamines).

- A physician, physician assistant, or advanced practice nurse must prescribe all services.
- Patients in SoonerCare Choice must have a referral number from their PCP/case manager.
- The supplies must be billed using a HCFA-1500 form.
- Pharmacies must have a medical supplier license in order to provide diabetic supplies.

Only the following items are eligible for regular coverage under the guidelines:

- 1 glucometer/year
- 1 spring loaded lancet device/year
- 3 replacement batteries/year
- 100 glucose test strips/month
- 100 lancets/month
- Insulin syringes

Diabetic supplies in excess of these limits must receive prior authorization by the Medical Professional Services Unit of the OHCA.

Diabetic Supplies Coverage for Medicaid Patients

Diabetic supplies are also covered for Medicaid patients under specific guidelines. The criteria for coverage include the following:

Reminder: OHCA Pharmacy Help Desk Information

Hours of Operation:

Monday-Friday	9:00 a.m. to 8:00 p.m.
Saturday	9:00 a.m. to 5:00 p.m.
Sunday	11:00 a.m. to 5:00 p.m.

Contact numbers:

271-6349	(Pharmacist OKC metro)
1-800-831-8921	(Pharmacist toll free)
271-9048	(Prescriber OKC metro)
1-877-269-2768	(Prescriber toll free)

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