



Florida's Initiatives in Behavioral Pharmacy Management

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Presentation Objectives

- To describe the program, its components and how they are meant to complement each other.
- To describe the expert panel process and its output.
- To describe how data drove the policy on which the program is based and the scope and weighting of the interventions.



Overall Strategies

- Develop/adopt best practice medication guidelines for major mental illnesses.
- Use educational and technological approaches to promote practices consistent with the guidelines.
- Educate consumers.
- Train prescribers in the use of practice guidelines.



Prospective Strategies: Encouraging Quality Prescribing Practices

- Collaborative development of evidence and consensus-based guidelines for the treatment of major mental illnesses of children and adults.
- Collaborative development of edits that may be used to review practices through analysis of pharmacy claims.
- Distribution and marketing of guidelines and edits through medical societies and publication in state medical journals.
- Medical advisory group meetings.
- Program website: www.flmedicaidbh.com



Technological Strategies: Improving Practices at the Point of Care

- eMPOWERx technology in PDA and desk top applications
- Immediate access to current 100 day patient drug histories- multiple prescribers, adherence, drug interaction alerts, electronic access to guidelines and application of quality edits
- Electronic prescription writing and transmission to retail pharmacy

Retrospective Strategies 1: Identifying and Intervening on Problematic Practices

- Edits to identify potential quality problems from claims data
- Monthly analysis of claims against edits
- Targeting prescribers based on volume of “unusual practices”
- Intervention letters detailing patients, clinical issues and enclosing recommended guidelines
- Request: Review medication strategies for identified patients
- Invitation to discuss contents and/or receive telephone consultation from experts



Retrospective Strategies 2: 1 on 1 Interventions with Selected Prescribers

- Academic detailing: Face to face contacts between physicians and pharmacists representing the program
- Peer to peer telephone contacts





The Expert Panel Process and Output

Florida's Expert Panel Tasks

- Development and timely update of guidelines for use of different classes of psychotherapeutic medications among different populations.
- Participation of state academic experts and community clinical leaders in conjunction with national experts and other key stakeholders.
- Based on review of relevant clinical trial data and assessment of critical issues and needs.
- 2-day annual meetings focusing on specific areas of psychopharmacology.



Florida's Expert Panel 2005-2007

- Jan, 2005
 - Development of guidelines for pharmacotherapy of schizophrenia and bipolar disorders.
- July, 2006
 - Development of guidelines for the uses of all classes of psychotherapeutic medications among children and adolescents.
- July, 2007
 - Development of guidelines for major depression
 - Updating guidelines for bipolar disorder and schizophrenia.



Agenda for 2007 Panel



- Revise 2005 schizophrenia best practice medication guidelines based on additional clinical trial data obtained since 2005.
- Revise definitions of unusual antipsychotic practice.

Florida Best Practice Medication
Guidelines for Treatment of
Schizophrenia, Bipolar Disorder, and
Major Depressive Disorder

2007

Steps in the Pharmacological Treatment of Schizophrenia, 2005

Effective control of positive symptoms without EPS



Assessment of response after adequate duration of treatment



Adequate treatment of co-occurring syndromes
Minimize other side effects

Florida Behavioral Health Collaborative Schizophrenia Best Practice Medication Guidelines

Level 1

- Monotherapy with any SGA except clozapine; given available evidence, iterations at this level can ≥ 2



Level 2

- If Level 1 ineffective or not tolerated:
- FGAs or clozapine



Level 3

- If Levels 1 & 2 ineffective or not tolerated:
- Clozapine if not attempted in previous trials
 - Clozapine augmentation if clozapine monotherapy is unsuccessful
 - Any antipsychotic + ECT



Level 4

- If Levels 1, 2, & 3 ineffective or not tolerated, or documented refusal of clozapine:
- Combination treatment, eg SGA + FGA
 - Combination SGA, FGA, or SGA + mood stabilizer

Conclusions from CATIE in the Context of All Available Research

- SGAs do provide greater ease and consistency than first-generation agents in obtaining an antipsychotic effect without motor side-effects.
- Modest doses of some FGAs reduce/eliminate the difference...FGAs may be a suitable option for some patients, particularly for those at low risk for motor side-effects.
- There are substantial differences among both first- and second- generation antipsychotic agents with regard to their propensity to cause metabolic and other adverse effects.

2007 Florida Guidelines for Pharmacological Treatment of Schizophrenia

LEVEL 0. **COMPREHENSIVE ASSESSMENT**



LEVEL 1. **Monotherapy with any SGA** other than
clozapine



LEVEL 2. If Level 1 ineffective or not tolerated: **FGA or
different SGA**



LEVEL 3. If Level 1 and 2 ineffective or not tolerated:
Clozapine or long-acting antipsychotic agent



LEVEL 4. If Levels 1-3 ineffective or not tolerated:

Clozapine if not tried earlier

SGA or FGA + ECT

Clozapine augmentation with SGA or FGA, if clozapine monotherapy not successful

SGA or FGA augmentation with anticonvulsant

Other antipsychotic combinations (if partial response with one agent)

Guidelines for Good Practice

Measurement-Based, Protocol-Driven, Individualized

- **Ongoing, careful monitoring is critical!**
 - **Reliable and repeated assessment of the efficacy of treatment using defined treatment targets.**
 - **Use of standard rating scales will facilitate this goal-
BPRS, CGI.**
 - **Careful assessment of possible adverse effects of treatment.**
 - **Protocols for health monitoring (e.g., American Diabetes Assoc. guidelines).**
 - **Ongoing collaboration with patient in decision-making.**
- **Standard protocols should be customized in response to individual vulnerabilities/needs and specific agent.**
 - **May use Florida assessment protocol attached to guideline**



Definitions of Unusual Antipsychotic Prescribing Practices

- **Polypharmacy**

- Concurrent use of two or more antipsychotic agents for periods exceeding 60 days
- Concurrent use of three or more antipsychotics

- **Dosing**

- Use of excessively high dose of antipsychotic agent
 - Aripiprazole: >30 mg/day; Chlorpromazine: >1000 mg/day; Clozapine: >600 mg/day
 - Haloperidol: >20 mg/day; Olanzapine: >30 mg/day; Paliperidone: >15 mg/day;
 - Perphenazine: >64 mg/day; Quetiapine: >1000 mg/day Risperidone > 8 mg/day;
 - Ziprasidone: >240 mg/day.

Context for Phase 1 Behavioral Pharmacy Management Program

- Issues:
 - Historical rise in expenditures for psychotherapeutic medications
 - Proposal to eliminate open access provision in Florida's Medicaid law
 - Players: Pharmaceutical manufacturers, providers, consumers and family members vs. people with budget responsibility in the executive and legislative branches



Growth in Expenditures on Psychotherapeutic Medications



FY 00-01	\$237,648,098
FY 01-02	\$323,232,592
FY 02-03	\$439,031,148
FY 03-04	\$520,529,637
FY 04-05*	\$680,000,000

*Forecasted in Spring of 2004

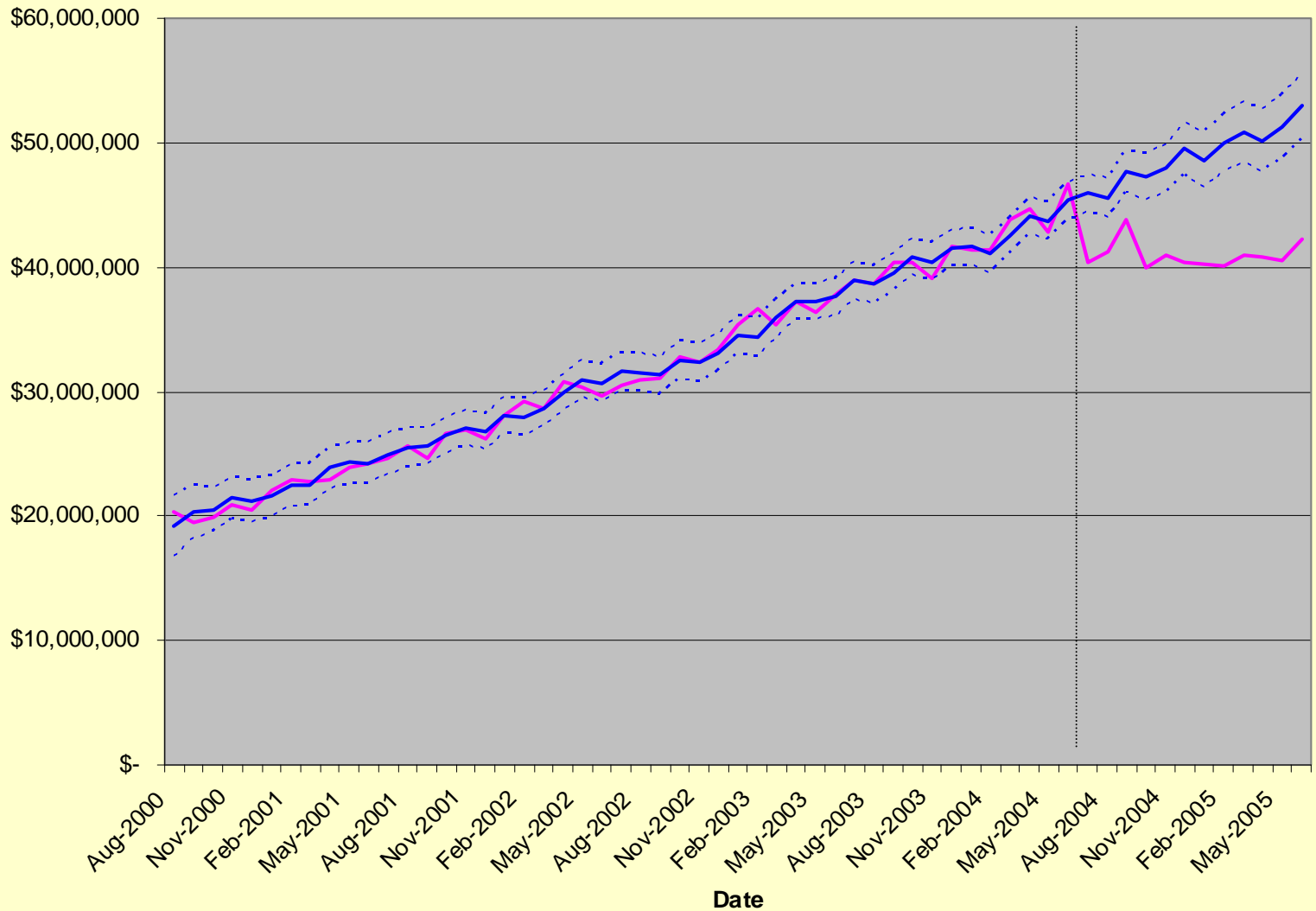
Policy Resolution Spring 2004

- Open access policy remains in statute.
- Five manufacturers pay for program interventions to be implemented by USF.
- Manufacturers guarantee \$34 million savings (actual vs. projected expenditures).



Savings Estimates Starting July 2004

Time Series Forecast for July 2004 – June 2005



Context for Phase 2 Medicaid Drug Therapy Management Program

- Issues
 - Expenditures no longer rapidly increasing
 - Questions about the quality and appropriateness of use of mental health meds
 - Series of feature articles on alleged overuse of medications with children in the child welfare system
 - Players: Selected child advocates and the Church of Scientology vs. professional community, providers, consumers and family members

Policy Resolution Ch. 409.912(39) (a)

(10) Medicaid Reform Legislation

- Improve quality of behavioral health drug prescribing practices
- Improve patient adherence
- Reduce clinical risk
- Lower costs





Determining Targets for Intervention

Who is generating scripts with potential quality problems?

Distribution of QI Expenditures 3/07-5/07 (Adults)



Physicians in Groups	QI Expenditures
Top QI MD (N=444)*	\$12.8
All other MD's (N=6,635)	\$4.8
Totals (N=7,079)	\$17.7

* QI exp > \$7,500

6.3% of MD's account for 72% of QI expenditures

Distribution of QI Prescriptions 3/07-5/07 (Adults)



Physicians in Groups	QI Prescriptions
Top QI MD (N= 444)*	120,559
All other MD (N=6,635)	88,101
Total MD (N=7,079)	208,660

* QI exp > \$7,500

6.3% of MD's account for 58% of all QI prescriptions

Distribution of QI Patients 3/06-5/06 (Adults)



Physicians in Groups	QI Patients
Top QI MD (N= 444)*	14,948
All other MD (N= 6,635)	18,663
Total MD (N= 7,079)	33,611

* QI exp > \$7,500

6.3% of MD's account for 45% of QI patients

Summary: Distributions of QI Expenditures, Rx and Patients



Top MD	Expenditure	Rx	Patients
Adult 6.3%	72%	58%	45%
Child 6.1%	63%	52%	37%

Adult MD's With > \$7,500/Quarter in QI Expenditures (Specialists and Non-Specialists)

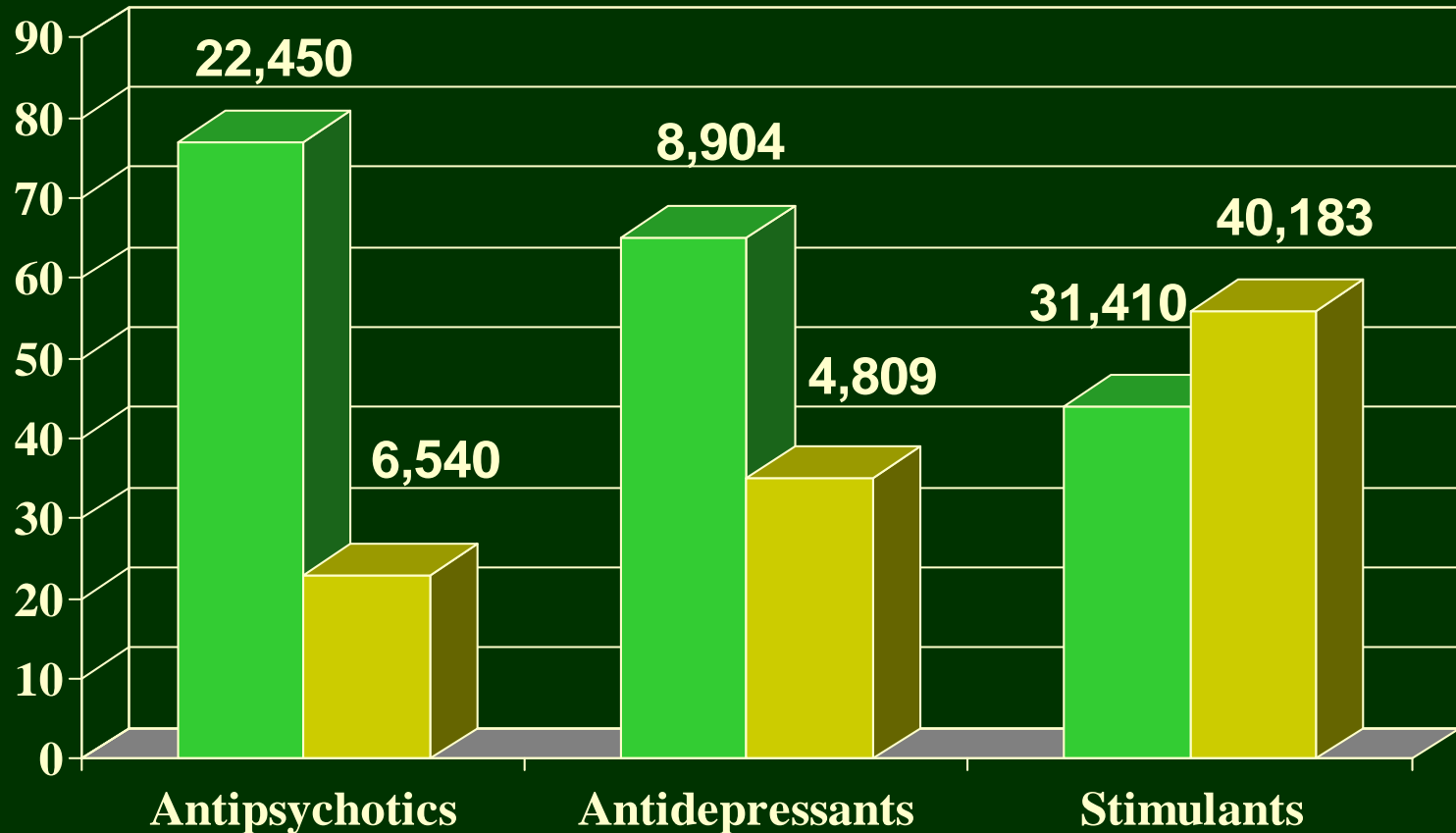


Top QI MD's	# Non-specialists	% NS
0-100	7	7%
101-200	21	21%
201-300	32	32%
301-400	31	31%
401-444	21	44%
Total	112	25%

Percent of Prescription

10/05-12/05

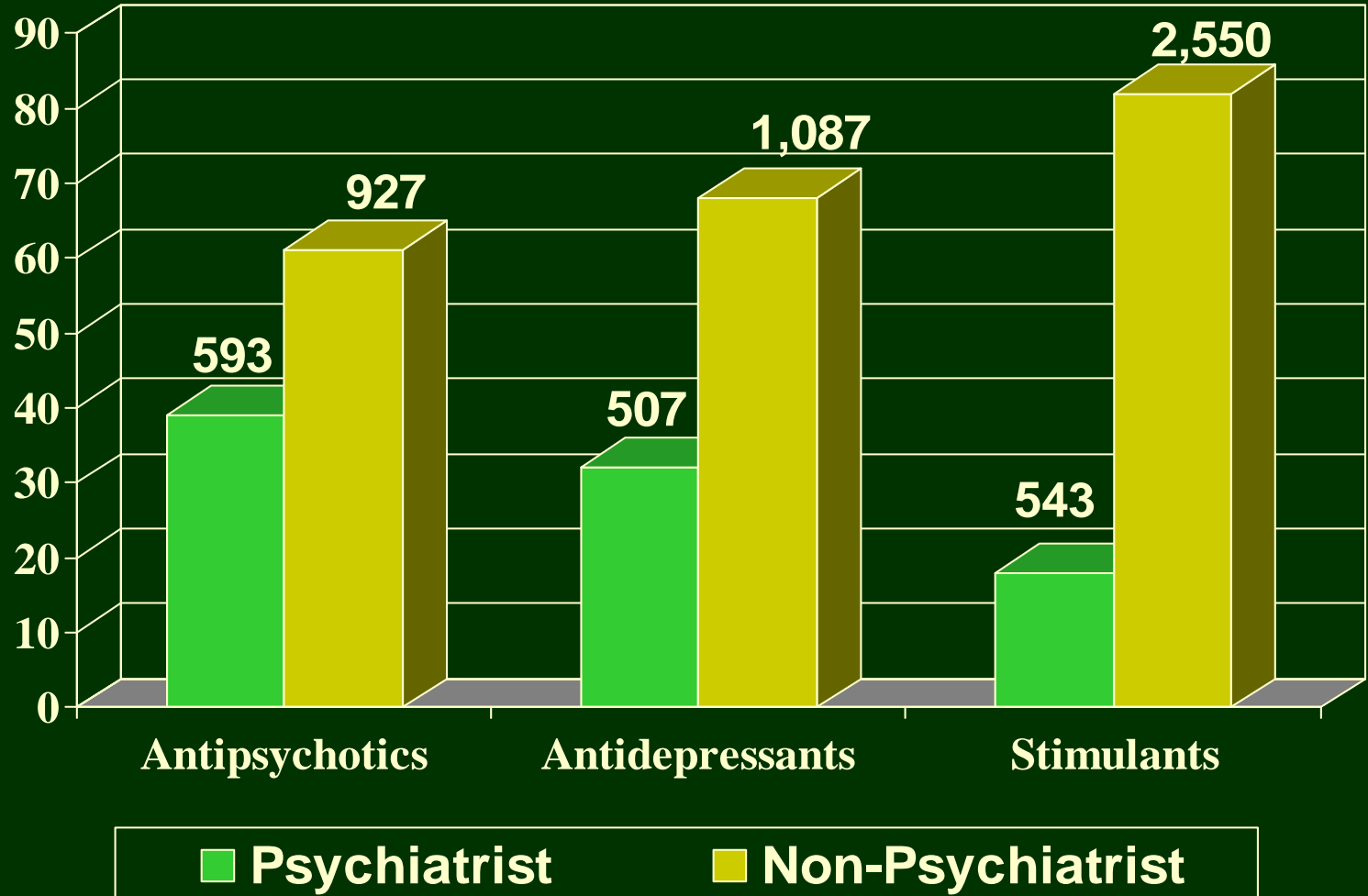
Psychiatrist vs. Non-Psychiatrist Children from 0-18 Years



Percent of Prescribers

10/05-12/05

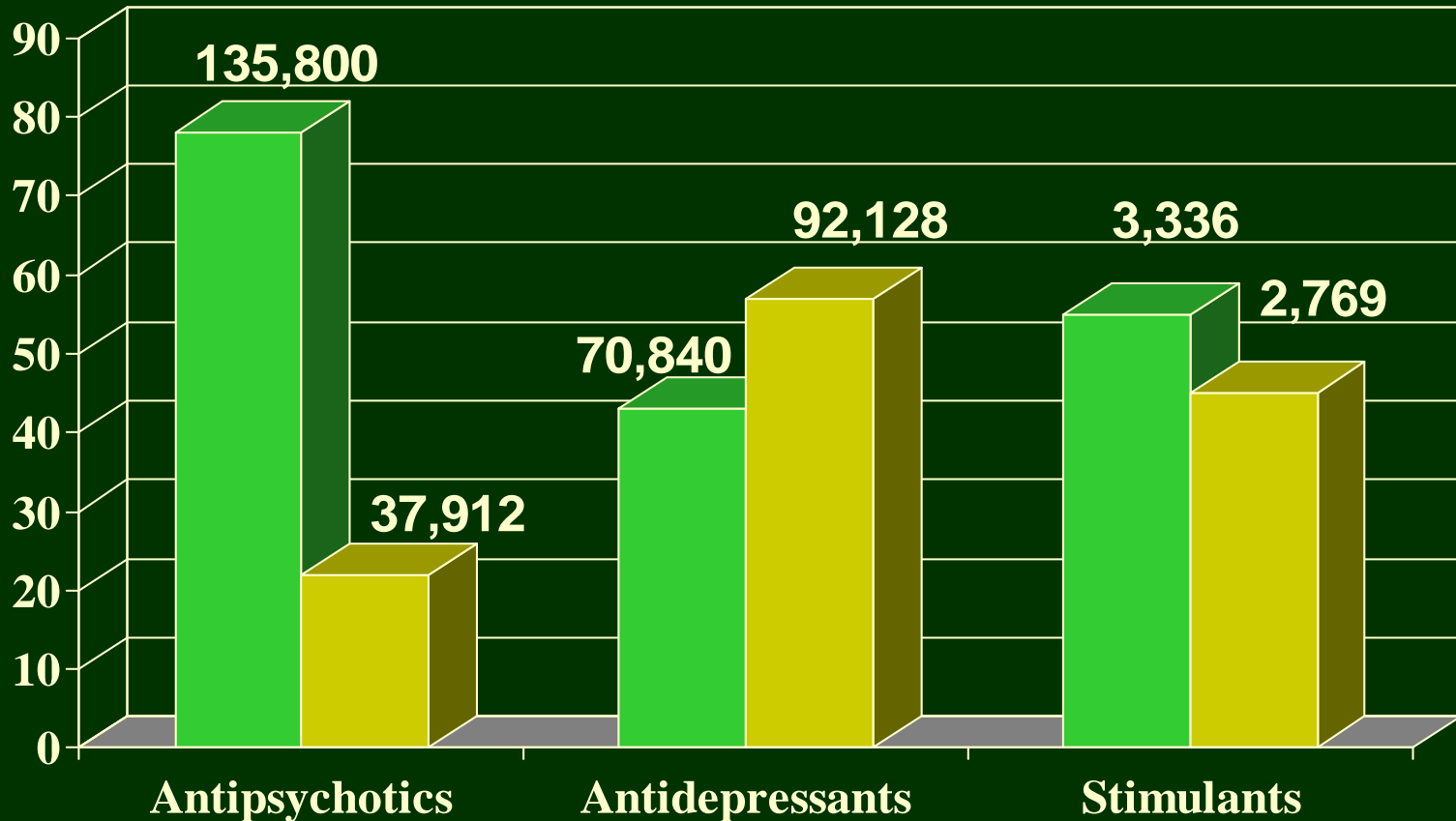
Psychiatrist vs. Non-Psychiatrist Children from 0-18 Years



Percent of Prescriptions

10/05-12/05

Psychiatrist vs. Non-Psychiatrist Adults from 19-65 Years

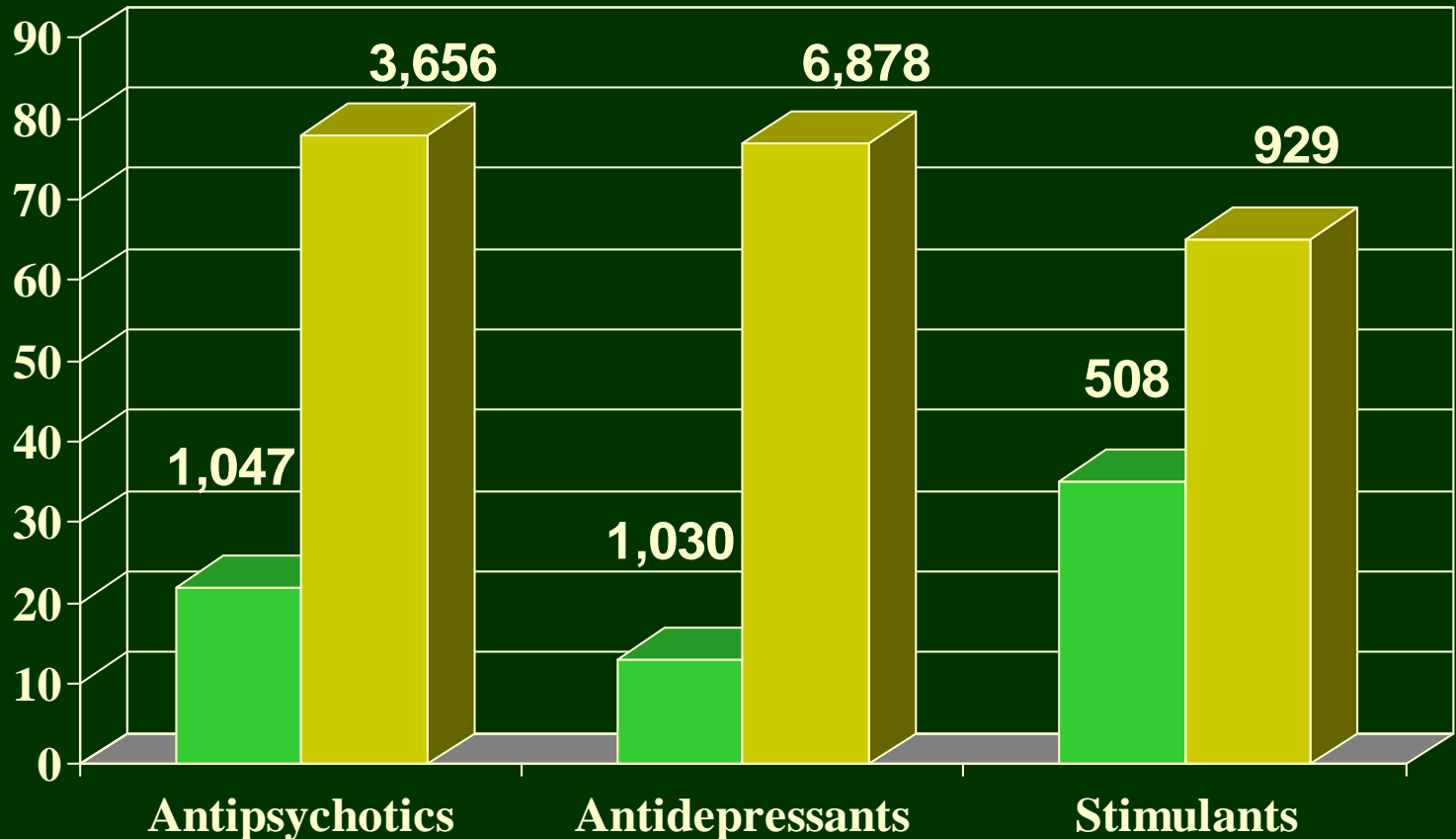


Percent of Prescribers

10/05-12/05

Psychiatrist vs. Non-Psychiatrist Adults

from 19-65 Years



Conclusion

- A small number of high volume adult and child QI MD's offers the greatest potential for impact
- A focus on these MD's will have a greater effect on QI expenditures than on QI scrips or patients
- Based on QI expenditures, the primary intervention targets should be psychiatrists
- There are many primary care physicians writing small numbers of antipsychotic scrips
- A quality initiative must find a way to reach these individuals



Evidence of Program Impact?

QI Expenditures/Day (Adults)



*Q1- 4/06-6/06 Q2- 8/06-10/06 Q3- 3/07-5/07

Total and QI Expenditures /Day (Adult)



Quarters	Total Expenditures	Total Expenditures /Day	Total QI Expenditures	Total QI Expenditures /day
Q1 (4/06-6/06)	\$49.3m	541,758	\$18.67m	205,165
Q2 (8/06-10/06)	\$48.8m	530,000	\$18.1m	196,739
Q3 (3/07-5/07)	\$49.9m	542,391	\$17.74m	192,826
Q1 vs. Q3		1.2%		(6%)

QI Patients/Day (Adults)



*Q1- 4/06-6/06 Q2- 8/06-10/06 Q3- 3/07-5/07

Total and QI Patients/Day (Adult)

Quarters	Total Patients	Total Patients/Day	Total QI Patients	Total QI Patients/Day
Q1 (4/06-6/06)	130,632	1436	36,647	402
Q2 (8/06-10/06)	132,498	1440	36,847	400
Q3 (3/07-5/07)	130,488	1418	33,611	365
Q1 vs. Q3		(.01%)		(9%)



QI Prescriptions/Day (Adults)



*Q1- 4/06-6/06 Q2- 8/06-10/06 Q3- 3/07-5/07

Total and QI Prescriptions /Day (Adult)



Quarters	Total Rx	Total Rx /Day	Total QI Rx	Total QI Rx/Day
Q1 (4/06-6/06)	756,033	8308	221,875	2438
Q2 (8/06-10/06)	757,907	8238	216,646	2355
Q3 (3/07-5/07)	805,430	8755	208,660	2268
Q1 vs. Q3		5%		(7%)

Summary: Quarter 1 vs. 3 Comparisons (All Adult Prescribers)

- *Small* reductions in QI expenditures, prescriptions and patients/day from 1st to 3rd quarter while total expenditures and claims/day increased and total patients/day was unchanged
- 6% reduction in QI expenditures/day
- 7% reduction in QI prescriptions/day
- 9% reduction in QI patients/day

Summary: Q1 vs. Q2 Comparisons (All Child Prescribers)

- *Small* reductions in QI expenditures, prescriptions and patients/day from 1st to 2^{ed} quarter
- 5% reduction in QI expenditures/day while total expenditures/day increased slightly
- 4% reduction in QI claims/day only marginally greater than reduction in total prescriptions/day
- 4% reduction in QI patients/day paralleled reduction in total patients/day



High Volume QI MD's

Total and QI Expenditures/Day (MD's Receiving Academic Detailing in Jan. 07)



Quarter	Total Exp.	Total Exp/day	Total QI Exp.	QI Exp./day
Q1	\$4.57m	\$50,198	\$2.88m	\$31,575
Q2	\$4.65m	\$50,522	\$2.76m	\$29,957
Q 1 vs. Q 3	.08	.6%	(4.2%)	(5%)

Summary Academic Detail MD's



- Small QI expenditure, prescription and patients/day reductions while totals remained constant
- Reductions for extreme QI group smaller than for all MD's Q 1 to Q 3.
- Reductions are partially due to regression to the mean
- Strategies for improving impact on high volume QI prescribers must be devised



Program Changes

Changes in Overall Program

- Focus interventions on smaller # of MD's with high volume QI activity
- Reduce the number of MD's receiving mailings from 1200 adult MD's and 800 child MD's to 400 and 200
- Assure QI edits are clearly the product of the expert panel process
- Substantially increase the number of academic detailing contacts (Target=100)
- Arm detailers with specific examples of QI patients and prescriptions and have them discuss follow up actions

Changes in Overall Program



- Conduct records reviews for selected high QI physicians whose practices are not responsive to previous interventions (50-100 records)
- Refer MD's for regulatory action if QI issues are serious, lack rationale and no change in practice is observed
- Redistribute PDA's to high volume QI physicians
- Work with selected CMHC's to increase the use of PDA's as a QI project

Changes in Overall Program

- Begin development of a child psychiatry network to provide telephone consultation (and sometimes referral) to primary care physicians especially in rural areas.
- Collaborate with Florida Pediatric Society, Florida Medical Association, and Florida Academy of Family Practice Physicians to reach primary care MD's.



Additional Changes in the Mailing Intervention



- Change the wording of the 2ed and 3ed MD letters indicating the interventions will increase in intensity. (Academic detailing and records reviews to follow)
- Reduce the size of the packets by eliminating the 100 day drug histories. (Refer to web access)
- Mail quarterly rather than monthly.
- Provide opportunities for feedback and consultation as follow up to mailings.
- Profile patients identified in mailings.

Final Conclusions

- Changing prescribing practices is extremely difficult
- Changes are small but appear to increase over time
- Strategies for impacting high volume QI MD's must be developed, evaluated and fine tuned if program impact is to increase significantly