

# CHCS

Center for  
Health Care Strategies, Inc.

## *Care Management Entity Quality Collaborative Technical Assistance Webinar Series*

# Psychotropic Medication

January 19, 2012, 2:00 – 3:30 p.m., ET

For audio and to participate, dial: **(866) 699-3239**

Meeting/Event Number:

In case of technical difficulties, call **(609) 528-8400**



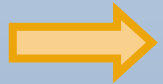
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# CHCS Priorities

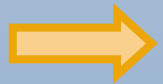
Our work with state and federal agencies, Medicaid health plans, providers, and consumers focuses on:



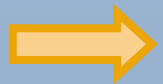
**Enhancing Access to Coverage and Services**



**Improving Quality and  
Reducing Racial and Ethnic Disparities**



**Integrating Care for People with  
Complex and Special Needs**



**Building Medicaid Leadership and Capacity**

# Maryland, Georgia and Wyoming Collaborative CHIPRA Grant Project

- Goal: Improving the health and social outcomes for children with serious behavioral health needs.
- Implement and/or expand a Care Management Entity (CME) provider model to improve the quality - and better control the cost - of care for children with serious behavioral health challenges who are enrolled in Medicaid or the Children's Health Insurance Program.

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# Psychotropic Medication Use with Children and Youth in Public Sector Care



*Kamala D. Allen, MHS*

*Director, Child Health Quality*

January 19, 2012

# Legislative Impetus to Improve Psychotropic Medication Use

- **Fostering Connections to Success and Increasing Adoptions Act (2008)**
  - Oversight of medications prescribed to children in foster care
- **Patient Protection and Affordable Care Act (2010)**
  - Medication Management Services - *Section 3503*
- **Child and Family Services Improvement and Innovation Act (2011)**
  - Protocols for effective use and monitoring of *psychotropic* medications in particular.

# Regulatory Impetus...

- Joint *Dear State Official* Letter from key US Dept. of Health and Human Services Agencies: CMS, SAMHSA, Administration for Children and Families (11/23/11)
- Particular concerns:
  - ▶ Disproportionate prescribing for children in foster care
  - ▶ Reliance on medication to address behavioral concerns
  - ▶ Polypharmacy
  - ▶ Off-label use and limited study in children

# High Rates of Use and Expense

- Psychotropic medications are being prescribed to very young children, at levels above those approved for use in adults, and often in combination with other medications.
- Rate of use for foster children is nearly six times that of TANF children in Medicaid, and comparable to that of children who have disabilities serious enough to qualify for Medicaid by virtue of SSI/Disabled status.
- Data from a mid-western state indicate that psychotropic medications are two of the top three pharmacy expenses in its Medicaid budget.

# Clinical Concerns

- Serious risks and side effects have been documented for adults, and there are clearly implications for adverse effects in children.
- Few of these medications are approved for use in children; however, off-label use is legal and common.
- Polypharmacy is a common - and sometimes necessary - practice but also occurs unnecessarily.
- Insufficient monitoring by - and lack of coordination of care among - providers, is particularly likely and problematic for children in foster care.



# States are Paying Attention

- Twenty-six states currently provide written guidance regarding psychotropic medication use for children and youth in foster care, and thirteen others are developing policies.
- 30 states submitted letters of intent for upcoming CHCS quality improvement collaborative focused on reducing inappropriate/unnecessary prescribing of psychotropics.

## Not Medication Alone...or First...

- AACAP guidelines recommend that “Youth in state custody should have access to effective psychosocial, psychotherapeutic, and behavioral treatments, and, when indicated, pharmacotherapy.”
- Forthcoming CHCS study indicates that in 2005, 1.7M (5.8%) children on Medicaid were receiving psychotropic medication and 29% were receiving them absent any other behavioral or physical health service.

## Promising approaches include:

- Moving away from “medication first” when possible, and toward other behavioral health services and supports
- Prescriber education about and adherence to guidelines for psychotropic treatment for children and youth
- Coordinated oversight by public child-serving systems and their managed care vendors
- Red flag systems with peer review/second opinion
- Providing clinical support by specialists to primary care providers
- Provider detailing and monitoring of prescribing patterns
- Patient, family, and provider education about the use of psychotropic medications in children and youth

# Take-aways...

- Children with serious behavioral health needs are a special needs population, and a high cost Medicaid population.
- Psychotropic medication use is a critical issue for this population.
- Development of and continued attention to systems to monitor and improve prescribing – and enforceable policies to support them – is needed.
- There is a meaningful role for CMEs in the monitoring and improvement of psychotropic medication use among this population.



CHCS CHIPRA Webinar:  
Psychotropic Medication  
January 19, 2012

John Straus, M.D.  
Vice President Medical Affairs  
Massachusetts Behavioral Health Partnership

# Topics

1. Data
2. CHCS BCAP
3. Improvement/Reduction Strategy
4. Psychiatry in Wraparound

# Data - Measures

1. Polypharmacy
2. Duplication within Class
3. Antipsychotic without BH treatment
4. Antipsychotic without appropriate diagnosis
5. Outlier Prescriber

# Data

1. Agree on Measures and Definition
2. Consider Risk Adjusting
3. Make measurement routine - quarterly
4. Prioritize a few measures - polypharmacy



# Data - Polypharmacy

1. 3 or more prescriptions of BH medication taken for at least 60 days in quarter.
2. BH medication includes primary list of medications that are always for BH and secondary list that count if taken along with a medication in primary list.

# CHCS BCAP

1. Random review of charts of youth with polypharmacy and duplication within class.
2. 1st polypharmacy prescription met “community standard”, often not prescribed by current prescriber.
3. Over 80% of youth stable and still on same “cocktail” 6 months later without any trial of simplification.

# CHCS BCAP

1. Pilot with high volume polypharmacy prescriber
2. Given list of 89 youth, picked 34 for trial of simplification
3.  $29/34 = 85\%$  had at least one medication removed.  $29/89 = 33\%$ .
4. Significant cost savings.

# Improvement/Reduction Strategy

1. MBHP developed quarterly report sent to prescribers with 20 or more youth prescribed 6 months of “stable” polypharmacy.
2. Most prescribers had “detail” call, all very supportive of initiative.
3. After 2 quarters, amongst population of 1,010 youth prescribed average of 3.5 medications for at least 6 months, 39.7% on at least one less medication (.5 less prescriptions per youth).

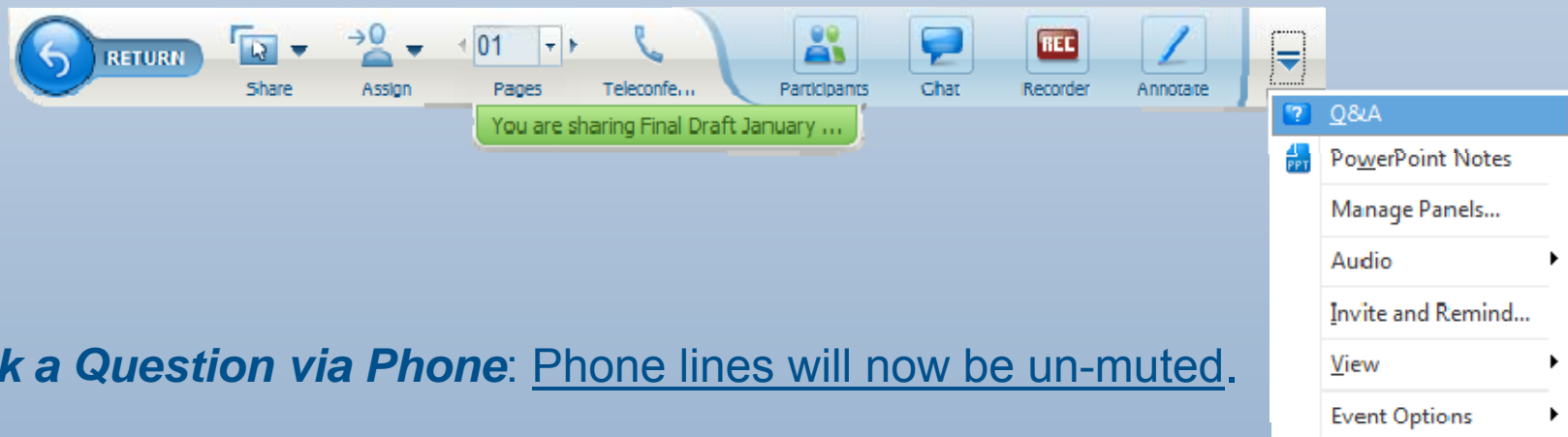
# Psychiatry in Wraparound

1. Need defined role.
2. Both consultant to staff and specific youth.
3. Advantage of evaluating youth in context of Wraparound team (part of care plan).
4. Availability of team to observe medication change.
5. Availability of family partner to interpret and support medication utilization.
6. Adequate financing.

# Questions?

To submit a question please use one of the following options:

• **Ask a Question Online:** Click the **Q&A** icon located in the hidden toolbar at the top of your screen.



• **Ask a Question via Phone:** Phone lines will now be un-muted.

Slides and a video archive of this event will be available on our website, at [www.chcs.org](http://www.chcs.org).

# Medication Reduction Strategies in Wraparound Milwaukee Outpatient Clinics


**Presented By:**

**Bruce Kamradt, Director,  
Wraparound Milwaukee**

**Dennis Kozel, MD, Medical Director,  
Wraparound Milwaukee**



# What is Wraparound Milwaukee


- A system of care organized to provide comprehensive services and supports to children and adolescents with serious emotional and mental health needs and their families
  - It is organized as a special managed care entity publically operated by Milwaukee County Behavioral Health Division under the 1915a provisions of the Social Security Act, which allows it to function as a type of HMO for a distinct Medicaid population within a specific geographical area (Milwaukee County)
  - Current enrollment is approximately 900 youth/families with 1400 families served annually
- 





# Specific Populations Served by Wraparound Milwaukee


## Youth:

- With a DSM-IV diagnosis
  - With a chronic condition likely to require services for a year or more
  - Currently or previously served across two or more child serving systems (i.e. Child Welfare, Juvenile Justice, Mental Health, special education)
  - At imminent risk of placement in a:
    - Residential treatment center
    - Psychiatric hospital
    - Juvenile correctional facility
- 



# Wraparound Milwaukee's Medication Management Approach

Wraparound Milwaukee developed and created medication clinics with our own group of child psychiatrists

- Because of:
    - Complexity of the clinical and medical needs of our population
    - Need for immediate assessment of medication needs that could not always be met in our Provider Network
    - Comfort level of many families coming to Wraparound Milwaukee
  - To:
    - Improve the continuity of care
    - Reduce costs
- 



# Wraparound Milwaukee Medication Clinics


- Three afternoon medication clinics for court ordered Wraparound youth (Bureau of Milwaukee Child Welfare, Delinquency)
- Two and a half days per week for voluntary Wraparound Youth (REACH\* Program)
- Urgent medication clinic

\*(Reaching, Engaging and Assisting Children and Families )






# General Principles of Medication Management

- Thorough assessment including the diagnosis of a psychiatric condition (this includes a medical history, developmental history, family history)
  - Linkage to Primary Medical Doctor (CHCS Best Clinical and Administrative Practices (BCAP) framework) i.e. “last seen” critical
  - Target symptoms
- 




# Initial Medication Strategies

- Try Mono-therapy before poly-pharmacy
  - Begin with low doses
  - If adding a medication, consider stopping a medication
- 




# Why Medication Strategies Fail

- Medication compliance (#1 reason meds are not effective)
  - Wrong diagnosis
  - Comorbid diagnosis (i.e. Alcohol and Other Drug Abuse (AODA), mood disorder, oppositional defiant disorder (ODD), etc.)
- 




# Reduction Strategies: How to do it

- Initial assessment, multiple medications, “do no harm”
  - Initial medication eval in Wraparound 4-6 weeks after enrollment:
    - allows Wraparound process to begin – team building, family needs, crisis plan, etc.
- 



# Reduction Strategies


## Review:

- Current medication issues/target symptoms (ADHD, anger, depression, etc.)
  - Current non medication, behavioral issues (defiance, runaway, poor effort, etc.)
  - Therapy issues (alliance with therapist, goodness of fit, modality, etc.)
- 






# Reduction Strategies: Patient and Family Education

- Begin with the patient (i.e. kids need to feel that they are being heard)
  - Collateral information from family, care coordinator, mentor, parent aide, etc.
  - Alliance with patient and family
- 




# Reduction Strategies

- School Reports (kids then parents/caregivers)
  - Home Reports (kids then parents/caregivers)
  - Medication:
    - Compliance
    - Side effects
    - Sleep
    - Appetite
    - Labs
- 




# Reduction Strategies

- Non-aggressive for 6 months then discuss taper
  - Absence of depressed mood for 12 months then discuss taper
- 




# Targeting Reduction Strategies

- Multiple meds, same diagnosis (i.e. 3 meds for ADHD)
  - Multiple meds, inadequate doses (i.e. low dose SSRI, low dose anti-psychotic)
  - Combinations
- 



# Reduction Strategies

- One medication at a time (when patient/family ready)
  - Medications without FDA approval for children or without research base
  - Consider short half life, withdrawal dyskinesia, psychological dependence, etc.
- 




# Reduction Strategies

- Options discussed
- Partnering
- 20 – 80
- Child and parent/caregiver decide



# Reduction Strategies with Professional Partners

- Wraparound Care Coordinators (med check attendance, monthly consultation)
  - Pediatricians (Downtown Health Center, Bureau of Milwaukee Child Welfare, Child Advocacy)
  - Child Psychiatrists (newer concept, training issue)
- 



# Special Populations

- Very young children: therapy first
- Developmentally disabled youth: poor adaptive skills
- Medically compromised children: compliance issues
- Youth involved with Child welfare (i.e. Foster kids): more meds





HOPE





Dennis Koziel, MD

Medical Director, Wraparound  
Milwaukee

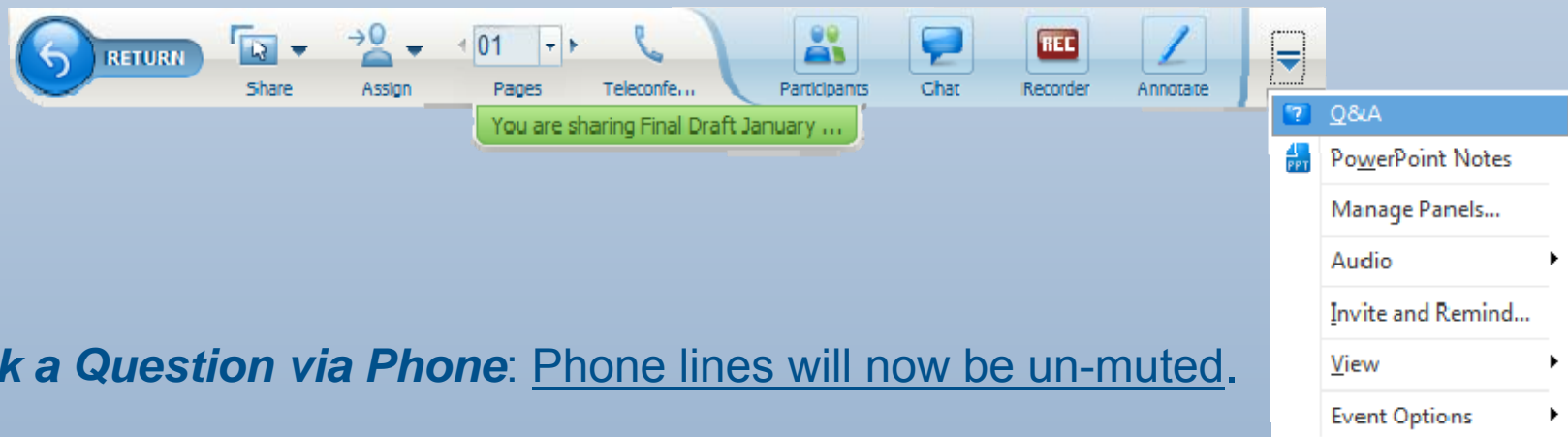
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