The Prescribing of Atypical Antipsychotics to Ohio Medicaid’s Children: An Update

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Department of Medicaid
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KEY DRIVER DIAGRAM

Project Name: Atypical Antipsychotic (AAP) Prescribing in FFS Youth
Project Leader: Mary Applegate

August 2013

SMART AIM
Reduce the safety violations in prescribing of Atypical Antipsychotics (AAPs) to FFS Medicaid youth by 10% by October 2014 as measured by aggregate reductions in these safety violations:
- 1 AAP prescriptions for <6 year old children
- 2 or more concomitant AAP prescriptions for over 60 days, and
- 3 or more concomitant psychotropic medications

Global AIM
Appropriate and effective use of pharmacologic agents as part of an effective and holistic strategy to improve outcomes for children and families

KEY DRIVERS
- Early access to Behavioral Health Services
- Policies and incentives
- Awareness Building
- Standardization/Guidelines
- Family Centered System
- Target high use populations including foster children
- Data Transparency

INTERVENTIONS
- Increase knowledge, availability & access across mental health services including primary care via care coordination
- Increase awareness of and access to alternative interventions & non-pharmacologic strategies
- Direct access to evidence-based therapies through specialty clinics
- Reduce antipsychotics use by reducing unnecessary prescriptions
- Reduce use of AAPs in children by 10%
- Promote evidence-based practice
- Develop collaborative care for children & families
- Reduce clustering of AAPs
- Increase availability of alternative care resources

- Increase or redesign reimbursement for psychosocial interventions, mental health care in primary care, non-medication supports
- Provide incentives & MOC for improvement learning collaboratives & offer AAP prescribing

- Launch public awareness campaign (Minds Matter)
- Engage stakeholders (families, schools, prescribers, day care centers, wellness workers, peer-to-peer education materials and public tools)
- Develop educational campaigns about AAPs
- Utilize enhanced technology (e-therapy), Telehealth
- Improve access & services

- Create common & public set of decision-driven guidelines, including step-down therapy & guidelines for approach to aggression
- Increase awareness of AAPs for children
- Increase awareness of AAPs for children
- Promote shared decision-making with families

- Engagement of clinicians through MH Collaborative, OOME, AASP, and professional organizations
- Telepsychiatry / CCM Model
- Behavioral communication tools, with informed consent process for referral to a collaborative practice
- Integrate foster PCMH with registry function, including centers of excellence
- Promote shared decision-making with patient/families
- Increase transparency/Direct feedback
- Develop collaborative relationship in referral & co-location

- Meaningful provider feedback and quality profiling as key component of QI
- Engage DOH for sustainability
- Identify high-volume provider/drug/issue feedback & targeted training
- Transparency, alignment, disproportionality and evaluation
**Project Focus Areas**

25% reduction in the use of:

- Atypical Antipsychotic (AAP) medications in children less than 6 years of age
- 2 or more concomitant AAP medications for over 2 months duration
- 4 or more psychotropic medications in youth <18 years of age

**Leadership Structure**

**BEACON Statewide Stakeholder Meetings/All Pilot Communities**
Facilitators: QI Vendor and Clinical QI Leader
Schedule: June 2013, Sept 2014, Nov 2015

**State Steering Committee (N = 25)**
Clinical Advisory Panel (N = 17)
Pilot Community Chairs (N = 3)
Facilitator: QI Vendor and Clinical QI Leader
Meeting Schedule: Bi-Monthly, Quarterly

**Central Community Steering Committee**
Clinical and QI Facilitators
Meeting Schedule: Quarterly meetings beginning in August 2013
Chair: Dr. Jonathan Thackeray

**Northeast Community Steering Committee**
Clinical and QI Facilitators
Meeting Schedule: Quarterly meetings beginning in August 2013
Chair: Dr. Steven Jewell

**Southwest Community Steering Committee**
Clinical and QI Facilitators
Meeting Schedule: Quarterly meetings beginning in August 2013
Chair: Dr. Rick Smith
**Smart Aim**

- Improve the safe prescribing of Atypical Antipsychotics (AAPs) in FFS Medicaid youth in Pilot Practice Group as measured by a drop in safety violations from 35.56% to 30% of all youth prescribed at least one AAP

**Global Aim**

- Promote the safe prescribing of AAPs to all children

**Key Drivers**

- Clear standardized clinical guidelines
- Prescriber awareness of own safe prescribing performance
- Prescriber awareness of total patient medications, other prescribers
- Technology-enabled decision support
- Access and adherence to non-medication evidence-based alternatives with feedback to prescribers

**Interventions** (Reliability Level)

2. Routine (weekly/monthly) prescription profile pushing out to prescribers with scripts outside of safety limits
3. Electronic prescribing modules developed to “not allow” unsafe prescribing at the point of prescribing
4. Real time access to non-medication parental & patient supports to facilitate successful duration of safer medication program

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**Minds Matter Toolkit**

- Differentiates target audiences
  - Prescribers
  - Consumers and parents
  - Community agencies and schools
- Clinical resources for prescribers
  - Includes non-pharmacological solutions
  - Care guides with assessment, diagnostic, treatment, monitoring & education aides
  - 6 Modules for CME and Maintenance of Certification
- Youth, parent, and community worker tools
  - Parent and community worker specific fact sheets, shared decision-making tools
- Links to existing resources
Decision Support Algorithms

Algorithm A

Antipsychotic Medication Management in Children Under 6 Years of Age


A.2. Does the assessment reveal target symptoms and/or a diagnosis that suggests that antipsychotic medications may be helpful?

A.3. BEFORE PRESCRIBING

- Might the existing treatment be exacerbating the child's behavior?
- The potential benefits and risks of psychotropic medication use must be weighed against the risks of untreated adolescents given that their long term consequences are poorly understood.
- Are other, less risky psychosocial treatments available in the community?
- Have these treatments been utilized?

A.5. Do not prescribe.

Decision Support Materials

Oppositional Defiant Disorder and Conduct Disorder Treatment Guide

DSM Criteria

Diagnostic criteria for DSM-IV Oppositional Defiant Disorder

- Repeatedly and persistently unreasonable demands in school, such as refusing to follow rules or regulations, or excessive complaints about teachers or other authority figures.

Diagnostic criteria for DSM-IV Conduct Disorder

- Aggression by people and possessions: repeatedly hitting, kicking, shoving, or otherwise attacking people, or repeatedly stealing or destroying objects or property.
- Destruction of property: repeatedly destroying or damaging objects or property on other people’s property or on public property.
- Theft of property: repeatedly stealing or taking property.
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Decision Support Materials

REFERENCE CHART OF DISORDERS AND EVIDENCE-BASED TREATMENTS FOR CHILDREN AND ADOLESCENTS*

Adjustment Disorders
What Works
Currently no medication or psychological treatments meet these criteria.

What Seems to Work:
- Interpersonal Psychotherapy (IPT) - IPT has the most support in that it helps children and adolescents address problems in their relationships so that they can become less depressed.
- Cognitive Behavioral Therapy (CBT) - CBT is useful in improving problem-solving skills, communication skills, and stress management skills. It also helps the child’s emotional state and support systems to enhance adaptation and coping.
- Stress Management - Stress management is particularly beneficial in cases of high stress.
- Group Therapy - Group therapy is beneficial in cases of high stress.
- Family Therapy - Family therapy helps in making needed changes within the family system. These changes may include improving communication skills and family interactions and increasing support among family members.

What Does Not Work:
- Pharmacology Alone - Medication is seldom used as a singular treatment because it does not provide assistance to the child is learning how to cope with the stressor.

Parent Fact Sheet Example

What every parent needs to know about Attention Deficit Hyperactivity Disorder (ADHD)

WHAT IS ADHD?
Attention Deficit Hyperactivity Disorder (ADHD) is a condition which includes difficulties with attention, increased activity, and difficulties with impulsivity.

WHAT ARE THE SYMPTOMS?
- Inability to pay attention
- Difficulty focusing on details and making careful mistakes
- Easily Distracted
- Loss of ability to tolerate delays
- Trouble organizing work
- Trouble following directions
- Learns new material or information less effectively
- Fidgets or wriggles
- Blows out a candle
- Exhibits impatience
- Difficulty in completing tasks
- Sucks on things
- Need difficulty sleeping
- Swallows or eats things

HOW IS IT DIAGNOSED?
ADHD is usually first diagnosed during the preschool years, but can emerge in your child. Ask the doctor and your child. Many children who are not diagnosed as ADHD in preschool will be diagnosed as a hyperactive child at a later age.

HOW IS IT TREATED?
Medication can help children with ADHD. However, it is important to discuss the risks and benefits of medication with your child’s doctor. Other treatment approaches may include therapy, social skills training, parent training, and modifications to your child’s educational program.

WHAT CAN I DO?
- Work with your child’s teacher and other people who spend time with your child.
- Not discuss medication and its effects
- Be patient and consistent in your approach.
- Help your child’s school

WHERE CAN I GET HELP?
See the ADHD Parent Resources Section in the Minds Matter Toolkit.

*Adapted from the National Institute of Mental Health. Adapted with permission from the American Academy of Pediatrics, Committee on the Psychosocial Aspects of Child and Adolescent Health.
Learning from Systems Observations
(Record understanding from direct observations of workers in the prescribing process)

1. Clinician prescribes AAP outside of safety limits.

2. Failed prior (safer) prescriptions

3. Escalation of symptoms/severity in context of lack of standardization in key clinical prescribing decisions

4. Failed or lack of access to non-medication, evidence-based alternative therapies

5. Delayed access to diagnosis and specialty services and earlier treatment

6. Lack of awareness and access to mental health expertise in general medical practice

Root Cause

The AAP Safe Prescribing Measure for FFS Medicaid youth

- **Numerator** = a count of ANY of the 3 safety violations in a given time period
  - Any AAP script for <6yo child
  - >2 AAP scripts at the same time
  - >4 scripts for psychotropic/mental health drugs

- **Denominator** = unique patients prescribed at least 1 AAP

- A RATE allows for better comparisons across time and the denominator allows for a direct statement of impact on number of youth impacted
### AAPs Feedback Table

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient DOB</th>
<th>Patient Medicaid ID</th>
<th>Under age 6 on atypical antipsychotic</th>
<th>Under age 18 on greater than 2 atypical antipsychotics</th>
<th>Under age 18 and on greater than 4 psychotropics</th>
<th>I can make a change now</th>
<th>Y = Yes</th>
<th>N = No</th>
<th>If No, why not? (see legend)</th>
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**Legend for Reasons:**
1. Not my patient now
2. Following guidance of specialist (Give name below in comments)
3. Unaware of other prescribers
4. Lack of access to appropriate specialist
5. Lack of access to non-medication alternatives
6. Tried and failed evidence based guideline treatments
7. Treatment resistance
8. Currently in gradual cross tapering
9. Request by parent or other
10. Patient poses risk to self or others

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### Pareto of Rx Errors for Psychotropic Drugs in CCHMC population

<table>
<thead>
<tr>
<th>Type of Rx Error</th>
<th>Individual Quantities &amp; Percentages</th>
<th>Cumulative Percentages</th>
</tr>
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<tbody>
<tr>
<td>Rx for pts on 4 or more psychotropics</td>
<td>3080</td>
<td>61.8%</td>
</tr>
<tr>
<td>Rx for pts rec 2 or more AP</td>
<td>1713</td>
<td>96.9%</td>
</tr>
<tr>
<td>Rx for pts &lt; 6 y/o on an AP</td>
<td>107</td>
<td>100.0%</td>
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**Legend:**
- Individual Quantities & Percentages
- Cumulative Percentages
Regional Pilot Community Care Collaboration Design

### Mission
High level population groupings

### High Level Coalitions
Necessary for funding grants and business plans

### Identification of patient streams
Data collection on patients (identify key issues in healthcare/comm. resources)

### Refined Coalitions based on Strategies
Strategies based on data collection may require additional partners

### Reduce prescribing of psychotropic medications above thresholds
Rounded coalition establishes aims, measures, initial design, concepts

- Standardization & Guidelines
- Consumer Empowerment
- Access & Coordination of Care

### Standardization and Guidelines (OMM Tool Kit)

|----------------------|--------------|--------------|----------------|--------------|--------------|
| Early adopter provider sites: | 1) Train learning modules and use tool kit  
2) Provide baseline and real time data for prescriber feedback  
3) Conduct monthly action calls  
Learning Modules 1,2,3 | | 2) Provide baseline and real time data for prescriber feedback  
3) Conduct monthly action calls  
Learning Modules 4,5,6 | | Pilot communities/early adopter sites:  
Refine, finalize, and implement tool kit, and data collection | Pilot communities:  
Implement regional roll-out of tool kit, collect final data  
Design statewide spread plan |
| Pilot community participants: | Identify gaps in current process | | | | |
| Consumer Empowerment  
Develop shared care decision making/informed consent/assent | | | | | |

### Pilot Communities Strategy Roadmap

|----------------------|--------------|--------------|----------------|--------------|--------------|
| Early adopter provider sites: | 1) Train learning modules and use tool kit  
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Design statewide spread plan |
| Pilot community participants: | Identify gaps in current process | | | | |
| Pilot community participants:  
Design improved systemic process for shared decision making | | | | | |
| Pilot communities/early adopter sites:  
Test shared decision making process | | | | | |
| Pilot communities:  
Design statewide spread plan | | | | | |

11/20/2013
# Pilot Communities Strategy Roadmap

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<tr>
<td><strong>Access and Coordination of Care</strong>&lt;br&gt;Connect existing behavioral health services in community and devise method of providing up-to-date referral resources and network</td>
<td>Pilot community participants: Identify, engage, and recruit behavioral health providers/centers in region.</td>
<td>Pilot community participants: Identify and implement strategy/method for providing up-to-date referral resources and network building</td>
<td>Refine Behavioral health provider referral resources and network building</td>
<td>Design strategy for regional roll-out</td>
<td>Implement regional roll-out</td>
</tr>
<tr>
<td><strong>Participate in Monthly Action Calls to Review State and Region Specific Data and Discuss Action Steps Based on Observed Patterns and Reasons</strong></td>
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### Days 1-14
- Complete Learning Module
- Received Notification to Review Information on Provider Portal
- GoTo Provider Portal: Review Patient Roster for Prescriptions Reaching Target Thresholds and Provider Specific Control Chart
- Identify Top Three Reason Codes for Observed Prescribing Patterns and Share via Provided Link

### Days 15-29
- Participate in Monthly Action Calls to Review State and Region Specific Data and Discuss Action Steps Based on Observed Patterns and Reasons
Questions

• Mary.Applegate@Medicaid.ohio.gov