

DCF Psychotropic Medication Advisory Committee
Monthly Meeting Notes

December 3, 2010 1:00PM
Riverview Hospital for Children and Youth
Middletown, CT.

PRESENT: See enclosed attendance record.

1. Call to order: the meeting was called to order at 1:07 pm. Dr. John DiLallo was introduced to the PMAC. Each member in turn introduced themselves to Dr. DiLallo.
2. Set date/time of next meeting: The next meeting will take place on January 7, 2011 from 1-3PM; RHCY AB Conference Room.
3. Minutes: The minutes of the November 2010 PMAC meeting were reviewed and approved with the following changes. Item 6. first item; change antidepressants to mirtazapine. Second item; change BMI to BMI percentile. The minutes will be posted on the website.
4. Announcements:
 - Feedback: Village for Families Annual Child Psychiatrist & APRN Breakfast held on November 11, 2010 from 8am – 1030am. Location: 1680 Albany Ave, Hartford, CT.
 - a. Dr. Narad reported: A blueprint for Medicaid was presented. Adequacy of services discussed. Also services for autism were discussed.
 - Preliminary Review of DSS Pharmacy Analysis: Highlights presented by Dr. Williams.
 - a. Report not yet approved by DSS. There is a presentation scheduled for January 2011.
 - b. A group of Husky children were labeled “DCF involved”. There is concern regarding what this means as DSS has no code to identify DCF involved clients. There is an indicator that DCF is connected to a case but this is a very broad marker. There needs to be a standard definition developed as to what “DCF involved” means.
 - c. Data shows females utilized medications more than males.
 - d. DCF involved were 10% of Husky population but accounted for 20% of the cost. DCF involved drug therapies were double the cost of the rest of the Husky population. It was noted that this may be due to patient acuity.
 - e. Five months of claims data shows over \$14 million for behavioral health medications.
 - f. The average cost per prescription was \$140 for DCF involved and \$95 for the rest of the population.
 - g. It was noted that increased drug cost may be due to a higher rate of compliance with medication therapy.

- h. Further analysis will provide information for education and outreach.
- Waste of medications was discussed. There may be some DCF policies that contribute to waste. Example; requirement for new prescriptions at discharge or transfer vs. the ability to transfer medications between facilities. Apparently the transfer of medications between facilities is allowed by policy.

5. DSS Provider Bulletins:

- Feedback regarding DSS optimal dosing program for children: At the last PMAC the optimal dosing program drug list was distributed and reviewed. PMAC members were asked to review this list and recommend what drugs should be removed from the list.
 - PMAC members were asked to contact Dr. Williams with recommendations for other drugs that should be removed from this list. Dr. Williams would then contact DSS (Jason) with the recommendation(s).
 - RESULTS: The restrictions on greater than QDay dosing for children have been removed.
- Requests for DSS collaboration: Dr. Williams reported working on three items with DSS.
 - Identify two points in time (2008 and 2010) and take a “snap shot” for all DCF committed children. Gather data regarding medication use such as what medications are being prescribed, how many medications, demographics of children prescribed psychotropic medications, etc. The goal is to identify trends showing the impact of the CMCU.
 - Review data from the summer of 2010 for all 4,000 committed children on psychotropic medications. Identify the prescriber, the medication(s) prescribed, demographics, and other data points. The goal is to identify prescribers who are not using the CMCU consent process.
 1. Feedback from CMCU indicates that they are not getting informed consent from pediatricians. This may be due to the M.D. not knowing the legal status of the child. Some options were discussed on how to increase compliance with informed consent via the CMCU. It was agreed to first determine how big the problem is via data collection/analysis as described above.
 - MOA to obtain medical claims data on every newly committed child to determine basic medical information for social workers, M.D.'s, MDE, etc. Jason Gott and Evelyn Dudly are working on this initiative.
- Rating Scales: a discussion ensued regarding required use of rating scales. Copies of scales utilized by Mass General were distributed, reviewed and discussed. It was noted that there are various anxiety scales, OCD scales, etc. all in the public domain. A modified aggression scale was discussed.
 - Discussion took place as to if it would be better to just make these tools available or take other action such as adding some or all of these tools as an addendum to the protocol. Possibly posting on the DCF

website or via a link on the website suggested. Providers could also be notified about these scales via the newsletter.

- ❑ The ease of use of various scales was discussed.
- ❑ Recommend CMCU review and identify scales to be considered for endorsement by PMAC. Endorsed scales can then be added to the protocol and an appendix. Use of these scales would not be required at this time.

6. Conversation with Mike Naylor MD

- ❑ As summarized by Dr. Siegel: As presented at the Academy meeting on trauma:
- ❑ Noted Dr. Naylor is responsible for monitoring psychotropic medication use in children for the state of IL. He has 16yrs experience in this role and has done various presentations and written several articles on the subject.
- ❑ It was noted that about 75% of states now have the equivalent of a CMCU. Processes used by various state CMCU's were discussed and compared. Several major points were identified:
 - Research studies needed re weight gain.
 - Issues surrounding polypharmacy.
 - Evaluate trending data re bipolar.
- ❑ Dr. Naylor's group uses the Texas algorithm. Noted that this now over 4yrs old and a bit outdated (example ADHD).
- ❑ Noted that the Texas algorithm is evidenced based and does tend to reduce combination therapy and there less polypharmacy is seen.
- ❑ PRN's are not allowed.
- ❑ A lot of education is done as part of the process.
- ❑ Data from Medicaid claims are evaluated and if it is determined that a prescriber did not go through the consent process a "strict" letter is sent. This is done at least every 180 days.
- ❑ Consent is not granted for medication without all required data being submitted.
- ❑ Turn around time is measured from when all needed data is submitted.
- ❑ Dr. Naylor has about 10FTE staffing level for support.
- ❑ Noted that they also have problems with Medicaid data collection and analysis.
- ❑ A 6mo ACR check is done.
- ❑ A copy of the act (law) and MED letter was distributed for review.
- ❑ Noted that there is a specialty field on the 465 form.
- ❑ Noted that the DCF CMCU is not as strict.
- ❑ The clinical outcome resulting from the use of these stricter rules/procedures was discussed. It is unknown if children are doing better or worse clinically.

7. Psychopharmacology Conference Planning Sub-Committee:

- ❑ Dr. Wolman declined to Chair this Sub-committee. A chair and co-chair are needed. Noted that it may be best if the chair or co-chair is a pediatrician as

this is our target audience for this year's conference. PMAC members wishing to volunteer please contact Dr. Williams.

- Noted that Yale may be having a similar conference in May.

8. Conversation with Dr. John DiLallo

- There was considerable discussion describing Dr. DiLallo's agency, it's function, procedures, etc. They manage/monitor about 6,000 children on psychotropic medications.
- The PMU amendments were distributed, reviewed, and discussed in detail.
- Methods of communication and the use of an EHR were discussed.
- Maladaptive aggression in youth algorithm was discussed as well as medications used for this condition.
 - Noted the use of an alpha-agonist is not evidenced based (this is a concern) but still may be good practice.
 - Accuracy of diagnosis discussed.
- The need for psycho-social intervention discussed as well as the stage of treatment.
- Discussed the need to require certain data (i.e. "data incomplete") such as Ht/WT. Recommend that this information be required when clinically needed on a case by case basis.

9. ADJOURNMENT: The meeting was adjourned at 3:05pm.

Respectfully Submitted:

David S. Aresco