IMPROVING THE APPROPRIATE USE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND YOUTH IN SUBSTITUTION CARE

Ajit Jetmalani, MD
Director, Division of Child and Adolescent Psychiatry
Clinical Professor
OHSU Doernbecher Children’s Hospital
HISTORY

• In 2009, the Oregon legislature passed House Bill 3114, which amended Oregon Revised Statute 418.571 concerning psychotropic medication for children in foster care.

• The law went into effect on June 30, 2010.
GAO report 2009

- Atypical antipsychotic use in pediatric patients increased by 65% from 2.9 million to 4.8 million prescriptions from Y2002-Y2009. The number of unique patients increased by 35% from 592,000 to 801,000 patients over the same years.
- GAO report revealed that 4% of youth in Medicaid and 20% of youth in foster care were receiving psychotropic medication.
- High rates of antipsychotic use for off-label indications.
- High rates of polypharmacy in foster youth.
DHS and Providers (now CCO’s) Must Assure:

• A mental health assessment occurring before any child in foster care receives more than one new psychotropic medication or any antipsychotic medication, except in cases of urgent medical need.
DHS Must Assure:

• An annual review of psychotropic medications is required for all children under the age of 6 on psychotropic medications or who are receiving more than two psychotropic medications.

• This annual review will be done by the Oregon Medicaid Drug Use Review (DUR) Program in concert with DHS medical personnel.
DHS \ AMH Mental Health Screening requirement

- All youth in placed in foster care shall have a mental health assessment within 60 days
GAO Letter to state Medicaid Directors

- Nearly One-Fifth of Foster Children Took Psychotropic Medications, and Nearly One-Third of Foster Children Who May Have Needed Mental Health Services Did Not Receive Them.
- Oregon one of 16 states asked to provide data about prescribing practices
- Implementation of State oversight under ongoing investigation.
• Psychotropic medications have been considered to be above routine medical care for many years in Department rules.

• Beginning July 1, 2010 DHS assigned the responsibility for providing consent for psychotropic medications to the local Child Welfare Program Manager or his or her Designee.
The Department of Human Services and the Oregon Health Authority made a joint application for and were awarded a Technical Assistance grant by the Center for Health Care Strategies (CHCS) in April 2012.

The 3-year grant was funded by Casey Foundation and it involved DHS Child Welfare and OHA Addictions and Mental Health and DMAP.

The states participating were: Oregon, Illinois, New Jersey, New York, Rhode Island, and Vermont.
Common Themes

- Trauma drives behavioral challenges and is under recognized.
- Aggression and sleep disturbance are symptoms commonly associated with antipsychotic overutilization and polypharmacy.
- Pediatric Bipolar disorder is overdiagnosed.
- Mental Health Care is delivered too late or ineffectively.
Common Themes

• Primary care providers are frequently on the front line (Friday afternoon syndrome) and do not have the support they require in terms of services and or expertise.
• Records do not follow the child.
• Medications are used before the use of non medical strategies.
• Once regimens start they may be continued without re-evaluation.
OREGON GOALS

• Improve the effectiveness of the consent process for psychotropic medication use.
• Expand collaboration among stakeholders in this quality improvement project.
• Improve the safety and effectiveness of psychotropic medication use through the utilization of best practices.
• Reduce use of antipsychotic medications for unapproved indications
• Reduce polypharmacy use (4 or more psychotropic medications)
STRATEGIES

• INFORMATION
• CONSENT
• CLINICAL PRACTICE
Information

• Youth in foster care (YOUTH ADVOCACY GROUPS)
  o What to expect in foster care and rights
    • Developed and distributed
  o Review of Psychiatric Medications
    • Tip Sheets Created and distributed to foster youth and care givers when psychiatric appointments are anticipated.
Newly Developed Resources

OREGON DEPARTMENT OF HUMAN SERVICES
Child Welfare

PSYCHOTROPIC MEDICATIONS
Guide for youth in Oregon foster care

THINGS YOU NEED TO KNOW...

What are psychotropic medications?
Psychotropic medication (pronounced “sike-oh-trope-ick”) 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

...
Information

• Foster Parents:
  o Trauma training
    • PSU OHSU Trauma Informed Oregon created this summer
    • Improving trainings in terms of content and duration
  o CPS training
    • Pilot project proposed and under consideration
    • Already utilized in Maple Star Homes
  o Medication / health care training
    • In place, continue to improve process and materials
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.
Information

- **DHS Staff**
  - **Trauma training**
    - Trauma Informed Oregon
    - Involve PSU training
      - Establishing curriculum
      - Establishing methods of consistent training
  - **CPS training**
    - Work with OHSU CPS advisory committee to develop curriculum and strategy for implementation
  - **Medication / health care training**
    - In place, improving process and materials
    - Created tip sheets
    - Consultation and second opinions now starting with OPALK (December 2014).
Information

• Providers:
  • Dashboards are going to Providers and CCOS
    o Some CCOs are starting QI projects using the data
  • Trauma informed clinics and clinicians
    o TIO focused on provider training primary and secondary
  • Evidence Based Guidelines
    o OPALK guidelines are being vetted by OCCAP and published on the web site
    o Providers are given guidelines after OPALK calls
## Pediatric Metrics Summary

**Report Date:** 1/7/2014

*Please refer to the Pediatric Measure Specification for descriptions of Numerators and Denominators (available in SharePoint Documents section)*

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<th>Denominator</th>
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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, lipids, glucose, blood pressure) is the standard of care when prescribing antipsychotics.

The following pages contain a list of Fee-For-Service (FFS) Medicaid patients 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 do not always reflect actual testing, that 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 filed 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

<table>
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<th>Personal/Family History</th>
<th>Baseline</th>
<th>4 wks</th>
<th>8 wks</th>
<th>12 wks</th>
<th>Quarterly</th>
<th>Annually</th>
<th>Q 5 Yr</th>
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<td>X</td>
<td>X</td>
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<td>Waist Circumference</td>
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<td>X</td>
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<td>X</td>
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</table>

If you have any questions or comments regarding that policy or would like a claim-based profile for any of these patients, please call 503-945-6553 or fax 503-947-2596.

Please indicate the status of this required laboratory work and fax this report within 30 days to DMAP at 503-347-1119.

Metabolic Syndrome Detection and Management

The 2007 International Diabetes Federation Consensus guidelines for the diagnosis of metabolic syndrome in children synthesized recommendations from the ADA, the World Health Organization, and the National Cholesterol Education Program (see table below).

- Weight is not a reliable surrogate marker for glucose and lipid abnormalities. Waist circumference predicts metabolic syndrome similarly to body mass index when gender, age, and ethnic group have been considered.
- The metabolic effect profile varies from one antipsychotic to another thus changing antipsychotics is an option to manage metabolic abnormalities for some patients.
- A meta-analysis found individual and group non-pharmacological interventions such as cognitive behavioral therapy and diet and exercise counseling reduce mean body weight (2.5 kg) and BMI (0.9 kg/m^2) in adults, but studies in children are lacking.
- Pharmacological strategies to mitigate weight gain include:
  - Metformin may prevent new weight gain in antipsychotic-naive patients and patients who have gained weight due to antipsychotic therapy.
  - A recent meta-analysis found only metformin, a thiazolidinedione, and topiramate superior to placebo at reducing weight gain.

Criterions for Metabolic Syndrome in Children and Adolescents

<table>
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<tr>
<th>Age group (years)</th>
<th>Obesity</th>
<th>Waist Circumference</th>
<th>Triglycerides</th>
<th>HDL C</th>
<th>Blood pressure</th>
<th>Fasting Plasma Glucose</th>
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<td>6–10</td>
<td>&gt;10th percentile</td>
<td>&gt;90th percentile</td>
<td>&gt;150 mg/dL</td>
<td>&lt;40 mg/dL</td>
<td>&gt;100 mmHg</td>
<td>&gt;100 mg/dL</td>
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<tr>
<td>11–16</td>
<td>&gt;90th percentile</td>
<td>or a child or a child or a child</td>
<td>&gt;150 mg/dL</td>
<td>&lt;40 mg/dL</td>
<td>&gt;100 mmHg</td>
<td>&gt;100 mg/dL</td>
</tr>
</tbody>
</table>

If you have any questions or comments regarding that policy or would like a claim-based profile for any of these patients, please call 503-945-6553 or fax 503-947-2596.

Please indicate the status of this required laboratory work and fax this report within 30 days to DMAP at 503-347-1119.
Consent

• Modified process:
• Clinician PARC (informs) with child and caregiver
• Form (173C) was changed to include line for youth and caregiver to sign for acknowledgement and assent

  o Caregiver provides information to caseworker/supervisor (verbal and written 173C)
  o Supervisor and caseworker reviews information (department protocols)
  o Caseworker notifies caregiver when and if to proceed with medication regime
Clinical Practice

- Disseminate Prescribing Flags
  - Poly pharmacy greater than 4
  - 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
Clinical Practice

• **Oversight**
  - Still considering a pre authorization process for oversight of requests for new antipsychotic for any child and any psychotropic for a child under the age of 6 (except stimulant)
  - Dashboards to providers
  - Dashboards to CCOs
  - When flags triggered
    - Communicate with provider
    - Peer review via OPALK
    - Option for tele medical evaluation now available
Youth in Foster Care

On any Psychotropic Medication

Last Quarter 2012- First Quarter 2015
Source: Oregon Medicaid Pharmacy Data Base
Youth in Foster Care

3 or more psychotropics

last quarter 2012 - first quarter 2015
Source: Oregon Medicaid Pharmacy Data Base
Youth in Foster Care

On an Antipsychotic Medication

Last Quarter 2012 - First Quarter 2015
Source: Oregon Medicaid Pharmacy Data Base
Youth in Foster Care

Under 6 on Psychotropics (other than stimulants)

Last Quarter 2012- First Quarter 2015
Source: Oregon Medicaid Pharmacy Data Base
Recommended Reading

- Guide for Advocates and Care Givers
  https://www.childwelfare.gov/pubs/factsheets/mhc-caregivers/