Improving the Appropriate Use of Psychotropic Medications for Children in Foster Care
Webinar Series

Kamala D. Allen
Director, Child Health Quality
Center for Health Care Strategies

July 17, 2013 – 2:30-4:00 PM EST
Dial-In: 888-329-8906 // Passcode: 725654
**Questions?**

*Ask a Question Online:* Click the **Q&A** icon located in the hidden toolbar at the top of your screen.
<table>
<thead>
<tr>
<th>Quality Improvement Collaborative (Casey Foundation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Six state teams (IL, NJ, NY, OR, RI, VT)</td>
</tr>
<tr>
<td>• Three-year system change initiative</td>
</tr>
<tr>
<td>• PMQIC Data Subgroup</td>
</tr>
<tr>
<td>• Impact measures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychotropic Medication Virtual Learning Community (SAMHSA/ACF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bi-monthly webinars</td>
</tr>
<tr>
<td>• Monthly technical assistance e-newsletter</td>
</tr>
<tr>
<td>• SharePoint Resource Center</td>
</tr>
</tbody>
</table>
Data Workgroup Charge

• Identify common data definitions for the project teams to use for key concepts.

• Identify common measures that can be used to collect and report impact on key indicators.
PMQIC Data Workgroup Members

Christopher Bellonci, Data Workgroup Chair

- IL: Jeanie Ortega-Piron, Mike Naylor
- NJ: Debra Lancaster, Mary Beirne, Brendan Lee
- NY: Molly Finnerty, Joan Gerring, John DiLallo
- OR: Kevin George, Ted Williams
- RI: Janice DeFrances, Leon Saunders, Colleen Caron
- VT: Cindy Walcott, MaryBeth Bizzari, Melissa Bailey
Defining Our Terms: Setting the Context for Data Definitions in Support of Psychotropic Medication Oversight and Monitoring

Christopher Bellonci, M.D.
Assistant Professor
Tufts University School of Medicine
Rates of Psychotropic Medication Use in Child Welfare Population: Nationwide

- Rates of psychotropic medication use range from 13-50% among children in foster care.
- Rates of antipsychotic use increased from 8.9% in 2002 to 11.8% in 2007.
  - Range from 2.8% in HI to 21.7% in TX.

Rates of Psychotropic Medication Use in Child Welfare Population: Texas

• 38% of the 32,000+ youth in foster care (less than 19 years old) were prescribed psychotropic medication
  ▪ 41% received 3+ concomitantly
• By age group, the 2005 annual prevalence of psychotropic medication in Texas was:
  ▪ 12.4% in 0-5 year olds
  ▪ 55% in 6-12 year olds
  ▪ 66.5% in 13-17 year olds

Source: Zito et al., 2008
Promoting Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care

• April 2012 joint memorandum from ACYF, CMS, and SAMHSA:
  ▪ Defines the issues surrounding psychotropic medication use by children in foster care
  ▪ Highlights available resources for states in developing their Annual Progress and Services Report
  ▪ Encourages increasing access to clinically appropriate screening, assessment, and evidence-based interventions for foster children with mental health and trauma-related needs

Fostering Connections to Success and Increasing Adoptions Act of 2008
(Public Law 110-351)

• Requires states to develop a plan for oversight and coordination of health care services for children in foster care, in coordination and consultation with Medicaid; pediatricians and other experts in health care; and experts in, and recipients of, child welfare services

• Ensures that children in foster care receive high-quality, coordinated health care services, with appropriate oversight of any needed prescription medicines
Child and Family Services Improvement and Innovation Act
(Public Law 112-34)

• Specifies that health care oversight plan must include an outline of “protocols for the appropriate use and monitoring of psychotropic medications”

• Establishes a statutory requirement that oversight of psychotropic medications be explicitly addressed in a state’s health care oversight and coordination plan
Factors that Influence Patterns of Psychotropic Medication Use in Foster Care

- Insufficient state oversight and monitoring
- Gaps in coordination and continuity of medical and mental health care across public health and social service systems
- Provider shortages, especially of board-eligible and board-certified child and adolescent psychiatrists, in some geographic areas (e.g., rural)
- Lack of access to effective non-pharmacological treatments in outpatient settings
Clinical Guidelines

- Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children’s mental health and trauma-treatment needs
- Informed and shared decision-making and methods for on-going communication
- Effective medication monitoring at both the client and agency level
- Availability of mental health expertise and consultation regarding both consent and monitoring issues
- Mechanisms for accessing and sharing accurate and up-to-date information and educational materials related to mental health and trauma-related interventions
PMQIC State Approaches

- Develop or revise informed consent procedures
- Develop method for generating real-time medication utilization data, in some cases from Medicaid-claims
- Develop a protocol for reviewing “red flags” or outlier prescribing practices based on age, dose, duration, diagnosis, class of medication, co-pharmacy and polypharmacy
- States develop the oversight and monitoring processes that are most appropriate for their jurisdiction and practice concerns
PMQIC Data Subgroup

• Comprised of representatives from each of the 6 participating states
  - Illinois, New Jersey, New York, Oregon, Rhode Island, and Vermont

• Goal: Identify and agree upon common definitions and measures that each state could implement to address the inappropriate use of psychotropic medications
PMQIC Data Definitions

• **Foster youth**: children placed away from their parents or guardians in 24-hour substitute care and for whom the state agency has placement and care responsibility (federal definition)

• **Young children**: all children under age 6 (5 years and 364 days old)

• **Consent**: defined by individual state laws or regulations (if they exist)
PMQIC Data Definitions

- **Psychotropic medications**: medications being used for an emotional or behavioral condition
- Medications automatically assumed to be for a psychiatric indication and included in this definition:
  - Antipsychotics
  - Stimulants
  - Antidepressants
  - Benzodiazepines
  - Anti-anxiety medications (incl. Buspar)
  - Mood stabilizers (e.g., Lithium)
Medications used for a psychiatric purpose, but not typically classified as psychiatric medication, require cross-referencing with their diagnosis in the Medicaid system.

This includes:

- **Alpha-agonists** (e.g., Clonidine and Guanfacine and their long-term analogs); use of these medications for hypertension in children is so rare that it could be assumed they are being used for a behavior indication.

- **Anti-convulsants**, if absence of a seizure disorder diagnosis, then assumed for mood stabilization.
PMQIC Data Definitions

cont.

• **Polypharmacy**: children taking more than one psychiatric medication or more than one medication within the same class (e.g., 2+ more antipsychotic medications) or “co-pharmacy”
  ▪ Child would need to be taking the medications simultaneously for 90+ days to be considered poly- or co-pharmacy
Dosage Guidelines

- **FDA approval for use in a pediatric population**
  - Use the associated/extrapolated dose for children under 13 years and those 13 to 18 as the PDR suggests

- **Multiple indications in youth**
  - Use the maximum dose for the psychiatric indication (PDR)

- **No FDA indication for the pediatric population**
  - Use the guidelines proposed by the Texas report regarding the care of children in foster care*

- **No FDA indication or guidance from the Texas report**
  - Use dosing parameters set forth in Appendix 1 of *Pediatric Psychopharmacology: Principles and Practice* (Editors Andres Martin, Lawrence Scahill, Dennis S. Charney, and James F. Leckman Oxford University Press, 2003)

- **None of the above sources set forth any guidance**
  - Use the adult PDR maximum

Baseline Measures for Metabolic Monitoring

- Baseline measures for monitoring second generation antipsychotics (SGAs) following the ADA/APA adult consensus guidelines
  - Exception: lipids checked annually, rather than every five years
- States can set their own protocols requiring more frequent measures, but this list = minimum standard
- States may monitor other meds – metabolic or other labs (i.e., Valproic acid, Lithium, etc.) – can define themselves
Minimum Metabolic Monitoring Protocol for SGAs

- Personal and family history: Baseline and annually
- Waist circumference: Baseline and annually
- Weight and BMI: Baseline, every 4 weeks up to 12 weeks, and then quarterly
- Blood pressure: Baseline, 12 weeks and annually
- Fasting plasma glucose: Baseline, 12 weeks and annually
- Fasting lipid profile: Baseline, 12 weeks and annually
# Pediatric Metabolic Syndrome Monitoring Form

**Patient Name**

Metabolic Syndrome is considered positive if a patient has any three of the five numbered risk criteria. If more than one cholesterol criteria (Total, LDL, HDL) are abnormal, count as one risk criteria. **Gray boxes indicate when to monitor for a risk factor** (These are recommendations for physician prescribing psychotropic medication to children and adolescents and does not indicate the duration for which psychotropic medication consent will be given to foster children). Items in Orange Shading represent critical junctions where monitoring data is mandatory to receive initial consent or renewal. For information regarding requesting DDPS consent for psychotropic medication and other general psychotropic medication resources log on to [http://www.psych.uic.edu/ddp](http://www.psych.uic.edu/ddp).

<table>
<thead>
<tr>
<th>Measure</th>
<th>Risk Criteria</th>
<th>References</th>
<th>Baseline</th>
<th>4 Weeks</th>
<th>8 Weeks</th>
<th>12 Weeks</th>
<th>Quarterly</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal/Family History</td>
<td>Personal/family history of cardiovascular disease, diabetes, hypertension</td>
<td>✐</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Body Mass Index (BMI)</td>
<td>BMI ≥ 85&lt;sup&gt;th&lt;/sup&gt; percentile (<em>see BMI charts</em>)</td>
<td>✐</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 2 Blood Pressure             | • SBP and/or DBP on ≥ 3 occasions ≥ 95<sup>th</sup> percentile is hypertensive (*see charts*)  
  • 90<sup>th</sup>-95<sup>th</sup> percentile “high normal/prehypertensive”  
  ✌ Take blood pressure of children <3 years at each visit only if other risk criteria are present | ✐          |          |         |         |          |           |           |        |        |
| 3 Fasting Plasma Glucose     | ≥ 6.1 mmol/L or ≥ 110mg/dl                                                    | ✐          |          |         |         |          |           |        |        |
| Fasting Lipids (2-18 years)  | Acceptable mg/dl                                                             |            |          |         |         |          |           |        |        |
| 4 Total Cholesterol          | < 170                                                                        | ✐          |          |         |         |          |           |        |        |
| 5 LDL                         | < 110                                                                        | ✐          |          |         |         |          |           |        |        |
| 6 HDL                         | > 45                                                                          |            |          |         |         |          |           |        |        |
| 5 Tri-glycerides             | < 150                                                                        |            |          |         |         |          |           |        |        |
| Lifestyle advice             | Activity level, diet, smoking                                                | ✐          |          |         |         |          |           |        |        |

*Draft Illinois Example*
Medication
Antipsychotic Switching Interventions Impact on Weight Control
Switching to Aripiprazole
Other Pharmacological strategies impact on Weight Loss
Orlistat
Anti convulsant agents
Topiramate
Zonisamide
Metformin

Diet and Exercise
Weight Management Interventions (behavioral counseling health education)
CBT/Motivational interviewing/supportive weightloss approach
Common Measures

Data gathered at baseline, and over the course of the 3-year initiative, will measure the **percentage of children in foster care:**

- On any psychototropic medication
- On specific classes of medications (e.g., antidepressants, stimulants, mood stabilizers, antianxiety drugs)
- On more than 1 medication from the same class (co-pharmacy)
- On 2, 3, and 4+ psychotropic medications
- **< 6 years old** on any psychototropic medication
- **< 6 years old** on 2, 3, and 4+ psychotropic medications
- **<6 years old** on antipsychotics
Common Measures

cont.

Will also measure:

- Implementation of evidence-based or promising interventions for sleep disorders and/or aggression
- Development of an informed consent process or increased adherence to the state’s informed consent process
Questions?

Ask a Question Online: Click the Q&A icon located in the hidden toolbar at the top of your screen.
Using Data to Improve Clinical Care

Molly Finnerty, MD

Director, Bureau of Psychiatric Services and Clinical Knowledge Enhancement Systems (PSYCKES)
New York State Office of Mental Health

Associate Professor for Research
Child and Adolescent Psychiatry
New York University Medical Center
Overview

- What is PSYCKES?
- PSYCKES Demo
- PSYCKES Implementations 2003-2013
  - Lessons Learned
- AHRQ-CMS National Collaborative for Innovation in Quality Measurement (NCINQ)
  - Antipsychotic Measures
Putting Medicaid Data to Work

- Medicaid data is a largely untapped resource
- Can be used to support clinical data
- Can be used to drive quality and lower cost
What is PSYCKES?

- An example of a web-based application that aggregates large volumes of Medicaid data into user-friendly reports
- A portfolio of secure, HIPAA-compliant web-based applications that make administrative data available to support:
  - Clinical decision-making
  - Quality improvement
  - Planning & oversight
  - Shared decision-making & patient education (MyPSYCKES)
- 3 PSYCKES applications
  - PSYCKES for State Hospitals (2003), all 26 state hospitals
  - PSYCKES-Medicaid (2008) over 400 programs
  - My PSYCKES (2010) 2 pilots, expanding to 15
PSYCKES Goals

- Support guideline-driven, cost-conscious quality improvement
- Support data-driven policymaking

Administrators

- Provide integrated, point-of-service access to patient data, to support clinical decision-making

Physicians and Supervisors

- Provide complete medication history as a reference and tool for treatment
- Patient reported outcomes and shared decision-making

Recipients and Family Members (MyPSYCKES)
PSYCKES Content

- Quality reports
- Clinical summaries
- Maps identifying regional variation
- Search for groups of patients or individual patients
Current PSYCKES Quality Indicator Sets

- 4 psychotropic medication related sets
  - Polypharmacy
  - Cardiometabolic
  - High dose
  - Youth set (high dose, polypharm >3, <6 yo)
- 3 hospital related
  - Hospital readmission (7, 30 days)
  - Preventable hospitalization (e.g., asthma, diabetes, dehydration)
  - High utilization (>4 inpatient/ER visits past year)
- High need/ineffectively engaged
- Health promotion
  - High utilization for medical cause
  - Annual physical
  - Diabetes monitoring
  - Diabetes screening for individuals on antipsychotics
- Behavioral care coordination
  - Medication adherence
  - High utilization behavioral health cause
Turning Data into Knowledge
Statement of Access and Confidentiality

WARNING: This computer system is solely for the use of authorized users for official purposes. Users of this system have no expectation of privacy in its use. To ensure that the system is functioning properly, individuals using this computer system are subject to having all of their activities monitored and recorded by system personnel. Use of this system evidences an express consent to such monitoring.

Unauthorized or improper use of this system may result in administrative disciplinary action and civil and criminal penalties. By continuing to use this system you indicate your awareness of, and consent to, these terms and conditions of use. If you do not agree to the conditions stated in this warning, LOG OFF IMMEDIATELY.

Secure Login for PSYCKES

Token

Note: To log-on with a new token, enter just the six digits displayed on the token device.
### Select Indicator Set for Details

#### Indicator Set

<table>
<thead>
<tr>
<th>Indicator Set</th>
<th>Population</th>
<th>On Any</th>
<th>N</th>
<th>%</th>
<th>Regional %</th>
<th>Statewide %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Youth Indicator</strong></td>
<td>Child</td>
<td>945</td>
<td>233</td>
<td>24.66</td>
<td>27.38</td>
<td>23.62</td>
</tr>
<tr>
<td>Readmission</td>
<td>All</td>
<td>236</td>
<td>43</td>
<td>18.22</td>
<td>16.89</td>
<td>14.27</td>
</tr>
<tr>
<td>Preventable Hospitalization</td>
<td>Adult</td>
<td>6</td>
<td></td>
<td>0.69</td>
<td>0.69</td>
<td>1.06</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>All</td>
<td>633</td>
<td>138</td>
<td>21.80</td>
<td>22.68</td>
<td>18.59</td>
</tr>
<tr>
<td>High Utilization - Inpt/ER</td>
<td>All</td>
<td>2,320</td>
<td>119</td>
<td>5.13</td>
<td>9.05</td>
<td>8.58</td>
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<tr>
<td>High Need - Ineffectively Engaged</td>
<td>All</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Promotion and Coordination</td>
<td>All</td>
<td>2,320</td>
<td>550</td>
<td>23.71</td>
<td>26.48</td>
<td>22.02</td>
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<tr>
<td>Dose</td>
<td>All</td>
<td>905</td>
<td>93</td>
<td>10.28</td>
<td>11.39</td>
<td>8.01</td>
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<tr>
<td>Cardiometabolic</td>
<td>All</td>
<td>69</td>
<td>34</td>
<td>49.28</td>
<td>71.39</td>
<td>66.17</td>
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<tr>
<td>BH Care Coordination</td>
<td>All</td>
<td>2,320</td>
<td>95</td>
<td>4.09</td>
<td>4.83</td>
<td>1.97</td>
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</tbody>
</table>

![Graph showing indicator set data](image-url)
### Indicator Set: Youth Indicator

Select indicator for detail.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>On Any</th>
<th>N</th>
<th>%</th>
<th>Regional %</th>
<th>Statewide %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth - BH Med &lt;6yrs old</td>
<td>Child</td>
<td>945</td>
<td>39</td>
<td>4.13</td>
<td>5.76</td>
<td>7.17</td>
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<tr>
<td>Youth - 3+ Polypharmacy</td>
<td>Child</td>
<td>631</td>
<td>136</td>
<td>21.55</td>
<td>22.30</td>
<td>18.34</td>
</tr>
<tr>
<td>Youth - High Dose</td>
<td>Child</td>
<td>901</td>
<td>93</td>
<td>10.32</td>
<td>11.42</td>
<td>8.03</td>
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</tbody>
</table>

**Summary**

<table>
<thead>
<tr>
<th>Population</th>
<th>On Any</th>
<th>N</th>
<th>%</th>
<th>Regional %</th>
<th>Statewide %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>945</td>
<td>233</td>
<td>24.66</td>
<td>27.38</td>
<td>23.62</td>
</tr>
</tbody>
</table>
Clinical Summary

Link from

- Quality indicator performance
- List of Medicaid enrollees with this quality flag
- Clinical summary for individual patients with this quality flag

Clinical summary content

- All pharmacy, inpatient, and outpatient services across treatment settings (paid by Medicaid)
- All FFS and managed care Medicaid data
- Up to 5 years of data
- Organized like a medical record
### Clinical Summary

**OMH PHI Please choose summary period**  
[Last 3 months]  [Last 6 months]  [Last Year]  [Last 2 Years]  [All Available (up to 5 years)]

**Clinical Report Date:** 6/21/2013  
(This report contains all available clinical data.)

**Name:** Jfbfgf Jbfadbj  
**Medicaid ID:** DICBAFJ HCFCDE  
**DOB:** 01/01/1999  
**Age:** 999

**Medicaid Eligibility:** TANF W/DEPRIV  
**Managed Care Plan:** No Managed Care (FFS Only)  
**Medicare:** No

<table>
<thead>
<tr>
<th>Indicator Set</th>
<th>Quality Flag Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH Care Coordination</td>
<td>3+ Inpatient - BH</td>
</tr>
<tr>
<td>Dose Indicator</td>
<td>Quetiapine Fumarate 400.00 mg (Recommended Max = 300.00 mg)</td>
</tr>
<tr>
<td>High Need - Ineffectively Engaged</td>
<td>Individuals with multiple MH Inpatient or ER admissions or a prior AOT order or forensic MH service use who also have no current connection to TCM (ICM/SCM/BCM) and limited outpatient MH service use (4 or FEWER visits in prior 6 months)</td>
</tr>
<tr>
<td>Hospital ER Utilization</td>
<td>4+ Inpt/ER-All</td>
</tr>
<tr>
<td>Polyparmacy</td>
<td>Antipsychotic Two Plus (Olanzapine + Quetiapine Fumarate)</td>
</tr>
</tbody>
</table>

### Behavioral Health Diagnoses - Primary and Secondary Dx (Most Recent Shows First)

- Attention Deficit Disorder
- Major Depressive Disorder
- Bipolar Disorder
- Personality, Impulse Control Disorders
- Conduct Disorder
- Other Nonpsychotic Mental Disorder
- Somatoform, Factitious Disorder
- Anxiety Disorder

### Medical Diagnoses - Primary and Secondary Dx (Most Recent Shows First)
<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Last Dose*</th>
<th>Estimated Duration</th>
<th>First Day Picked Up</th>
<th>Last day Picked Up</th>
<th>Active in Past Month</th>
<th>Most Recent Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quetiapine Fumarate</td>
<td>Quetiapine Fumarate</td>
<td>150 MG</td>
<td>8 Month(s) 1 Week(s) 4 Day(s)</td>
<td>10/26/2012</td>
<td>6/7/2013</td>
<td>Yes</td>
<td>Reddy Suguna C</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Olanzapine</td>
<td>5 MG</td>
<td>7 Month(s)</td>
<td>10/29/2012</td>
<td>4/29/2013</td>
<td>Yes</td>
<td>Reddy Suguna C</td>
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<tr>
<td>Seroquel Xr</td>
<td>Quetiapine Fumarate</td>
<td>200 MG</td>
<td>1 Month(s) 3 Week(s) 5 Day(s)</td>
<td>9/6/2012</td>
<td>10/4/2012</td>
<td>No</td>
<td>Samenfeld-Specht</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>James A</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Quetiapine Fumarate</td>
<td>100 MG</td>
<td>1 Month(s) 2 Week(s) 5 Day(s)</td>
<td>9/7/2012</td>
<td>9/28/2012</td>
<td>No</td>
<td>Samenfeld-Specht</td>
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<td>James A</td>
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<tr>
<td>Zyprexa</td>
<td>Olanzapine</td>
<td>20 MG</td>
<td>2 Month(s) 3 Week(s) 5 Day(s)</td>
<td>5/25/2012</td>
<td>7/23/2012</td>
<td>No</td>
<td>Samenfeld-Specht</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>James A</td>
</tr>
<tr>
<td>Service Type</td>
<td>Provider</td>
<td>Admission</td>
<td>Discharge Date/Last Date Billed</td>
<td>Length of Stay</td>
<td>Most Recent Diagnosis</td>
<td>Procedure(s)</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------</td>
<td>------------</td>
<td>---------------------------------</td>
<td>----------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>ER Medical</td>
<td>ELLIS HOSPITAL</td>
<td>12/14/2012</td>
<td>12/14/2012</td>
<td>1</td>
<td>Open Wound Of Scalp, Without Mention Of Complication [873.0]</td>
<td>Emergency Dept Visit</td>
<td></td>
</tr>
<tr>
<td>Inpatient BH</td>
<td>MOHAWK VALLEY PC</td>
<td>10/1/2012</td>
<td>10/25/2012</td>
<td>24</td>
<td>Unspecified Episodic Mood Disorder [296.90]</td>
<td></td>
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</tr>
<tr>
<td>ER BH</td>
<td>ELLIS HOSPITAL</td>
<td>9/28/2012</td>
<td>9/28/2012</td>
<td>1</td>
<td>Unspecified Episodic Mood Disorder [296.90]</td>
<td>Routine Venipuncture</td>
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<tr>
<td>Inpatient BH</td>
<td>ELLIS HOSPITAL</td>
<td>8/21/2012</td>
<td>9/6/2012</td>
<td>16</td>
<td>Unspecified Episodic Mood Disorder [296.90]</td>
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<tr>
<td>ER Medical</td>
<td>ALEANY MEDICAL CTR HOSPITAL</td>
<td>6/12/2012</td>
<td>6/12/2012</td>
<td>1</td>
<td>Contusion Of Hand(S) [923.20]</td>
<td>Emergency Dept Visit</td>
<td></td>
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<tr>
<td>Inpatient BH</td>
<td>FOUR WINDS SARATOGA</td>
<td>5/4/2012</td>
<td>5/24/2012</td>
<td>20</td>
<td>Unspecified Episodic Mood Disorder [296.90]</td>
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</tr>
<tr>
<td>Inpatient BH</td>
<td>ELLIS HOSPITAL</td>
<td>2/6/2012</td>
<td>2/22/2012</td>
<td>16</td>
<td>Unspecified Episodic Mood Disorder [296.90]</td>
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<tr>
<td>ER BH</td>
<td>ELLIS HOSPITAL</td>
<td>2/1/2012</td>
<td>2/1/2012</td>
<td>1</td>
<td>Other And Unspecified Special Symptoms Or Syndromes, Not Elsewhere Classified [307.9]</td>
<td>Emergency Dept Visit</td>
<td></td>
</tr>
<tr>
<td>ER BH</td>
<td>ST MARYS HEALTHCARE</td>
<td>6/16/2011</td>
<td>6/16/2011</td>
<td>1</td>
<td>Attention Deficit Disorder Of Childhood With Hyperactivity [314.01]</td>
<td>Emergency Dept Visit, Psy Dx Interview</td>
<td></td>
</tr>
</tbody>
</table>
PSYCKES Implementations

Clinical

Quality Improvement
PSYCKES Clinical Implementations

- Behavioral Health Organizations (BHOs)
  - 5 BHOs
  - Clinical reviews, share clinical information with hospitals, discharge planning/care coordination, target resources
- Behavioral health hospital implementation
  - 101 hospitals
  - Access to the same data as BHOs to review cases
- Emergency Room (ER) implementation
  - 15 ERs
  - Safety, efficiency, treatment/discharge planning
- Assertive Community Treatment
  - 41 teams
  - Intake, treatment monitoring, and follow-up post discharge
- Case management/health home care coordinators
  - 116 teams
Access to Clinical Data Improves Outcomes

- Access to electronic psychiatric records by non-psychiatrists decreases readmission rates
- Characteristics of chronic care management HIT systems associated with positive clinical outcomes
  - Population management reports
  - Population audit and feedback
  - Computerized prompts
  - Link to EMR (health information and data)

Sources: Kazubal et al 2012 and Dorr et al 2007
## PSYCKES Quality Improvement Projects

- **State psychiatric hospitals 2004 (26 hospitals)**
  - Antipsychotic Polypharmacy

- **Statewide CQI initiative in MH clinics (320 clinics)**
  - Phase I: Polypharmacy and Cardiometabolic (2008)
  - Phase II: Dose and Youth set (2010)
  - Phase III: Health Promotion and Behavioral Health Care Coordination (2012)

- **Hospital quality collaboratives (55 hospitals)**
  - Phase I: Cardiometabolic
  - Phase II: Behavioral Health Hospital Readmission
Benefits & Uses of Medicaid Data to Support Quality Improvement

- An array of quality measures can be assessed with Medicaid data
- No chart review, data extraction, or data entry
- Transparency – all stakeholders see the same information
- Meaningful and actionable data linked to individual clients
Lessons Learned from 3 Psychototropic Quality Improvement Initiatives

1. Antipsychotic Polypharmacy in State Psychiatric Hospitals (Phase I-IV)
2. Cardiometabolic CQI Initiative in hospital affiliated clinics (Phase I)
3. Statewide CQI Initiative in mental health clinics (Phase I)
   - Polypharmacy
   - Cardiometabolic
PSYCKES-Inpatient to Support QI in State Hospitals

Phase I
Implement PSYCKES

Phase II
Prior approval policy for Medical Director

Phase III
Feedback to hospital leadership on compliance with prior approval policy

Phase IV
End of feedback and policy approval policy
Prevalence of Antipsychotic Polypharmacy 3+
(April 2004 - Jan 2008)

Rate per 1,000 Inpatients

PSYCKES Implementation
Complete & Prior Approval Policy Begins
Feedback to Leadership Begins
Feedback and Prior Approval Policy End
Begin Hospital Self-Monitoring
Lessons Learned

- Giving physicians access to PSYCKES alone did not change practice.
- Policies can have a significant impact on antipsychotic polypharmacy, even if they are not monitored.
- Policies that are monitored have increased impact.
- Impact persists even after policies end.
- Success of this project was used to fund expansion.
Access to Medicaid data through PSYCKES was the incentive for participation.
Partnered with hospital associations.
Monthly learning collaborative calls:
  - Share data on impact
  - Clinics share challenges and strategies
13 of the 18 hospitals achieved reductions in prevalence rates (5 statistically significant) at 9 months.
## Decrease in New Starts of Cardiometabolic Indicator

### Table

<table>
<thead>
<tr>
<th>Population</th>
<th>Hospital</th>
<th>Dec 2010 (n)</th>
<th>Sept 2011 (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic</td>
<td>Collaborative</td>
<td>97</td>
<td>57</td>
</tr>
<tr>
<td>Psychotic</td>
<td>Non-Participating</td>
<td>227</td>
<td>175</td>
</tr>
<tr>
<td>Non-Psychotic</td>
<td>Collaborative</td>
<td>46</td>
<td>13</td>
</tr>
<tr>
<td>Non-Psychotic</td>
<td>Non-Participating</td>
<td>93</td>
<td>71</td>
</tr>
</tbody>
</table>

### Graph

**Decrease in New Starts**

Baseline (12/2010) vs. September, 2011

- Psychotic: -41%
- Non-Psychotic: -72%
- Non-Participating: -23%
- Non-Participating: -24%

**Note:**

- Collaborative
- Non-Participating
Lessons Learned

- It is easier to decrease new starts than to change an existing regimen.
- It is easier to decrease new starts for off label use.
- Small interventions from clinic leadership can have a large impact.
CQI Initiative in MH Clinics Phase I

- Clinics selected one of two projects (330 clinics)
  - Reducing psychotropic polypharmacy
  - Reducing use of high/moderate impact antipsychotics for those with existing cardiometabolic risk factors
- Clinics receive fiscal incentive for participation
- Track prevalence and fiscal outcomes in Medicaid
Impact of PSYCKES CQI Initiative on the Statewide Prevalence of Quality Concerns in the Medicaid Mental Health Clinic Population: Longterm Antipsychotic Polypharmacy

NYC - Participating, n=48
NYC - NonParticipating, n=53
ROS-Participating, n=62
ROS-NonParticipating, n=54
## Fiscal Impact

Per person savings highest for schizophrenia in polypharmacy project

Total savings higher for depression cohort due to higher number of individuals with depression

Not all cohorts improved in year 1; increased costs associated with youth related to lack of impact for youth in year 1

### Estimated Savings Due to PSYCKES CQI (Year 1)

<table>
<thead>
<tr>
<th></th>
<th>Number of Clients</th>
<th>Cost Difference-in-Difference per Client</th>
<th>Estimated Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Youth) Cohort 1</td>
<td>9935</td>
<td>$19.43</td>
<td>$192,996.65</td>
</tr>
<tr>
<td>Cohort 2</td>
<td>8467</td>
<td>$3.21</td>
<td>$27,207.54</td>
</tr>
<tr>
<td>(MDE) Cohort 3</td>
<td>7311</td>
<td>$(170.80)</td>
<td>$(1,248,750.16)</td>
</tr>
<tr>
<td>Cohort 4</td>
<td>6601</td>
<td>$(120.48)</td>
<td>$(795,272.27)</td>
</tr>
<tr>
<td>(Schiz) Cohort 5</td>
<td>4980</td>
<td>$(225.02)</td>
<td>$(1,120,578.07)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$(2,944,396.31)</strong></td>
</tr>
</tbody>
</table>

Per person savings highest for schizophrenia in polypharmacy project

Total savings higher for depression cohort due to higher number of individuals with depression

Not all cohorts improved in year 1; increased costs associated with youth related to lack of impact for youth in year 1
Lessons Learned

- Across large diverse group of clinics and providers improvement is possible – even high performers at baseline can improve
- Not all measures improve at same rate
- Youth measure needed focused attention
- ROI helps garner support for continuation/ expansion
The National Collaborative for Innovation in Quality Measurement (NCINQ)

- Developed under the Pediatric Quality Measurement Program
  - Aims to develop national quality measures for youth in Medicaid and the Children’s Health Insurance Program (CHIP)
- NCQA has partnered with Nationwide Children’s Hospital, New York University, NYS Research Foundation for Mental Hygiene, Rutgers (MEDNET), and other stakeholders to support measure development for youth in foster care and the general population
## Focus on Antipsychotics in Youth

### Trend of increasing use among youth
- Faster rate of increase among youth in Medicaid

### Concerns related to antipsychotics
- Youth more vulnerable to adverse metabolic impacts
- Youth more vulnerable to extrapyramidal side effects
- Long-term health impacts unknown

### Concerns related to services
- Youth less likely to have recommended laboratory monitoring
- Psychosocial interventions underutilized as first-line treatment for aggression and externalizing behaviors
- Regional disparities
- Disparities for youth in foster care, and with developmental disabilities
NCINQ Measures
Submitted for Public Comment

Measures to assess appropriateness/overuse of medications
- Use of antipsychotics in very young children
- Use of multiple concurrent antipsychotics in children
- Children on higher than recommended doses of antipsychotics
- Use of antipsychotics in children without a primary indication

Measures to assess use of needed services associate with medication use
- Follow-up care for children on antipsychotics
- Metabolic screening for children on antipsychotics
- Access to psychosocial care for children on antipsychotics
<table>
<thead>
<tr>
<th>Antipsychotic Measure</th>
<th>Client level performance</th>
<th>State distribution (state level performance)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Num</td>
</tr>
<tr>
<td>Antipsychotic Utilization Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Young</td>
<td>0.01%</td>
<td>5,962</td>
</tr>
<tr>
<td>AP Polypharmacy</td>
<td>4.4%</td>
<td>8,364</td>
</tr>
<tr>
<td>High Dose</td>
<td>7.5%</td>
<td>14,496</td>
</tr>
<tr>
<td>Without Indication</td>
<td>53.7%</td>
<td>104,487</td>
</tr>
<tr>
<td>Appropriate services for youth on antipsychotics (higher is better)</td>
<td></td>
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</tr>
<tr>
<td>Metabolic Screening – Glucose</td>
<td>34.3%</td>
<td>66,654</td>
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<tr>
<td>Metabolic Screening – Lipids</td>
<td>18.9%</td>
<td>36,840</td>
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<tr>
<td>Metabolic Screening -Both</td>
<td>17.5%</td>
<td>33,955</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>49.2%</td>
<td>95,646</td>
</tr>
<tr>
<td>Follow-Up</td>
<td>53.5%</td>
<td>29,228</td>
</tr>
</tbody>
</table>
Conclusion

- Final NCINQ proposed measures will be modified based on public comment/stakeholder input
- Antipsychotic measures are generally considered high importance and feasible
- This project underscores the importance of state engagement, and gaining familiarity with using psychotropic measures for youth in foster care
Questions?

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>September 2013</td>
<td>Use and financing of non-pharmacologic EBPs</td>
</tr>
<tr>
<td>November 2013</td>
<td>Trauma-informed assessments and treatment</td>
</tr>
<tr>
<td>January 2013</td>
<td>Facilitating cross-system data sharing; use of multi-system data for oversight and monitoring</td>
</tr>
<tr>
<td>March 2014</td>
<td>Education/Engagement of Providers</td>
</tr>
<tr>
<td>May 2014</td>
<td>Education/engagement of stakeholders (including family and youth) regarding policy and practice</td>
</tr>
<tr>
<td>July 2014</td>
<td>Psychiatric consultation models</td>
</tr>
<tr>
<td>September 2014</td>
<td>Red flag and response systems; implementation of oversight and monitoring policies and processes</td>
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