Psychotropic Medications
Workgroup for Child and Adolescent Mental Health

Questions from January 5, 2009 Meeting

[Numbering continued from previous meeting.]

26. Which drugs are considered psychotropic medications?

1. mood stabilizers
2. stimulants
3. anti-depressants
4. anti-psychotics

27. Which drugs are in each category?

DMH:

28. Does this data include any drugs new in the last 5 years?

DMH: No.

29. *What are the new drugs in the last 5 years?*

DMH: Bill McMains will check for new ones to be sure we have a complete list.

30. Does this data include all children in Medicaid only OR children, for example, in Medicaid Primary Plus with dual eligibility and a different primary payor? The difference is important because care for children in the second category would be paid for by a commercial insurer rather than Medicaid.

DMH: [John will connect with Russell Frank.]

31. Need to see variations regionally.

DMH: Yes, we potentially can do that.

32. How shall the group proceed? Do we want to focus more narrowly on children in Medicaid and/or expand the focus? Sharpen the focus?

- *One suggestion is to have the group generate a few hypotheses to explain variations and then pursue additional data to confirm, modify, or reject it.*

33. What are the obstacles to getting this type of data from private insurers/providers?

DMH: First step is to ask. VDH has had some previous cooperation on projects. Private insurers now have to have a QI project each year; we could suggest this to them. VITL has also been willing to bring data to share analysis; they do not yet pool. Pursue contacts with the Blues, MVP, and CIGNA.

34. Systems level data is an important starting point. Ultimately, we may also need to look at actual practice patterns at the individual level. That is the only way to determine if a prescription is actually appropriate care that produces positive results. Can that be done? If so, how?

35. Where are specific diagnoses in the 8 categories shown today?
DMH: Will list in the revised January 5 data presentation.

36. Group asked to separate autism out from the schizophrenia and other psychoses category.
DMH: Yes, can do that.

37. The percentage of medications under schizophrenia and other psychoses is low. Are these children getting their medication somewhere else?
DMH: In future analyses, DMH will ask DAs if they are farming out this type of service?

38. How is "General Practitioner" provider defined?
DMH: It is the Medicaid operational definition. [Alice to get from OVHA.]

39. How is "Other MD" providers defined?
DMH: It is the Medicaid operational definition. [Alice to get from OVHA.]

40. There are not 150 psychiatrists in the state. How did we get this number?
DMH: Counts psychiatrists with a Vermont Medicaid provider number which includes psychiatrists in other states who treat Vermont youth such as at Dartmouth-Hitchcock. Also, one psychiatrist could have more than one provider number (*e.g.*, a different number for each provider agency with which worked).

41. Nurse prescriber numbers seem very high. Possible reasons?

42. What percentage of pediatricians prescribe these medications?
DMH: [Walter to discuss with Russell Frank.]

43. Request for numbers to accompany the graphs.
DMH: Yes. Numbers will be added before posting to the website.

44. Request for cost data in the future.
DMH: Yes, we can get that.

45. Can we find out who started a medication? Perhaps one of small number of psychiatrists began a prescription and handed the follow-up to a pediatrician.
DMH: No, not cleanly. Would require a clinical study.

46. In theory, the 90801 CPT code would be used by a psychiatrist prior to a prescription by a pediatrician if a thorough assessment was conducted. Can we get that?

DMH: Yes, we can get the code to determine if an assessment was billed. The code cannot tell how thorough the assessment was.

47. Are there practice standards across all medical practice fields?

DMH: No. The American Psychiatric Association has formulated practice guidelines for some conditions, including a new one on ADHD. Many of the guidelines focus more on what should not be done than on what should.

48. How is "therapy" defined in the data?

DMH: As individual therapy (CPT code 90804).

49. *Can we look back in time?*

DMH: Medicaid data currently available back to 2000.

50. How long are children on medications?

DMH: There are many questions relevant to this issue which we can answer within the timeframe limits of 2000 to present. We cannot answer the question as worded.

51. Are some of these medications prescribed for non-mental health conditions (e.g., mood stabilizers as anti-seizure medication)?

DMH: Yes, some of them are. Unfortunately, the diagnosis is not available in the Medicaid paid drug claims database.

52. How will we account for serial trials of medication? Can we track length of time on a medication to help factor this into our conclusions?

DMH: Would require a clinical study.

53. Can we compare Vermont data to national estimates of prevalence of mental health disorders?

DMH: Yes, we can.

54. Is it possible to arrive at any conclusions about good vs. bad practice unless we begin with some standard or practice?

55. Will people mis-read the data unless there are many footnotes to explain what the data does and does not say and unless there is a context (e.g., a standard of practice) in which to evaluate any given piece of data?

DMH: The data already out there is being mis-read. This group was convened to help reduce the misinformation and to formulate better informed questions and answers.

56. Given that there are limits to the data and to the number of areas in which standards of practice exist, should this group focus on 1-2 areas (e.g., children less than 6 years old on

anti-psychotics, adolescents with depression)? We could compare practices around the state, look for other services being provided, and offer to help.

57. What supports are available to prescribers?

58. What additional services are being provided to children on medication?

DMH: We can determine other services provided by DAs through the Monthly Service Report (MSR) and Medicaid databases.

59. What percentage of the medications prescribed are taken in a manner that would work?

DMH: Would require a clinical study.

60. Can we look at the frequency of refills?

DMH: Yes.

61. Who is in charge of practice patterns?

62. Which states have guides or booklets for parents and providers?

DMH: Unknown. Possible to check out websites in other states and query the national levels of Federation of Families, National Alliance for the Mentally Ill, Knowledge Exchange Network.