Curbing the High Rates of Psychotropic Medication Prescriptions among Children and Youth in Foster Care

Appendices

Appendix A—Psych Meds Data Indicators by State

The data elements being collected by the following states are being used to quantify the number of foster children prescribed psychotropic medication, to identify providers who are prescribing outside of established safety parameters, to target providers who may benefit from outreach/education, to indicate the need for medication reviews, to determine whether children are receiving other first-line psychosocial interventions in lieu of, or in addition to, psychotropic medications, to trigger second opinion/consultation processes, and study regional trends in the provision of behavioral health treatment.

Type of Data Collected	Where It Is Being Collected
Number of Youth in Foster Care Receiving Psych Meds	California, Florida, Illinois, Indiana, Maryland, Michigan, Ohio, New York, Vermont, Washington
Polypharmacy Measures	Florida, Illinois, Indiana, Michigan, Ohio, New York, Vermont, Washington
Co-Pharmacy Measures	Florida, Illinois, Indiana, Michigan, Ohio, Vermont, Washington
Metabolic Monitoring Measures	Illinois, New York, Maryland, Ohio
Dosage Rates	Florida, Illinois, Indiana, Maryland, Michigan, Virginia, Washington
Prescription Rates By Age	Florida, Illinois, Indiana, Maryland, Michigan, Ohio, Vermont, Washington
Provision of Non-Pharmalogical, Psychosocial First-Line Interventions	Ohio, Vermont, Washington
Emergency Medication Prescription Rates	Illinois
Drug Indication based on DSM Diagnosis	Indiana, Maryland, Michigan, Virginia, Washington

Appendix B—Illinois Psych Meds Data Indicators

Illinois established an integrated data collection system using both state Medicaid billing information as well as pharmacy claims data. Reports from this system are drawn quarterly.

Data Indicator
Consent Violations
1. Number of wards on medication that are not in compliance
2. Number of medications prescribed that are not in compliance
3. Clinicians who prescribed the out of compliance meds for 5 or more wards
4. Clinicians who prescribed psychotropic meds without consent to 5 or more wards
5. Clinicians who prescribed a dose beyond consented range for five or more wards
6. Clinicians who continued psychotropic medications for more than 2 months without updated consent for 5 or more wards
7. Facilities that administered psychotropics without consent to 10 or more wards
8. Facilities that administered a dosage beyond consented range for 10 or more wards
General Data Indicators
10. Wards with psychotropic medication requests
11. All psychotropic medications prescribed
12. Total number of wards with psychotropic medication requests by gender and age
13. Wards on psychotropic medication by age for one medication and for 4 or more medications
14. Number of wards at age 4 and under on stimulants
15. Number of wards on one antipsychotic and on 2 or more antipsychotics
16. Number of wards on one mood stabilizer and 2 or more mood stabilizers
17. Number of wards on one antidepressant and 2 or more antidepressants
18. Number of emergency meds reported
19. Number of wards receiving emergency meds

Appendix C—Indiana Psych Meds Data Indicators

Indiana also developed a data collection mechanism that uses both state Medicaid billing information and pharmacy claims data to track psychotropic medication utilization among foster youth. These reports are drawn annually and show separate data for DCS wards vs. Non-DCS wards as well as children in in-home vs. out-of-home placements.

Data Indicator
1. % of children prescribed psychotropic medications by age: 0-5 years old, 6-12 years old, 13-17 years old, and 0-17 years old
2. Children age 0-17 prescribed five or more psychotropic medications concomitantly
3. Children 0-17 with a dosage exceeding maximum guidelines based on FDA-approved labels
4. Children under age one year prescribed a psychotropic drug
5. Children 0-17 with a dosage exceeding maximum standards published in the medical literature
6. Children 0-17 prescribed a psychotropic medication without a DSM IV diagnosis
7. Children 0-17 prescribed a psychotropic medication that is not consistent with the listed DSM-IV diagnosis (e.g., Seroquel with ADHD)
8. Children age 0-17 prescribed two or more antidepressant medications concomitantly
9. Children age 0-17 prescribed three or more mood stabilizers concomitantly
10. Children age 0-17 prescribed two or more antipsychotic medications concomitantly
11. Children age 0-17 prescribed two or more stimulant medications concomitantly
12. Children age 0-3 prescribed an antidepressant medication
13. Children age 0-3 prescribed an antipsychotic medication
14. Children age 0-2 prescribed a stimulant medication

Appendix D: Psychotropic Medication Usage Data Collection Recommendations

Red text indicates recommended mandatory minimum data indicators.
Green text indicates recommended best practice data indicators.

Psychotropic Medication Usage Data		
Specific Data Indicator (Percentage and number of children unless otherwise indicated)	**Recommended Frequency of Data Collection**	**Rationale**
Baseline Measures: Children 0-17		
Receiving psychotropic medications	Baseline and Quarterly	To accurately assess baseline prevalence and prescribing trends To measure the cumulative impact of policies designed to reduce potentially inappropriate prescribing practices
Receiving antipsychotics	Baseline and Quarterly	
Receiving stimulants, mood stabilizers, antidepressants, anti-anxiety meds	Baseline and Quarterly	
Polypharmacy Measures: Children 0-17		
Prescribed 5 or more psychotropic medications concomitantly	Baseline and Quarterly	To identify and track children most at risk for potentially harmful drug interactions
Prescribed four or more psych meds concomitantly	Baseline and Quarterly	
Prescribed three or more psych meds concomitantly	Baseline and Quarterly	
Prescribed two or more psych meds concomitantly	Baseline and Quarterly	
Co-Pharmacy Measures: Children 0-17		
Prescribed two or more psych meds from the same class	Baseline and Quarterly	To identify and address potentially redundant prescriptions
Psychotropic Medication Use--Age-Related Measures		
Under age one year prescribed a psychotropic drug	Baseline and Quarterly	To identify children receiving psych drugs at ages for which there is minimal or no clinical indication/ evidence of effectiveness
Under age 6 prescribed any psychotropic medications	Baseline and Quarterly	
Under age 6 prescribed an antipsychotic	Baseline and Quarterly	
Under age 6 prescribed stimulants, antidepressants, mood stabilizers, anti-anxiety meds	Baseline and Quarterly	
Children prescribed psychotropic medication	Baseline and	

by age: 0-5 years old, 6-12 years old, 13-17 years old	Quarterly	
Medication Management: Children 0-17		
On antipsychotics with claims for baseline metabolic tests (fasting lipid profile, fasting plasma glucose, BMI, weight, waist circumference, blood pressure, HDL and LDL levels	Baseline and Annually	To identify whether children are receiving timely and appropriate screenings based on drug side effect profiles To identify whether children prescribed psych meds are receiving appropriate follow-up care
Received a thorough physical examination and mental status exam prior to initiating treatment with psychotropic medication	Baseline and Annually	
Receiving psych meds with a follow-up visit with the prescribing physician within 6 months of rx date	Baseline and Every Six Months	
Dosage Measures: Children 0-17		
With a dosage exceeding maximum guidelines based on FDA-approved labels and/or other established dosage recommendations	Baseline and Quarterly	To identify whether children are receiving age-appropriate dosages To identify children who may be at greater risk of harmful side effects due to high drug dosages To identify providers who may be prescribing outside the recommended dosage based on FDA guidelines and/or other accepted parameters
With a dosage exceeding maximum standards established by the Texas Utilization Parameters in cases where there are no FDA-recommended dosages for the child's age	Baseline and Quarterly	
With a dosage exceeding established guidelines whose medical chart contains a rational for the prescribed dosage level	Baseline and Quarterly	
Emergency Medication/Crisis Services: Children 0-17		
With a claim for emergency psych meds	Baseline and Quarterly	To identify and track prescriptions without a completed JV220.To identify trends in usage of emergency services
Children 0-17 who received crisis services within the past three months	Baseline and Quarterly	
Children 0-17 with visits to the emergency room within the past three months	Baseline and Quarterly	
Drug/Diagnosis Correspondence		
Children 0-17 prescribed a psychotropic medication without a DSM and/or ICD diagnosis	Baseline and Quarterly	To identify drugs prescribed without clinical indication based on child's diagnosis
Children 0-17 prescribed a psych med that is not consistent with the DSM/ICD diagnosis	Baseline and Quarterly	

Appendix E—Snapshot of Psychotropic Medication Reductions Attributable to Data Collection

- New York has experienced a 25% reduction in antipsychotic polypharmacy, which they attribute to their data sharing processes.
- Ohio has demonstrated a 25% reduction in antipsychotic prescriptions to children under age 6, as well as comparable reductions in antipsychotic co-pharmacy and psychotropic polypharmacy.
- Illinois has also indicated decreasing trends among various high-risk prescribing practices, attributable to their enhanced data collection procedures.
- Vermont has also seen a decline in the prescription of antipsychotics to children, as well as the percentage of psych meds being prescribed by non-psychiatrist MDs.

Appendix F—Snapshot of State-Level Approaches to the use of Prior Authorization

- Maine has implemented restrictions at the pharmacy point of sale, disallowing the filling of certain prescriptions without prior authorization based on dosage, co-pharmacy, and potentially adverse drug interactions[1].
- Other states, notably Illinois and Michigan, have broadened the use of prior authorizations to prevent the use of psychotropic prescriptions among foster youth as a method of discipline or behavioral control or a substitute for less-risky psychosocial interventions, and in cases where the prescribed psychotropic is not consistent with the patient's diagnosis or target symptoms.
- Washington requires a second opinion prior to the administration of a psychotropic medication under various conditions, including, but not limited to, the absence of a DSM diagnosis in the child's claim record, psychotropic medications prescribed to children under 5 years old, and for prescriptions exceeding dosage limits for age based on established parameters.
- In 2014, California initiated the Treatment Authorization Request (TAR) requirement for all antipsychotic prescriptions. Each TAR must be approved by a third-party before the prescription can be filled, adding an additional layer of oversight over this drug class. Approximately 30% of TARs have been rejected upon first submission for lack of supporting documentation or because of duplicate requests, thus helping to ensure that such prescriptions are justified and appropriate. Between October 2014 and October 2015, CA has observed a significant reduction in the number of TARs submitted for approval, with a corresponding reduction in pharmacy claims for antipsychotic medications.

[1] Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapies. Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study. Retrieved from: http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html.

Appendix G—State Approaches to the Provision of Second Opinions/Specialist Consultation

- In Massachusetts, primary care physicians who treat children have access to the Massachusetts Child Psychiatry Project, allowing pediatricians rapid access to child psychiatrist consultants and available to Primary Care Physicians at no cost[2].
- In Michigan, consultations are automatically provided to prescribers based on established "triggers" such as a child on four or more medications, or a child under 5 years old on any psychotropic medication[7].
- Other models allow for consultation prior to providing consent. Such is the case in Oregon, where child welfare agency officials have access to a child psychiatrist consultant before making consent decisions[1].
- The state of Washington has taken a comprehensive approach, providing both a telephone consultation line for pediatric prescribers as well as a partnership between state Medicaid and medical centers to conduct second opinions via record reviews, leading to a 53% reduction in high-dose prescriptions, a 23% reduction in psychotropic prescriptions among children under 5, and an annual savings of 1.2 million[6].

Appendix H—State Approaches to Provider Outreach, Feedback & Education

- Alabama provides a focused mailing to prescribers of any antipsychotics to children under 18, as well as telephone outreach by child psychiatrists to prescribers of antipsychotics to children under age five[6].
- Colorado sends educational alerts and letters to prescribers detailing information about the psychiatric medication utilization of their patients. If post-intervention changes are not observed, follow-up letters and face-to-face meetings with peer consultants are conducted[6].
- Illinois maintains a watch-list of high-risk prescribers, utilizing this data to assess the impact of changes in consent policies on prescriber behaviors[3].
- Michigan created a system whereby child psychiatrists follow-up with prescribing physicians when indicated based on established triggers to review the case and provide consultation.
- Missouri uses the Behavioral Pharmacy Management System to analyze prescribing patterns for children and adolescents and send letters to prescribers offering consultation on best prescribing practices. An analysis of this intervention showed a significant reduction in the percentage of outlier prescriptions[6].

[2] Making Medicaid Work for Children in Child Welfare: Examples from the Field. June 2013. Center for Health Care Strategies.

[3] Models of Agency Consent for Psychotropic Medications, Technical Assistance Tool. June 2014. Center for Health Care Strategies.

Appendix I: Psychosocial Services Data Collection Recommendations

Red text indicates recommended mandatory minimum data indicators.
Green text indicates recommended best practice data indicators.

Psychosocial Services Usage Data		
Specific Data Indicator (Percentage and number of children unless otherwise indicated)	**Recommended Frequency of Data Collection**	**Rationale**
Psychosocial First-Line Intervention Indicators: Children 0-17		
With a claim for EPSDT services	Baseline and Quarterly	To identify whether psychosocial therapies are offered prior to, or concurrent with psych meds treatment To identify whether children are receiving specialty mental health services To identify whether children are receiving EPSDT services To identify per child spending rates for mental health treatment
On psych meds with a claim for EPSDT services	Baseline and Quarterly	
With a claim for psychosocial treatments prior to initiation of psych meds treatment	Baseline and Quarterly	
With a claim for psychosocial treatments concurrent to initiation of psych meds treatment	Baseline and Quarterly	
Without a claim for any psychosocial treatments prior to or concurrent with psych meds treatment	Baseline and Quarterly	
On psych meds with a claim for Day Rehabilitation/Day Treatment Intensive	Baseline and Quarterly	
On psych meds with a claim for Intensive Care Coordination	Baseline and Quarterly	
On psych meds with a claim for Targeted Case Management	Baseline and Quarterly	
On psych meds with a claim for Therapeutic Behavioral Services	Baseline and Quarterly	
On psych meds with a claim for Medication Support Services	Baseline and Quarterly	
Total annual dollar amount spent per child for psych meds	Baseline and Annually	
Total annual dollar amount spent per child for mental health services	Baseline and Annually	

Assessment and Reassessment Measures: Children 0-17		
With claims for evidence-based screening and trauma-informed assessment prior to initiation of psych meds treatment	Baseline and Quarterly	To identify whether children are receiving thorough screening/ assessment prior to treatment decisions To identify whether the chosen treatment is having the desired effects based on the child's treatment plan
On psych meds with a treatment plan indicating clinical need for pharmacological treatment	Baseline and Quarterly	
On psych meds and received assessment/ reassessment of medication effectiveness and side effects	Baseline and Annually	
On psych meds and received monitoring of well-being outcomes and trauma symptoms	Baseline and Annually	
On psych meds and visited a mental health clinician	Baseline and Quarterly	
On psych meds and had a CFT meeting	Baseline and Quarterly	

Appendix J: Provider Availability Measures Data Collection Recommendations

Red text indicates recommended mandatory minimum data indicators.
Green text indicates recommended best practice data indicators.

Provider Availability Measures		
Specific Data Indicator	**Recommended Frequency of Data Collection**	**Rationale**
Psychosocial First-Line Intervention Indicators: Children 0-17		
Number of child and adolescent psychiatrists per county	Baseline and Annually	To identify areas where provider shortages may be impacting care To identify whether prescriptions are being written by appropriately-trained physicians To identify whether foster care facilities have appropriate staffing and resources
Number of child and adolescent psychiatrists per child in foster care per county	Baseline and Annually	
Percentage and number of prescriptions for psychotropic medications by provider type per county	Baseline and Annually	
Number of non-MD mental health clinicians per county	Baseline and Annually	
Number of non-MD mental health clinicians per child in foster care per county	Baseline and Annually	
Number of Medicaid-participating Evidence Based Practice-trained clinicians per county	Baseline and Annually	
Number of therapeutic foster care beds per child per county	Baseline and Annually	
Number of therapeutic foster care facilities per child per county	Baseline and Annually	
Ratio of foster care facility staff to children in care per county	Baseline and Annually	
Ratio of public health nurses to children per county	Baseline and Annually	