Telephonic Psychiatric Consultation Models: Providing Clinical Expertise to Primary Care

Psychotropic Medication Use Among Children in Foster Care: Technical Assistance Webinar Series

Thursday, June 5, 2014
3:00 – 4:30 p.m. EDT

For teleconference only, dial: 1-415-655-0001; Passcode: 667 281 392
Questions?

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

• Context setting
  ► Kamala Allen, Director, Child Health Quality, CHCS

• Washington and Wyoming’s psychiatric consultation models and medication second opinions
  ► Robert Hilt, MD of Seattle Children's Hospital and University of Washington School of Medicine

• Massachusetts Child Psychiatry Access Project (MCPAP)
  ► John Straus, MD Founding Director of MCPAP

• Reactor: Oregon Psychiatric Access Line for Kids (OPAL-K)
  ► Ajit Jetmalani, MD Director, Division of Child and Adolescent Psychiatry, Oregon Health & Science University

• Q&A
Why Focus on Telephonic Consultation?

• Implications for increasing access to care and increasing appropriate use of psychotropic medications
  ➤ Children are more likely to be seen by primary care physicians (PCPs) than by specialists
  ➤ Shortage of child psychiatrists, nationally
  ➤ Support a peer learning approach to care

• Resource for PCPs, general practitioners, psychiatrists, social workers, and school-based clinical professionals
Key Components

- Screening for behavioral health needs
- Diagnostic Consultation
- Pharmacological Consultation
- Second Opinions
- Provider Education/Training
- Telemedicine (virtual visits)
National Network of Child Psychiatry Access Programs (NNCPAP)

• Includes programs from 31 states
• Representatives from these programs meet via regular teleconferences to discuss topics of mutual interest and benefit
• Focus on establishing a compendium of best practices and collecting baseline data for future program evaluation efforts
Medication Second Opinion and Elective Consults

ROBERT HILT, MD
UNIVERSITY OF WASHINGTON
JUNE 5, 2014
Increased Prescribing to Children

- All psychiatric prescribing to U.S. children increased by 20% from 2001 to 2010
- Antipsychotic use increased more quickly
  - >100% rise for all children age 10-19 from 2001-2010
- Overall, 7.5% of all 6-17 year olds were using psychotropic medications in 2011

Medco Reports; Rutgers 16 state study; Howie LD 2014
Medicaid System Considerations

- **Rising costs**
  - Before generics, antipsychotics were almost half of WA state’s Medicaid pharmacy budget

- **Outlier prescribing noted on mental health drugs for children**
  - Some unsafe regimens
  - Variations in care raised best practice concerns

- **Increased agency oversight**
  - 2011 law, Child and Family Services Improvement and Innovation Act (P.L. 112-34)
    - Requires monitoring of foster care psychotropic medications
Planning the Review System

- **Washington State review system began in 2005**
  - Leadership developed a focus of concern
    - State Medicaid medical director noted outlier cases
    - Pharmacy system generated data on use and variations in practice
    - Leadership team partnered with the university’s child psychiatry program
  - Psychiatric medication advisory workgroup formed to examine data and generate review guidelines
    - Community practice leaders
      - Pediatricians, psychiatrists, and family medicine doctors
    - Academic providers
    - Pharmaceutical representatives
Pre-Review Regional Variations: Antipsychotic Use in Children

Total Child Users

- 3.5%
- 1.8%
- 0%

Map showing regional variations in antipsychotic use in children.
Considerations in Developing Guidelines

- Should guidelines have “best practice” or “safety” as their goal?
- What references to use?
  - FDA guidelines
  - Research evidence
  - Consensus opinions
  - Other state examples
- What is the guideline vetting process?
Workgroup reviewed research, product labeling, consensus guidelines, weight/age graphs, and expert opinions; sent to Drug Utilization Review (DUR) board.

### Alpha Agonist Review Guidelines

<table>
<thead>
<tr>
<th>Drug</th>
<th>0-3 years of age</th>
<th>4-5 years of age</th>
<th>6-8 years of age</th>
<th>9-17 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catapres (clonidine)</td>
<td>Review required</td>
<td>0.2 mg</td>
<td>0.3 mg</td>
<td>0.4 mg</td>
</tr>
<tr>
<td>Kapvay (clonidine SR)</td>
<td>Review required</td>
<td>0.2 mg</td>
<td>0.3 mg</td>
<td>0.4 mg</td>
</tr>
<tr>
<td>Tenex (guanfacine)</td>
<td>Review required</td>
<td>2 mg</td>
<td>3 mg</td>
<td>4 mg</td>
</tr>
<tr>
<td>Intuniv (guanfacine SR)</td>
<td>Review required</td>
<td>2 mg</td>
<td>3 mg</td>
<td>4 mg</td>
</tr>
</tbody>
</table>

From Medicaid guide for services at palforkids.org
Considerations in Developing Implementation Plan

- Should there be denials at the point of sale?
  - Different plan for different medication types?
- Create a pre-authorization pathway?
  - Is this functionally possible?
- Who will perform the reviews?
  - Pharmacist
  - Psychiatrist
- Will reviewers only look at records, or discuss the cases with prescribers?
  - Scheduled call times?
Implement in Stages, or All at Once?

- **Washington**—implemented in stages
  - 2006: Stimulant and atomoxetine reviews began
  - 2009: Antipsychotic reviews began
  - 2010: Low dose Seroquel use at 50mg or less began and “Generics First” for ADHD or antipsychotics started
  - 2012: Reviews for >5 psychotropic medications, and >2 atypical antipsychotics for >60 days started
  - 2013: Alpha agonist reviews began

- **Wyoming**—implemented all at once
  - 2011: ADHD, antipsychotic, >5 med reviews all began

- Over 2,000 reviews completed since 2006
Workflow Example: Washington’s Second Opinion Review System

1. Prescription arrives at pharmacy triggering review
2. Medicaid requests supporting information from prescriber
3. Prescriber does not respond to Medicaid
4. Prescription is not authorized by Medicaid
5. Prescriber does respond to Medicaid
6. Second Opinion CAP has telephone discusses case with prescriber
7. CAP advice and recommendation on authorization sent to Medicaid
8. Medicaid makes final authorization decision

Key: CAP=child and adolescent psychiatrist

New antipsychotic is provided for up to 60 days during the review process.
Lesson 1: Team philosophy is all-important
- Support and advocate for the best care of the child
  - Align with the provider receiving the review
- Stay humble in the reviewer role
  - We don’t know what the most effective treatment would be for every patient
- Reserve denial recommendations for unsafe or truly inappropriate regimens

Lesson 2: Prescriber’s written rationale is usually insufficient to support an authorization
- We prefer doctor-to-doctor discussions
  - More ability to influence overall treatment
  - Recommend counseling, for instance
Running a Medication Review Program: Lessons Learned

- **Lesson 3**: If prescription can’t be filled until the review is completed, rapid processing time is vital
  - Delays undermine collaboration, which interferes with best patient care

- **Lesson 4**: Delivering a consistent message is a major challenge
  - Initial multi-center design had to be abandoned
  - A review leader needs to be present
  - Use audits to help ensure consistency
Running a Medication Review Program: Lessons Learned

- **Lesson 5: Will review a wide range of prescribers**
  - Overall about 50-50 specialists vs. primary care in our states

- **Lesson 6: Existence of reviews changes practice**
  - For ADHD prescriptions altered after a state request is made for a second opinion review:
    - 50% were changed prior to the scheduled review
      - Hawthorne effect
    - 28% were denied due to prescriber non-response
    - 20% altered due to the second opinion reviewer’s recommendation to deny the prescription
      - Remaining 2% altered later
Running a Medication Review Program: Lessons Learned

- **Lesson 7:** Recognize that even high risk regimens can be fiercely defended
  - Methylphenidate 450mg, or prescribing nine medications

- **Lesson 8:** A medication review is less welcomed than an elective consult
  - Medication Review program feedback surveys (2011-12):
    - Review was “useful” 53% of the time
    - Review was “not useful” 27% of the time
    - Others reported a “neutral” opinion
Elective Consults: A Medication Review Partner

- What providers prefer
  - Help only when I ask for it...

- Elective consults as supporting mandatory reviews
  - Right care at the right time
  - Decrease likelihood of needing “outlier” prescriptions

- WA and WY combined their elective and mandatory programs
  - Same consultants → same best practice message
Geography Influences Elective Consult Design

Washington State
Telemedicine Equipment
PCC calls with a mental health question on any patient 8AM-5PM PST

PAL CAP provides a rapid access phone consult

Summarized advice is faxed to PCC (by next day)

Full televideo consult if both desired by PCC & Medicaid child

PAL worker provides resource assistance or a phone consult (by PCC or CAP request)

Same day PCC feedback

CAP=child & adolescent psychiatrist
PCC=primary care clinician
Other Aspects of PAL (elective consult service)

- Free psychiatric care Category 1 CME conferences
- Free care guide for PCC
  - At palforkids.org and wyomingpal.org
- Audits and team consult approach ensure consistent care
Outcome of Elective Plus Mandatory Consults: Antipsychotics*

- PAL made 202 specific recommendations to change antipsychotic prescriptions (2008-2010)
- Second opinion performed 271 reviews of antipsychotics (2009-2010)
- Changes in antipsychotic (AP) prescribing in WA (2008→2011)
  - All Medicaid kids using APs decreased by 17%
    - Foster children receiving APs decreased by 25%
  - All Medicaid kids using 2 or more APs decreased by 17%
- WA Medicaid AP expenditures ↓ by $300,000 per month (2008→2010)
- Reduced regional variations in med use

*Washington figures only: 2010 was prior to the Wyoming program start
For More Information:

Dr. Robert Hilt, MD
Program Director for the Partnership Access Line
and
Program Director for the Medicaid Medication Second Opinion Programs of both Wyoming and Washington

Robert.Hilt@seattlechildrens.org
Questions?

*Ask a Question Online*: Click the Q&A icon located in the hidden toolbar at the top of your screen.
Massachusetts Child Psychiatry Access Project (MCPAP)

John H. Straus, MD
MCPAP Founding Director

Massachusetts Behavioral Health Partnership
Medical Director Special Projects
What is MCPAP?

• System of regional children's mental health consultation teams designed to help primary care providers (PCP) meet the needs of children with psychiatric problems.
Why use consult lines to reduce outlier prescribing of psychotropic medication?

- Early intervention
- PCP buy-in
- Promote non-medication interventions
- General behavioral health education
WHY?

Newtown

The Experiences of Massachusetts Families in Obtaining Mental Health Care for their Children

Health Care For All and Parent/Professional Advocacy League

Written by: Ariel Frank, Josh Greenberg and Lisa Lambert

October 2002

LEXSEE 410 F SUPP2D 18


CIVIL ACTION NO. 01-30199-MAP

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

410 F. Supp. 2d 18; 2006 U.S. Dist. LEXIS 3026

January 26, 2006, Decided
Family Experiences with MA Child Mental Health System

• 33% of parent respondents waited more than 1 year for an appointment with a child mental health provider

• 50% reported that the pediatrician never asked about child’s mental health

• 77% reported that the pediatrician was not helpful in connecting them to resources
Suitability of Primary Care Providers for Behavioral Health

• Patients and families often feel more comfortable and trusting of primary care providers
• Primary care providers have the opportunity for prevention and screening
• Primary care providers know the developmental context of symptoms
• Addressing psychiatric issues in primary care setting can reduce stigma
Vision

- Address shortage of child psychiatrists by increasing ability of PCPs to manage behavioral health (BH)
- Increasing integration of BH into Patient Centered Medical Home (PCMH) by including a non-prescribing clinician will lead to more pressure on PCP to do appropriate prescribing of psychotropic medications
Continuum of Collaborative Care

Less Complex

PCP

Primary Care Taking Lead

ChΨ

More Complex

ChΨ

Child Psychiatrist Taking Lead

PCP

PCP
An idea that has caught on….

- Alaska
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Illinois
- Iowa
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- Nebraska
- New Hampshire
- New Jersey
- New York
- North Carolina
- Ohio
- Oregon
- Pennsylvania
- Texas
- Vermont
- Virginia
- Washington
- Washington, DC
- Wyoming
- Wisconsin

*Red states are in development.*
6 MCPAP HUBS

Northshore Children’s Hospital
Antonia Pepper
Brianna Roy, LICSW
Tracey Terrazzano, LICSW
Jennifer McAdoo, LMHC
Jefferson Prince, M.D.
Lisa D’Silva, M.D.
Michele Reardon, M.D.
Joseph DiPietro, Psy.D.

UMass Memorial Medical Center
Kelly Chabot
Deanna Pedro, LICSW
Danette Mucaria, LICSW
Mary Jeffers-Terry, CNS
Negar Beheshti, M.D.
William O’ Brien, MSW

Baystate Medical Center
Arlyn Perez
Jodi Devine, LICSW
Barry Sarvet, M.D.
Bruce Waslick, M.D.
Shadi Zaghloul, M.D.
Sara Brewer, M.D.
John Fanton, M.D.
Marjorie Williams-Kohl, APRN

McLean Hospital/Brockton
Amanda Carveiro
Carla Fink, MSSA, LICSW
Charles Moore, M.D.
Tracy Mullare, M.D.
Mark Picciotto, Ph.D.

Tufts Medical Center Children’s Hospital Boston
Rachael Roy Gorton
Alexis Hinchey Davis, LICSW
Sigalit Hoffman, M.D.
Neha Sharma, D.O.
Eric Goepfert, M.D.
Enrico Mezzacappa, M.D.
Lauren McKenna

Mass General Hospital
Lauren Hart, MPH
Leah Grant, MSW, LICSW
Jeff Bostic, M.D., Ed.D.
Betty Wang, M.D.
MCPAP Services

• Telephonic child psychiatry consultation to PCPs within 30 minutes, M-F
  • Last quarter response time met target for 89% of consultations

• Face-to-face consultations (18% of youth served)

• Care coordination

• Transitional support when youth waiting for BH services

• PCP education – newsletter, practice meetings, continuing medical education, website (MCPAP.org)
The MCPAP Clinical Process Explained

• The previous slide shows in graphic form that a PCP with a question can get help from anyone on the team and that any interaction with the team may result in a face-to-face visit or care coordination to help the youth/family access community behavioral health services.
MCPAP Current Status

- 438 practices with 2,991 individual clinicians
- Over 98% of Commonwealth
- 20,641 encounters, 10,553 youth in FY2013
- Prescriber level care remains with PCP, 70% of time
- Costs $2.30 per child per year
- Commercial insurers mandated by legislature to cover their share
Diagnoses (% of total calls)

- ADHD
- Anxiety
- Depression
- Deferred Diagnosis
- Oppositional Defiance
- Other
- Autism Spectrum Disorder
- Mood Disorder NOS
- Adjustment Disorder
- Bipolar
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Substance Abuse
- Psychosis
- Developmental Delay
- Eating Disorder
- Substance Abuse
- Mood Disorder NOS
- Adjustment Disorder
- Mood Disorder NOS
- Adjustment Disorder
- Oppositional Defiance
- Deferred Diagnosis
- Depression
- Anxiety
- ADHD

- Cumulative FY 2005-FY 2012 (N=43,131)
- FY 2012 (N=8,706)
Medications (% of total calls)

- Cumulative FY 2005-FY 2011 N = 32,372
- FY 2011 N = 7,823

- SNRI
- Depakote
- Wellbutrin
- Other Antidepressant
- Atomoxetine
- Other Mood Stabilizer
- Benzodiazepine
- Other
- Alpha Agonist
- Atypical Antipsychotic
- SSRI
- Stimulant
- None
Types of Consultation Questions

- Help!
- Diagnostic question
- Treatment planning
- Unable to access BH resources
- Need second opinion
- Screening support

- Medication questions:
  - Side effects
  - Interim management

- Therapy questions:
  - Selection
  - Monitoring
  - Linkages
Outcome:
70% Medical Follow-up with PCPs

Mean MCPAP Satisfaction Survey Responses
Engagement Strategies

- Be helpful on every call
- Be a mentor
- Personalize the call
- Assist with care coordination
- Provide education in whatever format PCP wants
- Require no paperwork barriers for PCPs
Platform for System Improvements

- Perinatal/postpartum depression screening and management
- Improved screening and management of teen substance use
- Parent training for disruptive behavior in children under 6 using co-located PCP clinicians trained in evidence based practice, Triple P
Another Intervention to Reduce Outlier Prescribing

- Monitor outlier psychotropic prescribing on a patient level and communicate to prescriber when regimen unchanged for 6 months to suggest regimen simplification trial
For More Information:

Dr. John Straus, MD
MCPAP Founding Director
Massachusetts Behavioral Health Partnership
Medical Director Special Projects

John.Straus@valueoptions.com
Ask a Question Online: Click the Q&A icon located in the hidden toolbar at the top of your screen.
Oregon Psychiatric Access Line about Kids (OPAL – K): A Few Lessons

CHCS Webinar
June 5, 2014

Ajit N. Jetmalani, M.D.
Associate Professor of Psychiatry
Director, Division of Child and Adolescent Psychiatry
Oregon Health & Sciences University
Getting Started

• Define the need and the goals (for us this was part of a broader desire around health care transformation):
  – Help the Medical Home meet the “triple AIM”
  – Improve child psychiatry access for primary care providers that creates opportunities for mentoring, education, and consultation
  • Create a service that is blind to insurance and statewide for the care of all youth in Oregon
  – Improve access to children's mental health services in the primary care medical home, school based settings, and public health programs.
Getting Started

• Define the need and the goals (continued):
  – Utilize a biopsychosocial or ecobiodevelopmental frame
  – Improve appropriate prescribing of psychotropic medications
  – Reduce adverse outcomes by intervening earlier
  – Work to improve developmental and mental health promotion and prevention
  – Reduce the overall cost of health care by improving mental and physical health outcomes
Getting Started

• Create a coalition:
  – Multiple stake holders are much more potent than one group in a large statewide proposal
  • Child Psychiatry Association (OCCAP), Primary Care Association (OPS: pediatrics the most natural collaborators), Family association (OFSN), Academic Center (OHSU), State Mental Health (AMH/OHA) and foster care (DHS) Program.
Getting Started

• Consult with others:
  – Define the core team in your state
  – Join NNCPAP
  – Contact a program that seems to be aligned with your ideas
  – After some preliminary consultation, consider buying some regular time from another state and visiting their program (we did this with PALS)
  – Consider creating a regional view as we hope to with Washington State
Getting Started

• **Align the effort** with other state goals and needs like improving appropriate psychotropic prescribing for foster youth (DHS requirements).
  – Medicaid medication review practices (CCO quality and financial measures and incentives)
Getting Started

• **Funding** – Insurance blind is the only way to go! Advocate with state government and commercial companies:
  – Think in Triple AIM terms as you build your case
  – Utilize data from other states experiences
    • PCP feedback measures from MCPAP
    • Cost savings from PALS
    • Additional quality and access information from other states
Getting Started

• **Funding** – Braided funding strategies:
  – Create a menu of potential services that may be contracted out as you build your group of child psychiatrists so they are usually busy and not only waiting for calls:
    • Telephone consultation
    • Video patient consultation
    • Medication data / chart reviews for Medicaid or DHS
    • Provider to provider consultations for medication outliers as needed for payers or DHS
    • CME events for PCPs
Model Development

• Decide what **services** are most needed in your state, typical features include:
  – Telephonic consultation,
  – One time in person or video consultation, and
  – Coordination of care

(We are offering telephonic consultation to all, but only offering video consultation to youth in foster care in the beginning due to funding restrictions)

• Keep in mind the life of a PCP and what process will work best for them. Avoid a labor intensive experience…make it easy!
Model Development

• Out reach and enrollment:
  – We have people enroll with a paper or online form so that they know what to expect. That also allows us to assign a PCP ID and gather a three question survey (same questions as gathered by MCPAP).
  – We get ourselves invited to professional meetings and present briefly on the program and enroll folks there.
  – We visit large groups in all regions of the state to present the plan
  – We take a pediatrician child psychiatrist and staff if we can
  – We focus on rural and poor access areas first
Model Development

• **Identify your consultants:**
  – We chose to recruit a group of community and academic child psychiatrists each with 10 years of general experience or more (or significant tele-consultation experience); strong community reputation; biopsychosocial perspective; and who are known as good collaborators and teachers.

  – We hired them as faculty rather than contractors:
    • Malpractice coverage is clearer
    • Peer review is easier
    • Accountability to medical director is clear
    • Opportunity for shadowing / learning from each other
Model Development

• **Call Center:**
  – Make the phone call from the PCP easy with as few handoffs or wait times as possible. We are using our own staff as apposed to a call center as we want the PCPs to become familiar and confident with us.

• **Web Page:**
  – The landing page needs to be easy to find and have tabs that offer a range of connections. Ability to enroll in program, access care guides, and link to various sites of interest (in progress).
  – OPAL-K web page launched on June 18, 2014: www.ohsu.edu/opalk
Model Development

• Education
  – Each consult is an opportunity for education!
  – We also are providing adolescent depression and SBIRT screening and treatment seminars across the state in collaboration with Oregon Pediatric Association (START project: Screening Tools & Referral training).
  – Care guides: OPAL K is developing a set of guidelines to address various diagnosis and challenges. We hope to post our depression and ADHD guides in the next 2-3 weeks.
Model Development

• **Database:**
  
  – We have developed our database within REDCAP which is a secure HIPPA compliant methodology. We are not considered a research project but a quality improvement program, so we did not require IRB approval after completing IRB screening processes.
Model Development

• Database (continued):
  – We gather data that is aligned with the PALS program to eventually allow for a regional review of practices and outcomes. This includes the nature of the call, questions raised, medication and diagnostic considerations, non medical strategies, and any specific recommendations. This form is then sent by secure email to the PCP. The aggregate data (not with patient identifiers) is shared with the Oregon Health Authority to monitor OPAL K performance.
Model Development

• Telemedicine:
  – We are going to utilize Jabber software and web cams to perform video evaluations. This technology is not as good visually as other more sophisticated approaches, but the compatibility with other sites (PCP offices) and the expense (cheap) make this more realistic in a large spread out state.

• Reporting:
  – We report out to Oregon Health Authority on a quarterly basis.
Final Thoughts

• Incorporation of the impact of trauma on the development of mental emotional and behavioral challenges is a key lens to share.

• Why go it alone when so many have gone before you (reach out to your colleagues in other states)

• Beta test everything before going live (wish us luck)!!!

Thanks very much to MCPAP and PALS for all you have done to open up this effective and needed strategy,

And

Thanks to CHCS for supporting innovative practices and collaboration intended to improve the health of our population
For More Information

Dr. Ajit N. Jetmalani, M.D.
Associate Professor of Psychiatry
Director, Division of Child and Adolescent Psychiatry
Oregon Health & Sciences University
jetmalaa@ohsu.edu.

To access OPAL-K web page, click here:
www.ohsu.edu/opalk
### Upcoming Webinars in This Series

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
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<tbody>
<tr>
<td>September 2014</td>
<td>Red flag and response systems; implementation of oversight and monitoring policies and processes</td>
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Thank you for participating in today’s webinar!

Please complete the brief evaluation when you exit the webinar.