

**;Mental Health Prescription Drug Advisory Committee Meeting
Meeting Minutes, Open Session
November 4, 2009**

<p>MHPDAC Meeting Minutes, Open Session EDS / Forbes Field Capital / Cedar Crest Room Topeka, KS November 4, 2009</p>	<p>Members Present: Michael Burke, M.D, Ph.D., Chair Susan Crain-Lewis, L.M.S.W. Megan Dahman, Pharm.D. Eric Harkness Roy Menninger, M.D. Karen Moeller, Pharm.D. Eve-Lynn Nelson, Ph.D. Pam Shaw, M.D. KHPA Staff Present: LeAnn Bell, Pharm.D. Aimee Grubb, Recorder Margaret Smith, M.D., Shelly Liby</p>	<p>Public: Rick Shults, SRS</p>
TOPIC	DISCUSSION	DECISION AND/OR ACTION
<p>I. Announcements</p>	<p>Dr. Burke called the meeting to order at 10:06 a.m.</p>	
<p>II. Review and Approval of September 16, 2009 Meeting Minutes</p>	<p>Dr. Burke suggested deferring the review and approval of the minutes to the next meeting. This was due to the lengthiness of the minutes and needed adequate time to review.</p>	<p>Mr. Harkness moved to defer the review and approval of the minutes to the next meeting. Dr. Moeller seconded and it carried with a unanimous vote.</p>
<p>III. Old Business a. Review of State of Missouri statute regarding mental health drugs and current limitation on mental health drugs</p>	<p>Dr. Bell brought the language of Missouri Statute 208.2727 Psychotropic medications, access to for the members of the committee.</p> <p>Management allowed by the statute:</p> <ul style="list-style-type: none"> • Dose optimization (preventing dispensation of multiple units of a lower strength when the same dose can be achieved with a single unit of a higher strength tablet or capsule) • New drug combinations (i.e. Symbyax – olanzapine/fluoxetine) • Preferred Drug List for SSRIs • Atypical antipsychotic duplicate therapy • Limitations in place prior to statute enactment <p>Management they do:</p> <ul style="list-style-type: none"> • Dose optimization, including quantity limits on the higher strengths • Diagnosis restrictions on all ADD/ADHD treatments (this edit was in place 	

	<p>prior to statute enactment)</p> <ul style="list-style-type: none"> • 15 day quantity limit on any first fill of a drug with cost greater than \$150.00 (which includes all atypical antipsychotics and most mood stabilizers) • Preferred SSRIs, with fail-first requirement for non-preferred SSRIs <p>Dr. Menninger asked how the CNS program and the Missouri statute work together. Dr. Bell said the program is used in conjunction with the edits they have in place. It probably is a compounding factor when they estimate their savings because they can't isolate how much they save from the limitations at the point-of-sale. Ms. Lewis said the CNS program for Missouri is a lot more robust than Kansas'. Dr. Burke asked if the statute was enacted in 2007. Dr. Bell said from the research she found that is when it was enacted. Dr. Burke said although the CNS program would be separate from the statute if they were overlapping in time they could be confounding.</p>	
<p>VI. Summary table of Comprehensive Neuroscience Quality Indicators</p> <ol style="list-style-type: none"> Ten child quality indicators Ten adult quality indicators 	<p>This agenda item was tabled at our last meeting, and additional details were gathered in the interim. For each quality indicators (QI), a hard copy of the summary sheet was provided in September. For the child quality indicators, in addition to the summary sheet, there are tables that provide a breakdown of patient age and patient eligibility type by provider type.</p> <p>Dr. Menninger asked Dr. Bell if she has an impression of what stands out. Dr. Bell said it is interesting to be able to see who exactly are prescribing and how old the children are. Dr. Menninger said that he was surprised to see that about 75% of the prescribers were psychiatrists. Dr. Bell said overall about 65% of the prescribers are general practitioners. It is likely that the reason the percentage of psychiatrists prescribing is higher is because this data is based on outliers.</p> <p>Ms. Lewis pointed out that outliers are cropping up in foster care and JJA. Any intervention that is done needs to bring that part of the system into the dialogue in some fashion. Another hypothesis is there are two distinct populations in the outliers in terms of prescribers. If there is an intervention done there should be two different types of interventions. She noted, on the child tables, there is a very clear trend that the problem outliers were within the pre-teen age group.</p> <p>Mr. Harkness clarified that the ARNPs and PAs are operating under the observation of physicians. He said as a patient he gets more contact time with the ARNP than with the physician.</p> <p>Dr. Burke said because of the shortage of psychiatrists it is common to be using non-physician extenders and supervising them.</p> <p>Dr. Menninger said the percent of triggers varies widely. How do you define</p>	

“the problem”? How big do the numbers have to get to be considered a problem? Dr. Bell said that would be a question for the committee to answer. That is part of the reason why the committee was formed. Dr. Menninger stated he wants to know the opinion of KHPA. Dr. Bell said from the agency standpoint there is room for improvement. That being said, we are not subject matter experts so the agency has asked people that are subject matter experts to help determine how much of a problem it is and what is the best way to approach it. Dr. Menninger asked if there is an impression that the problem is greater or potentially greater in children. Dr. Bell stated her concern is more for the children because they have to live with it for a lifetime. Dr. Burke said part of the theme has been, particularly with psychotropic drugs, children and adolescents have been left out of clinical trial studies. There is not robust clinical trial data to support the usage of certain psychotropics in that age group. Efforts have changed now and children are being included in clinical trial studies. Part of the heart of the issue is children are getting medicines for which there isn't data to support safety and efficacy.

Dr. Burke said another issue is that the quality indicators can be difficult to interpret. For example use of five or more psychotropics during a 90 day period in children under 18 doesn't tell us that a child was taking 5 different pills every day; they may have tried different medicines that didn't work. Sometimes this data doesn't represent the level of concern that may be seen at the surface level. One area of interest would be dosing for example children that are on higher doses than recommended for adults.

Dr. Smith pointed out that while these patients may not be taking 5 different psychotropics a day, the cost of getting them on the right medication is an issue as well. The doctors may be prescribing a full 30 days of each prescription that is in turn being wasted if it doesn't work. Dr. Burke said it is a challenge to interpret the data. Dr. Shaw said her practice sees a lot of kids on 2 or 3 psychotropics at a time. She said these children are having a lot of side effects which in turn may cause major health issues as they become adults. She sees 1 or 2 children per week who have been diagnosed with bipolar disorder; when she was in training bipolar disorder was rare. There are children as young as 5 years old that have been diagnosed as bipolar. Mr. Harkness asked Dr. Shaw when she sees these children that have been diagnosed is she able to support that diagnoses. Dr. Shaw said she deals with children of all kinds and at one moment they appear manic and the next minute they can appear depressed as a part of their developmental progress. There are teenagers with the same diagnosis who are on drugs that aren't used for bipolar, that she has heard of. This is an issue. These children carry these diagnoses forward into adulthood and deliver babies.

Dr. Dahmen commented that the difference between adult and children is that in adults the literature supports that there are certain drugs that don't have the metabolic risks. That isn't the case with children. Children gain more weight on those drugs and have other metabolic side effects. There are clinicians that are not aware there are some drugs that don't have metabolic side effects on the adults, but do on children, so if a doctor is treating children the same as adults, that can be an issue. There is no literature on children that is good enough to make clear recommendations.

Dr. Menninger asked if it is conceivable, if we had a robust program that gathered increasing amounts of data over time, that we could begin to develop some clinical judgment. Dr. Burke said, regarding more information on 5 psychotropics within 90 days, charts would need to be pulled and reviewed. This would take a large amount of man power. Dr. Leeson said there is the KU Focus Study that is looking at some of this in a little more detail.

Ms. Lewis was concerned that the ARNPs that are prescribing the 5 or more psychotropics in a 90 day period were not doing so under the advisement of a psychiatrist. Dr. Smith said that many of them are working in the Community Mental Health centers. Dr. Bell said there is no way to find out where the ARNPs are working because they each have their own provider number. Dr. Leeson asked if there is a way to find out from the board of nursing whether or not they are credentialed as a psychiatric nurse practitioner. Fran Seymour-Hunter said they have to demonstrate that they have additional class training.

Dr. Moeller said another issue is whether or not the psychiatrists and nurse practitioners are trained in child psychiatry. In the rural mental health clinics the psychiatrists probably have minimal training in child psychiatry. Another issue may be that a drug isn't working and the provider adds to it instead of taking the patient off the drug that isn't working. Dr. Leeson said the 5 or more psychotropics in 90 days indicator is probably the weakest indicator for several different reasons.

Dr. Burke said it would have been nice to have a sheet that had a list of all the drugs that are considered psychotropic. Mr. Harkness asked to have a current list updated quarterly. Dr. Bell said CNS maintains the list. Mr. Harkness asked for a list with brand name, generic, and manufacturer. Dr. Leeson said may want to know what drug class each is considered to be in.

Dr. Dahmen was interested in the adult QI use of an atypical antipsychotic at lower than recommended dose for 45 days or more. She said if drugs are being used sub-therapeutically for a sustained period of time not only are we exposing

	<p>people to risks of side effects but it is also a huge cost. This may be a place to have an intervention. Sixty-six percent of the patients that were flagged in this QI were over the age of 65 so an argument could be that those patients needed less antipsychotic due to age. Dr. Bell said that those patients aren't all over the age of 65; some are on Medicare because of a disability.</p> <p>Mr. Harkness said in his experience it was better to be put on something totally different than to add a small dose of another drug to his regimen because that didn't work for him. Dr. Dahmen said there are areas where augmentation is supported in literature especially in depressive therapy.</p> <p>Dr. Menninger asked what we are doing with this information. Dr. Burke said this is a follow-up from the CNS presentation at the previous meeting. He said our committee should make recommendations to KHPA with the types of changes that should be made.</p>	
<p>V. Health Information Designs (HID)</p> <p>a. Presentation on Retrospective Drug Utilization Review Program</p>	<p>HID currently provides retrospective drug utilization review services for the KHPA Drug Utilization Review (DUR) Board for non-psychotropic drugs. In addition, the DUR Board chose antipsychotics as an intervention topic at their October meeting. The criteria used to identify potential opportunities for medication therapy improvement as well as how many patients were identified on that criterion was provided to the committee.</p> <p><u>Retrospective Drug Utilization Review Program</u></p> <p><i>Drug Utilization Review Board</i></p> <ul style="list-style-type: none"> • Federally mandated program (42CFR456). • Must include prospective drug utilization review (DUR) and retrospective DUR (RetroDUR). • The DUR Board is responsible for implementing and operating the DUR program and making recommendations to the Kansas Health Policy Authority (KHPA) regarding drug therapy issues. <p>Prospective DUR includes PA, diagnosis restrictions, quantity & dose restrictions. HID's focus is on RetroDUR</p> <p><i>Retrospective DUR</i></p> <ul style="list-style-type: none"> • The RetroDUR program provides education to physicians, mid-level practitioners, and pharmacists regarding outpatient medications. • This education is provided through: <ul style="list-style-type: none"> • Population-Based Interventions 	

- Academic Detailing visits
- Quarterly Newsletter

Intervention topics are selected by the DUR Board. Academic Detailing visits can regard a variety of topics. The Quarterly Newsletter is sent out to all prescribers and pharmacies that have written or dispensed for a Medicaid beneficiary in the past quarter. HID is also capable of sending out additional educational mailings based upon a specific state's request.

Population Based Interventions

HID has access to both pharmacy & professional claims data, this allows us to review medications as well as diagnosis. All data is run against our clinical criteria using a computer based review. All criteria 'hits' will be printed on the ICER report. Based upon the ICER and the intervention topic selected by the DUR board, patient profiles are generated for clinical review. A pharmacist reviews the patient medication and diagnostic history to determine if it is necessary for a letter to be mailed to the prescriber regarding the drug therapy issue. Letters, with patient profiles, are mailed to prescribers with response forms and self-addressed return envelopes. HID reviews provider feedback and enters it into a database.

- HID has over 3,000 clinically-based criteria.
- Criteria are developed and managed by a team of clinical pharmacists.
- All data are run against our clinical criteria using a computer based review.
- ICER includes all criteria 'hits' for a data cycle.
- Used to identify drug therapy issues and generate patient profiles for review.
- Patient profiles are generated based upon intervention topic selection.
- A pharmacist reviews the patient profile to determine if it is necessary for a letter to be mailed to the prescriber regarding the identified drug therapy issue.
- The patient profile includes both medications and professional diagnosis histories.
- Alert letters are mailed to the prescriber describing the potential drug therapy problem along with a 12-month comprehensive drug and diagnosis history profile.
- The prescriber is encouraged to fill out a feedback form and return it to HID.
- HID reviews prescriber feedback and tracks it in a computer database.

The alert letter is designed to provide prescribers with information to help them make sound clinical decisions regarding their patient.

Mr. Harkness asked what the prescriber's motivation would be to read and respond to these letters. Dr. Churchwell said hopefully the prescribers are finding these alerts to be educational, especially in a situation where they have prescribed a med and another doctor prescribes something else and the patient is taking them at the same time.

Dr. Menninger asked what percentage of the prescribers respond. Dr. Churchwell said it has been about a 30% response rate. Dr. Menninger asked how many letters were sent out. Dr. Churchwell said it was around 2000 letters. Ms. Lewis asked how many hits generated the letters. Dr. Churchwell said letters were sent on about 70% of the profiles reviewed. Ms. Lewis asked if there was any follow-up on the 40% that didn't respond to the letters. Dr. Churchwell said there 60 academic detailing visits she can do per year which could be used to follow-up with prescribers that receive multiple letters.

Mr. Harkness asked if any state has an incentive in place to get the prescribers to respond. Dr. Smith said in Washington state if the prescribers don't respond to a certain number of letters they get a phone call. Dr. Burke asked if there is any state where the Medicaid prescribing privilege is tied to responding. Dr. Smith said not that she is aware of. Dr. Burke said there is no consequence then.

Antipsychotic Intervention

- An intervention based upon antipsychotic medications was chosen by the DUR board to be performed in State Fiscal Year 2010.
- Criteria 'hits' are broken down by patient risk scores.

Risk Scores

- Calculated using factors that would increase a patient's risk for an adverse drug event or drug therapy problem.
- Individual Patient Factors:
 - Age
 - Gender
 - Multiple Providers
 - Concomitant Therapy or Diagnosis
 - Negating Therapy or Diagnosis

Dr. Burke said to come up with the individual risk scores there is a complex

<p>b. Review of Antipsychotic Intervention criteria selected by DUR Board at October meeting</p>	<p>computation with the different variables. Dr. Churchwell said the risk scores are calculated differently for each of the criteria.</p> <p><u>Review of Antipsychotic Intervention Criteria</u></p> <p>Dr. Churchwell presented a summary table for the antipsychotic intervention ICER. The hits were broken down by drug-drug interactions, overuse precaution, high dose alert, underuse precaution, therapeutic appropriateness, drug disease precaution, drug-drug marker and/or diagnosis, and therapeutic duplication. The total hits were 20,534 which is not the number of unique beneficiaries as patients can hit on more than one quality indicator. The total number of unique beneficiaries was 7,650.</p> <p>Dr. Menninger asked how you determine low, medium, or high risk scores. Dr. Burke said for each quality indicator it becomes an algebraic sum of particular items in those categories.</p> <p>Dr. Bell asked the committee to look over the quality indicators and give feedback about which ones are clinically relevant.</p> <p>Ms. Lewis asked if providers would get two letters from two companies all originating from KHPA. Dr. Bell said that wouldn't be very likely to happen because for the past six months we have only been using the refill indicators through CNS. Dr. Burke said the HID intervention will be a onetime thing. Dr. Menninger asked if this is a trial program. Dr. Burke explained that the DUR board does four interventions per year. The board then chooses some quality indicators to pull people who are really deviating from what is thought to be appropriate practice. Then educational information is sent out to those providers who have patients who are high risk. Dr. Menninger asked what this committee's role is with this. Dr. Burke said we don't know what this intervention will show. Dr. Churchwell said HID waits six months, after the letters are mailed, to look at the data.</p> <p>Ms. Lewis asked if there is a way to look at old data from CNS in order to get an apples-to-apples comparison. She said if she's going to be called on by this committee to make recommendations then she would like to see, from both companies, the criteria, total amount of hits, the total number of letters sent out, the response rate from the letters, and any data that can be found on changes in prescribing patterns from the providers who have received letters. Dr. Bell said there isn't a way to do an apples-to-apples comparison because they are different companies with different business models. Dr. Burke said there would probably be some similarity or overlap between some quality indicators. Ms. Lewis</p>	<p>The committee will review the quality indicators at home and send their comments to Dr. Bell by Thanksgiving.</p>
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	<p>requested that each company each provide their response rate because what she's hearing is that no one is reading the letters nor are they changing prescribing patterns. Therefore we may have to think about a PDL or something else. Dr. Leeson said the CNS packages didn't ask people to reply. You can't take a snapshot of the data and say people did or did not change their prescribing patterns. You need to look at the track records of the data. Dr. Shaw said the letters may make an impact on clinicians, but they may not return the feedback. Ms. Lewis said part of what we need to look at is anything we can get that shows changes in prescribing patterns because the ultimate goal is to change prescribing patterns. Mr. Harkness said the goal is to improve patient lives.</p> <p>Dr. Burke suggested the committee look over the quality indicators at home and send their comments and suggestions to Dr. Bell via email or postal mail. He pointed out that if there is a quality indicator that has no hits then those should not be included. The deadline to send comments/suggestions is by Thanksgiving.</p>	
<p>VI. Enhancement options for Comprehensive Neuroscience program</p>	<p>Interest in other/enhanced products offered by CNS was expressed at the September meeting. The CNS enhancement file was prepared by CNS staff outlining the additional services they could provide.</p> <p><u>Text of CNS Proposal for Expansion of the Behavioral Pharmacy Management Program:</u>The Kansas legislature has recently pointed out that paying millions for ineffective drugs is a luxury that can no longer be afforded in Kansas. KHPA is evaluating different mechanisms for the application of more efficacious use of drugs and drug management. CMT has been at the forefront of efforts to save healthcare organizations significant sums in behavioral pharmacy expenditures while at the same time improving health outcomes. Quality Indicators™ currently in use by CMT fall into three main categories: 1. improving the quality of prescribing of psychoactive medications to better conform to practice guidelines; 2. improving adherence to medications; and 3. detecting multiple prescribers of the same or same class medication. The QIs in the first of these categories are mainly concerned with reducing polypharmacy, encouraging prescribing within therapeutic dose guidelines, maintaining medication for sufficient periods of time to enable evaluation of response, and avoiding adverse side effects and drug-drug interactions. While these QIs have been shown to both improve clinical outcomes and reduce pharmacy expenses, more savings and even better care could be accomplished by direct specification of medication steps for each specific psychiatric diagnosis. KHPA currently messages on a small number of Quality Indicators and across a limited set of prescribers who are out of step with current best practice. KHPA does not utilize any expanded components of the BPM program, such as peer</p>	<p>The committee would like to see a price list and would like to know if Eli Lilly would be willing to sponsor additional program activities. Ms. Shaw would like to see the price list and similar information from HID. Dr. Menninger requested information on what services are presently provided to Missouri. Dr. Leeson suggested having Joe Parks from Missouri give a presentation on what their state does. Dr. Leeson asked for information from CMT about the prescription adherence intervention program; what are the data and outcomes that can be expected?</p>

consultation. In order to better leverage the BPM intervention, CMT can expand the application of the BPM intervention in the following areas:

Cost Containment and Treatment-Specific Quality Indicators: The new “Treatment-Specific Quality Indicators” use the most recent empirical evidence and clinical consensus guidelines to direct prescribers to select specific, efficacious, and cost-effective medications for each condition. These QIs favor generic preparations in all cases that the evidence documents their efficacy and safety and restricts switches and augmentations of initial monotherapy to agents that are maximally cost-effective. The new QIs will provide additional tools and support for maximizing KHPA’s desire to encourage monotherapy and generic usage where appropriate. For example, the new QIs specifically recommend one of two generic SSRI’s for the initial treatment of depression in a drug-naïve patient. Non-response is followed by a switch to another generic antidepressant medication. Partial response is followed by augmentation of the first antidepressant with one of several generic, evidence-based choices (e.g. lithium, thyroid hormone, or sustained-release bupropion). Similarly, the new QIs recommend generic risperidone or perphenazine as the initial choice for the treatment of newly diagnosed schizophrenia. Low doses of antipsychotics for non-indicated purposes (e.g. insomnia, anxiety, or PTSD) are discouraged. Clozapine is encouraged after two successive antipsychotic medications have failed in a patient for whom the MPR score documents adherence whereas depot antipsychotic medication is recommended in such a situation in which the MPR score indicates persistent non-adherence to oral antipsychotic medication. Similar QIs are available for bipolar disorder, ADHD, anxiety disorders, and dementia. This system should reduce pharmacy expenses substantially and may reduce the need for prior authorization programs, which are cumbersome for prescribers and expensive to implement for health plans.

Dr. Menninger said the paragraph above sounds like a restrictive drug list. He asked for clarification on that. Dr. Bell said they plan on doing mailings after. The letter would say, for example, we specifically recommend this generic SSRI for the initial treatment of depression in a drug naïve patient.

Greater Outcomes Impact through Expansion of the BPM Intervention for All Prescribers: Customers who receive maximum value from the BPM intervention message on all available Quality Indicators to all prescribers who appear to be out of step with current best practice per the CMT algorithms. Currently KHPA messages on a small set of Quality Indicators and only to 100 of the potential pool of prescribers whose practice may not be in keeping with

best practice. CMT can offer a pmpm pricing model to expand the intervention to all prescribers and project a rate of return on that investment. By spreading the intervention across all opportunities for change, KHPA can realize higher cost offsets and greater move to best practice across all behavioral health drug classes.

Complimenting the Prescriber Experience through Increased Peer

Consultation: We have shown that mailed Quality Indicators™ have positive effects on prescribing practices. It is clear, however, that some prescribers remain recalcitrant to standard audit and feedback. In only a minority of cases this is because the prescribing practice questioned by the QI is actually clinically justified. Peer consultation is effective in persuading many clinicians who do not respond to mailed QIs to change prescribing practices toward better and more cost-effective care. Peer consultation can be implemented for prescribers who fail to change prescription practices after mailed treatment specific QIs and can be targeted to prescribers at high-risk to be recalcitrant. This consultation will support the maximization of generic use of medications when clinically appropriate. It also identifies instances in which the unusual prescribing practice is justified and therefore further QIs are unnecessary. Specific language from the client in cover letters introducing peer consultation to prescribers increases the number that respond to the peer consultants' phone call. This system also identifies situations in which KHPA may wish to take further action to insure that the clinician adheres to appropriate prescribing guidelines.

Addressing Current HealthCare Concerns through the Opioid Monitoring

System: According to a recently released Substance Abuse and Mental Health Administration (SAMHSA) report, hospital admissions "for treatment of prescription painkiller abuse in the United States have risen dramatically over the past decade, from one percent of all substance abuse admissions in 1997 to five percent in 2007." Although it is extremely important to treat painful medical conditions promptly and adequately, we have found that a high proportion of narcotic analgesic prescriptions are given for diagnoses that do not support the use of opioids or that opioids are prescribed for unwarranted extended periods of time. The cost of unnecessary opioid prescriptions is significant, as is the cost of caring for the alarming increase in patients who become addicted to prescription opioids and require emergency room, acute hospital, and rehabilitation services. To address these needs, CMT has developed an Opioid Prescription Intervention (OPI) that identifies unnecessary opioid analgesic prescriptions and alerts prescribers to potential abuse. This OPI has potential to save both pharmacy costs and total healthcare services

expenditures.

Addressing Special Needs of Children through Special Monitoring of Antipsychotic Prescriptions to Young Children: Two atypical antipsychotic medications have been approved by the FDA for treatment of pediatric schizophrenia and bipolar disorder (one of these for irritability in autism), two other atypical antipsychotics have been recommended for approval for pediatric use by an FDA advisory committee, and several typical antipsychotic medications have been approved for children with psychotic disorders or tics. Neither of the two already approved second generation (SGA, atypical) antipsychotics on this list is approved for use in children under the age of 10. Nevertheless, there has been a rapid increase in antipsychotic prescribing to children, including those under five, of both unlabelled medications (e.g. olanzapine, quetiapine) and for unlabelled indications (e.g. ADHD, conduct disorder). Important questions have been raised about the safety and long-term risks of prescribing antipsychotic medications to children. Also, given that antipsychotic medications are among the most expensive drugs, unnecessary prescribing to any sector of the population results in substantial avoidable pharmacy costs. We have developed a special monitoring program to identify all antipsychotic prescriptions to children under age five, which can be extended upwards or downwards, which includes a higher rate of mailed QIs and of peer consultations than we use in other prescribing situations. This system has as its aim improving prescribing to children and reducing behavioral pharmacy costs.

Utilizing Local Leadership through the BPM for Local Systems of Care (BPM-LSoS): CMT's vast experience with audit and feedback approaches, like BPM, suggests that the more points of communication available on the same message, the more likely prescriber change is to occur. Communicating about best practice at the practitioner level as well as at the clinical and administrative agency level leads to greater "stickiness" in terms of message received and higher likelihood of action to be taken. CMT can implement a program which will serve as an enhancement to its Behavioral Pharmacy Management Program, called the ***Behavioral Pharmacy Management for Local Systems of Care (BPM-LSoS)***. This enhancement is for the purpose of generating information about prescribing practices at selected participating Community Mental Health Centers (CMHCs). The information can be used locally to allow:

- review of trends in practice patterns within a particular prescribing

community,

- comparison of prescribing practices within the community,
- local action for the improvement of the quality of care of adult (ages 18-64) and child (0-18) behavioral health patients, and
- efficacy based pharmacy management principles that focus on using the best medications that cost the least.

This program involves the analysis, packaging and delivery of aggregate community (by CMHC catchment area) BPM reporting that CMHC Medical Directors and Agency Directors can use in managing and monitoring the prescription regimens of the entire consumer population. This kind of reporting allows the Agency Director, Clinical Director, or Medical Director to analyze and evaluate prescribing practices of retained or contracted physicians, look for patterns of outlier behavior by physician or patient, and take systemic quality improvement (QI) actions to address areas of concern, e.g., academic detailing, messaging about best practice, CME educational activities, targeted peer consultation, etc. This approach allows for facilitated discussion of the QI actions involving the treating physician, CMHC medical director, the agency CEO and other clinical/medical staff as appropriate. The goal is for the use of aggregate information at the local management and coordination of care level to have a more powerful impact on quality prescribing and efficacious use of medications. *This program allows for the evaluation of the impact of local decision making on improved costs and quality of care in the area of behavioral pharmacy.* Additionally, the reporting provides CMHCs with information about other physicians' (those not either retained or contracted by the agency) prescribing patterns for consumers receiving services at the local community for continuity of care purposes. CMT's Clinical Team is available for consultation on the use of the reports, patterns of prescriptions seen, and ideas about intervention follow up.

Prescription Adherence Intervention (PAI) Program

There is widespread agreement that a major problem limiting the successful treatment of patients with serious mental illnesses, including schizophrenia, is poor adherence to prescribed medication regimens. In the recent Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study, 74% of patients discontinued their antipsychotic medications before 18 months; approximately 40% of them did so by their own "decision". In a recent CMT implementation of a Treatment Adherence Program (TAP) intervention in another state, 68% of the identified patients for the program had partial or total discontinuance with

their antipsychotic medication at the outset of the intervention. In a CMT review of other states' Medicaid pharmacy program data, up to 31% of patients that had been filling prescriptions of antipsychotic medications for a period of at least three previous months discontinued their medication in the most recent month of analysis. There is compelling evidence that discontinuation or lapse in antipsychotic medication contributes substantially to increases in frequency and length of hospitalization.

Despite the widespread nature and serious consequences of nonadherence to antipsychotic medication regimens, there is evidence that physicians are very often unaware when their patients discontinue their medications and that they overestimate their patients' adherence.

CMT offers its Prescription Adherence Improvement (PAI) Program that allows for:

- **Drug Utilization Review:** analyze prescription medication history of selected patients and selected drug classes to identify patterns of partial adherence (late or inconsistent refilling) as well as total medication discontinuance.
- **Pharmacy Surveillance for Continuous Monitoring of Medication Adherence:** analysis to acquire early notification of lack of timely refilling of a prescription for the treatment of a severe mental illness and/or a chronic physical condition.
- **Rapid Alert Notification:** alerts to case managers and/or designated contact persons when analysis of medication history indicates that their patients are late refilling or might have discontinued their antipsychotic medication and/or other essential medications.
- **Medication Possession Ratio (MPR) Notifications:** written notifications to prescribers, CMHC case managers or designated CMHC contact person of the Cumulative Medication Mean Gap Ratio (MPR) and Mean Gap Ratio level on a monthly basis for ongoing tracking and monitoring.
- **Aggregate Reports:** to KHPA that provides information in changes of MPR and GAP scores over time for patients enrolled in the program.
- **Impact Analysis:** on various aspects of patient outcome such as

hospitalization admit and readmission rate.

Coordination of Care for Children in the Kansas Medicaid Fee-for-Service Program

KHPA has expressed a concern and interest about the quality and safety of drug regimens for children being served through Medicaid in Kansas. Further, KS is embarking on a significant initiative to enroll greater numbers of uninsured children in the SCHIP program. The current concern about safety combined with the increase expectation of enrollment of children in the public payor system, requires increased need for tools and information to guide quality care for children.

Nationally, an increased awareness regarding children’s mental health needs has been highlighted in a number of reports including the Surgeon General’s Report and the President’s New Freedom Commission Report. It has been reported that one in five children has a diagnosable mental disorder and at least one in ten children has a serious emotional disturbance that causes substantial impairment in functioning at home, at school, or in the community. Rappley reported that 3 to 7% of children are affected by ADHD. ADHD is one of the most prevalent disorders in children and is one of the most treatable, with efficacy of stimulant treatment supported by a multitude of studies. Children in state custody have high rates of mental illness and co-occurring chronic healthcare conditions such as obesity and diabetes. Additionally, and especially for those involved in foster care and residential treatment, the often fragmented psychiatric and general healthcare treatments often lead to these children receiving care that is inconsistent with evidence based recommended practice. The systematic failure to coordinate psychiatric medication treatments, psychotherapy and general healthcare often produces additional problems.

CMT would like to offer a targeted Care Management Intervention (CMI) for children with complex needs served by KHPA that will improve the quality of care for these children and promote coordination of care among all their providers of care.

CMI identifies a complex needs group of children and generate a patient specific Integrated Health Profile Report (IHP) to be shared with community care providers (e.g., child welfare worker, MH case manager, physician, psychiatrist). In addition to promoting coordination of care, the project will

promote evidence based practices in the areas of psychiatric prescribing, psychotherapy, and general healthcare. The analysis will identify:

- children with prescribing practices not in conformity with practice guidelines and for whom psychotherapy is being underutilized
- children receiving psychotherapy but for whom medication treatment is being underutilized
- children with chronic medical conditions such as diabetes who are not receiving the evidence based recommended treatment for those conditions
- children with psychiatric medications without benefit of a mental health assessment, including those on ADHD medications

The IHP Report will provide services and drug history, residential status history, diagnostic history, health and safety alert information and CMT's proprietary Care Consideration™ recommendations. The goals of the program are to improve coordination of care, access to care, and overall quality of care for children.

Dr. Burke summarized what CMT can offer:

- More quality indicators
- More peer consultation
- Additional programs for community mental health centers
 - Looking at trends with individual mental health centers
 - Providing some practice guidelines and education
- Rapid alert notification - if someone didn't refill a prescription when it was due they would notify someone right away that it didn't happen. Dr. Bell said she's not sure how they would manage that because it implies a real time access to prescription claims which they don't have. This is all contingent on how much it costs and Eli Lilly's willingness to pay.

Dr. Burke asked if the committee would like to see a price list and if the committee would like to know if Eli Lilly would be willing to sponsor additional program activities. Dr. Shaw said she'd like to see the price list and similar information from HID. Dr. Bell said she would request pricing and speak with Eli Lilly about sponsorship. Dr. Menninger asked Dr. Bell to also find out what services are presently provided to Missouri. Dr. Leeson suggested having Joe Parks from Missouri give some information because their department supplements the CMT material aggressively. They have a number of staff and quite a few dollars directed to that outside CMT.

	<p>Dr. Leeson would like to see some information from CMT about the prescription adherence intervention program. What are the data and outcomes that can be expected?</p>	
<p>VII. KHPA State Fiscal Year 2011 Budget Initiatives</p> <ul style="list-style-type: none"> a. Provider Rate Leveling b. Streamlining Prior Authorization in Medicaid c. Mental Health Pharmacy Management 	<p>Dr. Bell provided information on the Budget Initiatives in the KHPA Fiscal Year 2011 Budget. Like other state agencies, KHPA was asked to reduce its expenditures to compensate for the State's reduced revenue caused by the economic downturn. The three budget initiatives provided were selected by the KHPA Board for inclusion in KHPA's FY11 budget. The mental health pharmacy management is directly applicable to this committee. In order for KHPA to manage mental health drugs, the statute that is currently in place would have to be rescinded. This committee would be requested to assist with implementing safety edits and a PDL for mental health drugs, specifically only for stimulants and anitdepressants. Concerns have been expressed that the KHPA Board did not listen to this committee's recommendations. To address that, the KHPA Board is our directive body. They review things outside of what the advisory committees review, in addition to the budget. The Board has to listen when the Governor says to cut the budget. The Board made this decision deliberately and they know the consequences. This is an advisory committee, so the decisions the committee makes are not binding on KHPA. KHPA's intention is to provide the best care possible for patients so we hope, under the committee's advice, we can implement these policies in the best possible way. These initiatives have been presented to the Governor. We don't know yet if he has accepted this as one of his budget reductions but we have no reason to think that he won't. Dr. Menninger asked if the governor does accept it where does that put the committee. Dr. Bell said if it is accepted and the statute is rescinded and KHPA is allowed to do management it will be the goal of this committee to assist in the development of a PDL for mental health drugs.</p> <p>Dr. Menninger said he thought what the committee had been discussing was a substitute for a PDL; a way of managing prescribing practices without the restrictions of a PDL. Dr. Bell said what she thinks the committee has been discussing is good ways to manage mental health drugs and whether that is a PDL or something else entirely has yet to be determined. There are committee members who are opposed to a PDL and other members who are in favor of a PDL. The committee, as a whole, has not determined what good strategies for mental health management are. Mr. Harkness said there are some members who are in between and see the advantages and disadvantages of both. Dr. Menninger asked if it is correct to say that reviewing these programs is potentially a replacement of a PDL. Dr. Bell said it is the intention of the KHPA Board, if this statute goes through, that we create a PDL. Dr. Smith said for other medications we use both retrospective and prospective DUR to manage</p>	

	<p>them. Dr. Bell said the programs that have been discussed would be in supplement to the PDL.</p> <p>Dr. Leeson clarified that the PDL would only be for stimulants and antidepressants. He said he doesn't know enough about stimulants to know if that was a good move, but as for antidepressants he thinks that was a good move because we aren't getting into the antipsychotics where there are so many differences between the agents and there aren't enough generic choices.</p> <p>Dr. Burke said this is important information for this committee that in fact the KHPA budget proposal included forming a limited PDL to assist with the management of psychotropic drugs. Dr. Bell said the proposal itself didn't specify that it would be limited to just stimulants and antidepressants. However, the estimate of savings, if we included antipsychotics, would be around \$10 million, but Dr. Bell felt that was too much to take on in the first year. Dr. Burke said antidepressants and stimulants are for the first year.</p> <p>Dr. Menninger said we are talking about this as if the only issue is the budget. This overlooks the enormous problem of cost shifting that potentially occurs when you start restricting medications and the interruptions that occur as the result of the ability to renew prescriptions promptly. There are a lot of other costs than just KHPA's budget.</p> <p>Dr. Burke said this is where this committee has some expertise. We've spent a lot of time discussing educational interventions to try to improve prescribing practices. What we haven't talked about is cost shifting things or PDL.</p> <p>Dr. Bell said she would hope that, with the advice of an advisory board of experts, the way we approach it is the best way possible.</p> <p>Dr. Menninger said the prior authorization issue is independent of a PDL. Dr. Bell said prior authorization is part of a PDL, but we would also be able to do prior authorization for other reasons.</p> <p>Dr. Shaw asked if there is a realistic expectation that the law would be rescinded. Dr. Smith said we don't know. Dr. Bell said it didn't pass last year, but the budget is a lot worse this year.</p> <p>Dr. Leeson said he would expect that if the proposed legislation was left wide open to go into all areas there would probably be a good fight on your hands, but if it was narrowly prescribed that it would only affect antidepressants and stimulants there might be a better chance of getting it through. Dr. Menninger</p>	
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	<p>said there would still be a fight.</p> <p>Dr. Burke said that the first two meetings focused on the state of the state and education efforts that are either ongoing or available. We learned a little bit about adopting practice guidelines and consultation systems. Clearly the focus has been on education and improving the prescriber. If this has been submitted as a budget then we need to make the pros and cons of a PDL the focus at the next meeting.</p> <p>Ms. Lewis said she doesn't disagree, but the one thing, from her perspective, that has been woefully absent in the discussion of the education, and maybe it doesn't exist, is any data about what happens as the result in terms of cost savings. There is a clear number that tells the governor and legislature how much money can be saved with a PDL, but there is no data showing what can be saved with education. Dr. Smith said she doesn't know how we would get that data. Dr. Burke said we have had some of the best organizations in the nation work for Kansas and the data that you get is limited. Ms. Lewis said the data we are seeing is not cost data it is prescribing data, outlier data, etc... There is comparison data in terms of how much is being saved on the Missouri side and other states. Missouri is putting in other money that needs to be figured into this, but is there a savings? If an educational effort is saving twice as much, half as much as this strategy that is important information. And if it doesn't do anything then why spend the money at all? Dr. Burke said part of the reason we cut back on the services CNS offers was at the end of a fiscal year we were never able to see any data that showed a financial impact. Ms. Lewis asked if that was requested. Dr. Burke said yes. Ms. Lewis asked Dr. Churchwell if HID would be able to provide that kind of information. Dr. Churchwell said she believes so. HID does some cost savings, but you can't say we sent this letter and it saved this much money there are other factors that have to be taken into consideration.</p> <p>Dr. Burke said the smoke and mirrors involved in cost benefit, cost effectiveness, and cost utility analysis it all gets vague, so it's hard to say. Ms. Lewis said she remembered seeing some kind of numbers about what was being saved. Dr. Leeson said they did provide projected cost avoidance, but they were based on calculations that you had to believe were accurate. Dr. Burke said you have to make a series of assumptions in order to come to that. Ms. Lewis asked if there are no assumptions in the cost savings of a PDL. Dr. Burke said this is harder data.</p> <p>Dr. Burke said when we discuss the PDL it should be an expanded discussion about cost shifting and other clinical costs in addition to pharmacy costs.</p>	
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	<p>Dr. Shaw said we should focus on what a PDL is supposed to do. It should affect cost, but the reality is it should be based on evidence in the research and in clinical practice about the use of the drug and the safety for the patient. If you focus on those two things usually the PDL is not onerous and they do save money. PDLs are supposed to be about safety and efficacy. Dr. Burke said our PDL committee has been successful and their mantra is we are not going to discuss cost. This is the beginning of another conversation.</p> <p>Dr. Leeson asked if this committee would ultimately propose a minimum necessary formulary or just talk about the issue. Dr. Bell said she needs to double check what the statute language says. The details are yet to be decided.</p> <p>Ms. Lewis suggested a document that the board could look at. Dr. Bell asked Ms. Lewis to send the reference. Dr. Burke asked for literature support at the next meeting. Dr. Menninger asked if he finds something relevant to send it to Dr. Bell. Dr. Bell said yes.</p>	
VIII. Adjourn	The meeting was adjourned with no further comment.	<p>Mr. Harkness moved to adjourn the meeting.</p> <p>Dr. Shaw seconded and it carried with a unanimous vote.</p>