Mental Health Prescription Drug Advisory Committee Meeting Meeting Minutes, Open Session March 22, 2010		
MHPDAC Meeting Minutes, Open Session Landon State Office Building Room 106 Topeka, KS	**Members Present:** Michael Burke, M.D, Ph.D., Chair Megan Dahmen, Pharm.D. Kimberly Harrison, Ph.D. Eric Harkness, R.Ph. Kristen Hellebust Michael Leeson, M.D., Ph.D. Roy Menninger, M.D. Karen Moeller, Pharm.D. Eve-Lynn Nelson, Ph.D. Pam Shaw, M.D. **KHPA Staff Present:** Andy Allison, Ph.D. LeAnn Bell, Pharm.D. Aimee Grubb, Recorder Margaret Smith, M.D., Shelly Liby	**Public:** Amy Campbell, Mental Health Coalition
TOPIC	**DISCUSSION**	**DECISION AND/OR ACTION**
I. Call to Order / Announcements	The meeting of the Mental Health Prescription Drug Advisory Committee was called to order at 10:10 a.m.	
II. Old Business: Review and Approval of: a. 9/16/09 Mtg. Minutes b. 11/4/09 Mtg. Minutes	No changes were made.	Dr. Shaw moved to approve the minutes. Dr. Dahmen seconded and it carried with a unanimous vote.
II. Comprehensive Neuroscience Contract Update	Dr. Bell updated the committee on the CNS contract. Shortly after the last meeting CNS sent the prices for the options previously presented. In a meeting with Eli Lilly, KHPA was informed that they decided to discontinue funding the program for this year based on both Eli Lilly and KHPA's lack of satisfaction with the program. KHPA is working to restart the program, and will be seeking guidance on how the program should be tweaked to make it more effective. Dr. Menninger asked if Eli Lilly is open to resubmit a request to fund the program. Dr. Bell said they are, but probably not until calendar year 2011 as funding for this calendar year should have been obtained in the fall of 2009. Representatives from Eli Lilly said they would try to find other funding for this year, but it is not likely to happen. Dr. Allison asked the committee to define the scope of the project and decide which kind of	

	educational interventions they think would work and once that has been decided we would ask Eli Lilly to waive their normal procedure and find money even sooner. Mr. Harkness asked about the annual cost of the program. Dr. Bell said Eli Lilly gave us about $250,000 to fund the program. Dr. Menninger asked if there is more than $250,000 available. Dr. Bell said she doesn't know but she will ask. Dr. Menninger asked what we have to work with, if they agree and we move in that direction, will it be the same amount as before or is it possible that Lilly will give us a larger amount of money to fund the program. Dr. Allison said that is an open question because the contract that we had with Eli Lilly pre-dated all of our management of the program. It came to us as a line item, an amount of money that we could mange, and we inherited the structure as well. We have a chance, while we are not under contract, to re-define and potentially re-scope the program. We aren't limited to asking just Eli Lilly for funding. The legislature is interested in expanding the educational program and has asked us to seek funding from outside sources. It might behoove the committee to think about different levels of funding and how the committee might prefer to use the funding. Dr. Burke said one of the other issues was how CNS compared to Health Information Designs (HID). Dr. Bell said the contract with HID is about $300,000 per year and they do all of our retrospective DUR programs. Dr. Menninger asked if HID has produced a list of program possibilities and costs. Dr. Bell said they have not. Dr. Leeson asked if Eli Lilly would be interested in funding HID. Dr. Bell said based on the preliminary discussions Eli Lilly seems to be open to checking into other vendors.	
III. Medicaid Children's Focused Study: Prescribing Patterns of Psychotropic Drugs Among Child Medicaid Beneficiaries in the State of Kansas - KU Office of Welfare and Children's Mental Health, Through a Contract with the Kansas Department of SRS	Dr. Allison said this study has now been mentioned in legislative discussions regarding the preferred drug list (PDL). It was brought up as a counter argument to a PDL before the Senate Ways and Means Committee by testimony from Mike Hammond and others before both the Senate and House. There was the general characterization in that testimony that the results of this study were at odds with the information we brought to this committee and the information in Chapter 9 of the Medicaid transformation. That raises questions that this committee is well suited to address such as, determining if there is a problem in Kansas and what concerns there are regarding the prevalence of the use of mental health medications, particularly among children. SRS commissioned the School of Social Work and a Ph.D. candidate there to look at this data.. There are members of this committee that also sat on an advisory committee to the main report however; it is our understanding that the committee was not	Dr. Menninger asked how many child beneficiaries are under Managed Care and Fee-for-Service. Dr. Allison said we would get a specific count and bring it back to the board. Dr. Burke said it would be interesting to look at the data prior to implementation and after implementation of PDL to see what affect it has had on clinical service use.

	the source of the recommendations. Dr. Menninger asked if the legislature received information from SRS and KHPA and someone concluded that there was a conflict with it. Dr. Allison said SRS did not testify, but the following quote from Mike Hammond's testimony refers back to the study: "A recent study was released by SRS which focused on prescribing patterns of psychotropic drugs among child Medicaid beneficiaries in Kansas. This report found that prescribing practices and the prevalence of the use of psychotropic medication in Kansas is quite similar to other States. The report goes on to say that the rates of psychotropic medication use by Kansas child beneficiaries aged 0-17 are consistent with other States; that available data indicate Kansas providers meet or exceed *standards of care* in most areas; and that overall prescription patterns, there is no alarming public health concerns. Equally important to note is that the report cautioned against implementing cost-containment strategies that would further limit access to quality mental health treatment. The report recommended establishing psychotropic medication practice, guidelines and protocols; publishing and disseminating evidence-based practice guidance on the use of psychotropic medications. The Advisory Committee who assisted with this study included experts such as psychiatrists, pharmacists, a pediatrician, educators in psychiatry as well as researchers. Dr. Shaw, a pediatrician at the University of Kansas and President of the Kansas Chapter of the American Academy of Pediatrics, also serving on the Mental Health Prescription Drug Advisory Committee, said, "I have reviewed the data from the SRS study and it isn't as bad as people think." It is important to point out that the recommendations from this study are very similar to what was identified as areas of consensus for the KHPA Mental Health Prescription Drug Advisory Committee." Dr. Allison said it is important for the committee to understand how its activities, observations and conclusions are being characterized in direct testimony to the Senate and House. Dr. Menninger asked what the other half of the conflict is. Dr. Allison said the recommendations that KHPA made in chapter 9 of the Medicaid Transformation Report do not comport with the SRS study's characterization of mental health drug use in the state. Dr. Shaw clarified that her quote in Mike Hammond's testimony was somewhat taken out of context. Dr. Bell referred to data from a report written by Dr. Theresa Shireman, who was consulted with at the beginning of the SRS study. This report	

	was done in the spring of 2009. She had some concerns with the way the data was characterized in the SRS report. When you look at the whole population, which includes all of the Managed Care plans, it is an overall 9% prevalence rate of children on psychotropic drugs. But when you look at just the Fee-for-Service data the prevalence rate is around 44-50%. Mr. Harkness asked Dr. Shaw to if she would care to characterize the study as a whole. Dr. Shaw said it depends on how you look at the data. The denominator is important. The denominator in the SRS study was 200,000 children which is all children who are on Medicaid. Dr. Allison said the differences in rates have to do with focusing on different populations. Mr. Harkness asked Dr. Allison what options are on the table other than education. Dr. Allison said direct management which has been KHPA's recommendation to the legislature for the past two years. This is the only component of pharmacy that is not managed directly. Dr. Menninger asked for clarification on Fee-for-Service and Managed Care. Dr. Allison gave a brief review of how the Medicaid program is organized. Mr. Harkness characterized the program by saying a large number of children, who are reasonably healthy, have been aggregated into the Managed Care program and don't cost much per capita. A smaller pool of sick children is in the Fee-for-Service program and cost quite a bit of health care dollars. Dr. Allison said he can't agree to the extreme characterization, but on average that is true. He doesn't want to conclude that within Managed Care, we are satisfied with outcomes, medical care, or use of psychotropic medication. But it is certainly true that they utilize medical care of all types at lower rates than the Fee-for-Service population. It is a concern, broadly speaking, that we are not managing the Fee-for-Service population, neither the children, nor the adults. Dr. Menninger asked what the magnitude of the 200,000 beneficiaries are in the Managed Care program. Dr. Allison said probably around 2/3, but we can do a specific count and bring that back to the committee. Dr. Bell went through the report for the committee. ***<u>Annual Prevalence</u>*** *In SFY2008, the annual psychotropic medication prescription prevalence*	

	rate for Kansas Medicaid-enrolled children ages 0-17 was 9.0% (see Table 5 on page 49). A recent comparable study of one state's Medicaid population revealed an overall prevalence rate of 8.9% in 2007, down from a high of 9.3% in 2002. *Boys prevalence rates (11.2%) were nearly twice that of girls (6.6%), which is consistent with other studies.* *Consistent with other studies of child Medicaid recipients, prevalence rates increased progressively by age.* *Nearly three-quarters of children on the Severely Emotionally Disturbed (SED) Waiver (72.9%) received psychotropic medications, and slightly more than half (51.5%) of children with an SED but not receiving Waiver services were prescribed psychotropic medications.* Dr. Bell asked Dr. Leeson to provide a description of the SED Waiver. Dr. Leeson said the waiver is designed for individuals who otherwise would be at risk of state hospitalization. There are specific criteria that they must meet in order to get on it. Dr. Allison asked Dr. Leeson which SED children might not be medicated. Dr. Leeson said Opposition Defiant Disorder, Conduct Disorder would both be avenues to the SED waiver and there are some parents who won't agree to putting their child on medication. *The prevalence of psychotropic medication prescriptions among children in Kansas foster care was 28.5%, more than three times the rate of Medicaid children not in foster care (7.9%).* Dr. Menninger asked why the rate of children in foster care is three times the rate of children on Medicaid. Dr. Shaw said foster care kids are usually the most disturbed because their parents can't take care of them or have traumatized them. *Rural counties (11.3%) had the highest prevalence rates and urban counties (8.0%) the lowest, though the effect size of population density was weak. (See Appendix K for a map of Kansas counties and population density groups.)* *The SRS region with the highest prevalence rate of psychotropic medications was the South Central region (11.6%). The West region had the lowest prevalence rate (7.0%). (See Appendix J for a map of SRS*	

	regions.) Dr. Allison said there are substantial differences by geography. Mr. Harkness asked if this is statistically significant. Dr. Allison said yes. ***Mental Health Diagnosis*** *81.3% of children and youth receiving psychotropic medications in SFY2008 had a mental health diagnosis at some point during the year.* *80.0% of children and youth receiving psychotropic medications in SFY2008 had a mental health diagnosis within 90 days of their prescription fill date.* *70.3% of children 0-4 years old had a mental health diagnosis within 90 days of their fill date compared to 82.4% of 5-9 year olds, 80.7% of 10-14 year olds, and 77.8% of 15-17 year olds.* Dr. Menninger asked what this tells us about the issues. Dr. Shaw said one thing that was looked at, as far as the data, was how many of the children who are getting these prescriptions actually have a mental health diagnosis. The problem with data is that it is a point in time. The problem is also with the drugs. There are children that are getting drugs that are in the psychotropic class, but without a mental health diagnosis. Dr. Leeson said this is all claims data, so if the diagnosis wasn't on the claim it wouldn't show up. The SED waiver kids may have other insurance so they could have used Medicaid to fill the prescription, but their other insurance for the doctor visit. Dr. Menninger said with this many questions it seems like this information is neither informative or nor particularly helpful. Dr. Leeson said that they did try to pull out all of the seizure drugs that were being prescribed for a seizure diagnosis. *92.1% of youth on the SED Waiver had a diagnosis within 90 days of their fill date, compared with 92.5% of those considered SED but not on the Waiver.* *Children with a mental health specialist prescriber were considerably more likely to have a mental health diagnosis within the study year or within 90 days of their prescription fill date, compared to children with a non mental health specialist.*	

	Polypharmacy *Annual polypharmacy rates (Measure 3) provides rates of polypharmacy using a one-year observation period and requiring no additional criteria for overlap in drugs.* *60-day polypharmacy rates (Measure 4) provides a more conservative view by tracking for a minimum of 60-days concurrent prescriptions of psychotropic drugs. The prescriptions had to completely overlap for at least 60 days.* *60-day interclass polypharmacy rates (Measure 5) is similar to Measure 4 except that it tracks concurrent psychotropic drug prescriptions across drug classes, using a 60-day criterion.* *60-day intraclass polypharmacy rates (Measure 6) tracks concurrent psychotropic drug prescriptions within drug classes, using a 60-day criterion.* ***Annual Polypharmacy Rates*** *On average, Kansas child Medicaid beneficiaries received 2.2 psychotropic drugs in SFY2008.* *The median number of drugs received was 2.* *The maximum number of drugs received at any time during SFY2008, was 16.* *Most children in the sample (69.4%) did not receive more than two drugs at any time during SFY2008.* *Of child Medicaid beneficiaries receiving psychotropic drug prescriptions, 14.5% received 3 drugs at any point during the year, 7.8% received 4 drugs, and 8.3% received 5 or more drugs.* *Males, older youth, youth on the SED Waiver, youth with more than one comorbid diagnosis, youth with mental health specialist providers and prescribers, and youth in foster care or JJA status were more likely to receive multiple drugs.*	

	60-Day Polypharmacy Rates *One third of the 18,820 children who received medications (33.4%) received 2 or more drugs concurrently for 60 consecutive days or longer.* *4,507 children (23.9% of the study population) received no drugs for a minimum of 60 days.* *3,979 children (21.1% of the study population) received 2 drugs for 60 consecutive days or longer. The largest proportions of children to receive 2 drugs for 60 days were: those who had prescribers with a MH specialty (31.0%); those with MH diagnoses (23.6%); those 10-14 years old (23.5%); children on the SED Waiver (32.2%); those in foster care (27.6%) or JJA (26.6%).* *1,645 children (8.7% of the study population) received 3 drugs for 60 consecutive days or longer. The largest proportions of children to receive 3 drugs for 60 days were: youth 10-14 and 15-17 years old (10.4% and 10.2%, respectively); youth on the SED Waiver (17.2%); youth in foster care (14.3%);youth with five or more diagnoses (26.7%); and youth who saw prescribers with a MH specialty (15.3%).* *504 children (2.7% of the study population) received 4 drugs for 60 consecutive days or longer.* *160 children (0.9% of the study population) received 5 drugs or more for 60 consecutive days or longer. The largest proportions of children who received 5 drugs for 60 days: were 10-14 (1.0%) or 15-17 years old (1.3%); on the SED Waiver (1.9%); had 4 (2.4%) or 5 (4.2%) MH diagnoses; and were prescribed drugs by a MH specialist (1.5%). Also noteworthy are 51 youth with no MH diagnosis and no outpatient provider who received 5 drugs concurrently for 60 days or longer.* Dr. Allison asked for an example of 5 drugs that a child may be on. Dr. Moeller said conduct order and oppositional defiance disorder are hard to treat so they may get a lot of medications. Dr. Allison quoted from the SRS report, "In keeping with these recommendations, that the AAP made in 2008, a number of states have recently created psychotropic medication parameters or oversight mechanisms for children in foster care (e.g., Arizona, California, Illinois, Tennessee, Texas, Florida) after case reviews unearthed serious problems, such as a child receiving psychotropic medications without a mental health diagnosis, cases in which 5 or more	

	medications were prescribed concurrently, cases in which 2 or more medications from the same class were prescribed concurrently, and cases in which very young children received psychotropic medications (Naylor, Davidson, Ortega-Piron, Bass, Gutierrez, & Hall, 2007)." With that being said Dr. Allison asked the committee whether that observation in the report applies to this finding in Kansas. Dr. Leeson said he doesn't think we can conclude from this study that there were children without a mental health diagnosis. As for the 5 or more medications prescribed concurrently, that is a judgment call. ***60-Day Polypharmacy, Interclass*** *This study used seven drug classes, adapted from the American Hospital Formulary Service (AHFS) classification system. They are:* *1. Antidepressant* *2. Antiparkinson* *3. Antipsychotic* *4. Anxiolytics (anti-anxiety)* *5. Mood stabilizers* *6. Sedative hypnotics* *7. Stimulants/ADHD* *4,202 children and youth (22.3% of the study population) received 2 drugs from different drug classes for 60 days or longer.* *1,717 (9.1% of the study population) received 3 or more drugs from different drug classes for 60 days or longer.* *In Kansas in SFY2008, stimulants, antidepressants, and antipsychotics were most prevalent among the entire Medicaid-enrolled population. Use of these medications any time during SFY2008 yielded Medicaid child population prevalence rates of 6.1% for stimulants, 3.7% for antidepressants, and 3.6% antipsychotics. This compares to rates in a 2007 study (Vermont) of 3.6%, 4.0%, 2.0%, respectively.* *Mood stabilizer prevalence was .8% in Kansas, compared to 1.8% in a comparable state Medicaid study (Vermont).* *Overall, stimulant and antipsychotic prescription rates in Kansas were somewhat higher than in Vermont, while antidepressant and mood stabilizer rates were somewhat lower. It is possible that mood stabilizer rates were lower in Kansas because seizure disorder specific use of mood*	

	stabilizing anticonvulsants such as Depakote were excluded from the study. *The above rates are for psychotropics for any amount of time during the year. However, when examining children who received psychotropic medications for 60 days or longer in SFY2008, rank order of drug classes changes from stimulants, antidepressants, and antipsychotics to stimulants, antipsychotics, and antidepressants.* *Kansas antipsychotic rates are high compared to other states and previous studies. This increase in antipsychotic use reflects current national trends. Given the severity of possible adverse side effects, this finding deserves further scrutiny.* Dr. Leeson asked about the basis of the disagreement between the SRS study and chapter 9 of KHPAs Transformation Report. Dr. Allison said the disagreement is how the reports are characterized. He discussed some of the differences between the two reports. There was a discussion about the ease of the prior authorization (PA) process and PDL compliance in Kansas. Dr. Burke said there are a variety of easy ways for a clinician to obtain any medication they want whether it is preferred or non-preferred. Filling out a PA form gives the doctor an opportunity to think about whether the non-preferred drug is really necessary for the patient. ***60-Day Polypharmacy Rates – Intraclass*** *Antipsychotics were most often prescribed concurrently. Antidepressants were the second most concurrently prescribed drug class. Stimulants were third. Prior study of polypharmacy has generally found the highest rates within the antidepressant drug class. This study's finding of high intraclass use of antipsychotics is novel.* *601 youth (3.2% of the study population) received 2 or more antipsychotics concurrently for 60 consecutive days or longer. Highest concurrent antipsychotic use was found among: children and youth with SED status, youth with more comorbid diagnoses, and youth in JJA or foster care custody. Of children who received antipsychotics fewer than 60 days, children 0-4 had the highest prevalence rates (17.0%), which might be an indicator of clinical trial use.*	

	505 youth (2.7% of the study population) received 2 or more stimulants concurrently for 60 consecutive days or longer. Highest concurrent stimulant use was found among: children in the 10-14 age group, children and youth on the SED Waiver, those who had more comorbid diagnoses, and those with a mental health prescriber and provider. *480 youth (2.6% of the study population) received 2 or more antidepressants concurrently for 60 consecutive days or longer. Highest concurrent antidepressant use was found among: youth aged 15-17, youth on the SED Waiver, youth in foster care, and youth who had multiple diagnoses or providers with mental health specialty.* *238 youth (1.3% of the study population) received 2 or more mood stabilizers concurrently for 60 consecutive days or longer.* *95 youth (0.5% of the study population) received 3 or more drugs concurrently within the same class of drugs for 60 consecutive days or longer.* Dr. Burke said there are guidelines and data that support the concurrent use of antidepressants. In terms of multiple antipsychotics there isn't data to support that. Dr. Bell asked if receiving 3 or more drugs in the same class concurrently is appropriate in some cases. Dr. Burke said there are certain antidepressants that are very old, inexpensive and because of their sedating properties, are used as non-addictive sleep aids. They would show up as a 3rd antidepressant, but are really being used as sleep aids. ***Very Young Children*** ***Antidepressants and Antipsychotics in Very Young Children (0-3)*** *329 children younger than 4 years old received a psychotropic drug in SFY2008. Since there were a total of 84,886 Kansas children younger than 4 receiving Medicaid in SFY2008, this represents a prevalence rate of 0.4%. 128 children 0-3 (38.9% of those in the study population) were prescribed antipsychotics in SFY2008. 69 children 0-3 (21.0% of those in the study population) were prescribed antidepressants in SFY2008. 11 children 0-3 (3.3% of those in the study population) were prescribed both an antidepressant and an antipsychotic in SFY2008.* *Risperidone (Risperdal), an atypical antipsychotic, was the most prescribed drug in this age group, followed by the top 3 stimulants*	

	prescribed for the study population. *Although an antipsychotic was the most prevalent drug, ADHD and behavior disorders were the most prevalent diagnoses in this group.* *These data suggest that antipsychotic medications are being prescribed for behavior management, possibly including mood stabilization and inattention/impulsivity in very young children.* *Although a large number of data were missing on prescriber specialty type, psychiatrists were the single specialty type that prescribed the most risperidone, an antipsychotic, to this Focused Study on Psychotropic Drug Prescriptions Among Child Medicaid Beneficiaries/August 2009 Executive Summary/Page viii population. However, aggregate comparisons of psychiatric prescribers to all other non-psychiatric prescribers show that the majority of risperidone prescriptions were made by nonpsychiatric prescribers.* *Children with autism or other developmental disorders made up only 6.3% of children 0-3 who received drugs.* Dr. Moeller said there are no atypical antipsychotics approved for children less than 5 years of age. ***Psychostimulants in Very Young Children (0-2)*** *139 children under age 3 received a psychotropic prescription in SFY2008. Since there were 70,814 children younger than 3 receiving Medicaid in SFY2008, this represents a prevalence rate of 0.2%.* *34 children under age 3 (24.5% of those in the study population) received stimulant prescriptions in SFY2008.* *More than half of the children under 3 (57.1% of those in the study population) determined "Not SED" received a stimulant.* *Those children with 2 or more comorbid diagnoses and those children seeing a mental health specialist were most likely to be prescribed a stimulant.* ***<u>Duration of Psychotropic Drugs</u>*** *On average, Kansas child Medicaid beneficiaries received 118 days of psychotropic medications.* *The median number of days children received psychotropic drugs was 86*	

	days. *Boys 10-14 years old, children on the SED Waiver, youth in foster care, youth with more diagnoses, and youth with a prescriber with a mental health specialty received more days of prescriptions.* ***Service Utilization*** *The average number of days between fill date and receipt of community based services among those youth who received community based services (81.2% of the study population) was 30.9 days.* *13 days was the median time lapse between prescription fill date and community based service receipt.* *Because at least one youth had 361 days elapse between fill date and service, the mean is likely skewed and the median more accurate.* *Children with no mental health diagnosis and children with non mental health prescribers and outpatient providers had longer gaps between prescription and service receipt.* ***Supplemental Findings*** *At the request of the Advisory Committee additional findings were conducted after an initial review of findings. These data provide information on the top diagnostic categories and top medications for different subgroups based on gender, age, SED status, foster care status, JJA status, prescriber specialty, and number of diagnoses.* ***Recommendations*** *Recommendations were generated by KU researchers with input from the Advisory Committee and the Kansas Department of SRS. Recommendations are aimed toward state administrators of Medicaid, rather than clinicians. The following are ideas for specific, state-level strategies that could help support and ensure safe and appropriate psychotropic prescription practices for children and adolescents.* *1) Establish practice guidelines and protocols, or adopt established guidelines such as those developed by the AACAP, for prescribing of psychotropic medications to children and adolescents.*	

	a) *Consider establishing Kansas-specific Medicaid prescribing guidelines and suggest practices that would require additional documentation by the prescriber.* Dr. Shaw said that sounds like they are describing a PDL. Dr. Leeson said AACAP is very vague in their practice guidelines. He said that the recommendation is not a PDL it is to have practice guidelines. Dr. Allison asked what else they might mean. Dr. Leeson said that if an antipsychotic is being prescribed to a child under the age of 4 the documentation pattern should look different than if the child was 17. Dr. Bell asked if that would be prior to when they got the prescription filled or is it a suggestion for the clinic chart. Dr. Burke said it sounds like there isn't an implementation strategy recommended. 2) *Consider the development of a public document that helps to clearly and succinctly disseminate evidence-based information on psychotropic medications.* 3) *Develop new strategies for monitoring prescriptions of psychotropic medications to children and adolescents.* a) *Consider a special focus on young children (i.e., younger than 6 years) that would allow intensive review and implementation of corrective action.* b) *Consider a monitoring system that would identify specific prescribing situations that warrant further review of a patient's record.* Dr. Menninger said the above bullets are something the agency is able to do. Dr. Allison said it's a question of degree. He said education or intervention to try to change prescribing patterns is a very labor intensive process. Some states have gone to peer counseling which means paying market rates for a clinician to make the call and therefore is very expensive. He said we would be glad to ask for donations to support that sort of program. Dr. Menninger said this specifically refers to gathering information on practice patterns. Before a system for intervening is considered we need to have more specific information about who and where which is what CNS does. Dr. Allison said that is part of what they do, but one of the questions is if you find 500 prescribers doing something do you intervene with 100 or 10 and in what way do you intervene? Dr. Menninger said that the results were inadequate so that raises the question was the effort to gather them adequate in the first place. Dr. Leeson said it is a matter of how intensive the program is going to be implemented. Dr.	

	Menninger asked about the number of quality indicators that were used. Dr. Leeson said around 25 initially and later in the program it was around 10. Dr. Allison said the issue is if you have a fixed budget then the question is where you concentrate the interventions. Dr. Menninger said at the time the budget wasn't fixed, it was a gift from Lilly. We could have expanded beyond that because they did not specify the amount of money. Dr. Leeson said we could have turned on all of the indicators but it still would have been the top 100 prescribers that got a letter every month. Dr. Allison asked if the letters are effective at all; are they more effective if you blanket or target. He said the question for the committee is what will work. Dr. Burke referred to the Cochrane report that stated receiving letters about prescribing practice has low impact. 4) *Consider establishing a multidisciplinary committee to monitor psychotropic practices for children in foster care and JJA, with a special emphasis on proper prescribing practices and continuity of care.* 5) *Consider a variety of other strategies that would assist with ensuring safe and appropriate psychotropic prescription patterns. The following are strategies that have been implemented by other state Medicaid programs. They are offered to generate ideas that could be developed and customized for the state of Kansas.* *a) Use quarterly or biannual reports on psychotropic medication use to identify trends in key quality and safety clinical indicators.* *b) Hire a medical director that oversees all prescriptions of psychotropic medications to children and youth insured by Medicaid.* *c) Create medical consultation phone lines that can be used by prescribers.* *d) Establish regional psychopharmacology expert networks that provide access to prescribers for consultation.* *e) Develop and disseminate web-based handbooks and trainings on relevant and timely topics for prescribers, especially prescribers without a mental health specialty.* *f) Implement interactive software for child welfare and juvenile justice staff to track and monitor prescriptions of children and youth in state custody.* *g) Implement shared decision-making models to be used with prescribers, parents, and older adolescents to increase communication and collaboration around decisions about whether to use psychotropic medications.*	

	h) Implement public education campaigns to help inform parents and youth of the benefits and risks of psychotropic medications. *6) Conduct additional Focused Studies to expand upon this study's findings, such as examining psychotropic medication dosing by age of child.* Dr. Allison said our dilemma is that we are paying for and providing, without any guidance, these medications without a science base. We see the side effects and know the concrete consequence because of those side effects. Mr. Harkness said we also know the concrete evidence for not treating the pathology. Dr. Allison said not all of these circumstances are going to end up in a hospital or in a suicidal condition. Dr. Leeson said he reviews cases to see whether or not there was an attempt to do non-pharmacological management. There are some cases where an antipsychotic was the first thing tried. Those are the kinds of cases that should be on the table. Dr. Burke asked if there is a thought to have direct management for children only or for everyone. Dr. Allison said the edits themselves could be tailored to a population, and the scope of the committee is not limited to children.	
IV. Review and Discussion of Literature on Preferred Drug Lists	Dr. Allison said we are heading toward having the committee talk about what the next steps should be. The committee will need to help with describing and proposing a new educational retrospective effort. Then the question will be is that enough and if not what other kinds of changes should we make. Dr. Burke said that there is a spectrum of PDL from a cost containment focus to a focus on quality improvement. He also pointed out that the PDL in Kansas has been recognized nationally as one of the more successful programs in the country based on our approach to implementation and routine practice. There are procedures that could be used to improve quality of care. Dr. Allison said many states have implemented different kinds of restrictions that were imposed and then studied. He referred to a New England Journal of Medicine article written in 1994. In that article there was a finding that the imposition of the prescription limits has a 17 to 1 cost. In this study, a three drug limit was implemented; the focus of this study was schizophrenic patients. Dr. Allison quoted the following from the article, "*Nine states limit the number of prescriptions per patient per month that are reimbursed by Medicaid, but there are no data on the*	Dr. Burke suggested an example of a PA form be presented at the next meeting. Dr. Burke suggested drafting a PDL model. Dr. Allison suggested coming up with a couple scenarios and share them with the committee in advance. He asked Dr. Menninger to bring to the committee the studies that are relevant to those. Dr. Shaw suggested we include Missouri and what they do.

	effects of such caps on people with chronic mental illnesses. In September 1981, the New Hampshire legislature limited Medicaid reimbursement to three prescriptions per month as a cost-cutting measure during a budget crisis that was precipitated, in part, by reduced federal support for the Medicaid program. Patients who filled more than three prescriptions in any month were usually unable to pay for them out of pocket; this policy therefore reduced the use of essential medications (such as insulin and cardiac drugs) among elderly patients with chronic diseases and increased nursing home admissions. Eleven months later, after litigation by New Hampshire Legal Assistance, a public legal-aid agency, the state replaced the cap with a $1-per-prescription copayment." Dr. Allison asked if this committee would recommend a 3 prescription per month cap on all medications for all Medicaid recipients. The committee said no. Dr. Allison said the conclusion is then that this study is irrelevant to the proposal that KHPA has put forward. (Soumerai, Stephen, et al. "Effects of Limiting Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia." *New England Journal of Medicine*. 1994; 331(10):650-655) Dr. Allison referred to a Health Affairs article "Use Of Atypical Antipsychotic Drugs For Schizophrenia In Maine Medicaid Following A Policy Change". He said the issue is somewhat different in this article. Dr. Shaw said this article blends Medicaid and Medicare. Dr. Allison said this is frequently cited for reasons not to do step therapy for atypical antipsychotics. Dr. Allison quoted from the article: "*In July 2003 the Maine Medicaid program expanded its preferred drug list (PDL) by implementing a PA and step-therapy policy affecting new atypical antipsychotic users. Atypical antipsychotic spending was slightly lower in both states. Observed increases in treatment discontinuities without cost savings suggest that atypical antipsychotics should be exempt from PA for patients with severe mental illnesses. The primary effectiveness measure in a recent large trial of antipsychotic therapy for schizophrenia was the time until a patient discontinued initial therapy, as measured by discontinuation or a switch in pharmacotherapy. Such changes occur commonly and indicate attempts to treat schizophrenic symptoms. We decided a priori to use a similar composite end point, with discontinuity defined as evidence of a gap in therapy or switching to or augmentation with another antipsychotic."* Dr. Allison said that as the endpoint they are measuring was the intended result of the policy, they've only demonstrated that step therapy leads to steps. (Soumerai, Stephan, et al. "Use of Atypical Antipsychotic Drugs for Schizophrenia In Maine Medicaid following a	

	Policy Change." Health Affairs. 2008; 27(3):w185-195.) Dr. Allison said one possibility would be to sort out the studies on interventions and try to classify them into the sets of interventions that we might consider in Kansas. Dr. Menninger said that would make sense. Dr. Burke said there are two ways to look at this. One would be to sort through the literature and try to organize it so that it's relevant. Another would be to put together a proposal and reflect the literature against the proposal. There was a discussion about the legislature and the things they are asking for and proposing. Dr. Allison asked the committee to provide their input on the CNS program; about what will work and what won't, within the next week. Dr. Burke asked if it's still possible to have HID as the vendor. Dr. Allison said yes, but first we need to know the content. The vendor and source of funding are separate.	
V. Next Steps	The committee ran out of time to discuss this.	
VI. Adjourn	The meeting was adjourned at 2:05 p.m. with no further comment.	Mr. Harkness moved to adjourn the meeting. Dr. Moeller seconded and it carried with a unanimous vote.