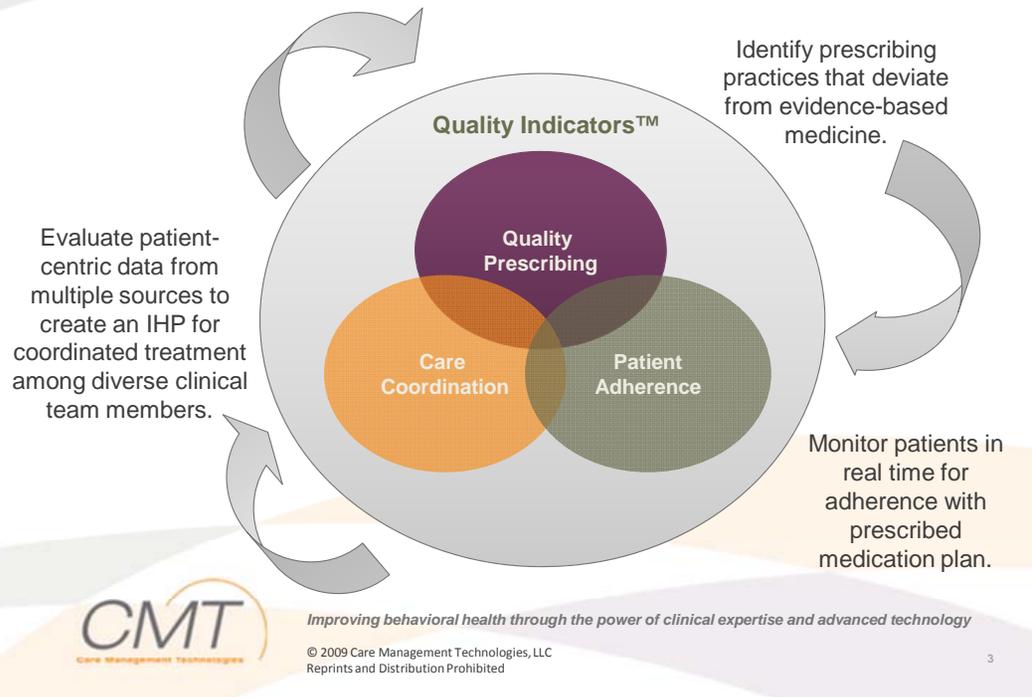


**Mental Health Prescription Drug Advisory Committee Meeting
Meeting Minutes, Open Session
September 16, 2009**

<p>MHPDAC Meeting Minutes, Open Session EDS / Forbes Field Capital / Cedar Crest Room Topeka, KS September 16, 2009</p>	<p>Members Present: Kathleen Barrett, A.R.N.P. Michael Burke, M.D, Ph.D., Chair Susan Crain-Lewis, L.M.S.W. Megan Dahman, Pharm.D. Debra Doubek-Phillips, M.D. Kristen Hellebust Kimberly Harrison, Ph.D. Roy Menninger, M.D. Karen Moeller, Pharm.D. Eve-Lynn Nelson, Ph.D. Russell Scheffer, M.D. Pam Shaw, M.D. Karen Wakefield, A.R.N.P KHPA Staff Present: LeAnn Bell, Pharm.D. Aimee Grubb, Recorder Brenda Kuder, R.N. Shelly Liby CNS Staff: Lynn Hamilton Jack Gorman, M.D.</p>	<p>Representatives: Ann Mattingly, Bristol Myers Squibb Richard Mesquias - Eli Lilly Amy Campbell - KS MH Coalition</p>
TOPIC	DISCUSSION	DECISION AND/OR ACTION
<p>I. Announcements</p>	<p>Dr. Burke called the meeting to order at 10:03 a.m.</p> <p>Dr. Bell introduced Brenda Kuder. She is the Deputy Medical Director and is filling in for Dr. Smith since she was unable to attend.</p>	
<p>II. Review and Approval of June 24, 2009 Meeting Minutes</p>	<p>On page 2 change psychologist to psychiatrist on Dr. Scheffer's introduction.</p> <p>Dr. Burke said at the last meeting Dr. Andy Allison, Acting Executive Director of KHPA, explained that the MHPDAC has been formed and the initial charge is to come up with recommendations for safe and cost effective management of mental health drug use in Kansas. The motivation for this charge is clinical and fiscal effectiveness and efficiency in the state. The background is that mental health drugs have been carved out of the state's preferred drug list activities. This creates some potential problems. One</p>	<p>Dr. Scheffer moved to accept the minutes with the change discussed.</p> <p>Dr. Doubek seconded and it carried with a unanimous vote.</p>

	<p>issue is that the state has limited the oversight of mental health drugs. The second issue is the rising cost of psychotropic agents is drawing on a fixed resource pool. The feeling, at many levels of the state, is this draw is unsustainable. The committee is not charged with developing a mental health preferred drug list or formulary; our charge is to make recommendations for improvement in safe and cost effective management of mental health drugs. That could include recommending the formation of a mental health preferred drug list, but that's not a specific item the committee will be working on.</p> <p>It was also mentioned at the last meeting that the initial focus will be on children. This is because in part children are always a public health concern. The broader constituency of the state can relate better to issues concerning children. The same issues are relevant to adults.</p> <p>There was general discussion about different agencies that oversee drug use in Kansas, how they work, and the Behavioral Pharmacy Management program that Kansas has been using to help with mental health drugs. The committee came up with a variety of questions, e.g. what is going on in terms of the current oversight of mental health drugs, what does that look like, how effective is that; what about the population, who are the children that are being treated with mental health drugs and what are the numbers; what is the usage of mental health drugs, particularly in the child population, look like in Kansas.</p>	
<p>III. Prescriber Education Efforts</p> <p>a. Presentation on Kansas Behavioral Pharmacy Management Program by Comprehensive Neuroscience Staff</p> <p>b. Cochrane Review – Academic Detailing</p> <p>c. Cochrane Review – Audit and Feedback</p>	<p><u>Prescriber Education Efforts</u></p> <p>Dr. Burke introduced Comprehensive Neuroscience (CNS) program services that Eli Lilly has sponsored for Kansas for several years to help with oversight of mental health drug use. This introduction was followed by a formal presentation by CNS.</p> <p><i>Presentation on KS BPM Program by CNS</i></p> <p>Lynn Hamilton, Care Management Technologies (CMT), a division of CNS, introduced herself and Dr. Jack Gorman. Dr. Gorman is the director of the program.</p> <p><u>Care Management Technologies Evolution</u></p> <p>Ms. Hamilton said what CMT does is focus on three different areas shown below.</p>	<p>Dr. Menninger would like to hear an evaluation of the CNS program.</p>

Care Management Technologies Evolution



CMT developed a unique disease management system that improves quality and reduces cost by identifying problematic instances of medical care and providing targeted education to prescribers to bring clinical practice more in line with optimal care.

Program Description

- CMT Quality Indicators™ (QI's) are operationally defined instances of care that are likely to be inappropriate and/or unnecessarily costly.
- QI's are developed with guidance from leading experts based on available science, guidelines, and quantified studies of expert opinion.
- The CMT Behavioral Pharmacy Management (BPM) program applies QI's to pharmacy data.
- Enhanced programs apply QI's to other healthcare claims datasets (e.g., office visits, laboratory, hospitalization).

Behavioral Pharmacy Management in Context

The prescriber writes the prescription. The patient has it filled at the pharmacy. The prescription claim may go through a clearinghouse or a pharmacy benefit manager. Then it goes through claims adjudication or third party administrator (TPA). Then the claims come to the clients, in this case is the State of Kansas. Kansas extracts the claims and sends them to CMT. CMT bumps them against the quality indicators that have been chosen for the program. This helps to identify those practices that are outside of what would be considered best practices. That then triggers the mailing process that goes to the prescribers.

The board was provided with an example of a mailing that would go to a prescriber. CMT offers an adult program for people 18-64 years of age and a child program for children under 18.

The first page of the packet is an introductory letter that talks about the program.

The next page is a pharmacy feedback intervention form. It shows the prescriber which patients are hitting against which quality indicators. It gives the prescriber an opportunity to look at the patients and the quality indicators and send feedback that is then relayed back to the state.

The third page is the prescriber summary report. It gives the prescriber information on a three month period. It gives a summary of the patients that have hit a quality indicator and which quality indicators have been hit and a brief description.

The next pages are patient profile reports that the prescribers can use in a variety of ways. They may put it in patient files or they may use it for discussion in clinical meetings.

The last pages are the Clinical Considerations™. An example is shown below.

Use of 2 or More SSRIs for 60 or More Days

Clinical Issue	Clinical Consideration	References
<ul style="list-style-type: none"> ❑ Combining SSRIs offers no additional benefit when compared with an adequate dose of one agent. ❑ Increased risk of side effect may contribute to poor adherence. ❑ May reflect failure to discontinue ineffective treatment or interruption of cross-titration. 	<ul style="list-style-type: none"> ❑ If you haven't already, please consider assessing whether each medication has been tried at the optimal therapeutic dose for sufficient time before adding any new medication. ❑ If you haven't already, please consider ensuring that, when switching medications, the first medication is discontinued. ❑ If there is a clinical need for a second antidepressant (for example, in treating comorbid anxiety and depression or residual depressive symptoms), if you haven't already, please consider using agents with complementary mechanisms of action, rather than two SSRIs. ❑ If you haven't already, please consider reviewing medication use and adherence with patient and/or family. ❑ If you haven't already, please consider reviewing the original diagnosis and consider revising treatment to reflect the current clinical formulation, including comorbid psychiatric and physical disorders. ❑ If you haven't already, please consider psychosocial interventions; cognitive-behavioral therapies may improve treatment response. ❑ If you haven't already, please consider referral for psychiatric consultation (if you are not a psychiatrist). 	<ul style="list-style-type: none"> ❑ Shelton RC. The use of antidepressants in novel combinations. <i>J. Clin. Psychiatry</i> 2003; 64 (Suppl. 1): 14-18. ❑ Stahl SM. Basic mechanisms of antidepressants, Part 1: Antidepressants may have seven different mechanisms of action. <i>J. Clin. Psychiatry</i> 1999; 59 (Suppl. 4): 5-14. ❑ Trivedi MH et al. Algorithm for the treatment of chronic depression. <i>J. Clin. Psychiatry</i> 2001; 62 (Suppl. 6): 22-29. ❑ Suppes T, Dennehy EB, Hirschfeld RM. The Texas Implementation of Medication Algorithms: Update to the algorithms for bipolar disorder. <i>J. Clin. Psychiatry</i> 2005; 66 (7): 870-886. ❑ Hollon SD, Jarrett RB. Psychotherapy and medication in the treatment of adult and geriatric depression. <i>J. Clin. Psychiatry</i> 2005; 66: 455-468.

Dr. Menninger asked why failure to refill prescriptions in 30 days a significant indicator. What if the doctor is terminating a medication? Dr. Gorman said that the source of data is from claims data. CMT has no access to what the clinician has written in the chart or discussed with the patient. That means there will inevitably be some false-positives with respect to the lettering to the clinicians. He reminded the committee that the letters are not prescriptive. They don't tell the clinician what they can and cannot do, they are simply informative. In the case that the clinician had decided to stop the medication and it is not a situation in which the patient has become non-adherent then the clinician can ignore the letter; if possible it is best if the clinician sends the feedback form in stating that the medication has been discontinued. He asked the committee to bear in mind a couple other things:

1. The failure to refill quality indicator is only used for medications that are chronically administered, e.g. antipsychotic medications.
2. The leading cause of relapse or re-hospitalization for patients with schizophrenia or bipolar disorder is because they have stopped taking their medication. A large

- number of these patients become non-adherent.
3. Clinicians almost never know when the patients stop taking their medications. CMT did a study recently and were able to document this.
 4. In terms of antidepressant medications; those are usually prescribed by primary care physicians who don't have a much contact with the patient.

When you put all of this together, the risk of a false-positive is much smaller than the risk of a false-negative.

Clinical Development Process for Quality Indicators™

Dr. Gorman said there are about 150 quality indicators spread in three areas and three age groups. The three areas are:

- Prescription that doesn't meet the criteria evidence based medicine,
- failure to refill prescriptions, and
- duplicate prescriptions – instances in which a patient is getting the same very similar medications from multiple prescribers.

The three age groups are:

- Children,
- adults, and
- the elderly.

Dr. Gorman reminded the board that CNS and its division CMT is an independent company and is not part of the Eli Lilly company. Fewer than 50% of CMT's clients' programs are funded by a grant that Eli Lilly gives to the client which is the case in Kansas.

The quality indicators were all developed first by identifying a clinical opportunity and a clinical need. Then on the basis of extensive research in the clinical literature, extensive conferences, looking at the clinical guidelines, and taking into account the clinical expertise of a panel of experts. It is a very lengthy process of review and approval and then an IT process to develop and test to make sure they do identify the situation that is wanted. There are reviews of the quality indicators at weekly meetings where they are modified, eliminated or new ones are created. All of the clients play a role in this because the culture of prescribing and clinical care does vary from place to place and region to region. There are some things that individual clients care more about, don't care about, or sometimes disagree with what the guidelines say. CMT does their best to

tailor the quality indicators to meet the scientific criteria set by the client.

Key Features of Current CMT QI Development

- Client Customization (e.g. project on pediatric antipsychotic prescribing)
- Appropriate Use of Opioid Analgesics
- Evidence-based Use of Antipsychotic Medications (e.g. generic alternatives, appropriate dosing)
- Evidence-based Use of Antidepressant and Mood Stabilizing Medications (e.g. value of lithium, equality among antidepressants)
- Judicious Use of Psychostimulant Medications for ADHD
- Appropriate Identification and Treatment of Substance Abuse
- Revisiting Medications to Treat Dementia
- Value of Psychosocial Treatments
- Logical Approach to “Off-Label” Prescribing

Child Focused QI Development Example

- Increased reported frequency of multiple psychiatric disorders in childhood/adolescence, including bipolar disorder, ADHD, autism spectrum.
- Blader & Carlson (Biol Psychiatry, 2007): bipolar disorder inpatient diagnosis for adolescents increased four-fold from 1996 to 2004.
- Outpatient diagnoses given by physicians do not always reflect actual diagnosis.
- Polypharmacy also increasing among children without evidence base (McIntyre RS, Jerrell JM, J Clin Psychiatry, 2009).
- Antidepressants in children increase risk for cardiovascular events, orthostatic hypotension, seizures, insomnia and headache (Jerrell & McIntyre, J Clin Neurology, 2009).
- Antipsychotics in children increase risk for obesity, type 2 diabetes, dyslipidemia, cardiovascular and cerebrovascular events, hypertension, and orthostatic hypotension (McIntyre & Jerrell, Arch Pediatr Adolesc Med, 2008).
- Stimulants for ADHD may increase the risk of sudden death (Gould et al, Am J Psychiatry, 2009)
- Health Care Reform will lead in to increased enrollment for children in SCHIPS and Medicaid resulting in greater need to focus on quality and costs for child psychopharmacology

CMT Solution – Customized Pediatric Focus

- Developed Quality Indicators™ Specific to Antipsychotic Use in Young Children (under age six)
- Peer Consultation Targeted Specifically to Child Prescribing
- CME Webinars on Child Psychotropic Use
- CMT Newsletter for State Agency Clinical Leads on Recent Research in the Area of Pediatric Pharmacotherapy
- ADHD Specific Quality Indicators Segmented by Child and Youth Age Bands
- Care Management Integration Profile Customized for Child Specific Populations – Children in Custody, ADHD, Complex Needs

History of the BPM program

- Began program in May 2006
- Mailings occur monthly, with Adult and Children mailed on a every other month basis
- We do not mail to the same prescriber/patient combo two months in a row
- Originally program mailed on 18 Adult and 14 Child QIs (currently we mail only on 7 QIs, 5 Adult and 2 Child)
- We mail to the Top 100 Prescribers

Dr. Menninger said the Cochrane report says audit and feedback can be effective, but the best results are modest to minimal. Does that affect the use of it? Dr. Gorman said the Cochrane report identified an effect size of 0.4 which is a moderate effect size which is considered, in research, to be a pretty good outcome.

Dr. Menninger asked if CMT makes individual visits or telephone calls. Ms. Hamilton said the only type of individual visits would be outreaches for which the clients have contracted Dr. Burke said there is outreach for non-mental health drugs that are reviewed by the state and this has been arranged as part of the program contracted to assist the DUR and PDL programs. Dr. Menninger asked why we don't have this for mental health drugs. Dr. Burke said this is not included in the service package provided by CNS that is sponsored by Eli Lilly for Kansas. Ms. Lewis said we haven't financed that option. Dr. Gorman said that peer-to-peer consultations are provided for some clients because the program is tailored to what the client wants.

Dr. Nelson asked how often the feedback forms are sent in. Ms. Hamilton said she doesn't have the exact statistics on that.

Ms. Hellebust asked, in regards to the QI failure to refill, if physicians are able to follow-up on the patients that are failing to refill and if there is any benefit that has been seen. Dr. Gorman said there is a study called The Treatment Adherence Program where they looked at this with a control group. There was a statistically significant improvement in the medication possession ratio (MPR), which is the measure used for adherence, defined as the ratio of medication the patient has divided by the number of days of medication the patient is supposed to have. If a medication is a chronic medication and the patient has filled prescriptions in a 90 day period that cover 30 days of that period then the MPR is 0.3. It is not a measure of what pills are going in the patient's mouth.

Prescriber Ranking

- KHPA mails to the Top 100 Prescribers
- Prescriber ranking is most commonly based on outliers and cost
- Kansas implemented a more targeted prescriber ranking. This ranking reflects a specific targeting of prescribers as described :
- The top volume prescribers are identified as those that encompass 75% of the claims in the State. Within that 75% pool, rank is based on the percent of the prescribers' claims (numbers, not dollars) hitting an active QI.

Dr. Burke asked if the number of QIs were decreased for a reason. Dr. Bell said that in the last year we cut back to just the refill reminders because the outcome and future of the program was unknown.

Dr. Burke said the CNS program has good potential, but over time summary reports weren't able to answer what the response rate was, what the outcome of the intervention was, or what the benefit was, so a question the committee might want to think about is whether this is the kind of program that we want to develop or is there a limitation to how much this type of program can do. Dr. Burke said in Medicaid there is a drug utilization review (DUR) responsibility to be overseeing usage. In Kansas, with that 2002 carve out of psychotropic drugs; the DUR Board itself and the PDL Committee weren't able to do that directly. The Eli Lilly sponsored CNS program offered an opportunity for the state to meet the federal obligation and to do some level of oversight. We are meeting our federal obligations, but the question is what has been the benefit of the CNS? Is it helping or not helping. Ms. Lewis clarified that we are only mailing to 100 prescribers. We are mailing only to the high volume prescribers, so the prescriber who is doing a smaller quantity, but bad quality may not ever show up because it isn't high volume. She suggested that a program that has the potential to be robust has been scaled back or not been invested in sufficiently to have a significant effect on prescriber behavior.

Dr. Gorman said in most instances these disease management programs are not initiated as experiments with prospective design or randomization. Usually programs are run and then there is a need to assess how they work. The way that they work is usually not subjected to rigorous statistical analysis.

CMT Application of Multiple Baseline Methodology

- Innovative approach to identifying a concurrent comparison group.
- Claims are analyzed for all patients receiving an intervention across a 12-month intervention program.
- The intervention cohort at a particular evaluation point is compared to the remaining patients who have not yet received an intervention.
 - The comparison group becomes smaller at each evaluation point.
 - The last cohort includes all remaining patients.
- Mixed effect cell means model accounts for the auto-correlation and uses time before and after an intervention to estimate cost avoidance.

Cost Avoidance in Child Population

Mail Date	Count of Patients	Months of Follow-up	Cost Avoidance PUPM
July 2006	465	20	\$84
August 2006	207	19	\$54
October 2006	133	17	\$98
January 2007	112	15	\$72
March 2007	85	13	\$80
May 2007	81	11	\$77
August 2007	75	9	\$54
Average PUPM Cost Avoidance			\$77

Cost Avoidance in Adult Population

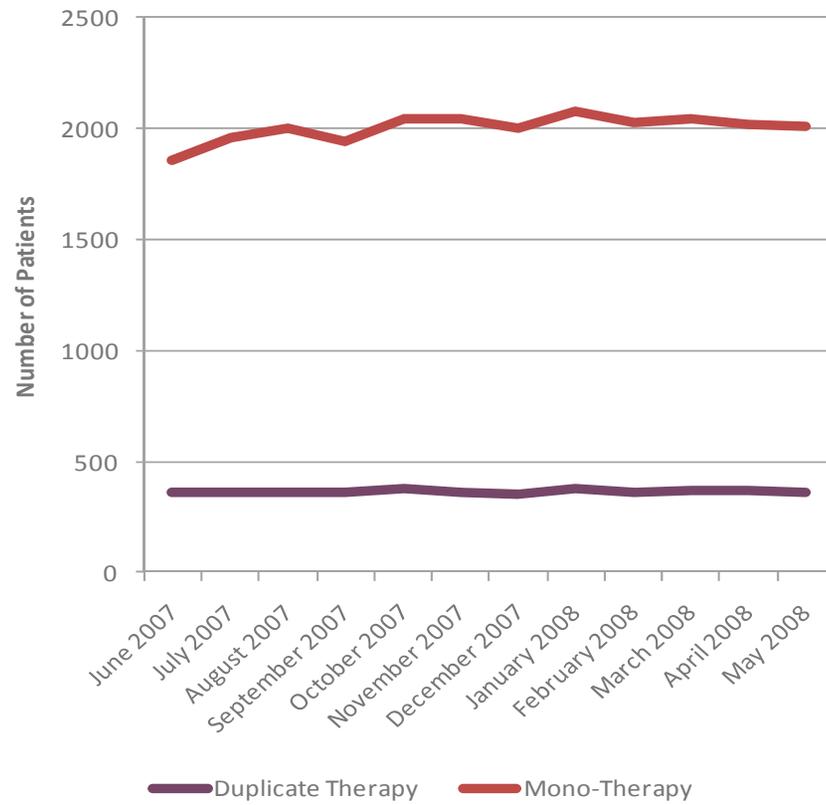
Mail Date	Count of Patients	Months of Follow-up	Cost Avoidance PUPM
June 2006	276	21	\$38
July 2006	170	20	\$63
October 2006	159	17	-\$3
November 2006	96	16	\$18
January 2007	108	14	\$16
March 2007	90	12	\$32
May 2007	80	10	-\$24
August 2007	160	7	\$50
Average PUPM Cost Avoidance			\$31

Analysis Overview

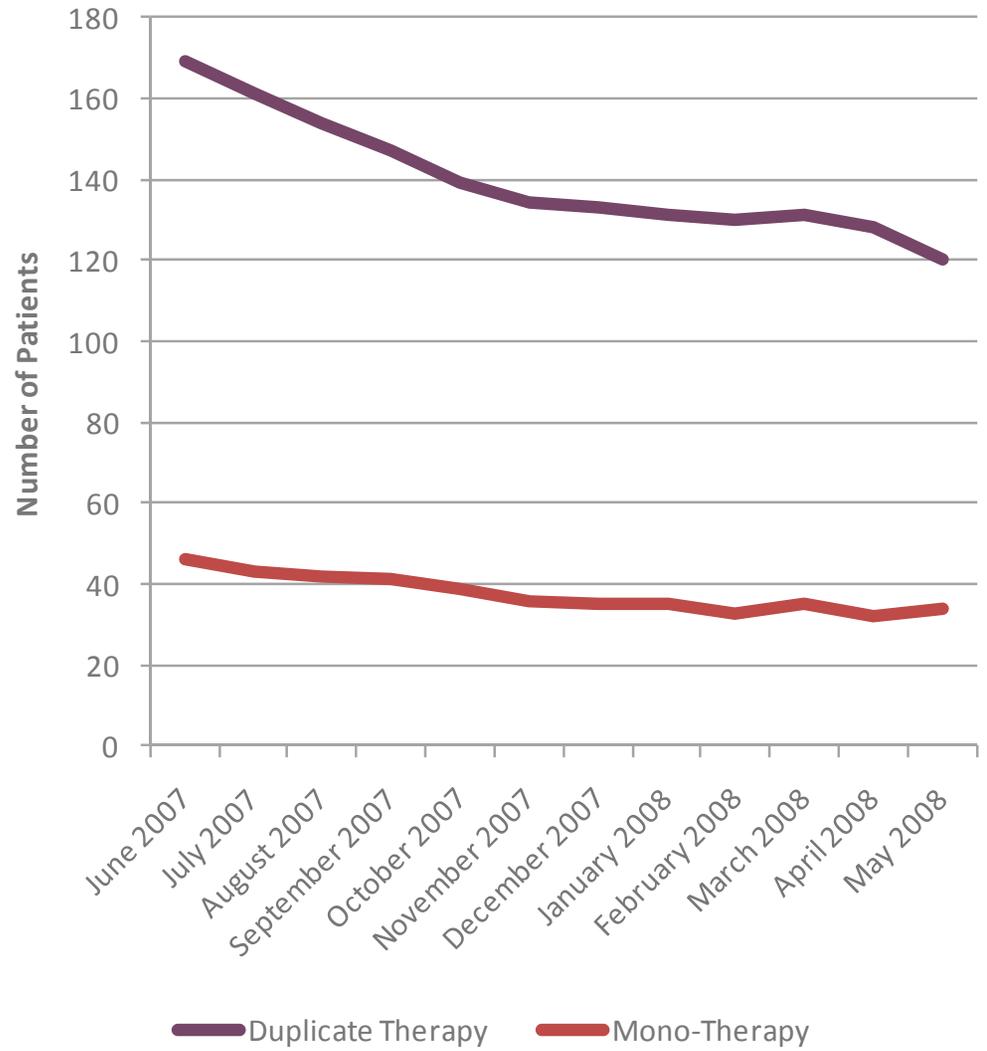
- Kansas was interested in evaluating the impact of the BPM program on overall behavioral medication use.
- Kansas was interested in reviewing patients switching from duplicate therapy to monotherapy.
- CNS believes that while monotherapy is ideal, moving patients from duplicate therapy to monotherapy is difficult and duplicate therapy is not always sensitive to inappropriate prescribing*.

Duplicate Therapy to Monotherapy Adult Analysis

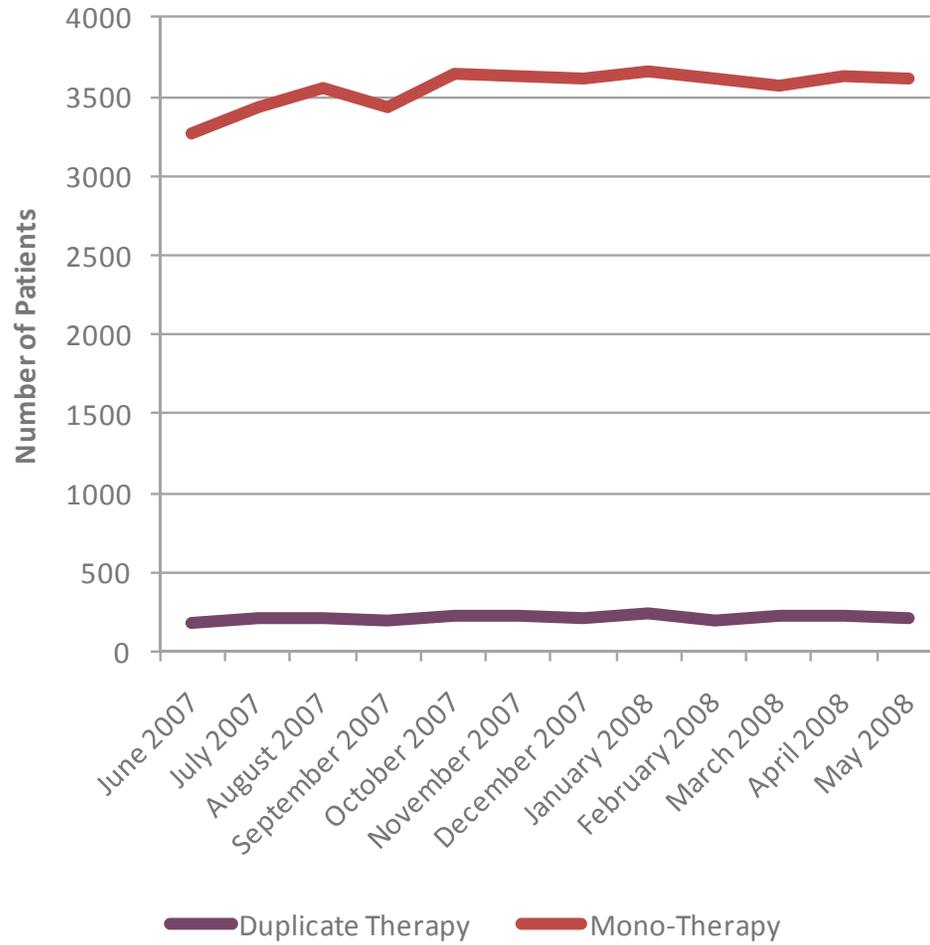
Adult – Total Population: Atypical Antipsychotics



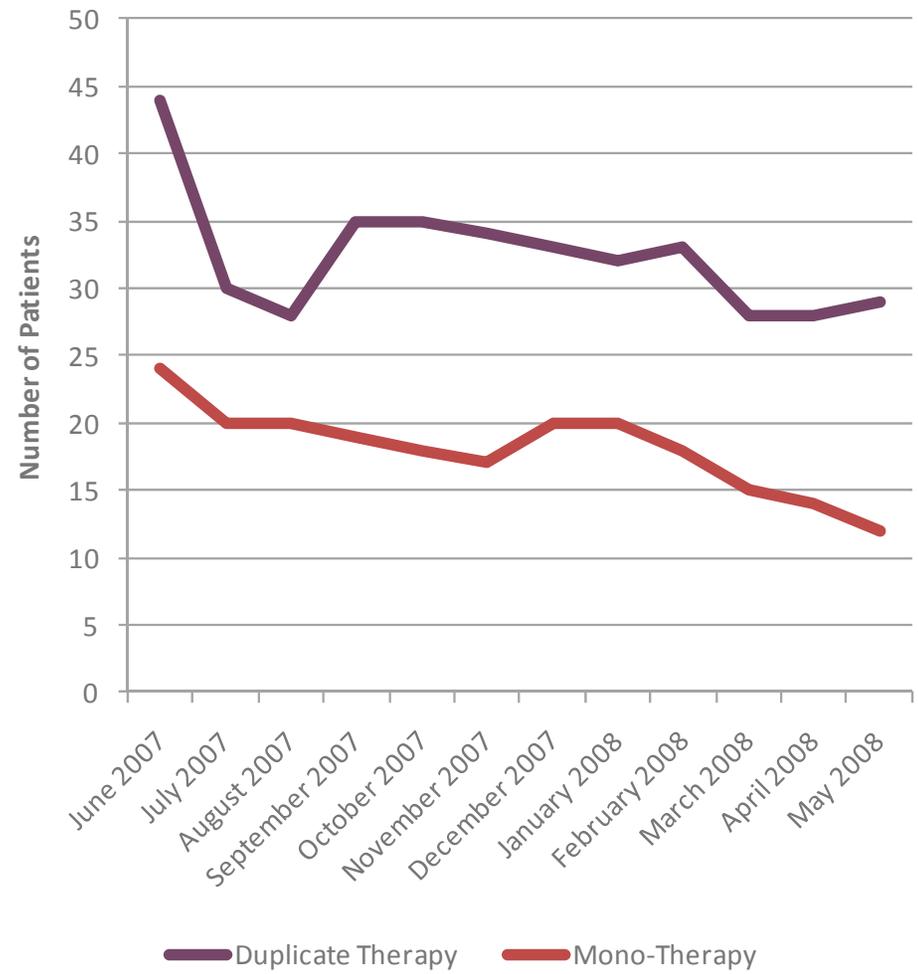
Adult Population in BPM Program: Atypical Antipsychotics



Adult – Total Population: Benzodiazepines

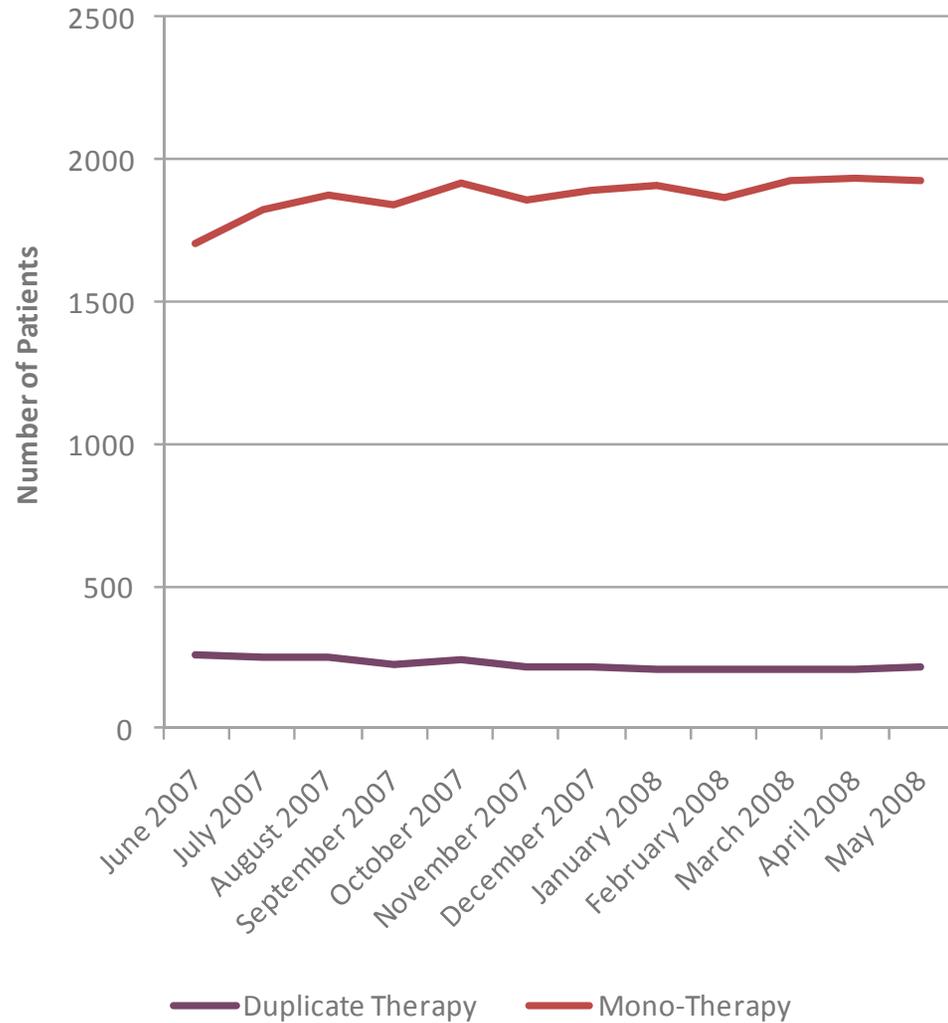


Adult Population in BPM Program: Benzodiazepines

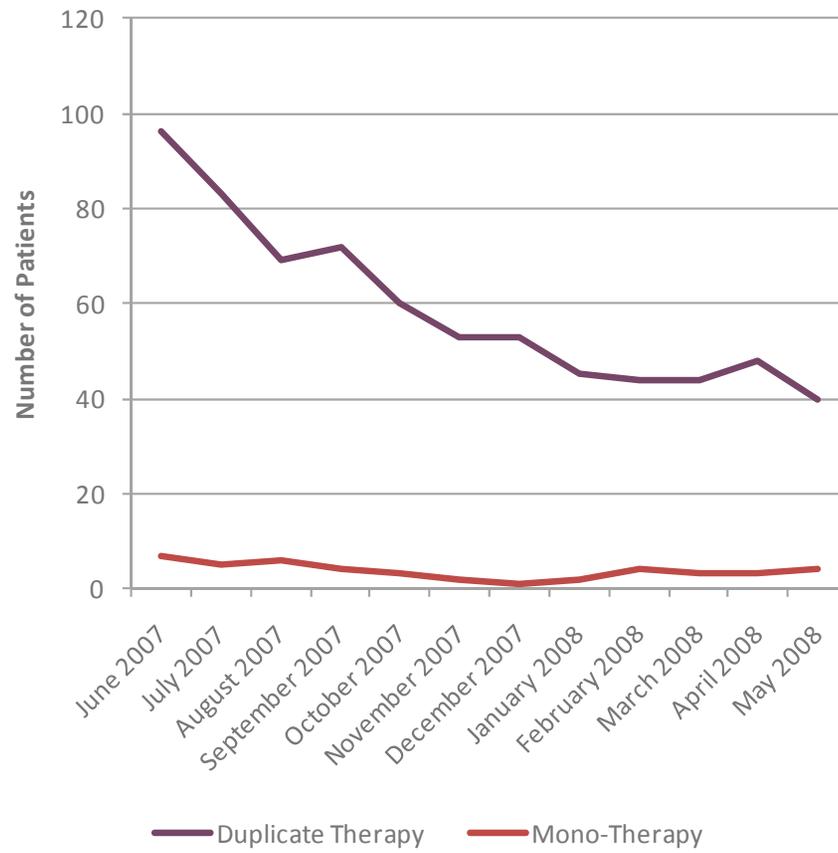


Duplicate Therapy to Monotherapy Child Analysis

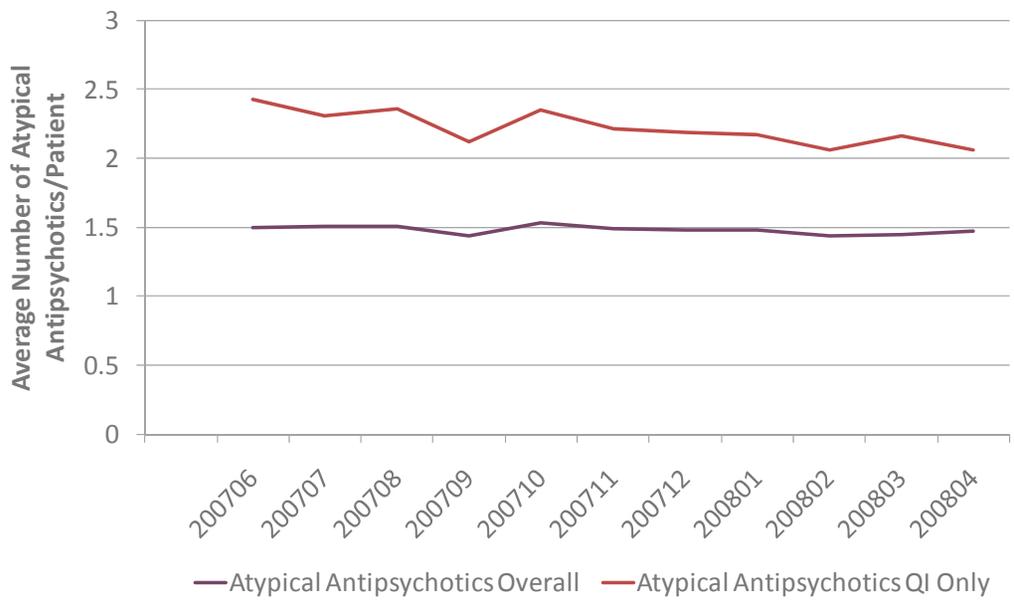
Child – Total Population: Atypical Antipsychotics



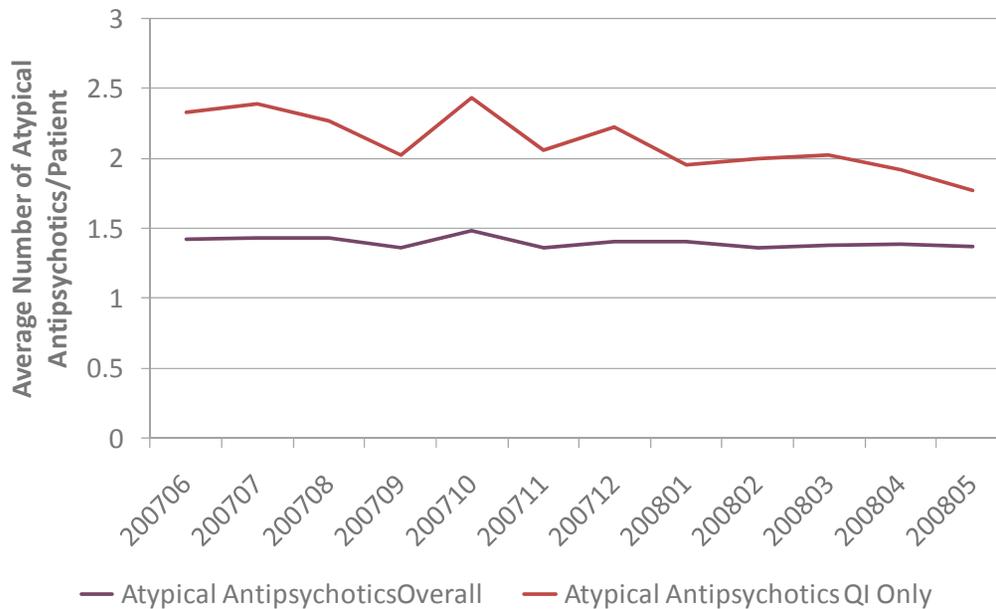
Child Population in BPM Program: Atypical Antipsychotics



All Adult Patients and Patients Triggering a QI



All Child Patients and Patients Triggering a QI



Multiple Baseline – Multi State Results for Adults

CUSTOMER	N MAILING COHORTS	PT. MONTH FOLLOW-UP	DECREASE IN COST / PT. / MONTH	TOTAL COST AVOIDANCE
State A	25	135,237	\$67.24	\$9,093,336
State B	11	27,207	\$29.42	\$800,430
State C	13	186,729	\$25.20	\$4,705,571
State D	23	422,330	\$89.62	\$37,849,215
State E	2	31,261	\$55.65	\$1,739,675
State F	19	52,978	\$92.56	\$4,903,644
State G	2	5,807	\$54.40	\$315,901
State H	6	50,018	\$119.58	\$5,981,270
Kansas	8	17,947	\$31.00	\$549,539

Multiple Baseline – Multi State Results for Child

CUSTOMER	N MAILING COHORTS	PT. MONTH FOLLOW-UP	DECREASE IN COST / PT. / MONTH	TOTAL COST AVOIDANCE
State A	25	47,422	\$36	\$1,692,017
State B	12	10,615	\$43	\$457,188
State C	17	114,098	\$31	\$3,513,077
State D	22	68,518	\$163	\$11,182,138
State E	3	2,369	\$59	\$138,752
State F	18	34,368	\$74	\$2,549,075
State G	3	4,185	\$43	\$180,792
State H	15	72,053	\$75	\$5,387,536
Kansas	7	19,845	\$77	\$1,529,577

Comparison with Other States

MO Model	PA Model	NC Model	KS Model
<ul style="list-style-type: none"> • BPM for 836,129 eligibles • 40 total QIs • 1000 prescribers • Adherence intervention for 1000 patients • MRM intervention for 1000 adults/1000 children in custody • Pre Diabetes identification/Diabetes screening and referral • Long Term Care Pharmacy Initiative • MR/DD Pharmacy Initiative 	<ul style="list-style-type: none"> • BPM for 42 Access Plus Counties 300,000 eligibles • 43 total QIs • 1000 prescribers • MRM for 1300 adults/800 children • Webinar training series • Consultation Component 	<ul style="list-style-type: none"> • BPM for 1,682,000 eligibles • 14 total QIs • 400 prescribers • One MRM Pilot for 800 consumers • Consultation Component for child prescribing 	<ul style="list-style-type: none"> • BPM for 284,500 eligibles • 7 total QIs • 100 prescribers

Dr. Doubek asked what the statistics show in the private sector that have been doing this type of program for years. Dr. Gorman did not give specific numbers but said the studies that are being done by the insurance companies are included in meta-analyses when they are published. Dr. Doubek said she finds the prompts to be very helpful. Ms. Lewis asked Dr. Doubek how much time it takes to look at the information, make a judgment and send it back. Dr. Doubek and Dr. Shaw both said it takes a minimal amount of time.

Dr. Burke asked if the cost savings in the slides presented by CNS represent strictly pharmacy costs or do they incorporate the associated clinical costs as well. Dr. Gorman said they are pharmacy costs only. He said to keep in mind in a behavioral pharmacy management all that is received is pharmacy claims data.

Dr. Menninger asked why the committee is hearing about this program. Dr. Bell said she invited them to inform the committee for two reasons: 1) because this is something we've been doing for a few years and 2) it is a potential option for the future. Dr. Menninger asked if the potential option is to continue it or increase it. Dr. Bell said to continue, to increase or discontinue it.

Dr. Doubek referred to Multiple Baseline – Multi State Results for Adults and state D that had a total cost avoidance of \$37 million dollars. She said that's huge and asked how long that program has been going on. Ms. Hamilton said that state D is Missouri. They have a very robust program. Dr. Burke said his understanding is that the Missouri data includes all classes of drugs not just psychotropics.

Dr. Burke suggested to Dr. Bell that it may be useful to have Health Information Designs (HID), another pharmacy benefit management program used in Kansas, to present how their program works to the committee.

Ms. Wakefield asked if the Missouri model has the consultation component. Ms. Hamilton said it isn't listed on the slide, but they do. Dr. Bell said the State of Missouri has a psychiatrist on staff that does a lot of outreach.

Ms. Lewis asked for some feel for the administrative cost and the cost of a more robust program. She wants the true cost of putting together a robust program

Dr. Harrison asked if there is any mechanism beyond the letters and consultation. Ms. Hamilton said they have a company that does outreaches also. One client does internal peer consultations. Ms. Lewis asked if it is possible to send a letter to the patients if the doctor hasn't responded to the letter. Dr. Gorman said they are open to discussing it. The company mission has generally been to help clinicians and not put clinicians in a

	<p>position where they are being challenged by their patients.</p> <p><i>Cochrane Review – Academic Detailing/ Cochrane Review – Audit and Feedback</i></p> <p>Dr. Burke said in both of the Cochrane reviews provided to the committee the potential to change behavior by letter writing to prescribers was identified but considered relatively small. It tended to be the greatest among providers who deviated the most from the standard of care practices. This opens up the larger topic of the utility of direct mailings. He suggested the committee review the Cochrane reports to reflect on the potential effectiveness of direct mailings.</p> <p>Ms. Lewis asked if we are talking about effectiveness as in reduced cost or changing behavior. Dr. Burke said the relevant measure is change in practice with the hope that improved practice is ultimately more fiscally efficient.</p>	
<p>VI. Psychiatric Problems: Why We Should Care – Presentation by Dr. Russell Scheffer</p>	<p><u>Psychiatric Problems: Why We Should Care</u></p> <p>Dr. Scheffer said this is a modified presentation that he gave to the Wichita Business Coalition about why they should care about child psychiatry.</p> <p><i>Overview: Why We should Care</i></p> <ul style="list-style-type: none"> • Psychiatric problems are very common • Behavioral problems are even more common • Psychiatric problems are very treatable • Psychiatric care is cost effective! • Some answers - How we can help • Stigma: It hurts us all <p><i>The real problem in Kansas</i></p> <ul style="list-style-type: none"> • Lack of good training in the diagnosis and treatment of psychiatric disorders • All but 5 of the states counties are Federally determined to be underserved for psychiatry • Only 1 (Johnson) would be considered “ok” for child psychiatry. • The need for real time support and training <p>The CDC and NIH do a door-to-door clinical interview of a representative sample of the United States in regards to psychiatric conditions. In any given year almost 30% of adult Americans and 20% of children meet criteria for a psychiatric disorder. That does not</p>	<p>Dr. Burke requested more information on the collaborative care model.</p>

mean they are diagnosed or treated. Half of all psychiatric illnesses start by the age of 14 and 75% start by age 24. These are disorders that start young and because they tend to be chronic, affect people throughout their lives.

It is the 'right' thing to do

- Societies are judged by the way they treat their most vulnerable members.
- Psychiatric disorders are real disorders of the brain
- They occur in by far the most complicated organ in the body.
- The brain consists of 100 billion neurons and support cells organized into tracts, organelles, etc.
- The heart is a muscle, wire (conduction system) and tube (coronary arteries)
- That the brain would not 'break' is the probably the single most scientifically unsupportable idea in medicine
- These are not character flaws or pull yourself up by your own bootstraps conditions

Some consequences of psychiatric problems for business

- Training new people costs time and money
- Absenteeism: People who personally are affected, or whose family are affected and miss work because of it
- Presenteeism: People who physically show up but because they are impacted by their own or a relatives illness are less than optimally productive
- "Preserve the Fighting (Working) Force" Psychiatry is the only medical specialty that returns soldiers to the battlefield and also returns workers to the factory or office

What does child psychiatry have to do with business?

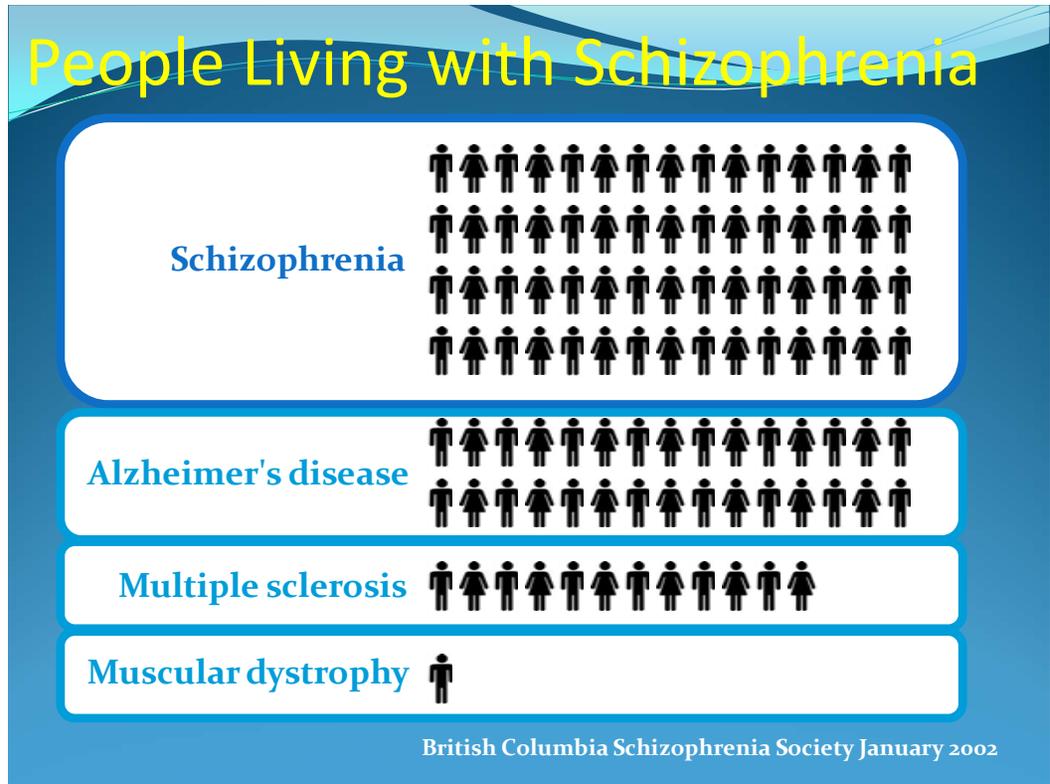
- Parents have to leave work to pick up kids
- Stay home with kids
- Worry about their kids even if at work
- Missed work for an occasional appointment is almost always less problematic than that missed if the child is functioning well the rest of the time.
- Allowing time off for appointments is less costly than the "...isms"

Psychiatric problems are very common

- 5 of the top 10 causes of suffering in the world are psychiatric conditions: #1

Depression, Schizophrenia, Substance Abuse, self-inflicted injury and Bipolar disorder

- 40+% of Americans will suffer from a diagnosable psychiatric problem in their lifetime
- Nearly 30% meet criteria every year
- ½ of these start before age 14, 75% by age 24
- No other medical conditions affect so many people so early
- No family will be unaffected



Ten Leading Causes of DALYs

Risk	Disease or injury	Male ^a	Female ^a	Total ^a
1	Major depressive disorder	15,321	27,651	42,972
2	Tuberculosis	10,937	8,736	19,673
3	Road traffic accidents	15,554	4,071	19,625
4	Alcohol use	13,096	1,752	14,848
5	Self-inflicted injuries	7,550	7,095	14,645
6	Bipolar disorder	6,736	6,453	13,189
7	War	7,899	5,235	13,134
8	Violence	11,040	1,915	12,955
9	Schizophrenia	6,646	5,896	12,542
10	Iron-deficiency anaemia	5,003	7,508	12,511

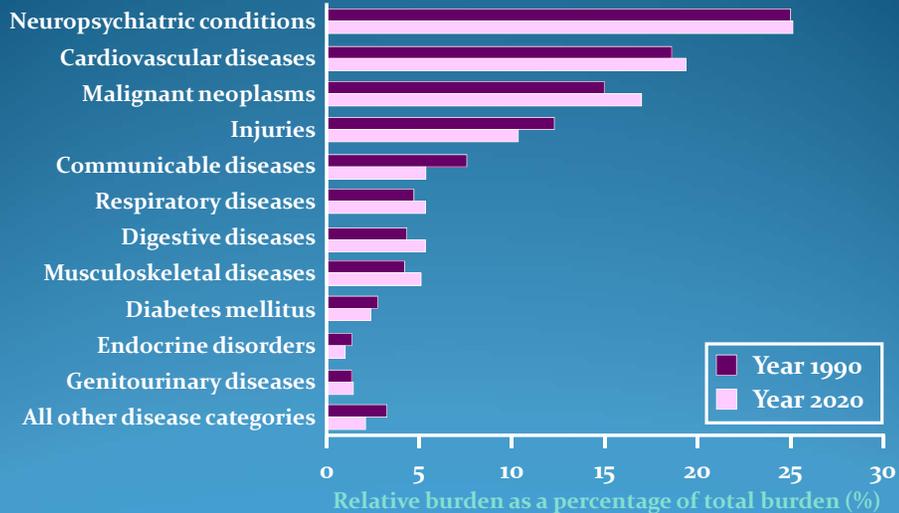
DALYs, disability-adjusted life years

^aValues are DALYS (thousands)

Murray & Lopez 1996

Dr. Scheffer pointed out that road traffic accidents and violence frequently have to do with psychiatric conditions as well. Many single motor vehicle accidents are actually suicide attempts that are not identified.

Relative Burden of Diseases and Injuries in World's Established Market Economies



Burden of disease was assessed by using DALYs, a combined measure of time lost due to premature mortality as well as severity-adjusted disability

Murray & Lopez 1996

New drugs^a and ten-day treatment cost of different therapeutic categories (USD, 2004)

Therapeutic category	No. new drugs	Ten-day treatment cost (USD)		
		Median	Mean	Range
Anti-neoplastic	13	848	1,455	41 – 4,182
Respiratory / allergy	8	301	264	7 – 1,300
Cardiovascular	16	184	969	14 – 7,912
Anaemia / water / electrolytes	5	138	294	43 – 959
Infectious diseases	18	137	468	14 – 3,682
Endocrinology	6	129	547	11 – 1,685
Skin diseases	4	120	102	12 – 158
Gastrointestinal	7	65	113	43 – 390
Ophthalmology	9	51	334	32 – 1,687
Central nervous system	23	50	64	9 – 180
Gynaecology / urology	10	38	106	12 – 532
Musculoskeletal	5	29	81	23 – 202

^aApproved by the FDA between January 1997 and July 2003

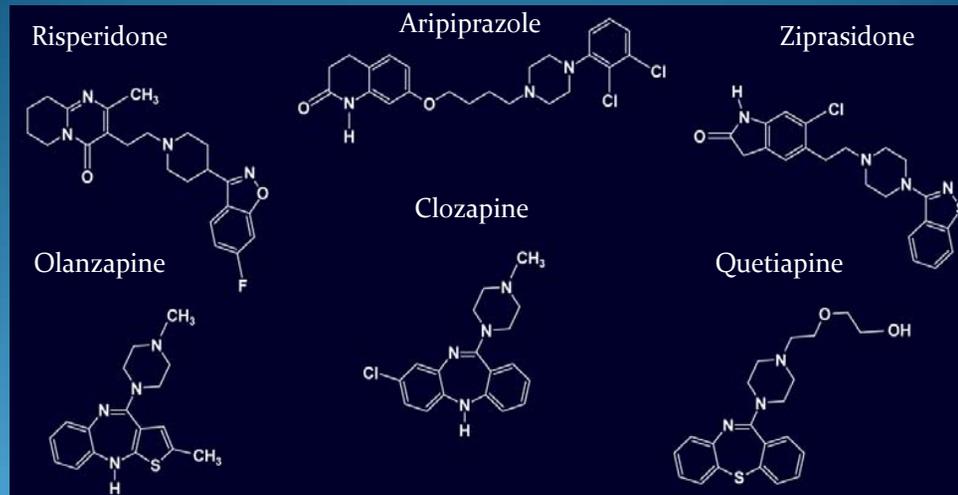
Falagas et al 2006

Dr. Scheffer said when you compare the costs to other disorders and their treatment psychiatric costs are moderate.

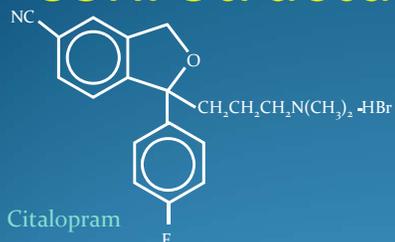
He said he was happy to hear Dr. Gorman talk about not being excited about using restrictive preferred drug lists. Around the country as these programs have marched out, you can, in the short run, decrease costs in regards to pharmacy but there are other costs associated.

The next two slides show the other reason why there should not be a restrictive preferred drug list. These drugs are not interchangeable. They are chemically, dramatically dissimilar. What works for one patient may not work for another patient. These are not minor modifications of the same chemical structure.

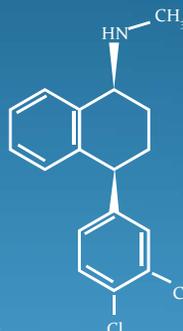
Chemical Structure of "Atypical" Antipsychotics Why they are all NOT the same!



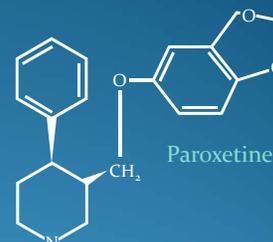
SSRI Structures



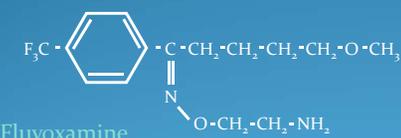
Citalopram



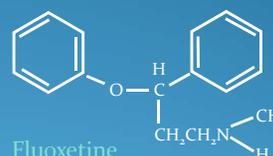
Sertraline



Paroxetine



Fluvoxamine



Fluoxetine

Celexa package insert, Forest Laboratories, Inc.
Physicians' Desk Reference. 1998.

Psychiatric problems continued

- 10-20% of psychiatric patients die by suicide
- Suicide is tied with homicide as the #2 killer between 10 and 25 years of age.
- If you exclude accidents (#1 cause) and homicide, suicide kills more 10-25 year olds than all other medical specialties combined (oncology, cardiology, hiv, etc.)
- Many of these suicides are preventable.
- Patients with psychiatric illnesses die on average 25 years earlier than peers
- Mostly because of concurrent medical illnesses
- If lucky, we will all live long enough to die of cardiovascular disease or cancer.

Behavioral problems are even more common

- One point of confusion is that people see others with and without psychiatric illnesses making bad choices.

- Some of these are purely behavioral problems.
- If you include these types of problems then many more people can benefit from our help

Psychiatric problems are very treatable

- Early identification
- Early intervention
- Access to care
- Engagement in care

In schizophrenia there is a significant decrease in outcomes if a patient goes more than six months with untreated illness. The average time it takes for a patient with schizophrenia to get medical attention is over one year. So the average person is already in a very vulnerable position where they are less likely to respond to treatment.

Psychiatric care is cost effective

- GAO found that full parity cost only 1% for the federal government
- For every dollar spent on psychiatric care \$2-3 decrease in overall health care spending
- This is the only documented area where doing a better job of treatment decreases costs
- NOTE: Even preventive care increases costs! It may make individuals healthier but it does increase costs. Screening tests and other interventions must be applied to the entire population to help the minority that will be affected.

Ms. Wakefield asked about Dr. Scheffer's point about lower costs. Dr. Scheffer said what has been shown when a population of people has new psychiatric services introduced or a barrier is decreased where they can get psychiatric services, for every dollar spent \$2-3 go down on the medical side. If a patient comes in with depression and has stomach ache and headache the primary care doctor is doing tests to try to figure out what is wrong with the patient when if there had been a screening up front the patient could have gotten on the right treatment and there could have had less suffering. In regards to diabetes there is not a doubt that some of the medications have a propensity to cause diabetes. The people with serious mental illnesses, and their family members, are more prone to have diabetes. This is a place where education can help. Ms. Lewis said this is one more reason to ensure there is open access, particularly those with family history of diabetes.

Psychiatry saves money!

- Most psychiatric patients seek help from primary care first.
- Because of lack of training these clinicians often do not evaluate or treat.
- Because of lack of referral resources many do not refer or treat.
- Because the differential diagnosis does not focus to a single non-psychiatric medical problem, many referrals and procedures can occur that are unnecessary or even harmful
- Substance abuse and depression (as examples)

Depression

- Approximately 10% of the population is affected
- Very treatable but frequently not diagnosed
- In house screening and possibly treatment can be helpful

Drug and alcohol problems

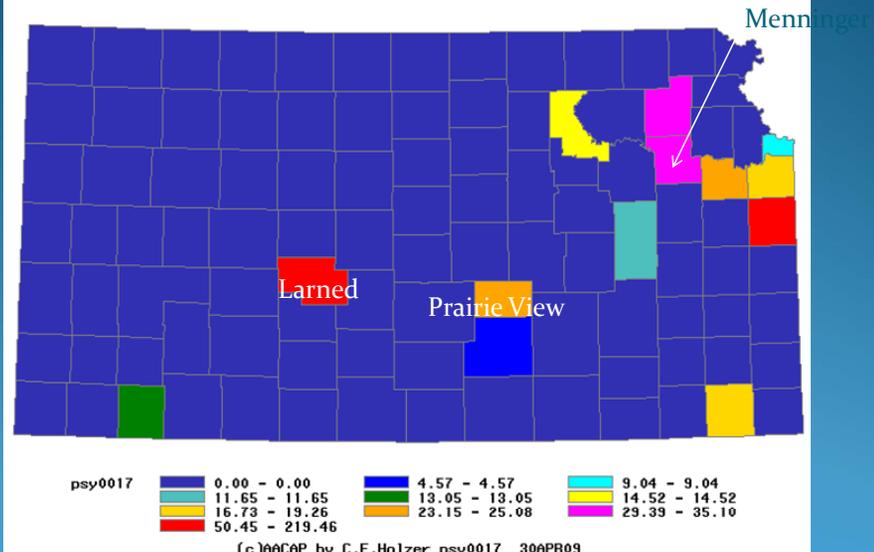
- Investment in treatment is very important for those you want to retain
- Many industries have cultures of hard drinking
- Those who are invested in their careers and are at risk to lose it have the best motivation and success rates.
- 10-12% of Americans abuse drugs or alcohol every year.
- You cannot tell by looking!

Workforce shortages are dramatic

- Cognitive specialists and primary care are paid less than interventional specialists for similar or more difficult work.
- This can be addressed
 - Scholarships / loan repayment – this is done in primary care
 - Better reimbursement for cognitive services of equal or more effort than procedures.

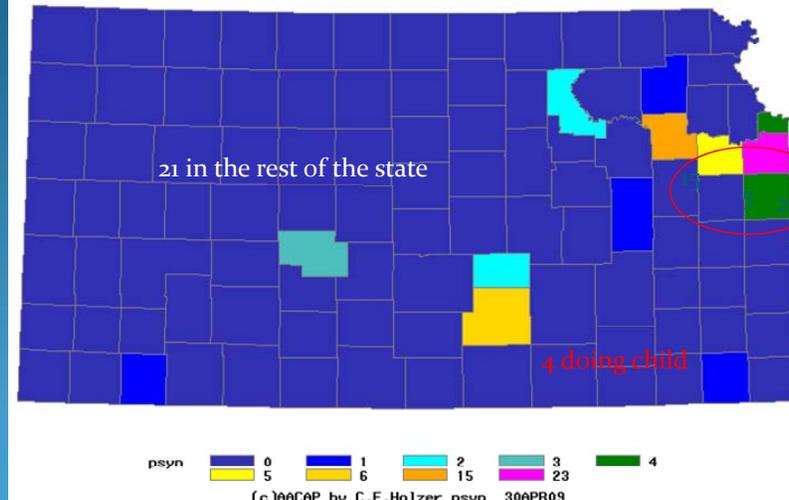
Kansas: Practicing Child and Adolescent Psychiatrists 2009

Rate per 100,000 children age 0-17 (2007)



Kansas: Practicing Child and Adolescent Psychiatrists

Number per county



Some answers

- Train more psychiatrists
- Incentivize them: Pay as much for this as a 15 minute minor surgery
- Collaborative models with primary care
- Hold your insurance companies accountable for adequate numbers of providers of psychiatric and other mental health care.
- Psychiatrists (esp. Child Psychiatrists) are the shortest specialty group in the US. The only specialty that has been every shortage specialty list ever created.
- Work with your legislators to support these life-saving and cost saving treatments including access.

Collaborative Models with Primary Care

- Psychiatrists can provide support to a large number of primary care clinicians

- An average psychiatrist can realistically care for 300-500 patients. Some go as high as 1,000 but give poor care.
- For every psychiatrist who supports 50 primary care docs, 1,000's of patients get good care.
- This requires a new paradigm for payment.
- Over 1,000 primary care doctors in KS and WI were surveyed. They identified 4-(5) areas for assistance.

The Model: Collaborative Care

The Evaluation Clinic: A 2 Visit Evaluation and Feedback

- Diagnostic assistance
- User friendly treatment guidelines

Needs Some Financial Support e.g., not reimbursable.

- CME Continuing Education
- Phone support (\$)
- Telepsychiatry (\$)

Ms. Nelson, who works in telemedicine, said telemedicine does allow more providers to be in the counties that are underserved. Dr. Scheffer gave an example. If a psychiatrist is sitting in the office in Kansas City and has taken over the full care of the patient in Ellis county, they don't get a force multiplier effect because somebody in Kansas City isn't getting care because someone in Ellis county is. If telepsychiatry is used in a collaborative model the psychiatrist gives the primary care doctor and the patient consultation.

What we would need to help

- Better reimbursement for psychiatric evaluations (Step 1)*
- Treatment guidelines will be free
- Minimal support for CME/CE
- Call Center(s): Suggestion 1 in Wichita, 1 in Northeast**
- Telepsychiatry support for second opinions and more complicated cases*.

Dr. Moeller asked who would be in the call centers. Dr. Scheffer said there are many options. The idea is to have a triage person and then the majority of the calls would need to be addressed by either a nurse practitioner or physician. He also thinks there is a role

for people with social work backgrounds. Dr. Moeller asked if they would be full time staff. Dr. Scheffer said the ideal situation in the call center would be that when a call comes in it would be transferred to a doctor in real time or the call would be returned within 15 minutes.

Dr. Burke asked if people would be eligible to use the call center only if they have gone through a comprehensive psychiatric evaluation initially. Dr. Scheffer said in Massachusetts they only took calls from people they developed a contractual relationship with.

Dr. Moeller asked what types of calls are received. Dr. Scheffer said the calls are more focused on medications.

How would this help?

- #1: Better care: ~80% of people with psychiatric illnesses can get good care if this model is used.
- #2: Decreased cost per individual
 - Less polypharmacy / rational polypharmacy
 - Less drug-drug interactions
- #3: Not creating these problems would avoid many problems.
- Examples: Our group takes more medications off seriously ill youth than puts them on.

Research and Education

- We can test and develop new treatments for these problems
- We can develop ways of determining which treatment is the correct one (pharmacogenetics and individualized medicine).
- We can assist in assessing and improving care delivery methods.
- We can train new and existing doctors to 'do it better'
- Role of KHPA?

Stigma: It Hurts Us All

- There are many types of stigma.
- This includes not going to care at a psychiatry office
 - i.e. pushing for care in another setting
- Some people are very open, many others are not.
 - This is an individual choice

	<ul style="list-style-type: none"> • Every family will be affected by mental illness! • Stigma by the health care community is particularly detrimental. <p>Dr. Burke summarized by stating the morning started with a vendor’s presentation about one approach to pharmacy benefit management which is more of a traditional approach using claims data. Now Dr. Scheffer has presented a collaborative care model with psychiatrists providing consultation and education to primary care providers.</p> <p>Dr. Menninger asked what the committee is supposed to do with the information that was presented by CNS. Dr. Burke said at this level, he would see the committee as becoming informed about available options. So what was presented this morning would be one option for pharmacy benefit management. That would be a program in line with the committee’s charge to make recommendations for improving the efficient and effective use of psychotropic drugs. Dr. Menninger asked if the committee will get to a point to make a recommendation later on. Dr. Burke said he envisions that the committee will develop a list and then prioritize recommendations to KHPA</p> <p>Dr. Menninger would like to hear an evaluation of the CNS program. Dr. Burke said there are other groups that do the same thing. The State of Kansas contracts with other companies to handle non-mental health drugs. It would be useful for the committee to hear how another company does the reconciliation between claims data and quality indicators. Dr. Menninger said he knows very little about this process, so it is very important to have an adequate understanding of what is out there.</p> <p>Ms. Hellebust asked for a mission statement for the committee. Dr. Burke said our charge is to come up with recommendations for clinically effective and fiscally efficient management strategies for mental health drugs in Kansas. We could include some version of a PDL ultimately as one of the things on our list of recommendations. This is an advisory committee not a PDL committee, with the expectation to make recommendations for efficient management of mental health drugs in Kansas.</p>	
<p>V. Gabriel Myers Workgroup – Florida Department of Children and Families a. Case Overview b. Workgroup Presentation – Medicaid Drug Therapy Management Program for Behavioral Health</p>	<p><u>Gabriel Myers Workgroup – Florida DCF</u></p> <p>Dr. Burke said this particular case led to a spotlight on mental health drug use in youth in the state of Florida.</p> <p><i>Case Overview and Workgroup Presentation</i></p> <p>Dr. Burke gave a clinical overview. Gabriel Myers was a Caucasian male who was born January, 2002 in a state other than Florida and eventually moved from Ohio to Florida. In June, 2008 in Florida he was with his mother who was found to be intoxicated and the</p>	

<p>c. Workgroup Final Report</p>	<p>state removed him from her custody. Subsequently in September, 2008 he was placed in foster care. Information became available to the state that he had been sexually abused and involved in sexually inappropriate behaviors in Ohio, but the details were not available. Initially the state of Florida placed him with his uncle but there was some question of physical abuse and he was placed in another foster home. He started counseling with a focus on sexual issues. He had an Individual Education Plan (IEP). He had a psychiatric evaluation and psychological assessment and was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Impulse Control Disorder not otherwise specified. In December, 2008 he was seen by a psychiatrist and was prescribed Vyvanse[®] for his ADHD. In February, 2009 Lexapro[®] was added. The report doesn't give the clinical notes to support the medication changes. In March, 2009 he had some episodes of violent behavioral dyscontrol in his foster home and is taken back to the psychiatrist. Lexapro[®] was discontinued and Symbyax[®] was started. Symbyax[®] is a combo drug of Prozac[®] and Zyprexa[®]. In April, 2009 he had another episode of behavioral dyscontrol, this time at school. There were recommendations that he needed to go to a new school, see a new therapist, start a new treatment plan, and needed to see his psychiatrist, but the next day while at home he hung himself in the bathroom shower. The Department of Children and Family Services Secretary called together a task force group to study this case and to try to come up with what went right and what went wrong.</p> <p>The committee was provided with a summary and their recommendations. Dr. Burke said that in looking at the recommendations, at least 70% of them have to do with mental health drugs although in this case there were numerous psychosocial and systems problems which seemed more relevant than the medication. Before the behavioral dyscontrol at home that led to the medication changes, this child went through losing visiting privileges with his mother and grandparents. He was abruptly changed to a new foster home. He was changed to a new after school program. His therapist was changed without a transition period. It appears the uncle had withdrawn involvement. All of this happened between February and March when he started having violent outbursts. After March all the references are to get the child to a psychiatrist for medication assessment. The focus becomes medication and the report appears to center on medication. But in fact there are psychosocial issues that immediately precede the deterioration of this child. The committee concurred with this summary assessment.</p> <p>Dr. Menninger said this is the way modern psychiatry thinks. There are very few options or interests in examining the child psychologically let alone do any psychotherapy. To rush to the pill seems to be the universal answer. Dr. Burke said there was a lot of discussion of the pill. In the report there was a criticism that no one could find adequate therapy notes. He was theoretically getting therapy, but no one was writing it down.</p>	
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Ms. Wakefield and Ms. Lewis stated from the report the actual psychiatric diagnosis was unclear. It was suggested that that the behavioral outbursts may have been a response to the various and multiple abandonments the child was experiencing.

Dr. Burke said he's not sure, as a physician, that he's ready to make a diagnosis because the report is incomplete. He agreed that the psychosocial issues were significant and timely. Another issue was that no one ever, by the time of the suicide, had been able to get the records from Ohio for review.

Dr. Shaw said This case is an indictment of the foster care system. Dr. Shaw said it's very difficult to get records from Ohio to Florida. Dr. Burke asked if the Florida court could subpoena the records from Ohio. Dr. Shaw said if they are mental health records, then no, unless there is an indictable offense.

Dr. Shaw said in foster care systems when children move from home to home the foster parents don't know what happened in the previous home. They have limited or no medical history or psychiatric history And most of the time, as a parent, they have no idea how to deal with a child that has these issues because it isn't like parenting a regular child.

Dr. Burke said Gabriel's foster parents appeared to be in violation of the policies because on the day he committed suicide they left him alone with someone to supervise him that wasn't technically supposed to be in the home.

Dr. Burke commented that the Florida taskforce recommendations are about how everything needs to be improved and that their system fell apart and didn't work. But 70-80% of the bulleted recommendations focus on the drugs. How big of a role did drugs actually play?

Ms. Lewis said she worked in the Ohio child welfare training center for many years. She said she knows how Ohio parents and case managers are trained. The fault of the drugs is they enabled everybody to abdicate any kind of responsibility at any other point in the system. There are a whole series of things that the foster parents should have known and that the case managers should have been doing. She said she has had this kind of case and has not had to put the child on drugs if you can properly implement the pieces in the foster care system.

Dr. Burke said it was best stated by Ms. Lewis that the indictment of the medication enabled abdication of responsibility. As a psychiatrist, Dr. Burke said that in his opinion the patient's pharmacotherapy wasn't particularly aggressive. The patient only saw the

psychiatrist a few times and only had one or two med changes. What about hospitalization for crisis stabilization? Dr. Menninger said this is the kind of child that could have been helped in the children's unit at Menninger's; for a period of time, protected and constrained. Ms. Lewis said foster care systems, when they are well set up, have that level of capacity within their own providers and families within a much more naturalistic setting at greatly reduced cost.

Dr. Menninger asked why the committee is reviewing this case. Dr. Bell said that while it didn't make national news she had been following this case, and as it developed, seemed to be highly applicable to medication use. Regardless of whether it is actually related to medication use, based on the committee discussion thus far, she thought it was a good case for the committee to process with regard to what is relevant to Kansas

Dr. Scheffer said when patients are looked at from a psychiatrist's point of view we talk about bio-psycho-social model. Biologically, the medication treatments are an art form to be really good at, but it doesn't take much to be adequate. All kinds of people get psychological training. The social stuff hits kids the hardest. A huge risk factor for suicide is loss. He said he may have prescribed this child a medication to try to help him deal with the losses. A question is why a clinician would do this. It is because they are trying to help. Dr. Moeller agreed.

Dr. Shaw asked if there is a question about the medications he was on. Often patients on Medicaid are being seen by adult psychiatrist primarily. Sometimes she questions the drugs that are prescribed to the children because they don't deal with children.

Dr. Burke said the report references a need to make a medication management appointment after the episodes of behavioral dyscontrol, but then there isn't any data that those appointments were made or what the follow through was.

Dr. Menninger said the medications he got were not that big of deal compared to the setting, to his losses, to the inadequacy of a fixed individual who would serve as his case manager.

Dr. Burke said he would concur with Dr. Menninger. It was an indictment of their social welfare system. Dr. Scheffer said there is bad psychopharmacology that goes on, but for the most part the doctors are just trying to help. Sometimes the doctors need help. Dr. Burke said as he reads the report the recurring question seems to be who is in charge.

Ms. Lewis said if we were to look at expanding the data we are willing to collect, one thing we might attempt to find out is if the Medicaid beneficiaries that are on mental

	<p>health drugs are getting the psychotherapy needed. Dr. Bell said she doesn't disagree with that, but pharmacy claims are paid at point of sale whereas providers have 12 months to submit claims, so it could be 12 months down the line before we would know that the beneficiary isn't going to appointments.</p> <p>Dr. Menninger said one he found to be interesting is that there were 36 people involved in this case, excluding the committee. It shows that this is no one's child, as stated in the first sentence of the report. If the committee is going to learn from this, we would need to ask how our system handles a multiple faceted problem that brings in 10-20 people for one function or another. Dr. Burke said the Gabriel Myers committee made the recommendation that there would be a designated healthcare advocate for each foster child who could ensure ongoing review, communication, responsiveness, etc.</p> <p>Dr. Burke asked if there is anything the committee wants to carry forward from this case, and suggested that perhaps a relevant issue is that foster children are particularly at risk because they don't have a dedicated adult advocate.</p>	
<p>VI. Mental Health Drug Prescribing in Kansas Medicaid – Potential for Improvement?</p> <p>a. Drug Use in Foster Care</p> <p>b. Summary of Select Comprehensive Neuroscience Quality Indicators</p> <p>c. Discussion</p>	<p><u>Mental Health Drug Prescribing in Kansas Medicaid</u></p> <p><i>Drug Use in Foster Care</i></p> <p>Dr. Bell said SRS is also doing a study specifically on medication use in foster care. It isn't ready yet, but when it is she will bring it to the committee.</p> <p>From January – June, 2009 there were 9466 children eligible for foster care. There were 2678 children who received at least one of a list of drugs compiled by Florida Medicaid while in foster care during that time. 28.3% of Kansas foster care eligible children received a specified drug. 15.2% of Florida foster care eligible children received a specified drug. The Florida report is based on information that is entered into their tracking system. They do not use claims data.</p> <p>Dr. Scheffer said foster care is an enriched sample because of social and parenting issues.</p> <p>Dr. Shaw pointed out that there a lot of seizure drugs on the list because they can sometimes be used for mental health issues, but it is possible that the data is picking up people who are just being treated for seizures.</p> <p>Dr. Burke said that the committee thought that it was an interesting discrepancy between Florida and Kansas, but that there are a variety of possible reasons for that.</p> <p><i>Summary of Select CNS Quality Indicators</i></p>	<p>The summary of select CNS</p>

	<p>Dr. Bell compiled data provided by CNS into number of beneficiaries, number of prescribers, what number of prescribers were in each specialty, how many patients that specialty was writing for. On the bottom of the sheet is a description of the population codes.</p> <p>Dr. Burke said it would be interesting to have the two tables meshed. For example are the psychiatrists seeing the foster care children? Another thing that jumps out is the nurse practitioner issue. We have seen there is a desperate shortage of psychiatrists, so are these nurse practitioners who have special training? Dr. Bell said the psychiatrist/nurse practitioner prescriber is a situation where the patient is getting prescriptions written by both.</p> <p>See Decision and/or Action</p>	<p>quality indicators was tabled until the next meeting so that the members could have more time to look at the data.</p>
<p>VII. Possible Resources</p> <ul style="list-style-type: none"> a. Texas Medication Algorithm Project b. Florida’s Medicaid Drug Therapy Management for Behavioral Health c. American Academy of Child and Adolescent Psychiatry Practice Parameters d. Other States <ul style="list-style-type: none"> i. Preferred Drug Lists ii. Georgia Medicaid – Results of PDL Implementation 	<p><u>Possible Resources</u></p> <p>Dr. Burke asked the committee for thoughts about the utility of practice guidelines as part of their ultimate recommendation to KHPA. Dr. Scheffer said primary care doctors want basic treatment guidelines.</p> <p>Dr. Scheffer said he would like to see providers document why they go outside of the indicators. Not questioning them, but it would be important to understand in practice. Dr. Burke said that CNS earlier estimated they get less than a 10% response rate. Dr. Moeller pointed out that the letter explicitly says, “you do not need to respond to us about these messages unless you want to alert us to a claims error or wish to share a clinical comment” so it isn’t encouraged to send them back. Dr. Burke said that’s why he thinks it would be useful to see another company’s presentation which may have a different approach to getting feedback from providers.</p> <p>Dr. Shaw said in general primary care physicians are receptive to guidelines. They don’t necessarily like to be told what to do, but they do want guidelines.</p> <p>Dr. Burke asked how we decide what guidelines. Dr. Moeller said we should come up with our own guidelines for Kansas.</p> <p>Dr. Scheffer said the guidelines have to be broad. If you narrow it too much you can get into trouble. He said Texas was building their evidence based information into their algorithm.</p> <p>Ms. Lewis suggested we provide guidelines, but we should require a feedback loop if they deviate that will be used, not necessarily to penalize them, but to help tweak the</p>	

algorithm.

Dr. Burke said he liked the idea of keeping it short and general. Probably fairly early in the algorithm if things aren't working suggestion to seek outside assistance. If a provider deviates they should get consultation or justify it. Dr. Burke said there are a couple problems with this. One is that it can become very expensive.

Dr. Bell asked if this would happen before the patient started taking the medication or later. Dr. Scheffer said he was originally thinking of this as a feedback mechanism; for example a flag comes up and a letter is sent asking for justification.

Dr. Shaw suggested that ideally this is tied to reimbursement. Best practices are usually tied to payment. Dr. Burke said tying best practices to physician reimbursement doesn't punish the patient whereas if the prescription is not paid for at the point of sale because the doctor deviated then the only person who gets punished is the patient.

Dr. Burke said he wants to be sensitive to his clinician colleagues who already have plenty of paperwork.

Dr. Scheffer said he would prefer that it was done at the beginning not linked to payment. Education first.

Dr. Burke said the PDL committee studied marinol and educated providers about appropriate use and provided an alert for clinicians to prepare for future edits based on practice guidelines that were going to be implemented in the next quarter This is a ways to introduce the issue and tie to payments.

Dr. Burke asked Dr. Bell if Missouri has psychotropic drugs on their PDL. Ms. Lewis said no they have a carve-out. Dr. Bell disagreed, and said Missouri can manage psychotropic drug use with some prior authorization.

Ms. Hellebust said it sounds like we are getting punitive. What will be the effect of the providers? Dr. Scheffer said people will quit because they don't get paid enough.

Dr. Burke summarized that the committee appeared to have agreement that practice guidelines would be valuable and retrospective follow-up on practice guidelines would be helpful in shaping clinical practice. It needs to have some teeth, but can't be so strong as to be a turn off to providers so that they stop providing.

Dr. Burke said in general there is a consensus that practice guidelines to educate and

	elevate the level of practice are a good idea. They should be fairly brief. It would be nice to do retrospective reviews to find people who deviate. Focus on providing support and specialty consultation and not be punitive.	
VIII. Adjourn	The meeting was adjourned at 1:56 p.m.	Ms. Lewis moved to adjourn the meeting. Ms. Hellebust seconded and it carried with a unanimous vote.