Improving the Use of Psychotropic Medication among Children and Youth in Foster Care: A View from the States

Please standby, the webinar will begin shortly.

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Improving the Use of Psychotropic Medication among Children and Youth in Foster Care: A View from the States

CHCS National Webinar
March 21, 2018, 1:30 – 3:00 pm ET (10:30 am – 12:00 pm PT)

Made possible through support from the Annie E. Casey Foundation.
To submit a question online, please click the Q&A icon located at the bottom of the screen.

Questions that cannot be addressed due to time constraints will be shared after the webinar.
I. Introduction and Background

II. Perspectives from Illinois and New Jersey

III. Q&A Session

IV. Perspectives from Oregon and Vermont

V. Q&A Session and Closing Remarks
Today’s Presenters

Kamala Allen, MHS
Center for Health Care Strategies

Michael Naylor, MD
University of Illinois at Chicago
Children and Family Services
Comprehensive Assessment and Treatment Unit

Mary Beirne, MS, EdD, MD
Robert Wood Johnson Medical School
New Jersey Department of Children and Families
Office of Child and Family Health

Kevin George, MSW
Oregon Department of Human Services
Office of Child Welfare Programs

Ajit Jetmalani, MD
Oregon Health & Science University
Oregon Health Authority

Brenda Gooley, MSW
Vermont Department for Children and Families
Family Services Division
Why the Focus on Psychotropic Medications?

Kamala D. Allen, MHS
Vice President
Director, Child Health Quality
Center for Health Care Strategies
Changes in the Number of Children Receiving Psychotropic Medications

Between 2005 and 2011, the number of children covered by Medicaid increased by nearly 12% to 32.4M.

During that same period, Medicaid-covered children receiving psychotropic meds increased by 28%.

And expenditures for those medications increased by 70% — a $1B increase, from $1.6B to $2.7B.
In 2011, **2.1M+ children in Medicaid received psychotropic medications**. The age distribution is as follows:

- **13-18 yrs. old** (850K children) - 39%
- **6-12 yrs. old** (1.1M children) - 52%
- **0-5 yrs. old** - 8%

From 2005 to 2011, children ages 0-5 receiving these medications increased by 130% — from 78K to 179K.
Of the 2.1M+ children receiving these medications in 2011, nearly half (47%) did not receive accompanying behavioral health services. And almost one-third (30%) are getting more than one of these medications — 47% for children in foster care.
Children Receiving Psychotropic Medications by Aid Category

- **TANF**: 4.9% (1,477,243)
- **Foster Care**: 24.4% (205,923)
- **SSI/Disability**: 29.5% (473,879)
Responses to the Concern

- **Legislative**
  - Child and Family Services Improvement and Innovation Act (2011) requiring protocols for effective use and monitoring of psychotropic medications
  - Fostering Connections Act (2008), requiring coordination of care and oversight of medication use

- **Federal**
  - Numerous congressional hearings
  - Safe and Judicious Antipsychotic Use in Children and Adolescents (2013)
  - Cross-System Summit: Because Minds Matter (2012)
  - Administration for Children and Families information memo (4/2012)
  - Tri-Agency Dear State Director Letter (11/2011)

- **National**
  - Medicaid Medical Director’s Learning Network and Rutgers (2010)
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Improving the Use of Psychotropic Medication for Children in Foster Care

- Three-year, six-state quality improvement collaborative
  - Illinois, New Jersey, New York, Oregon, Rhode Island, Vermont

- Project goal
  - Address systemic and programmatic barriers to the appropriate use of psychotropic medication for children and youth in foster care who have behavioral health needs.

- States’ areas of focus
  - Improving the consent process
  - Improving data-sharing for monitoring/oversight
  - Increasing knowledge among provider, case worker, family and youth
  - Reducing inappropriate use of antipsychotics
  - Reducing inappropriate use among young children (e.g., under age 6)
  - Increasing provider adherence to evidence-based practice
Illinois Department of Children and Family Services Psychotropic Medication Consent Program

Michael W. Naylor, MD
Director, Clinical Services in Psychopharmacology
University of Illinois at Chicago
Brief Background on Child Welfare System

- State-administered system
- Census
  - 2013 - 15,888
  - 2017 - 14,305
- Centralized consent and review process
  - Established by Rule 325 of the Joint Committee on Administrative Rules
    - Administration of Psychotropic Medications to Children for Whom the Department of Children and Family Services is Legally Responsible
  - Consent provided by Department of Children and Family Services (DCFS) Guardian
  - Requests from providers to prescribe psychotropic medications reviewed by the Clinical Services in Psychopharmacology (CSP)
Key Concerns at Start of PMQIC

• **Challenges we set out to address:**
  
  • Getting Medicaid payment data for psychotropic medications, medical medications, diagnostic procedures, therapies, psychiatric hospitalizations and emergency room visits.
  
  • Assuring that all foster children on psychotropic medications have appropriate consent.
  
  • Decreasing the rate of inappropriate psychotropic medications for foster children 5 years of age and under.
  
  • Assuring that foster care children on second generation antipsychotics are closely monitored for the development of the metabolic syndrome.
  
  • Establishing guidance regarding the use of maintenance pharmacotherapy and recommendations informing the decision to stop psychotropic medications.
Goal 1: 100% of foster children on psychotropic medications will have a current consent

• **Actions**
  - Obtained an interagency agreement allowing for bilateral transfer of Medicaid payment and DCFS consent data.
  - Implemented a hard edit in the Healthcare and Family Services (HFS) Medicaid Management Information System (MMIS) system to prevent pharmacies from dispensing psychotropic medications without consent.

• **Partners**
  - DCFS, University of Illinois at Chicago (UIC) Clinical Services and Psychopharmacology (CSP) and HFS

• **Financial strategy**
  - Oversight and consent mechanism for psychotropic medications written into state law
  - Behavioral Health Consent Decree
Impact on Goal 1

• Impact:
  • Positive
    • Virtually 100% of new psychotropic medication prescriptions have been reviewed by the CSP and approved by the DCFS Guardian.
  • Negative
    • All psychotropic medications prescribed to foster children require HFS prior authorization, even medications on the Preferred Drug List.
    • There is often a delay in filling medications after discharge from the hospital and with increases in dosage, even if DCFS has consented to a range that includes the prescribed dosage.
Goal 2: Decrease the rate of inappropriate requests for psychotropic medication in foster children ages 5 and under

• **Actions**
  
  • Devised and distributed guidelines on psychotropic medications for preschoolers
  
  • Wrote and published Policy 325.4 which details the process for obtaining an evidence-informed assessment and psychosocial services for preschool-aged children with emotional and behavioral problems
  
  • Designing DCFS trainings to inform the field about the procedure for getting consent for psychotropic medications for preschoolers

• **Partners**
  
  • DCFS, UIC CSP and HFS (DocAssist)

• **Financial strategy**
  
  • Oversight and consent mechanism for psychotropic medications written into state law
  
  • Behavioral Health Consent Decree
Impact on Goal 2

• **Impact:**
  - Greater utilization of psychosocial services for preschoolers
  - Better oversight of design and implementation of care plans and mental health treatment plans for preschoolers with severe emotional disturbances
  - Prescribers are following recommended prescribing guidelines > 66% of the time
Sustainability

• The DCFS psychotropic medication consent and oversight processes are written into state law
  • Funded directly through the DCFS budget

• Specific projects, e.g., evaluations and psychosocial services for preschoolers are funded through contracts with providers
  • Illinois is moving to a Managed Care Organization for foster children

• Some projects are sensitive to varying priorities of different Directors
Lessons Learned

“Patience grasshopper.”
Lessons Learned

Progress in State systems is more like Brownian motion than laminar flow
Lessons Learned

Beware the unintended consequences of public policy on health care delivery
Contact Information

Janet Ahern
DCFS Guardian
(312) 814-8600
Janet.Ahern@Illinois.gov

Lisa Robinson
Assistant DCFS Guardian
(312) 814-8600
Lisa.Y.Robinson@Illinois.gov

Michael W. Naylor
Director, Clinical Services in Psychopharmacology
(312) 413-4567
mnaylor@uic.edu

Catherine Francis
Associate Director, Clinical Services in Psychopharmacology
cfranci1@uic.edu
(312) 413-4617
NJ Efforts to Improve Psychotropic Medication Use

Mary F. Beirne MS, Ed.D., M.D.
Chief Child and Adolescent Psychiatrist
Office of Child and Family Health
NJ Department of Children and Families

Clinical Assistant Professor
Robert Wood Johnson Medical School
Rutgers University

March 21, 2018
The New Jersey Department of Children and Families Division of Child Protection and Permanency (CP&P) is organized into 46 local office throughout the state.

At the start of the PMQIC project there were 6,950 children in out of home care in New Jersey. At the end of 2017 there were 6,168 children in out of home care.

Each local office has a Child Health Unit (CHU) located within each local office with nurses who provide health care case management for each child in out of home care, working closely with the casework team.

In New Jersey the biological parents retain the right to provide consent for the medical care of their children until parental rights have been terminated. The CP&P Local Office Manager may provide consent for medical treatment when parental rights have been terminated or parents are otherwise unable to provide consent.
New Jersey’s Psychotropic Medication Policy, which addresses the use and monitoring of psychotropic medication for children under child protection care and supervision, was issued in January 2010 and was revised in May 2011, pre-dating development of the Psychotropic Medication Quality Improvement Collaborative.

Three challenges that impeded the improvement of psychotropic medication use for children in foster care:

- System-level challenges to improving policy compliance regionally and locally
- Lack of a framework to assess the progress and well-being of individual children who are taking psychotropic medications
- Identifying which children on psychotropic medication in foster care are at highest risk and how to review them
1. **Improve compliance with the Psychotropic Medication Policy components** by ensuring that children in foster care who are prescribed psychotropic medication have a treatment plan, informed consent and psychiatric evaluation (when indicated) in the record.

2. **Develop and implement a quality assurance tool** to assess the progress of individual children/youth who are taking psychotropic medications.

3. **Create and conduct a process for on-going quality assurance reviews** of at-risk cohorts of children.
New Jersey Goal 1

Goal:
- Improve compliance with the Psychotropic Medication Policy components by ensuring that children in foster care who are prescribed psychotropic medication have a treatment plan, informed consent and psychiatric evaluation (when indicated) in the record.

Strategies:
- New Jersey developed a data dashboard and feedback loop to monitor and share on-going information and trends.
- A workshop on psychopharmacology and psychotropic medication policy was developed and delivered to support this focused effort on psychotropic medication and policy compliance.
% Youth on Psychotropic Medication With Treatment Plan in Record


- Rate
% Youth on Psychotropic Medication with Consent in Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (Aug. 12)</td>
<td>83.5%</td>
</tr>
<tr>
<td>4/15/2013 (Nov. 12)</td>
<td>84.1%</td>
</tr>
<tr>
<td>7/15/2013 (Feb. 13)</td>
<td>86.2%</td>
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<tr>
<td>11/26/2013 (May 2013 Trackers)</td>
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<td>2/12/2014 (Aug. 2013)</td>
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<td>4/4/2014 (Nov. 2013)</td>
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<tr>
<td>7/15/2014 (May 2014)</td>
<td>87.2%</td>
</tr>
<tr>
<td>9/5/2014 (Aug. 2014)</td>
<td>89.1%</td>
</tr>
<tr>
<td>12/15/14 (Nov. 15)</td>
<td>88.5%</td>
</tr>
</tbody>
</table>
% Youth on Psychotropic Medication with a Psychiatric Evaluation on Record

Baseline (Feb. 2013)
11/26/2013 (May 2013 Trackers)

86.6% 88.5% 89.1% 88.5% 88.5% 88.3% 89.2%

92.2%
New Jersey Goal 2

Goal:
- Develop and implement a quality assurance tool to assess the progress of individual children/youth who are taking psychotropic medications.

Strategies:
- NJ developed a quality assurance tool focused on well-being and progress of children under the care and supervision of child protection.
- The quality assurance tool was embedded into a red flags tool - a comprehensive tool to monitor the developmentally appropriate benchmarks for wellness in children and youth.
- Information about the Pediatric Health and Red Flags Tool may be found at http://www.fxbcenter.org/resources_library.html
% Nurses Trained on Quality Assurance Tool

- Keep sounds and transition effects to a minimum
- Too much animation is distracting
- Avoid using outdated photos and too much clip art
New Jersey Goal 3

Goal:

- Create and conduct process for ongoing quality assurance reviews of at-risk cohorts of children.

Strategies:

- NJ identified at-risk cohorts of children as those children under the age of six who are prescribed psychotropic medications and children/youth who are prescribed four or more psychotropic medications.

- Utilizing the existing Child Health Program nurse trackers (excel spreadsheets), these cohorts are stratified quarterly and shared with DCF’s Chief Child/Adolescent Psychiatrist. Each child in these groups is assessed for compliance with NJ DCF Psychotropic Medication Policy guidelines regarding appropriate practice and whether follow up is needed and completed.

- Once established, the process was fully implemented. It evolved to include collaboration with the Child Health Unit’s Psychiatric Advanced Practice Nurse to follow-up and reinforce any issues identified in the review.
% Children in At Risk Cohorts Reviewed Using Quality Assurance Protocol

- Keep sounds and transition effects to a minimum
- Too much animation is distracting
- Avoid using outdated photos and too much clip art

- 100.0% 2/12/2014 (Aug. 2013)
- 100.0% 4/4/2014 (Nov. 2013)
- 100.0% 5/15/2014 (Feb. 2014)
- 100.0% 7/15/2014 (May 2014)
- 100.0% 9/5/2014 (Aug. 2014)
- 100.0% 12/15/14 (Nov. 15)
Sustainability

- Goals 1, 2 and 3 established systems for identifying, reviewing and supporting appropriate treatment of children with mental health need.

- Over the course of the Collaborative these systems were refined to facilitate on-going review after the end of the Collaborative.

- Dedicated staff to continue these reviews will be essential to sustain the progress and continue this work.
Lessons Learned - Collaboration

- Compliance with policy components improved because of enhanced collaboration between casework and medical professionals, and between state agencies and community providers. Parallel collaboration between New Jersey and PMQIC partner states contributed to our ability to design improvements in our strategies for review and support of the well-being of these children.

- Robust field teaming between casework staff, nurses and CMOs, enhanced the capacity to understand the needs of these children and families and to identify resources to support them. Engagement with system supports, such as Medicaid and IT, are essential to providing an aggregate view of the children and families, and facilitating the development of new strategies for documentation and data review.
Lessons Learned - Focus

- It is clear that the work of the PMQIC can be maintained through continuing focus on the challenges faced by the children and families served by the DCF. Mental health concerns are frequent concomitants of the circumstances that bring children and their families to child protection.

- DCF must balance competing demands from numerous spheres of responsibility, but focus on the health concerns of children with mental health need must continue as a primary focus of attention and support. Dedicated staff to focus on the evolving needs of these children and families is necessary to advocate for the most appropriate treatment and safety monitoring.

- Regular and continuing education about diagnoses, treatment alternatives, lifestyle interventions, medication and safety is essential to learn about safety concerns and new interventions.
Lessons Learned – Dynamic Flexibility

- As the department establishes the renewed processes for identification, support and review of children with mental health needs, it will be important to shift the focus to improving the quality and array of services available to treat these disorders.

- Greater awareness of evidence-based approaches to evaluating and treating mental health disorders, and improved capacity to provide these services in the community, will support this work going forward.

- Implementation of non-pharmacological and lifestyle interventions to address issues that contribute to the severity of mental illness will be important. Increased attention to non-pharmacological interventions for sleep problems or educational challenges can modulate the impact of psychiatric illness.

- A shift in the way we work with families to restructure our work to address root causes of the issues that bring children to child protection, such as substance use, has the potential to reduce the disruption and trauma facing these families.
Contact Information

Mary F. Beirne, M.S., Ed.D., M.D.
Clinical Assistant Professor
Robert Wood Johnson Medical School
Rutgers Behavioral And Health Sciences
Chief Child and Adolescent Psychiatrist
The New Jersey Department of Children and Families
Office of Clinical Services
50 East State Street, PO Box 717
Trenton, New Jersey 08625
Office: 609-888-7105
Mobile: 732-609-1849
To submit a question online, please click the Q&A icon located at the bottom of the screen.

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Improving Appropriate Utilization of Psychotropic Medication in Oregon for Youth in Foster Care

A Joint Effort of the Department of Human Services, Oregon Health Authority, Oregon Health & Science University and Oregon State University Pharmacy Program

Kevin George, M.S.W.
Foster Care and Youth Transition Program Manager
Office of Child Welfare Programs
Oregon Department of Human Services

Ajit Jetmalani, M.D.
Professor and Director
Oregon Health & Science University
Division of Child and Adolescent Psychiatry

Consultant to
Oregon Health Authority and
Department of Human Services
Key Concerns: Psychotropic Medications Quality Improvement Collaborative

- Oregon State Statutory requirements concerning the oversight of psychotropic medication use for children in foster care falls solely on DHS, whose staff do not typically have the clinical knowledge needed to determine appropriate use;

- Oversight of psychotropic medication use for children in foster care by each department does not reflect the redesign of integrated and coordinated health care delivery systems; and

- A lack of clinical and behavioral health expertise within Oregon to support coordinated care organizations (CCOs) and providers considering psychotropic medication use as part of the treatment plan for a child in foster care.
Oregon Goals

1. Expand collaboration among stakeholders during this quality improvement project.

2. Improve the effectiveness of obtaining consent/authorization by
   a) Increasing Information all parties have, and
   b) Improving process for providing authorization.

3. Improve the safety and effectiveness of psychotropic medication use through the utilization of best practices.
GOAL 1: Increase Collaboration among Stakeholders

- A Psychotropic Medication Stakeholder Advisory Committee was created to define high risk prescribing practices and review common drivers.

- The committee identified trauma as an experience with underlying aggression as the common driver.

- Advisory Committee included a cross section of professionals; Psychiatrist, Nurse, Pediatric Care Physician, Foster Parent, Youth Advocate and Caseworker and Social Worker.
GOAL 2a: Improve Consent Effectiveness through Education and Information

- Foster Parents and DHS staff:
  - **Trauma training**
    - Portland State University (PSU) - Oregon Health Sciences University (OHSU) Trauma Informed Oregon
    - Improving training content and duration
  - **Collaborative Problem Solving training**
    - Pilot project within public Child Welfare foster care
    - Utilized within private foster care agency: Maple Star Oregon
  - **Medication / health care training**
    - In place, continue to improve process and materials
    - Created tip sheets; participate in national committee Making Healthy Choices
    - Consultation and second opinions now starting with Oregon Psychiatric Access Line – Kids (OPAL K).
PSYCHOTROPIC MEDICATIONS
Guide for youth in Oregon foster care

THINGS YOU NEED TO KNOW...

What are psychotropic medications?
Psychotropic medication (pronounced “sih-kot-roh-pick”) medications affect a person’s mind, emotions, moods, and behaviors. These medicines are used to help people with thoughts, feelings, and emotions that are getting in the way of day to day life, and to help a person feel better.

Sometimes your thoughts, emotions or behaviors get in the way of doing things you want to do. Maybe you’re not able to sleep at night or do your homework or have fun with friends. One option that can make you feel better is psychotropic medication. Doctors and nurse practitioners prescribe these medications to reduce symptoms such as anxiety, difficulty paying attention, depression and racing thoughts. If other things like talk therapy, or exercise are not helpful. These medications can have many benefits. They also can cause negative side effects and can be harmful if not used correctly.

What is informed consent?
Consent means to give permission for something to happen. Informed consent means a doctor gives you specific information about the risks and benefits of a medication or treatment before permission is given for the medication to be used. Make sure you have all of the information you need to decide if these medications are a good option for you. Because you are in foster care, the law says your caseworker also has to give consent for you to start any new psychotropic medication.

What are my options?
Your doctor or mental health specialist

Questions to ask before consenting to a new medication
- What is my diagnosis?
- What is the name of the medication you recommend?
- Are there any alternatives to taking this medication?
- How much do I have to take and how often?
- How long will I have to take it?
- When will it start working?
- How will I know it is working?
- What are the side effects?
- What side effects do people my age most commonly experience?
- Will the medication make me gain weight? What can I do to keep my
**NEWLY DEVELOPED RESOURCES**

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**PSYCHOTROPIC MEDICATIONS**
Guide for caseworkers and advocates of foster youth

**BEFORE PSYCHOTROPIC MEDICATIONS ARE PRESCRIBED, CONSIDER THE FOLLOWING**

Has your foster child had a comprehensive mental health and physical health evaluation within the past 30 days? Recognize that all youth in foster care have a history of traumatic life experiences, loss and separation from caregivers. Trauma and loss may cause a range of emotional and behavioral challenges that mimic psychiatric illnesses such as ADHD and bipolar disorder or cause problems like aggression and insomnia. Youth in foster care do have higher rates of these challenges than the general population and may require medication as part of a comprehensive plan.

Many non medical strategies can improve challenges that are due to trauma:

- Relationships with caregivers that are empathetic, predictable, flexible and structured.
- Being physically active or trying music, dance or other art.
- Focusing on areas of strength and interests that are not based on performance.
- Helping the child identify things that trigger their fears (loud voices, being hungry, bedtimes, etc.)
- Helping youth share triggers and ways they may deal with them.
- Using trauma-focused Cognitive Behavioral Therapy and other psychotherapies.
- The Collaborative Problem Solving (CPS) approach is a trauma informed philosophy and approach that can reduce challenging behaviors and improve outcomes with youth in foster care.

Have non medication strategies been considered and implemented before using a psychotropic medication?

When a child has an identified mental health condition and is receiving psychotropic medications, practices that should be documented:

- The provider is aware of key elements of the child’s history;
- The provider discusses non medical strategies to address challenges;
- The medical recommendations include risks, benefits, or alternatives to the plan;
- The treatment plan identifies trauma history and other environmental factors in a child’s life;
- The treatment plan identifies the child’s strengths;
- The treatment plan identifies the child’s triggers.
Goal 2b: Improve Consent Process

- Foster Caregiver and Youth Review Psychotropic Tip Sheets
- Clinician informs child and caregiver and fills out Form (173C)
- Form (173C) was changed to include a line for youth and caregiver to sign for acknowledgement and assent
- Caregiver provides information to DHS caseworker/supervisor (verbal and written 173C)
- Supervisor and caseworker reviews information (department protocols) and determines Authorization (Consent)
- Caseworker notifies caregiver when and if to proceed with medication regimen
  - Oregon Statue requires notification to biological parents, child attorney
GOAL 3: Improve the safety and effectiveness of psychotropic medication use through the utilization of best practices

- Strategy was to increase shared information and knowledge to improve consistency.

- Newly adopted best practice guidelines infused with a trauma lens were created and distributed to providers by OPAL K and Oregon Council of Child and Adolescent Psychiatry (OCCAP).

- A consensus opinion regarding prescribing risk flags was distributed to DHS Case workers and Supervisors and to health care providers and Coordinated Care Organizations (CCO) the health care system in Oregon.
Oregon Psychiatric Access Line about Kids (OPAL-K)

Welcome to OPAL-K.

Phone
Toll-Free: 1-855-966-7250
Portland Metro: 503-346-1000

OPAL-K call center hours
9 a.m. - 5 p.m.
Monday through Friday, excluding major holidays
OPAL-K is not a walk-in clinic or in-person referral line

OPAL-K provides free, same-day, Monday through Friday, child psychiatric phone consultation to primary care providers in Oregon.

OPAL-K is a collaboration between OHSU’s Division of Child and Adolescent Psychiatry, the Oregon Pediatric Society (OPS) and the Oregon Council of Child and Adolescent Psychiatry (OCCAP).

The program expands the availability of high-quality mental health treatment to Oregon youth via timely psychiatric consultation, medical practitioner education, and connections with mental health professionals throughout the state.

How can OPAL-K help

Collaboration
Improving Best Practices

- **Disseminate Prescribing Flags**
  - Poly pharmacy 3 or more
  - Two or more medications in the same class
  - Antipsychotic prescribing without metabolic monitoring
  - Medication for children under six other than stimulants
  - Antipsychotics (under six, multiple, longer than 6 months without a diagnosis)

- **Oversight**
  - Dashboards to providers
  - Dashboards to CCOs
  - When flags are triggered (communicate with provider, peer review via OPAL K)
Clinician Fax – Metabolic Monitoring of Antipsychotics

Attention:

Fax:
Your pediatric patients receiving antipsychotics without claims for routine glucose monitoring

The FDA issued a safety warning for all second generation antipsychotics recommending monitoring of blood glucose. Careful monitoring for metabolic abnormalities (body composition, lipid, glucose, blood pressure) is standard of care when prescribing antipsychotics.

The following pages contain a list of Fax For Service (FFS) Medications that you are identified by the pharmacy claim as the most recent prescriber of an antipsychotic and who do not have annual glucose screening claims. We understand claims data are always subject to实际情况 in the medical record. The laboratory claims may be delayed and errors are made in prescriber identification.

The chart above reflects the proportion of patients without annual glucose screening who recently filled an antipsychotic prescription indicating you are the prescriber. For your reference, overall Medicaid rates and, when available, rates for your specialty are included.

Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes (2004) Diabetes Care, 27(2), 596-601

If you have any questions or comments regarding this policy or would like a claims-based profile for any of these patients, please call 503-437-6513 or fax 503-437-2596.

Please indicate the status of this required laboratory work and fax this report within 30 days to DMAP at 503-347-1119.
Percent of Youth in Foster Care on any Psychotropic Medication (19.6 % in 2009)
New start antipsychotic rate in children in the Oregon Medicaid program 2002-2015

Key: PMPM = Per Member Per Month. Denominator = All eligible children in Oregon Medicaid under 18 years old. Numerator = All eligible children in Oregon Medicaid under 18 years old with a newly started antipsychotic.
Sustainability of the Culture Change

- DHS created a Health and Wellness Team in Child Welfare that is accountable to ensure these activities, educational materials and support continue for children, families and caseworkers.

- Oregon Health Authority and Department Human Services co-fund Medical Consultant for consistency and immediate access across state agencies.

- Oregon Legislature provided pilot funding followed by ongoing funding for Oregon Psychiatric Access Line – Kids (OPAL-K)
Lessons for the Field

- Cross-program collaboration with stakeholders from the beginning is key (include families, caregivers and youth with lived experience).

- Medications are neither good or bad; they are a potential tool that should be considered in the context of a biopsychosocial view of a child’s challenges, with particular awareness of the impact of trauma on this population.

- Approach this with a trauma-informed lens overall, including how all partners treat each other; seek to support youth, families, caregivers and providers in creating a collaborative relationship towards what is best for the child rather than seeking to shame or coerce to achieve “improvement.”

- Tools: Collaborative Problem Solving [http://www.thinkkids.org/]
Contact Information

Kevin George, M.S.W.
Foster Care and Youth Transition Program Manager
Office of Child Welfare Program
Oregon Department of Human Services
500 Summer St. NE
Salem, Or. 97301

Kevin.george@state.or.us

Ajit N. Jetmalani, M.D.
Director, Division of Child and Adolescent Psychiatry
Joseph Professor, Child and Adolescent Psychiatry Education
Oregon Health & Science University
Mail Code DC7P
3181 SW Sam Jackson Park Road
Portland, Oregon 97239-3098
jetmalaa@ohsu.edu
phone: 503 494 3794
fax: 503 418 5774
Best Practice regarding the use of antipsychotic medications for children in foster care
The Vermont Landscape

- Vermont has a state-administered child welfare system.
- Child Welfare and Youth Justice are integrated in the Vermont system.
- There were about 1000 children in custody when this project began.
- There are about 1300 children in care in Vermont today. The significant increase is primarily due to the opioid epidemic.
- DCF workers are responsible for providing consent for psychotropic medications for children in foster care.
Why this Issue?

- Growing awareness in Vermont and Nationwide that children in foster care use all psychotropic medications at a higher rate than other children on Medicaid.

- Given the life histories of these children, a higher rate is not unexpected; yet, there may be services and supports that could diminish or eliminate the need for these medications for some children.

- There is growing awareness of the role of trauma in the lives of children and youth in foster care, and of strategies to address that trauma.

- While psychotropic medications can be beneficial, they can also have serious side effects that are often not considered at the time of consent.

- Prior to this collaborative, Vermont did not have any guidance to ensure decisions to consent would be based on the benefits, side effects, duration and alternatives.

- At the beginning of the project our data was insufficient and inaccurate, and quality assurance procedures did not exist.

- At the start of the project, children in Vermont Foster Care were prescribed anti-psychotics five times more often than other Medicaid youth.

- Given the serious side effects associated with antipsychotics in particular, new policy required DCF workers learn benefits, risks and alternatives.
“As soon as I turned 18, I took myself off the meds...”

QUOTE FROM FORMER YOUTH IN CARE

Prior to the project, Vermont had no real “taper down” practices, and connections with the Department of Vermont Health Access had not yet been established.
Efforts undertaken by Vermont

Vermont DCF partnered with the University of Vermont’s Psychiatry team to ensure consultation in circumstances of greatest risk:

- The child is under the age of 6;
- Two or more antipsychotics are recommended concurrently;
- Dosage exceeds maximum recommendation;
- A child’s parent(s) object.
Efforts undertaken by Vermont

- New oversight for children and youth already on antipsychotic medications.
- Informed consent ensures:
  - careful diagnostic assessment
  - discussion of risks and benefits
  - avoiding unnecessary Rx to young children
  - use only one antipsychotic medication
  - monitoring with weights and labs, and attempt to discontinue if possible.
Medication Trends

% Vermont Medicaid Insured Youth Taking Psychiatric Medications

- ADHD
- Antidep
- AntiPsych

6-12 Year Olds

13-17 Year Olds
Total # of Children in Foster Care on 4 plus Psychotropic Medications simultaneously for 90 days or more (regardless of drug class)
Percentage of Children in Foster Care on Antipsychotic Medication
Ages 6-12

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFY 2013 2nd Half</td>
<td>10.30%</td>
</tr>
<tr>
<td>FFY 2014 1st Half</td>
<td>10.34%</td>
</tr>
<tr>
<td>FFY 2014 2nd Half</td>
<td>6.87%</td>
</tr>
<tr>
<td>FFY 2015 1st Half</td>
<td>5.90%</td>
</tr>
<tr>
<td>FFY 2015 2nd Half</td>
<td>4.39%</td>
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<tr>
<td>FFY 2016 1st Half</td>
<td>5.99%</td>
</tr>
<tr>
<td>FFY 2016 2nd Half</td>
<td>5.81%</td>
</tr>
</tbody>
</table>
Percentage of Youth in Foster Care on Antipsychotic medication
Ages 13-17

- FFY 2013 2nd Half: 22.51%
- FFY 2014 1st Half: 23.33%
- FFY 2014 2nd Half: 19.59%
- FFY 2015 1st Half: 19.47%
- FFY 2015 2nd Half: 17.38%
- FFY 2016 1st Half: 16.90%
- FFY 2016 2nd Half: 16.26%
Key Tools

- Policy: “Anti-Psychotic Medications for Children in DCF Care”
  - Form: “Consent for Use of Anti-Psychotic Medication for Children / Youth in DCF Custody” (an educational tool for workers)
- UVM Child Psychiatry Consultation Services
  - Form: “Consultation for Children Prescribed Psychotropic Medication”
- DVHA Pharmacy Tool: Provides all Medicaid prescription history
  - Quarterly DVHA report: provides trends in prescribing amongst Medicaid and foster care population
I thought the prescribing doctors would have concerns about the new process, but instead prescribers were relieved – parents often push back [on over-prescribing], but the DCF worker used to turn to us and say “whatever you feel is best.” Now workers are asking about the risks and benefits of various medications, advocating in a good way.

**Dr. David Rettew, Director of the UVM Pediatric Psychiatry Clinic**
Qualitative Impact

- Accurate data for children in DCF custody prescribed psychotropic medications including anti-psychotics.

- UVM child psychiatry consultation available to DCF workers needing to provide informed consent of antipsychotic medications and to the pediatricians providing care for these children and youth.

- Approximately 5-10 consults occur each year.

- The Department of Vermont Health Access has developed a pharmacy tool that provides comprehensive reports on the use of psychotropic medication in the foster care population. The tool is shared with DCF and aids in quality improvement efforts.
Vermont has learned that with focused time and attention on these issues, we really can make a difference!

Brenda.gooley@vermont.gov
(802) 760-0610

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In Summary: Keys to Improvement

- The right goal: Appropriate use relative to needs
  - Trauma-informed lens
  - View of psychotropic medication as only part of the service array

- Cross-agency and stakeholder collaboration
  - Data-sharing
  - Coordination of services

- Workforce
  - Clinical expertise
  - Training for agency staff and providers

- Effective practices, tools and relevant resources

- Sustainable funding
New CHCS Resource Center

- Houses publications, tools, and webinars to help states improve the oversight and monitoring of psychotropic medication use for children and youth in foster care.
- Also features profiles on select states from the learning collaborative, including the states participating in today’s webinar.
- Visit www.chcs.org/psychotropic-meds-resource-center/
Visit CHCS.org to...

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services

- **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries

- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources

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