MHMAC Meeting – May 8 2018 NOTES

1. Main purpose of meeting was to reorganize all of the P.A.s into four forms. "Streamline"
2. Grant and Lakin continue to resist any efforts to go beyond one year authorizations – require annual renewal forms, etc.
3. Grant confirmed phasing out "gold card" prescribing for psychiatrists
4. Appears that the process promised by Mosier – to carry over approval to a following meeting so that the public would have a chance to speak on known policy proposals – has been abandoned (did not ask anyone)
5. Grant complained about process taking too long, something about a kid coming out of a PRTF on too many prescriptions that she is calling out as a reason for review of all prescribers. Also, brought up the parity issue and the confidentiality of records issue again (same as her testimony)
6. Minutes no longer include all of the detail – Porter asked why, Grant said contracted note-taker can't take 90 hours to document all of it
7. Did away with the 60 day anti-psychotics renewal auto-override – wanted to change to five days – think it ended up at 30…

11 P.A. criteria. There is a 12th that isn't posted yet. Intend to implement through our own monitoring instead of P.A. because the mood stabilizer affects very few patients.

Narrow down the 11 criteria into 4 catch-all P.A.s – so the only thing that is going to hit at the pharmacy is the most basic safety criteria.

Added the improvements that you've made in some of the latest P.A.s – like if only a verbal was allowed except if rejected, have added a written option.

Added in some new medications that have come out since the P.A. was approved.

Added _____

Very simplified version, very easy for a P.A. form to be filled out.

Provider type for children three and under, definitely needs to be a specialist. Might want to discuss the provider type in some of the other categories.

Klingler – are we going to require that a child who turns 18 while still in high school has to suddenly change treatment and get a new diagnosis?

Must have a diagnosis of adult AD/HD in the previous 365 days – why would we require that? Could it just be an AD/HD diagnosis? Same code.

MCO representatives – computers are set by days, hard and fast.

Have there been issues? No one seems to have any.

Grant – if there haven't been any problems, do we need to go back and make these edits?

Todd – we have to make the edits anyway.

Group agrees to cross off the word "adult".

Lakin – so, is there not an ADD diagnosis? No, it was dropped.

Milhuff – what does the written peer to peer consult look like?

Helps to avoid the phone call scheduling problem.

Simply adds the written option everywhere there was a verbal requirement.

Milhuff – would like to include psychiatric nurse practitioners would like to be included in the provider option

Moeller – would have a problem with practitioners prescribing for a non-common use, off-label use.

Porter – psychiatric nurse practitioner inherits a case started by a psychiatrist – on clozapine, was sleeping 16 hours a day and needs the successful continued treatment, but you are saying that they would be rejected.

Todd – if the patient is stable and has been on it for a year, it should be continued.

Porter – so, will it be interrupted?

Grant – no, because the P.A. has already been approved.

Porter – so it would be approved and then there would be renewal criteria at the end of the year

Lakin – it wouldn't be that much of an issue, there aren't that many psychiatric nurse practitioners out there.

Adma – these are criteria we have vetted time and time again, we are just consolidating and streamlining them.

Adma – do the new medications have to come through the committee

Porter – although, I don't know that this is to be a permanent committee, right?

Grant – all new medications must be approved

Milhuff – my point is that there are practitioners out there who are serving these clients and they are specialists

Lakin – we looked back on the majority of psychiatric prescriptions, and the majority were prescribed by nurse practitioners, and the majority did not have psychiatric training

Milhuff – we have been talking about streamlining the process and reducing the workload, and so the concept of renewing these annually should be considered. I am not coming up with this on my own, there are many complaints out there and I am trying to carry their message

The purpose is so the patient will see the physician at least once a year.

Consider the mental health system. We are obligated to see these patients at least once a year. If we aren't seeing them, there are going to be inquiries.

Grant – we are attempting to have the bare minimum criteria, and if you look at the

Milhuff -As a representative of a group that is implementing this, it is a major time consuming issue

Would like to drop the requirement that it has to be re-approved every year. Why not let it be approved and call it good?

Adma – are there other states that are doing this?

There are a lot of states that aren't even doing this pre-approval process.

Porter – the people that you don't know of have dropped out of treatment. Every time we get one of these and fill out the questions, we are trying to screen for the few that

There may be providers who let the metabolic labs portion slip, and this is a reminder.

Milhuff – I get how simple the actual form is. It is the process of getting them approved. And we are removing the gold card which means a lot more administrative work

What about the requirement for prescribing by a psychiatrist?

That is what is being removed.

But I thought we approved that.

Grant - It is going to be phased out. It won't be required unless they go outside the parameters.

Grinage – it looks like the requirements of every year will be across

Grant – all P.A.s have the requirement of a renewal once a year, and mental health parity says that they won't be treated any different.

Grinage – just because all of them are done that way doesn't mean that it is the streamlined way to do it.

Milhuff – I am just trying to keep in mind what we learned at our first meeting, which was that we were trying to target the outliers and not to create busy work.

Jenkins – I do not think that the three questions are burdensome, but we still have to fill out all of the other part. Is there any way that we could look at technology to streamline?

Grant – we could maybe do that in the future. If we don't approve these today, we won't have the streamline process available. We do have opioid approvals online

Klingler – why can't we just attach a face sheet with that information.

Grant – might be an option in the future

Porter – the point is, the mental health centers are really having to hire staff just to deal with this. A few minutes per sheet, plus re-entering all the patient information and medication info – it all adds up.

Grant - And all provider types have to do that, and we are trying to move to that process. We are trying to streamline the process, but will not be doing things differently for this area and

Milhuff – it all adds up and this is a problem

Grant – (becomes emphatic) and this is why we had a patient leave a PRTF with a three times the proper dose prescription because someone let that go through and it was probably a preferred provider.***

Moeller – I am okay with these and would make a motion.

Milhuff – there is a 72 milligram generic methylthenidate (not on the list)

Will have to look at this.

Approved.

Under multiple concurrent use:

Porter – is there any way that we can provide _____ as a sleep aid?

Grant – that isn't on here and I do have a note that we might want to address that in the future

Moeller – not sure I agree with the two or more

Grant – which wouldn't be flagged

Porter – I wonder if we could look at a mid-range age here instead of 18.

Grant – insert under 13 –

Porter – unusual to use Wellbutrin and an SSRI under 13, but could be common for 16.

Todd - We don't have those dosing guidelines here, because those meds were just for adults.

Porter – how much of a problem is it – does it happen often?

Moeller – maybe it is not a big deal, I have seen some ___ other points

Porter – both of those, I have seen times that are appropriate, but would not always be appropriate

Milhuff – one of the problems with multiple concurrents, I worry that it is not clearly expressed that it is appropriate to use _____ and _____ as sleep aids, it is going to one of those things that will come up a being dinged.

Grant – so we can add "except for _____and _____ when used as a sleep aid".

Discussion of some other medications that are indicated for sleep aid, but can be harmful if taken often.-

Porter – motion to adopt

Passed.

Antipsychotic medications

No new medications included.

Promised legislative committee to address the problem of antipsychotic use in seniors with dementia.

Require one or more diagnoses to be given an antipsychotic while in a long term nursing facility.

Schizoaffective disorder, schizotypal, delusional disorder, and other non-mood psychotic disorders,F20-F291), Huntington's disease (G10), Tourette's syndrome or current edition of approved indicators for antipsychotic medications use.

Grinage – would be important to also have the associated behaviors before authorization – some form of violence or something, referred to information from Council on Geriatric Psychiatry information regarding appropriate term of use.

Porter – why would we reject the FDA indicated use for bipolar or severe depression in this age group, and something about adjunct prescription with anti-depressant for severe depression.

Walked back through. Grinage and Porter saying they are not geriatric psychiatrists, but know that there are

Jenkins – well, should they still trigger a P.A. and then get the follow-up?

Grinage – are they trying to stop use of antipsychotics for patients with psychosis?

No, just trying to avoid prescribing to patients with dementia

My opinion is that it must be in there and be well -defined.

Lakin – We are like 50th in the nation and we were once 51st. A lot of it is just lack of proper diagnosis.

Grinage – the problem is that there are no nursing homes for people with difficult behaviors and so they want to medicate people who have these behaviors and that is a problem. I think it needs to have the psychosis diagnosis AND the associated violent behavior.

Porter – first, I want to make sure that we have the proper FDA indicated diagnosis in here before we argue about how to deal with it.

Adma – want to have all of the approved indications in there.

Grant – can we say the FDA items – and insert them later?

Porter – my vote will be contingent on them being in there.

Murff - Is it the age that is the important part or is it the residing in the long term care facility? This population can move and if we aren't going to deal with the community population, that may not be practical to implement.

Adma – think the goal should be to look at all of the over 65 population

Lakin – the focus is on where people reside, that is what CMS and others are looking at. More about what the Legislature wanted, avoided legislation that would be more restrictive. Want to be able to go back and say this was addressed.

Todd – that isn't identified to the MCOs – might be living in the community

Milhuff – if we just say all of the FDA approved indications, we had better be careful, there is an older med approved for hyperactivity.

Grinage – my concern when we talk about long term facilities, we do need to reduce the usage. Could we just say that non-emergency anti-psychotic medications should only be used for agitation or psychosis in patients with dementia. This is the APA position, and it even goes further in referring to use only when "severe, dangerous, or cause significant distress for the patient". I think everything else should be what we discussed.

Grant – ok, then can we look at bullet three.

Adma – implementation wise – as the doctor pointed out: does the patient have dementia, list all,, then, if answers are yes, would be approved.

Murff – we would probably just have a yes or no question

Porter – walked through patient going to the hospital because they are in distress, prescribed in the hospital formulary – now they go back to the nursing facility. Do they get the medicine or not?

Murff – discharge doesn't usually occur until the ongoing meds are facilitated. Shouldn't be an interruption in meds if going directly to the nursing facility.

Porter – so, scenario where someone is exhibiting violence in the facility….

Todd – are you saying it is something that would come out of the cart? They aren't waiting for approval.

Discussion about how they are reviewed.

Grinage – this doesn't distinguish between long term care facilities and all other settings.

Grant – and maybe we can do some data pulls on the other side and see if we need to address it there.

Porter – there is a medicine in review to be used to treat agitation associated with dementia.

Any new drug will come here for approval.

Adma – listed the FDA indicated uses to be included

(note – not clear if every person in a facility will require a P.A. or if every person over 65 will require it)

Zhou - Want to cross out long term care facility and replace with non-dual eligibility group.

More operational for us to identify which 65 year olds – non-Medicare.

Milhuff – we put a lot of thought for younger people being in the care of a specialist. Should we

Lakin – I think most geriatric units have psychiatric consults, although don't know what happens in the rural situations

Murff - Another operational – should that go into the general prescribing guidelines for the reviewer's perspective?

Grant – could be at the end of the educational piece

Murff – is this an either/or or is it "and"?

Grinage – well it depends if there would ever be a case where you should approve the use? This is where we need to have the long term care folks come in and tell us what they need.

Grant – so move that down to the guidelines portion?

Grinage – maybe that should be a part of the first bullet?

Grant – think it is an "or" situation

Lots more conversation about how it would be applied and when allowed.

Re-writing again.

Grinage – really waters it down,

Guy with curly hair and beard – Amerigroup physician - Do you mind if I make a comment? What CMS is really trying to get a handle on is the overuse of these medications for agitation. My fear is that putting things like that in there, everyone is going to check the box.

Milhuff – we are taking something that is pretty complicated and boiling it down to a simple form.

Porter – you could certainly cause significant distress – being paranoid is significant distress. That is how the APA words it, but it gives leeway to those who are doing what we don't want them to do.

Grinage – there is a significant amount of pressure on these providers.

Porter – we could shave off "significant distress"

Milhuff – expect that paper is assuming there is a detailed psychiatric examination

Grinage – if there is a question and they need to have a consult, that is one thing, but if we take out the entire indications recommendation you are removing options

Jenkins – you are not suggesting that the person with the significant distress is not going to get the medication, but they are going to get it with a peer to peer review.

Maybe pull out the "significant distress" indication.
Lakin – does it matter if it is for the self or others – dangerous to self or others.

Milhuff – there are some recommendations at the end of this document – we might be able to address this altogether.

Multiple Concurrents –

Grant – Suggesting streamlining - Remove the provider types for 6 to 18 years of age – access issue

Members have concerns. Some issues with the language. Could mean anyone could prescribe more than one med to a youth, but not one.

Adma – our discussion had a purpose and we vetted this very carefully

Grant – okay, I was just looking at streamlining.

Klingler – if kids need to be on this they need to see Dr. Milhuff or someone like this.

Grant – issue of the use of three or more AP used concurrently for greater than 60 days

Should it be 120 days.

Milhuff – the 60 days were generous

Porter – sometimes we don't want to pull things away when they are doing well.

Discussion of kids and variable needs.

Jenkins – could split the difference and call it 90 days. I never touch an antipsychotic in November or May or the start of school.

Grant = if something is three times the FDA dose, why would we allow it for more than 5 days?

Milhuff – how many examples do you have of that?

Grant – I just think we don't give 60 days for any prior authorization of any medications, it is just unsafe.

Porter – so, a person leaves the hospital with five days medication and an appointment with MHC in two weeks. They go to the pharmacy and trigger the PA and only get five days?

Moeller – don't you have to have a two week follow up?

Porter – that is not always a med check, could be a therapy appointment. Assume good care was provided ordering the multiple

Grant – the problem is that What if they come out of a CMHC and

Porter – I am talking about someone who was stabilized at the hospital.

Zhou – can we do the 30 override for the Our real problem is where we are giving the 60 day override and contacting the outpatient doctor but we aren't getting the

Can you stipulate that it is not applicable unless the dosage is outside the range?

Grant – I would feel better about that – at least it has a safety trigger

That can be so variable from patient to patient, but a high dose would be harder to defend. And it could have just been an error, could have been a decimal.

Moeller – and I know when we discharge a patient and their insurance rejects

Porter – even a day or two or four after just being discharged from the hospital is just a

I don't know how easy it is to call a doctor at the state hospital

We also have kids in the foster system, and we can't get ahold of the case worker or the guardian and we don't even know who else to get ahold of.

Moeller – hopefully we are following up with

Grant – I still know the MCOs are struggling with how to deal with the 60 day vs. the 5 day.

Zhou – it is just making it more complicated now

Grant – cannot they just call the discharging doctor instead of waiting for the community physician?

Moeller – or sometimes we will just change the medicine because they say they can't afford what was prescribed

Porter – I get that 60 days could be abused, but if you could avoid the criteria if the patient could show they have the discharge documentation?

Klingler – can I throw something out there? I didn't know that less than half of our state hospital prescribers are licensed providers. I had always assumed people were being sent out with appropriate treatment and now I have concerns about the overrides. Learning that made me really concerned.

Adma – institutional licensees have all complete medical school and completed psychiatric residency. The only thing they haven't done is passed the step 3 state exam.

Moeller

Adma – if you don't complete all of the three years, you mi

Grinage – there is only one other state that allows that, and it is New York and they only allow it for three years.

Milhuff – do you do Medicaid outpatient work? No. What would your colleagues say about this?

They are used to it, they do it all the time.

But what would they say about these patients.

I just wonder if we are getting enough representation by pharmacists who are doing Medicaid P.A.s all the time. I know what our pharmacists would say. The mechanisms aren't working very well.

Jenkins – could we ask someone who does inpatient work in our audience?

Dr. King – in audience (Univ of KS) – we recently have had issues – had an issue where P.A.s were triggered three in a row and pharmacy would not fill it, was on a weekend, did not get the 60 day override

Grinage – that may have been the Sunflower glitch we had where P.A.s were popping up without merit on basically all of the antipsychotics – maybe something else

Moeller – and that caused issues
Dr. Kay – yes, that did cause a lot of issues

Grant – so, we could approve the forms for _____ and _____ and get those moving down the road. Talked about how it took three meetings to get rules approved and we spend too much time

Once we get this new document we can do the education and move to more online

Something about the issues with getting these issues through the committee

Porter - We may spin our wheels sometimes, but throwing the 65 year old approvals on the end of this required a lot of discussion and isn't just an administrative thing.

Grant – so what do we want to do with the anti-psychotic piece,

Porter – want that to be more than five days.

Klingler – what about 30

Porter – this weekend thing won't happen if we have 30 days.

Grant – maybe we go with the 30 days and then we will have more data..

Grant - Changing "documentation of" to "attestation of"

Todd – so will that mean that an "attestation of" will also be okay for all the data with the 65 year olds?

Grant – we already have the monitored HEDIS measures so we could strike that whole bullet point and just add "patient stable in the past year"

Adma – I thought the purpose was to get the physician to do the measurements

Milhuff – and one of the reasons for the 60 days was because patients wouldn't get some of the physical requirements and needed 60 days and if we are taking that off the table, don't need that any more.

Attestation is good.

Reviewed chart:

Removing something – prochloramazine? From the list and the table.

Changing the language.

Renewal requirement changed to attestation and patient stable and seen in the last year.

Milhuff – question about the general prescribing recommendations – recommending non-pharmacological interventions for geriatric care.

Adma – motion to approve.

Rolling all of this into one document in order to allow providers to go to one document online.

Grant – requests approval to roll into one document instead of four documents.

Had a request for public comment, so don't think we have time to review the single document.

Grinage – first of all, a lot of work went into this. Appreciate that. Much easier. I think one document is okay if it works, but I would want to look at it. The four forms are fine.

Porter – on this form, I know we just talked about it not being online, if you could just add in bold print that adding a face sheet to it is acceptable, you would be so much more popular with the CMHCs.

Lakin – I'm just worried about the two sheets being separated.

Grant – with our goal to have it online, how would that work?

Porter – I think this would just be until we get the online form.

Murff – the main thing is getting all the information. The face sheet is fine as long as we have what we need. We don't like to deny for lack of information.

Grant – I might be able to make a copy/paste face sheet or upload it.

Adma – problem with one document, if someone is just renewing an anti-depressant, we would have to print all four pages in order to fax it.

Milhuff – another comment – asks for the diagnosis in two places.

Grant – okay, think we will work on it and then send it out

Jenkins – we have two committees working on youth and adolescent issues, working on common goals -

Dr. King _ University of Kansas – Committee – on sub-group with Dr. Jenkins challenged with providing educational information to providers to talk about what medications are indicated for youth and adolescents. Looked at some other states. Got permission to use guidance documents from Texas, updated and tweaked them. Have a draft. Would like to propose that we could get everyone's opinion and perhaps provide the documents online.

Grant – I think the group has reviewed what has been approved by this committee, and also looked into general guidelines and other options. I know telepsychiatry is going on right now and also want to allow providers to link to this information.

Jenkins – could you also talk about consultation models?

Dr. King/Cain? – at KU looking at using ECHO model for connecting specialty providers with primary care providers to connect at the same time while the group of specialists will provide didactic information on some topic like child psychiatry and then present a case in order to have a conversation about that. Would have them weekly on various topics. Would also have small clinic time available so that the providers could continue to see their patients, but could get help on some of the more difficult issues.

Presented poster on ECHO at national child psychiatry conference. Technology that began in Arizona as a way to get hepatitis treatment information out. Avoid having specialists take over patients, but enable primary care physicians to manage their patients.

Milhuff – just had an autism ECHO program that was excellent.

Have been held on stroke and other medical issues.

Psychotropic Medication Use in Children in Foster Care Work Group (Began between SRS and KU years ago) Showed overprescribing 28.5% v. 9% in general population of kids in 2009. National Report in 2011 was followed by a communication from CMS in 2012. All state agencies are part of the work group. Pulled in Dr. King/Cain?, Dr. Jenkins, and Annette over the past year and a half. Will be getting this work out to prescribers and to those who work with children in foster care.

Grant – one reason they are coming to us is for this group to review and approve their work before getting it out to providers.

Adma – how long have you been meeting? Siince 2015.

Kids in foster care are difficult to treat because they are very mobile. The lack of sharing information, the lack of an electronic portable passport makes it different for subsequent providers/ CMHCs to pick up treatment and coordinate care.

In 2016, and largely due to our something – Kansas was put on a PIP. The service array for kids in foster care was not sufficient. Group started meeting in 2016, had MCOs, CDDOs, CMHCs and PRTFs at the table and began continuous process improvement. Analyzed root cause analysis (about 13) and came up with resolution plans. Want to see children with a placement every month and a PRTF/other placement, the number grew 29% in a year. (Several hundred). Over half the kids have a diagnosed disability but less than half were on their disability waiver. They are low users of Medicaid services but high users of antipsychotic medications. They aren't staying anywhere long enough for coordinate care. Did complete a white paper of the 13 months of work. Have a lot of attachments and data. Presented to all of the state secretaries.

The Child Welfare Task Force plans to do a full report January 2019. Turned over this information to them. Plan to present the work to them.

High Needs Work Group – has run concurrently and have some overlap and information sharing. Also looking at placement stabilization and other issues. Number of children are growing – over 7500. We have a placement crisis as well, especially for our high needs youth. Then we have wait lists at PRTFs, the highest level of care other than acute hospitalization. There are only so many beds available and they are private facilities. They also take kids from out of state. We have kids who need this placement who can not get it.

Have recommendations regarding this situation, lack of services situation, MCO approval issue – captured all of that in the white paper. One of the key recommendations is an electronic health passport to be accessible by any medical provider. Broke down the recommendations into intermittent,

longer term, etc. One of our providers – St. Francis – has therapeutic foster care in Oklahoma, but not in Kansas. Had to discontinue in Oklahoma because only two families were still willing to do it. Missouri is in a law suit right now for similar issues.

Would like to come back and do a full report in August.

Grant - when I spoke to the Legislature, I mentioned that Kansas added mental health to the Federal CFR which left out substance use treatment. And they should go back and strike that because it creates a problem where no provider can go to the data and see the treatment or the medications that they are on. More said here about the disservice to the providers caused by the lack of information. And the less we would need to rely on the CMHCs to do all of it, the outliers could take care of their own (Does she mean rural areas? Don't know.)

Adjourned – Grant says she will take these to the DUR committee. So, they have apparently dropped the policy of carrying over issues in order to facilitate public input.