FFY 2012 Medicaid Drug Utilization Review Annual Report

Response ID: 3 ; 100106588 Data

2. Page 2

1. I. STATE

I-1. STATE NAME ABBREVIATION

IA

2. II. MEDICAID AGENCY INFORMATION

II-1. Identify State person responsible for DUR Annual Report preparation.

Name

First Name : Susan
Last Name : Parker

3. Address

Address : 100 Army Post Road
City : Des Moines

4. State

IA

5. Zip Code

50315

6. Email

sparker2@dhs.state.ia.us

7. Phone (number only, no hyphen, example 4107860000)

5152564634

8. II-2. Identify pharmacy POS vendor – (Contractor, State-operated, Other).

Contractor

9. Please enter the vendor name or explain:

Goold Health Systems (GHS)

10. II-3. If not State-operated, is the POS vendor also the MMIS Fiscal agent?

No

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11. III. PROSPECTIVE DUR

III-1. Identify prospective DUR criteria source.

Other

12. If answer to III-1 above is "Other", please specify here

MediSpan

13. III-2. Are new prospective DUR criteria approved by the DUR Board?

No

14. If answer to III-2 above is "No," please explain

This is a collaborative effort between the State, POS Contractor and DUR. Most new proposed criteria are reviewed by the DUR.

15. III-3. When the pharmacist receives prospective DUR messages that deny the claim, does your system:

c) a) and/or b) above - depending on the situation

16. If answer to III-3 above is "c)," please explain

A helpdesk override may be used or a PA is required.

17. III-4. Early Refill:

III-4. a) At what percent threshold do you set your system to edit?

	Percentage
Non-controlled drugs:	90%
Controlled drugs:	90%

18. III-4. b) When an early refill message occurs, does the State require prior authorization for non-controlled drugs?

No

19. If answer to III-4 (b) above is 'Yes', who obtains authorization?

19. If answer to III-4 (b) above is 'No', can the pharmacist override at the point of service?

No

20. III-4. c) When an early refill message occurs, does the State require prior authorization for controlled drugs?

No

22. If answer to III-4 (c) above is 'Yes', who obtains authorization?

21. If answer to III-4 (c) above is 'No', can the pharmacist override at the point of service?

No

22. III-5. Therapeutic Duplication:

III-5. a) When there is therapeutic duplication, does the State require prior authorization for non-controlled drugs?

Sometimes

25. If answer to III-5 (a) above is 'Yes', who obtains authorization?

26. If answer to III-5 (a) above is 'No', can the pharmacist override at the point of service?

23. If answer to III-5 (a) above is "Sometimes," please explain

Prior authorization is required where there is a duplication between oral and injectable antipsychotic. Prescribers are to submit request on the Concurrent IM/PO Antipsychotic PA form. NSAIDs also require PA when used concurrently.

24. III-5. b) When there is therapeutic duplication, does the State require prior authorization for controlled drugs?

Sometimes

29. If answer to III-5 (b) above is 'Yes', who obtains authorization?

30. If answer to III-5 (b) above is 'No', can the pharmacist override at the point of service?

25. If answer to III-5 (b) above is "Sometimes," please explain

CNS Stimulants require PA if used concurrently.

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26. III-6. State is providing DUR criteria data requested on Table 1- Prospective DUR Criteria Reviewed by DUR Board, indicating by problem type those criteria with the most significant severity levels that were reviewed in-depth by the DUR Board in this reporting period.

No

27. If answer to III-6 above is "No", please explain

Prospective DUR criteria is provided by the POS vendor and is reviewed/commended on by the DUR Board prior to implementation.

28. TABLE 1 – PROSPECTIVE DUR CRITERIA REVIEWED BY DUR BOARD

Indicate by problem type those criteria with the most significant severity levels that were reviewed in-depth by DUR Board.

FOR EACH PROBLEM TYPE BELOW IN THE FIRST COLUMN LIST THE DRUGS/ DRUG CATEGORY/ DISEASE COMBINATIONS FOR WHICH DUR BOARD CONDUCTED IN-DEPTH REVIEWS.

PROBLEM TYPE KEY:
INAPPROPRIATE - IA; THERAPEUTIC - TC; DRUG DRUG - D/D; DRUG ALLERGY - D/A; DRUG DISEASE – D/Dis;

	AHFS TC (Level 2)	AHFS TC (Level 4)	AHFS TC (Level 6)	AHFS TC (Level 8)	Drug Name	Disease	Criteria Implemented
IA DOSE1							
IA DOSE2							
IA DOSE3							
TC DUPLICATION1							
TC DUPLICATION2							
TC DUPLICATION3							
D/A INTERACTION1							
D/A INTERACTION2							

D/A INTERACTION3							
IA DURATION1							
IA DURATION2							
IA DURATION3							
D/D INTERACTIONS1							
D/D INTERACTIONS2							
D/D INTERACTIONS3							
D/Dis CONTRAINDICATION1							
D/Dis CONTRAINDICATION2							
D/Dis CONTRAINDICATION3							
OTHER (specify)1							
OTHER (specify)2							
OTHER (specify)3							
OTHER (specify)4							
OTHER (specify)5							
OTHER (specify)6							
OTHER (specify)7							
OTHER (specify)8							
OTHER (specify)9							

29. III-7. State has included Attachment 1 – Prospective DUR Review Summary

Yes

30. If answer to III-7 above is "No", please explain

30. <u>ATTACHMENT 1 - PRODUR REVIEW SUMMARY</u>

This attachment is a year-end summary report on prospective DUR screening. It should be limited to the Top 20 type/drug combinations which generate the largest number of messages. For each problem type/drug combination included, a denominator must be reported. The denominator is the total number of prescription claims

adjudicated (during a given time period) for the drug compared to the number of messages generated for the problem type/drug (incorrect dosage/drug) during the same time period. Denominators permit comparison in percentage terms of the relative frequency of different problem type/drug combinations. For problem type/drug combinations involving more than one drug (e.g., drug/drug interactions), the denominator is the number of prescription claims for the drug submitted for adjudication.

Include for the Top 20 problem type/drug alerts with a severity of Level 1:
*** The number of messages generated by the system and a denominator. The number of messages must relate to problem type/drug combinations (incorrect dosage/drug). Report levels of messages by problem type only, incorrect dosage or drug only are not acceptable.**
*** The number of messages overridden (i.e., adjudication process carried through to completion even though a message was generated).**
*** The number of reversals/cancellations/denials (i.e., adjudication not carried through to completion) and data on types of interventions by pharmacists and the outcomes of such interventions suing applicable NCPDP standards (e.g. Standard Format Version 5.1).**
*** The number of refill too soon messages, duplicate prescription messages transmitted and, where applicable, claims denials.**

State Abbrev-FFY-ATT.#-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) AZ-2012-ATT.1-PRS

Attachment 1 File Name

IA-2012-ATT.1-PRS

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31. Attachment 1

IA-2012-ATT.1-PRS.doc

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32. III-8. State has included Attachment 2- Prospective DUR Pharmacy Compliance Report, a report on State efforts to monitor pharmacy compliance with the oral counseling requirement.

Yes

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34. If answer to III-8 above is "No", please explain

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33. ATTACHMENT 2 - PROSPECTIVE DUR PHARMACY COMPLIANCE REPORT

This attachment reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid agency, the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the OBRA 1990 prospective DUR requirement. This report details State efforts to monitor pharmacy compliance with the oral counseling requirement. This attachment should describe in detail the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.

State Abbrev-FFY-ATT.#-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) AZ-2012-ATT.2-PPCR

Attachment 2 File Name

IA-2012-ATT.2-PPCR

34. Attachment 2

IA-2012-ATT.5-GDSP.doc

5. Page 5

35. IV. RETROSPECTIVE DUR

IV-1. Identify the vendor that performed your retrospective DUR activities during the time period covered by this report. (company, academic institution or other organization)

Company

36. Organization Name

Goold Health Systems (GHS)

37. IV-1. a) Is the retrospective DUR vendor also the Medicaid fiscal agent?

No

38. IV-1. b) Is this retrospective DUR vendor also the developer/supplier of your retrospective DUR Criteria?

No

39. If answer to IV-1 (b) above is "No," please explain

GHS uses the MediSpan Retrospective DUR Criteria.

40. IV-2. Does the DUR Board approve the retrospective DUR criteria supplied by the criteria source?

No

41. If answer to IV-2 above is "No," please explain

Provided by MediSpan

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42. IV-3. State has provided the DUR Board approved criteria data requested on Table 2 – Retrospective DUR Approved Criteria

No

43. If answer to IV-3 above is "No," please explain

Not reviewed by DUR Board

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44. TABLE 2 – RETROSPECTIVE DUR BOARD APPROVED CRITERIA

Therapeutic categories reviewed by the DUR Board (Check All Relevant Boxes)

On the vertical axis, list the therapeutic categories number reviewed by the DUR Board and on the horizontal axis list the therapeutic categories (AHFS level2 and level 4) and the problem types that may be associated with a therapeutic category. If the retrospective DUR program has approved criteria for drugs in a given therapeutic category, check boxes for the relevant problem types for which criteria have been established.

DRUG PROBLEM TYPE KEY
ID = Insufficient Dose; DDI = Drug/ Drug Interaction; IDU = Incorrect Duration; DDC = Drug/ Disease Contradiction; OU = Over Utilization; TD = Therapeutic Duplication; UU = Under Utilization; AG = Appropriate Use of Generics;

THERAPEUTIC CATEGORY - TC

	AHFS TC (Level 2)	AHFS TC (Level 4)	ID	IDU	OU	UU	DDI	DDC	TD	AG
			Y	Y	Y	Y	Y	Y	Y	Y
THERAPEUTIC CATEGORY 1										
THERAPEUTIC CATEGORY 2										
THERAPEUTIC CATEGORY 3										
THERAPEUTIC CATEGORY 4										
THERAPEUTIC CATEGORY 5										
THERAPEUTIC CATEGORY 6										
THERAPEUTIC CATEGORY 7										
THERAPEUTIC CATEGORY 8										
THERAPEUTIC CATEGORY 9										
THERAPEUTIC CATEGORY 10										
THERAPEUTIC CATEGORY 11										
THERAPEUTIC CATEGORY 12										
THERAPEUTIC CATEGORY 13										

THERAPEUTIC CATEGORY 14										
THERAPEUTIC CATEGORY 15										
THERAPEUTIC CATEGORY 16										
THERAPEUTIC CATEGORY 17										
THERAPEUTIC CATEGORY 18										
THERAPEUTIC CATEGORY 19										
THERAPEUTIC CATEGORY 20										

45. IV-4. State has included Attachment 3 - Retrospective DUR Screening and Intervention Summary Report

Yes

46. If answer to IV-4 above is "No," please explain

46. <u>ATTACHMENT 3 – RETROSPECTIVE DUR SCREENING AND INTERVENTION SUMMARY REPORT</u>

This is a year-end summary report on retrospective DUR screening and interventions. Separate reports on the results of retrospective DUR screening and on interventions are acceptable at the option of the State. The report(s) should:

*** Report the level of criteria exceptions by drug class (or drugs within the class) and problem type. (An exception is an instance where a prescription submitted for adjudication does not meet the DUR Board-approved criteria for one or more problem types within a drug class.)**

NOTE:

a) Reporting levels of criteria exceptions by only drug class (drug) or problem type is not acceptable.

b) Year end summary reports should be limited to the Top20 problem types with the largest number of exceptions.

*** Include a denominator for each drug class/problem type for which criteria exceptions are reported. A denominator is the number of prescription claims adjudicated for a drug class (or individual drugs in the class) during a given time period compared to the number of criteria exceptions for the drug class (or individual drugs in the class) during that time period.**
*** Also report, for each drug class/drug and problem type included in this summary report, the number of interventions (letters, face-to-face visits, etc.) undertaken during the reporting period.**
*** States which engage in physician, pharmacy profile analysis (i.e., review prescribing or dispensing of multiple prescriptions for multiple patients involving a particular problem type or diagnosis) or engage in patient profiling should report the number of each type of profile (physician, pharmacy, patient) reviewed and identify the subject(s) (diagnosis, problem type, etc.) involved.**

State Abbrev-FFY-ATT.#-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) AZ-2012-ATT.3-RSIS

Attachment 3 File Name

IA-2012-ATT.3-RSIS

47. Attachment 3

IA-2012-ATT.3-RSIS.doc

7. Page 7

48. V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act requires collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your MMIS been designed to incorporate this data into your DUR criteria for both Prospective DUR and Retrospective DUR?

No

49. If 'No' to V, when do you plan to include this information in your DUR criteria?

07/01/2016

50. Comment for V

To be determined

8. Page 8

51. VI. DUR BOARD ACTIVITY

VI-1. State is including a summary report of DUR Board activities and meeting minutes during the time period covered by this report as Attachment 4 - Summary of DUR Board Activities

Yes

52. If answer to VI-1 above is "No," please explain

52. ATTACHMENT 4 - SUMMARY OF DUR BOARD ACTIVITES

This summary should be a brief descriptive report on DUR Board activities during the fiscal year reported.

*** Indicate the number of DUR Board meetings held.**
*** List additions/deletions to DUR Board approved criteria.**

a. For prospective DUR, list problem type/drug combinations added or deleted.
b. For retrospective DUR, list therapeutic categories added or deleted.

*** Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens.**
*** Describe DUR Board involvement in the DUR education program. (e.g., newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring).**

State Abbrev-FFY-ATT.#-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) AZ-2012-ATT.4-SDBA

Attachment 4 File Name

IA-2012- ATT.4-SDBA

53. Attachment 4

IA-2012-ATT.4-SDBA.doc

54. VI-2. Does your State have a Disease Management Program?

Yes

55. If answer to VI-2 above is 'Yes', is your DUR Board involved with this program?

No

56. VI-3. Does your State have a Medication Therapy Management Program?

Yes

57. If answer to VI-3 above is 'Yes', is your DUR Board involved with this program?

No

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58. VII. GENERIC POLICY AND UTILIZATION DATA

VII-1. State is including a description of new policies used to encourage the use of therapeutically equivalent generic drugs as Attachment 5 - Generic Drug Substitution Policies

Yes

59. ATTACHMENT 5 – GENERIC DRUG SUBSTITUTION POLICIES

Describe any policies used to encourage the use of generic drugs such as State maximum/minimum allowable cost (pricing, higher dispensing fee for generic and/or lower co-pay for generics). Include relevant documentation.

State Abbrev-FFY-ATT.#-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) AZ-2012-ATT.5-GDSP

Attachment 5 File Name

IA-2012- ATT.5-GDSP

60. Attachment 5

IA-2012-ATT.5-GDSP.doc

61. Answer to question VII-2 and VII-3 below use TABLE 3 – GENERIC UTILIZATION DATA

Please provide the following utilization data for this DUR reporting period for all covered outpatient drugs paid. Exclude Third Party Liability.

Computation Instructions:

1. Generic Utilization Percentage: To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:

N ÷ (S + N + I) × 100 = Generic Utilization Percentage

2. Generic Expenditures Percentage of Total Drug Expenditures: To determine the generic expenditure percentage (rounded to the nearest $1000) for all covered outpatient drugs for this reporting period use the following formula:

$N ÷ ($S + $N + $I) × 100 = Generic Expenditure Percentage

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I (see Key below), which can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Drug-Utilization-Review.html (Click on the link "an NDC and Drug Category file [ZIP]," then open the Medicaid Drug Product File 4th Qtr 2012 Excel file). This file will be made available from CMS to facilitate consistent reporting across States with this data request.

KEY:
Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market.
Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market. Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity.

	Total Number of Claims	Total Reimbursement Amount Less Co-Pay
Single-Source (S) Drugs	665863	161059376.05
Non-Innovator (N) Drugs	3531922	46880752.14
Innovator Multi-Source (I) Drugs	483227	73539246.08

62. VII-2. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in Table 3 - Generic Drug Utilization Data.

Number of Generic Claims

3531922

63. Total Number of claims

4681012

64. Generic Utilization Percentage

75.5%

65. VII-3. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period using the computation instructions in Table 3 – Generic Drug Utilization Data.

Generic Dollars

46880752

66. Total Dollars

281479374

67. Generic Expenditure Percentage

16.7%

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68. VIII. PROGRAM EVALUATION/COST SAVINGS

VIII-1. Did your State conduct a DUR program evaluation/cost savings estimate?

Yes

69. If answer to VIII-1 above is "No," please explain

69. VIII-2. Who conducted your program evaluation/cost savings estimate? (company, academic institution , other institution)

Company

70. Organization Name to VIII-2

GHS

71. VIII-3. State is providing the Medicaid program evaluations/cost savings estimates as Attachment 6 – Cost Savings Estimate

Yes

73. If answer to VIII-3 above is "No," please explain

72. ATTACHMENT 6 - COST SAVINGS ESTIMATE

Include copies of program evaluations/cost savings estimates prepared by State or its contractor noting the methodology used.

State Abbrev-FFY-ATT.#-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) AZ-2012-ATT.6-CSE

Attachment 6 File Name

IA-2012- ATT.6-CSE

73. Attachment 6

IA-2012-ATT.6-CSE.doc

74. VIII-4. Please state the Estimated net savings amount. $

747655

75. VIII-5. Please provide the estimated percent impact of your state's cost savings program compared to total drug expenditures for covered outpatient drugs. Divide the estimated net savings amount provided in Section VIII, Question 4 above by the total dollar amount provided in Section VII, Question 3. Then mutiply this number by 100.

Estimated Net Savings Amount / Total Dollar Amount * 100 =

0%

76. IX. FRAUD, WASTE AND ABUSE DETECTION

IX-1. Do you have a process in place that identifies potential fraud or abuse of controlled drugs by recipients ?

Yes

77. If 'Yes' to IX-1 above, what action(s) do you initiate? Check all that apply.

b. Refer recipient to lock-in program
c. Refer to Medicaid Fraud Control Unit (MFCU) or Program Integrity
d. Other

78. If check to above is "d. Other," please explain

The DUR contacts prescribers and pharmacies based on profile reviews. The DUR also sends out the Quarterly Narcotic Utilization Report to prescribers identifying members that are using three or more prescribers and/or pharmacies to obtain narcotic medications.

79. IX-2. Do you have a process in place that identifies possible fraud or abuse of controlled drugs by prescribers ?

Yes

80. If 'Yes' to IX-2 above, what action(s) do you initiate? Check all that apply.

b. Refer to MFCU or Program Integrity

81. If check to above is "d. Other," please explain

81. IX-3. Do you have a process in place that identifies potential fraud or abuse of controlled drugs by pharmacy providers ?

Yes

82. If 'Yes' to IX-3 above, what action(s) do you initiate? Check all that apply.

b. Refer to MFCU or Program

84. If check to above is "d. Other," please explain

83. IX-4. Does your State have a Prescription Drug Monitoring Program (PDMP)? See Attachment 7 – Prescription Drug Monitoring Program for a description of this program.

Yes

86. If 'No' to IX-4 above, does your State plan to establish a PDMP?

84. ATTACHMENT 7 – PRESCRIPTION DRUG MONITORING PROGRAM

In FY 2002, Congress appropriated funding to the U.S. Department of Justice to support Prescription Drug Monitoring Programs (PDMPs). These programs help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collections system exists. States that have implemented PDMPs have the capability to collect and analyze data on filled and paid prescriptions more efficiently than those without such programs, where the collection of prescription information can require a time-consuming manual review of pharmacy files. If used properly, PDMPs are an effective way to identify and prevent diversion of the drugs by health care providers, pharmacies, and patients.

Please attach the file which describe your PDMP and explain how the State applies this information to control fraud and abuse.

State Abbrev-FFY-ATT.#-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) AZ-2012-ATT.7-PDMP

Attachment 7 File Name

IA-2012- ATT.7-PDMP

85. Attachment 7

IA-2012-ATT.7-PDMP.doc

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86. X. INNOVATIVE PRACTICES

X-1. Have you developed any innovative practices during the past year which you have included in Attachment 8 – Innovative Practices.

No

87. ATTACHMENT 8 - INNOVATIVE PRACTICES NARRATIVE

Please describe in detailed narrative form any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs. (e.g. disease management, academic detailing, automated pre-authorizations, continuing education programs).

State Abbrev-FFY-ATT.#-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) AZ-2012-ATT.8-IPN

Attachment 8 File Name

88. Attachment 8

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87. XI. E-PRESCRIBING

XI-1. Has your State implemented e-prescribing?

No

88. If 'No', are you planning to develop this capability?

Yes

89. If 'Yes', please respond to questions XI-2 and XI-3 below.

89. XI-2. Does your system use the NCPDP Origin Code that indicates the prescription source?

No

90. XI-3. Does your program system (MMIS or pharmacy vendor) have the capability to electronically provide a prescriber, upon inquiry, patient drug history data and pharmacy coverage limitations prior to prescribing?

No

92. a) If 'Yes', do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

93. b) If 'Yes', please explain the evaluation methodology in Attachment 9 – E-Prescribing Activity Summary.

94. ATTACHMENT 9 – E-PRESCRIBING ACTIVITY SUMMARY

Please describe all development and implementation plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (e.g. number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).
State Abbrev-FFY-ATT.#-Abbreviated Report name (NO SPACES!) Example for Arizona: (each state should insert their State code) AZ-2012-ATT.9-EAS

Attachment 9 File Name

95. Attachment 9

91. c) If 'No', are you planning to develop this capability?

No

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92. XII. EXECUTIVE SUMMARY

The Iowa Medicaid DUR Commission had a successful year with overall direct total cost savings of $3.77 for every dollar spent on the program administratively. Overall, the

program produced a net cost savings of $747,654.95 versus a net cost savings of $615,600.07 in FFYE 2011.

Patient-focused review saw a savings of $328,419.35 versus a savings of $275,771.01 in FFYE 2011. Total dollars saved per patient evaluated was $238.16.

Total cost savings for the problem-focused studies for FFYE 2012 is $689,235.60 versus $609,829.00 in FFYE 2011. This increase is due to a larger number of members evaluated thus resulting in an increased number of members with a positive impact versus the prior year. Thirteen focus studies were evaluated in FFYE 2012 compared to fourteen in FFYE 2011. Eleven of these focus studies were designed to promote appropriate therapy and optimize patient outcomes and two of the focus studies addressed inappropriate use of medication.