Behavioral Health Partnership
Oversight Council
Coordination of Care Committee

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Co-Chairs: Maureen Smith & Sharon Langer
David Kaplan, BHPOC Staff

Meeting Summary: March 28, 2012
1:30 – 3 PM
LOB Room 2A

Next Meeting: **May 16, 2012 @ 1:30 PM in Room 2600 LOB**
*** Note* This is a Date and Room Change.**

Attendees: Co-Chair Sharon Langer, Ray Batista, Michelle Chase, Alyse Chin, Maureen Fiore, Bill Halsey, Robin Hamilton, Elizabeth Hammond, Colleen Harrington, Brenetta Henry, Lisa Honigfeld, Ellen Mathis, Sabra Mayo, Judith Meyers, Steven Moore, Trevor Ramsey, Kimberly Sherman, Eunice Stellmacher, Lee Van Der Baan

Co-Chair Sharon Langer convened the meeting at 1:30 PM, welcomed all members, and informed the committee that her Co-Chair, Maureen Smith would not be at the meeting due to previous scheduled surgery. Introductions were made and attendance was taken.

Proposed Revision to Mission Statement of Coordination of Care Committee

Proposed new mission The Committee will work with the Departments of Social Services, Children and Families, and Mental Health and Addiction Services, and the administrative services organizations that administer medical, behavioral health, dental and non-emergency transportation, to identify and monitor key issues that may impact whether individuals and families in the HUSKY Health program and Charter Oak Health Plan receive person-centered coordinated services. The Committee and its partners, along with parent and community input, will seek to ensure that participants in the HUSKY Health program and the Charter Oak Health Plan receive behavioral health care that is coordinated with their medical (primary and specialty care), dental, pharmacy, and transportation services.

Sharon Langer, Co-Chair asked the Committee on feedback on the newly proposed mission statement and Brenetta Henry suggested that parent and community input should be incorporated into the language of the statement and the Committee members agreed.

Co-Management of Psychotropic Medications in Primary Care

Judith Meyers, President and CEO of the Child Health and Development Institute of CT explained that CHDI was a free-standing not-for-profit that works to help and sustain an effective community based health and mental health system for children in Connecticut. One of their goal areas is to focus on integrated care to build the capacity of primary care providers (PCPs) to address the mental health concerns of patients. The CHDI has produced a number of reports about integrated care, particularly in primary care and has worked very closely with the BHP and DSS in the writing of these reports.

The next phase of work is to focus on one significant and challenging aspect of integrated care: the management of psychotropic medications in the primary care setting. Through a review of the literature and surveys conducted in Connecticut, the following is clear:

- The use of psychotropic medications is on the rise.
- Pediatric primary care providers prescribe a greater percentage of these medications than do mental health specialists.
- Stimulant medication for attention deficit/hyperactivity disorder (ADHD) is the most commonly prescribed medication by primary care providers.
- Reports on the medications most commonly prescribed by PCPs, including stimulants, antidepressants, and anti psychotics, as well as concerns associated with polypharmacy (prescribing two or more psychotropic medications at the same time).
- Beyond stimulants, many PCPs are uncomfortable with prescribing psychotropic medications as they do not find that they are well prepared or supported to take on the responsibility.

Research consistently shows an increase in the number of children prescribed various classes and combination of psychotropic medications. These increases have been seen across different populations, including very young children and adolescents, children insured by Medicaid and commercial insurance, and those in foster care.

One concern about recent trends in pediatric psychopharmacology is that many of these medications have not been studied or approved for use with children; thus little scientific evidence exists for understanding their immediate or long-term effects on a child's growth and development. Often these medications are prescribed "off label", meaning for a mental disorder or age group for which they were not approved by the Federal Drug administration (FDA). Because of the lack of sufficient scientific evidence to support the use of psychotropics with children, careful diagnosis, treatment planning and monitoring for the effects are all the more critical.

Another significant factor that affects appropriate medication in utilization by children is acceptance by families. Prescribing a medication is not equivalent to a child or adolescent actually taking the medication. Many factors influence a parent or child's adherence to a medication regime including cost, side effects, attitudes and beliefs about psychotropic medications and mental illness, and the relationship with the prescribing provider.

Approximately one-quarter to one-half of all pediatric office visits now involve a psychosocial concern, and primary care providers prescribe the majority of psychoactive medications used by children and adolescents. In light of the decreased availability of mental health specialists, inadequate insurance coverage for mental health services and less stigma associated with primary care compared to mental health treatment, supporting child health providers in addressing mental health issues is critical to effectively meeting the needs of children.

The review of the literature and available data clearly indicates that children nationally, as well as in Connecticut, use a significant amount of psychotropic medications; and primary care providers prescribe a significant proportion of these medications. Yet PCPs have consistently reported lack of knowledge, capacity and comfort in taking on sole professional responsibility for this role. The lack of empirical support for many of these medications and "black box warnings" issued by the FDA about potential risks of certain classes of antidepressant medication adds to the discomfort.

Prescribing patterns for children enrolled in HUSKY in Connecticut. Based on data reported by Value Options, 9.1% of children, birth through 18 enrolled in calendar year 2009 were treated with a psychotropic medication (27,8888 of the 308,160 children enrolled) and 8.7% in 2010 (28,045 of 321,053). The most commonly prescribed medications in 2010 for these Connecticut children included:

- Stimulants (53% of the children who were prescribed behavioral health medications)
- Antipsychotics (26%)
- Antidepressants (25%)

Pediatric providers, including primary care physicians, nurse practitioners, physician assistants, and pediatric specialists wrote prescriptions for nearly half of the psychotropic medications prescribed for children covered by the HUSKY program (49.5% in 2009 and 49.8% in 2010). The vast majority of these prescriptions were for stimulants; 65.6% of youth on stimulants had at least one prescription written by a pediatric provider, followed by antidepressants (28.1%), mood stabilizers (24.5%) and antipsychotics (20.6%).

Approaches to improving management in primary care. Emerging consultation models in the states of Massachusetts (Child Psychiatry Access Project) and Washington (Partnership Access Line) are improving the capacity of PCPs to effectively manage psychotropic medication treatment in children. Connecticut has the opportunity to take these strategies to the next level by building a co-management approach between primary care and behavioral health providers. To that end, the report offers six recommendations for moving toward a co-management solution, which can help ensure that children with behavioral health conditions will receive access to optimal care.

Recommendations:

1. **Training** in psychotropic medication prescription and management as well as collaborative care in pediatric postgraduate and continuing medical education with an emphasis on ongoing collaborative learning opportunities.
2. **Support for collaborative relationships** between primary care and behavioral providers including evidence-based diagnostic tools, practice guidelines, seamless connection to services and ongoing participation of both specialties.
3. **Funding** for integrated care by both Medicaid and commercial insurance.
4. **Family Involvement** in building and evaluating co-management models.
5. **Recognize that the mental health care services system cannot consist of medication alone** and ensure efforts to support other behavioral health therapeutic services that delivered with or without medication.
6. **Continuous Improvement** in prescribing and managing medications through ongoing research and monitoring.

Adoption of these recommendations will contribute to improved assessment and treatment of mental health disorders in children, especially when it comes to psychotropic medication management. Properly planned, monitored and assessed, co-management facilities not only better patient outcomes but also a more efficient and sustainable system for addressing children's behavioral and mental health care. For more information see: CHDI's IMPACT Magazine September 2011, report on Pediatric Psychopharmacology; Improving Care Through Co-Management which can be found on the CHDI website at www.chdi.org

Michelle Chase said in her own experience, pediatricians take over more of the medications but will often have no follow-up. She wanted to know what is the standard of care. Judith referred to a handout of an outline (see attached) of a program that the CHDI is developing and piloting for a practiced-based tools assessment for the co-management of psychotropic medication for children that will develop recommendations for system and policy supports. The *approach* will be to work with the following three primary care practices and their behavioral health partners.

- ✓ Whitney Pediatrics (Hamden)/Yale Child Study Center
- ✓ Pro Health- Gerard Calnen (Enfield) and APRN in his practice
- ✓ CT Children's Pediatric Clinic (Charter Oak) and the Institute of Living
- ~~✓~~

~~o~~ Dan Connor ,Chief of Child Psychiatry, UCHC and Ken Spiegelman, Community Pediatrician in Manchester will provide expert consultation and Susan Macary will be the Coordinator.

The *Method* will be to design and test tools to assist in the co-management of children in the primary care with mild to moderate depression and mild to moderate anxiety with focus on medication management. This will include children with ADHD (the three categories of concern by the American Academy of Pediatrics) and also addresses screening, referral, and treatment. The *Tools* will include clinical algorithms (maps), decision-supports, targeted visit templates, and family-centered educational materials. *Practices* collecting and reporting data on results of universal screening, use of algorithms and the behavioral, emotional and mental health histories of the families will be studied. The pilot program will enroll ten patients in each practice to evaluate the efficacy of the tools. The next step will be for practices to be tested and results evaluated.

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Bill Halsey of DSS asked for the age range of the pilot. The pilot targets school aged children from approximately 5 years to adolescents. He also suggested that since CHNCT was the ASO for the HUSKY population, CHNCT should be involved in the coordination of care for this program. In the meantime, if families are struggling with health issues, they should get in contact with BHP and CHNCT and talk with an intensive care manager. These two organizations will provide referrals to where these families can go that are within the network. When calling the ASOs, there are three levels of contact; 1.) Basic customer service number through Value Options (CTBHP) and CHNCT (HUSKY Health) 2.) Case management care coordination and 3.) Pro-active coordination of complex needs. Michelle Chase said, again, that in her own experience, when she does contact the ASO and/or providers, things do not happen, results are not there. Providers are not acting in a way they are supposed to. Co-Chair Sharon Langer said that the conversation will continue for real and constant quality care improvement.


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Update on HUSKY Health Transition (CHNCT)

Ray Batista of Community Health Network Connecticut said that the transition from three managed care organizations to one administrative services organization (ASO) has met with great success. Since November, there have been a number of webinars explaining about the partnership. The results have been positive but there is always room for improvement. Sometimes it is challenging to find a provider within a ten or twenty mile radius but to date all clients have been able to access a provider within the community without too traveling too far. CHNCT staff is finding some gaps but they are moving to correct those deficiencies. Through fliers, multiple community events in libraries and community centers, and on the internet, they are educating the public and providers about HUSKY Health and the changes that went into effect since January 1 to improve the connection between behavioral health and medical care services. The website is www.huskyhealth.com/members for more information on the program and events.

Update on Non-Emergency Medical Transportation

Lee Van Der Baan of the Department of Social Services assisted by Robin Hamilton of Logisticare gave the update. As of April 1, 2012, Logisticare will still operate as a capitated entity (meaning Logisticare will pay the claims) and all clients will be served by Logisticare. Clients who call the three brokers will be cited new phone numbers with information on how to obtain their non-emergency medical transportation (NEMT) needs. As of July 1, 2012, Logisticare will be the full-fledged “ASO” or single broker to arrange all transportation services for the State. The Department will then be responsible for claims payments. Logisticare will establish a Connecticut website with information about its NEMT services which will be helpful to both providers and clients. Not only will the Website schedule rides for appointments but it will have the capability to handle all comments, complaints, concerns and/or suggestions. Not all details related to the website have been worked out but DSS and

Logisticare are willing to take suggestions for Website features. Measures to determine the effectiveness of the new system are under development. Co-Chair Sharon Langer wanted to know if the Medicaid information for this Website would be a part of the DSS or Logisticare's Website. She also requested that DSS/Logisticare provide a time frame to the Committee as to when the Website will be up and running. She remarked that access to transportation is critical for many consumers and families. There are ongoing concerns about the impact of limiting which family members (e.g., sibilings) may ride in cabs on access to transportation and in turn access to medical and behavioral care, Sharon asked when this policy will be spelled out and asked that the Department of Social Services update the Committee at its May meeting. Lee said this depends on the execution of the contract and that he would talk with Sharon later about this. Brenetta Henry said that families like the one provider and that the transition, in her opinion, is going smoothly for families. Michelle Chase asked how to cancel a previous scheduled ride if the medical appointment was changed or cancelled. Lee said that the person should just call Logisticare. She also brought up the issue that under managed care her health plan had reimbursed her for mileage at only $1.73. She said certainly this should help defray transportation costs if parents could continue to receive mileage reimbursement rather than utilize cab services through the broker.

Other Business

Co-Chair Sharon Langer requested that due to a scheduling conflict the next Coordination of Care meeting be changed from May 23, 2012 to May 16, 2012. Those present agreed to the change and the Committee will meet in May in Room 2600 LOB. BHP OC Administrator, David Kaplan, advised committee members that the change will be reflected in the master schedule located on the BHP OC Website and that it can be accessed by going to www.cga.ct.gov and clicking on to the Public Health Committee page and then clicking onto the Behavioral Health Partnership Oversight Council section on the bottom of the page to where the BHPOC Website is located and all agendas, membership list, schedules, and summaries can be found. Hearing no other comments or questions, Co-Chair Sharon Langer adjourned the meeting at 2:56 PM.

Next meeting: May 16, 2012 Rm. 2600 LOB 1:30 PM-3:00 PM

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