

PROCEEDINGS

**NASMHPD Medical Directors Council and the
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Missouri Institute of Mental Health
University of Missouri – Columbia School of Medicine**

**2003 Best Practices Symposium
October 27 - 28, 2003
Boston, Massachusetts**

*Transforming Knowledge and Research into Practice in the Public Mental Health Sector:
Focus on Utilization of NRI's Performance Measurement System Data, Reducing Medical
Morbidity, Guiding Physician Practice to Ensure Open Formularies, and Effective Use of
LOCUS and Treatment Planning*

Monday, October 27, 2003

Utilization of NRI's Performance Measurement System Data

*Moderator: Steven J. Karp, D.O.
(State of Pennsylvania)*

*Faculty: Robert Littrell, Pharm. D.
Director
University of Kentucky Research and Data Management Center
Lexington, Kentucky*

*Harry Hughes
Assistant Director
University of Kentucky Research and Data Management Center
Lexington, Kentucky*

The Symposium's opening session was an interactive workshop for participants to learn about and explore the data contained in the NASMHPD Research Institute's Performance Measurement System. Dr. Karp, who served as moderator, commented that, once Medical Directors learned how to access and utilize the vast amount of data, they could use the Performance Measurement System to assist with decision-making in their state.

Dr. Littrell and Mr. Hughes of the University of Kentucky Research and Data Management Center led participants through the Performance Measurement System (see www.rdmc.org/nripms/). To

access the secure site and obtain detailed information on their participating facilities, Medical Directors need a UserID and password. (Medical Directors who do not yet have access should obtain a letter from their Commissioner authorizing access and contact Dr. Littrell.)

Once in the site, Medical Directors located data in multiple formats, including data stratified by age or forensic status. Mr. Hughes noted that available data is often from the previous quarter, given the lag time necessary to collect and clean data from facilities before posting to the web. One Medical Director raised the concern about comparability of data elements across states, for example the readmission rate. Mr. Hughes agreed that the comparability of data was dependent upon the variability of state definitions.

Dr. Littrell also highlighted the features that are available to non-participants. This information included: (1) a report listing the enrolled facilities in all states and the measures that each facility selected; and (2) a series of national public reports that has aggregated data on all measures from most facilities (over 95 percent) and provides national averages for comparison.

Medical Directors spent their remaining time working with their state's data on the site at the various Internet work stations.

Reducing Medical Morbidity

Co-Section Moderators/Presenters:

*David Pollack, M.D.
Medical Director
Mental Health & Developmental Disability Services Division
Office of Mental Health Services
State of Oregon*

Faculty:

*Kenneth Duckworth, M.D.
NAMI Medical Director and
Clinical Consultant, Massachusetts Department of Mental Health
Boston, Massachusetts*

Dr. Duckworth, who formerly served as Medical Director in Massachusetts, described the state's initiative to examine its mortality rate among consumers in the Massachusetts mental health system. He noted that such a project required a strong commitment from the Commissioner and a positive working relationship with the Department of Public Health.

The Massachusetts Department of Mental Health (DMH) serves approximately 25,000 adults with serious and persistent mental illness. The system encompasses 1,200 inpatient beds, 7,000 residential placements, and community support services for 20,000 individuals (e.g., outreach, housing assistance, care coordination, medication administration, money management, support or activities of daily living, appointments, and transportation). DMH eligibility criteria consist of a

qualifying DSM-IV diagnosis (e.g., schizophrenia, mood disorder, anxiety disorders, disassociative disorders, eating disorders, borderline personality disorder) for at least one year with functional impairment which persistently and substantially interferes with role functioning in major life activities. Exclusionary diagnoses include substance related disorders, neurological impairment, dementia, mental retardation, autism and other developmental disorders. DMH consumers also must have no other means or agency to provide services.

Dr. Duckworth explained that studies over the last 40 years have shown that psychiatric patients have a standardized mortality ratio 1.35 to 4.2 times that of the general population, often due to unnatural deaths. One analysis of more than 150 death reports indicated an increase in mortality rates from unnatural deaths across a variety of psychiatric conditions.

Dr. Duckworth and his colleagues examined the natural causes of death for people served by DMH during 1998 and 1999. His aim was to establish a baseline for the mortality rate in order to assess quality of state services and to determine whether clinicians were prioritizing the right clinical concerns during their limited amount of time with patients.

Dr. Duckworth shared the data on DMH deaths from several illnesses broken down by age. The data revealed that:

- DMH consumers had a higher rate of cardiovascular death than the general Massachusetts population, a mortality ratio of 2.0 and 2.5 in 1998 and 1999 respectively. As DMH consumers aged, their rates of death grew more similar to the general state population.
- Death rates from pneumonia and influenza were relatively small numbers among DMH consumers: 21.2 (1998) and 13.9 (1999) deaths per 100,000. Yet, the risk ratio was 5.1 and 4.0 times the risk for the general population for this completely preventable cause of death. Dr. Duckworth suggested that one intervention to address the incidence of pneumonia and influenza would be to establish a good working relationship with the Department of Public Health and ensure that DMH consumers had access to flu shots and immunizations.
- The rate for chronic lower respiratory disease among the DMH population was 4 or 5 times higher than the general Massachusetts population, although the total number of cases was not very high.

Dr. Duckworth offered the results of another Massachusetts study, the Central Massachusetts DMH Morbidity Review, which reflected the importance of focusing on lung and heart problems for public mental health consumers. The study involved almost 550 individuals in residential services in the Central Massachusetts area; 60 percent of the individuals were male and the average age was 42. Nurses reviewed all the medical problems listed in the individuals' charts and found the following prevalence of illnesses among the study group:

- Pulmonary/respiratory 29 percent

- Cardiovascular 28 percent
- Endocrine (almost all diabetes) 21 percent
- Gastrointestinal 16 percent
- Muscolosekletal 15 percent
- Neurological 9 percent

Dr. Duckworth also discussed a study by Benjamin Druss and colleagues that appeared in the *Archives of General Psychiatry* in June 2001. In its examination of interventions used for people who had heart attacks, the study found that people who had psychiatric illnesses were profoundly less likely to receive cardiology interventions (e.g., angiograms, angioplasty). The authors observed, “Deficits in quality of medical care seemed to explain a substantial portion of the excess mortality experienced by patients with mental disorders after myocardial infarction.”

Dr. Duckworth noted that there are many unanswered questions surrounding these troubling mortality rates for public mental health consumers. The field needs to explore and better understand variables such as depression’s impact on heart functioning, interplay between the completeness of treatment recommendations for people with schizophrenia and perceptions of their treatment compliance, impact of off-label use on medical conditions, role of polypharmacy in premature death, and the impact of the newer medications on cardiovascular mortality.

Massachusetts DMH will continue conducting annual reviews of mortality rates to determine the cause of death for their patients. Massachusetts is one of the first states to implement a statewide mental health information system, which includes cardiovascular prompts to collect this important data. Massachusetts DMH also is working with a group from Massachusetts General Hospital and looking at patient care practice guidelines for people with serious and persistent mental illness (e.g., recommendations around weighing consumers on the day they start a new medication or measuring glucose levels twice per year).

Dr. Duckworth noted that the examination of mortality data can raise cultural questions about how medicine is practiced within the public mental health systems. Instead of clinical staff only focusing on psychiatric symptoms and leaving “lifestyle changes” to be discussed by other staff, the medical culture may need to evolve to address mortality risk factors. Dr. Duckworth demonstrated that the medical culture is capable of changing by showing data comparing the paucity of doctors who shared the diagnosis of cancer with their patients in 1961 with the complete reversal by 1988 when almost all doctors shared the diagnosis with their patients.

Dr. Duckworth also discussed his educational activities in his role as NAMI Medical Director. At peer support groups across the country, he provides educational interventions about the high risk of cardiovascular death. In addition, consumers who have made lifestyle changes to help reduce their risk share their motivating stories.

Dr. Duckworth suggested that, if more states collected mortality data, Medical Directors could launch a national conversation about premature death among people with serious mental illnesses. He invited Medical Directors to consider joining or launching similar efforts in their own states. A

multi-state study would provide a larger sample size and better opportunity to identify more conclusive trends.

Following the presentation, Medical Directors engaged in a lively dialogue. One Medical Director suggested that the discussion about premature mortality underscored the importance of the interface between the mental health and primary care systems. Physicians need to be concerned about both directions: the mental health needs of patients in the primary care system and the medical/surgical needs of people with serious mental illnesses in the mental health system.

Participants discussed why persons with serious mental illnesses do not receive quality care for all of their health needs. In some cases, consumers have difficulty navigating the health care system, which may suggest the need to co-locate primary care providers with mental health providers. In other instances, primary care providers do not know how to relate to people with serious mental illnesses, who may communicate and present their symptoms in a confusing or ambiguous way. This problem would indicate the need for education and cultural changes in the primary care system. As importantly, the mental health system should better address the health concern of its patients; too often patient preventive health efforts (e.g., desire to quit smoking or change diet) are minimized or dismissed by clinical staff.

The data implies that it may be helpful to establish some reasonable medical practice guidelines which recommend screenings and lab work to occur at specific intervals for various settings. Given the limited amount of time and resources, the guidelines could identify and prioritize which screenings achieve a sufficient “bang for the buck” and address the most pressing mortality concerns for mental health consumers.

Some Medical Directors spoke of the value of integrating data bases, particularly having access to the death certificate data base in their state. In Oregon, the SMHA has direct access to the database and can review the specific causes and manners of death for their patients. Some Medical Directors noted that death certificate data sometimes have weaknesses; attending physicians may simply write cardiac arrest without indicating secondary or tertiary causes, perhaps artificially inflating the number of cardiac deaths. Another participant suggested that the Medical Examiner database also may be useful, as ME reports have expanded explanations of the cause of death.

Serving as moderator, Dr. Pollack observed that the Medical Directors Council might want to establish best practice recommendations in the event of death (e.g., important parameters to consider, extent of substance abuse comorbidity, types and results of previous lab tests) and consider a collaborative, multi-state effort to collect mortality data on a broader basis.

Dr. Pollack also discussed an Oregon initiative where the state mental health authority joined with Health Resources and Services Administration (HRSA) to use a health care disparity model and examine four different disease states (cardiovascular disease, diabetes, asthma, and depression) in a primary care population. The collaborative process resulted in more people with cardiovascular disease, diabetes and asthma being identified as having increased risk for co-morbid depression,

while professionals were recognizing more medical and surgical concerns for individuals with serious mental illnesses.

Other recommendations generated by participants and presenters:

- Medical Directors should have an effective working relationship with their public health colleagues, particularly epidemiologists.
- The Medical Directors Council may want to incorporate a mortality component into its upcoming Technical Report on integration with primary health. The Council also could produce a document addressing standards of medical care aimed at preventing premature mortality (e.g., when to weigh, when to draw bloods) for use by Medical Directors.
- Dr. Duckworth advised participants to break down the seemingly overwhelming problem of premature mortality into more manageable pieces by asking mental health staff to consider how they might incorporate health information into their policies and clinical decisions. How can the organization's culture and policies support a health orientation? How can community mental health centers and clubhouses incorporate information on healthy lifestyles?
- A cultural change will be necessary so that physicians think about preventive medical care and not assume that lifestyle changes are within someone else's purview. The chronic care model may be helpful as it allocates responsibilities for screening, follow-up and patient education among appropriate team members.
- Medical Directors may want to use premature mortality data to educate clinicians, consumers, and family advocates. Patient education curriculum could incorporate content about risk factors and healthy lifestyles.
- Discussions about preventive medical care may want to embrace the paradigm used by the Institute of Medicine, namely the concepts of universal, selective, and indicated prevention. Such distinctions would clarify which interventions apply to everyone and which are for certain at-risk subgroups.

Participants agreed to continue the discussion about possible future steps for the Medical Directors Council during the business meeting on the following day.

Tuesday, October 28, 2003

Guiding Physician Practice to Ensure Open Formularies

Co-Section Moderators/Presenters:

*Daniel Luchins, M.D.
Clinical Director
Office of Mental Health
Department of Human Services
State of Illinois*

*Joseph Parks, M.D.
Medical Director
Department of Mental Health
State of Missouri*

*Faculty: Raulo S. Frear, Pharm.D.
Vice President, clinical Services
Express Scripts
Bloomington, Minnesota*

Dr. Parks described a Missouri initiative, the Missouri Mental Health Medicaid Pharmacy Partnership, which was designed to engage physicians around appropriate prescribing standards of care, enhance the quality of services, and save money.

The Missouri DMH serves 36 percent of its residents with serious mental illnesses, as well as 5 percent of persons who do not have a serious mental illness but have a psychiatric need. The Department faces the same tough decisions as other providers, namely whether to (1) provide the best care to a few people; (2) give minimally adequate care to many people; or (3) give something to everyone. He explained that publicly-funded systems also must consider which choices are politically viable. During recent budget cuts, services that have been relative winners and received funding increases have been medication access and children's services. Components that have experienced cuts or "lost" include provider rate increases, general rehabilitation/case management programs, psychotherapy, and dental services.

Dr. Parks also detailed choices made within the Missouri Medicaid program. The program saved money through some relatively easy choices, such as implementing early refill, dose optimization, more assertive maximum allowable costs for pharmacies, and inclusion of OTC drug coverage. Long term choices to maximize efficiency include instituting disease management and case management for those individuals receiving nine or more prescriptions per month.

Missouri Medicaid also instituted some hard choices, including proton pump inhibitor step therapy, prior authorization for new drugs (with special consideration for mental health and HIV drugs),

spend down reform, dropping 32,000 eligible individuals from the rolls, and dropping dental coverage.

Elaborating further on the dilemma facing administrators, Dr. Parks explained that medication expenditures represent opportunity costs. For example, \$2 million spent on psychotropics could have been spent to fund the following activities in his state:

- Increase psychiatric time for standard medication visit from 15 minutes to 20 minutes
- Raise the Medicaid fee for a service medication visit from \$12.50 to \$40.00
- Fund the mandate that a psychiatrist be present at case management team meetings
- Provide a standard package of services for another 350 persons with serious mental illnesses
- Add a substance abuse treatment component to all community and inpatient programs
- Provide psychiatric evaluation and medication services to all substance abuse treatment programs
- Add a nurse to all community case management teams.

SMHA's need to think explicitly about the opportunity costs when they invest dollars to keep open formularies. Missouri DMH spent close to \$14 million on new psychiatric medication for its community and inpatient programs.

Thus, if decisions about pharmaceutical access must be made, who will make the choice? Some possibilities include individual physicians, professional groups, governmental agencies, private sector contractors, legislators and/or voters. The choice boils down to deciding what is the right amount of the new psychotropic therapies for whom, how to fund the therapies, and how to fit this funding choice among other choices.

Dr. Parks suggested that many steps have been taken to try and control costs through mass purchasing and internal utilization review. To address this burgeoning problem, all players need to take an active role. Doctors have to become more cost conscious. Medicaid programs must pursue clinical quality. The Pharmaceutical Research and Manufacturers Association (PhRMA) must fight inappropriate usage as much as it promotes appropriate clinical indicators. SMHA's must help Medicaid manage utilization. As Dr. Parks pointed out, all of these players can succeed or fail together.

Missouri Mental Health Medicaid Pharmacy Partnership is a collaborative between the Missouri Department of Mental Health (DMH), Missouri Department of Medical Services (DMS), Comprehensive Neurological Sciences (CNS), and Eli Lilly and Company. CNS had developed a process of examining Medicaid claims data and identifying opportunities to improve prescribing for individuals and physician practice. CNS piloted the process in Philadelphia with the Medicaid managed care program that covered 50,000 lives; the pilot achieved costs savings of 10-12 percent. Aiming to test the process in a bigger program, CNS approached Missouri, which has a population of 5 million and 500,000 Medicaid recipients statewide. Eli Lilly sponsored the project and provides funding directly to CNS.

CNS performed a one-time opportunity analysis on Missouri's Medicaid pharmacy data with twelve quality indicators (e.g., failure to refill medication). Missouri then chose which indicators it wanted to pursue. Today, the state has between 24 – 30 indicators.

Subsequently, the project conducted monthly analysis of Medicaid pharmacy claims. The system identified opportunities for improving prescribing practice for both individual patients and for physician patterns/practices. Once the analysis was complete, the state began to conduct outlier prescriber education and management activities, including providing best practice recommendations and information to physicians on an ongoing, monthly basis. Generally, the physician contact is in the form of letters, but sometimes phone contact occurs.

The project has an advisory council whose members include representatives from the state psychiatric societies, medical school psychiatry clinics, Missouri State Medical Association, community mental health center advocates, private practice groups, and DMS. The Advisory Council assists with selecting the best opportunities for improving prescribing practices; ensuring communication to physicians is helpful in content and supportive in tone; and assuring that best practice recommendations are current and appropriate

Initially, state personnel sent a one-page mass mailing to all 20,000 prescribers in the Missouri Medicaid program. The letter described the concerns about spiraling pharmaceutical costs and educated physicians about the scope of the problem. Most prescribers did not realize that 2 antipsychotics constituted 10 percent of the Medicaid pharmacy program and that psychotropics represented 3 out of the top 4 categories and 34 percent of the total Medicaid spend.

Of the 500,000 enrollees, about one third use a psychiatric medication. The initial set of indicators flagged about a quarter of that one-third as potentially questionable. Those flagged claims involved 22,000 prescribers, about half of whom had hits on the indicators for at least one patient. Thus, with the quarterly spend on behavioral health medication being almost \$70 million, slightly more than a third of that amount was flagged by indicators as potentially questionable claims.

Dr. Parks also shared the data about prescribing practices. Of 34.5 percent of patients receiving psychiatric medication:

- 29.6 percent received antipsychotics, with 4.3 percent receiving 2 or more
- 63.6 percent receiving antidepressants, with 8.9 percent receiving 2 or more
- 25 percent receiving mood stabilizers, with 27 percent receiving 2 or more

Currently, Missouri examines drug classifications versus individual medications. Dr. Parks noted that how medications are classified can be significant. For example, when Clonapin was changed from the mood stabilizer classification to the anxiolytic category, there was a dramatic change in numbers.

Dr. Parks also shared several batches of data on antipsychotic usage which gave a more detailed picture of prescribing practices. He stated that 29.6 percent of those who receive a psychiatric medication received an antipsychotic, with 85.5 percent of those individuals taking atypicals and 14.5 percent receiving typicals. The state then examined more closely the prescribing for atypical antipsychotics, flagging high and low doses for a number of atypicals (Clozapine, Olanzapine, Quetiapine, Risperidone, Ziprasidone and Aripiprazole). Analysis revealed that approximately 6 percent of patients were on high doses, 11 percent were on low doses with about 83 percent within the recommended dose range.

The system also has the capacity to flag problematic practices for those prescribing atypical antipsychotics, including:

- Multiple prescribers (1.6 percent). In these cases, physicians received a mailing alerting them that another doctor was prescribing antipsychotics for the same patient.
- Out over 15 days (3.5 percent). This statistic represents a patient's failure to refill a mid-level or high dose antipsychotic and suggests patient non-adherence.
- Out over 30 days (1.9 percent). A letter is sent to the physician after the 30-day notice.
- Two or more switches (0.5 percent). Two or more medication switches within 60 days may indicate that the physician is not allowing sufficient time to determine if the treatment is effective.

In instances when physicians are prescribing two antipsychotic and the dosing level is low/low (20.1 percent) or high/high (16.4 percent), letters are sent. The low/low letter suggests other prescribing practices the physician might want to consider (e.g., trying a high dose of the first medication before adding another antipsychotic). The letter invites physicians to submit information explaining the case or their decision, but does not require it. The specific antipsychotics which tend to have low/low doses are Seroquel (57 percent), Risperdal (48 percent), Zyprexa (44 percent), and Abilify (31 percent). The antipsychotics that tend to have high/high doses are Zyprexa (66 percent), Abilify (42 percent), Seroquel (35 percent), Risperdal (27 percent), and Geodon (26 percent).

When physicians responded to the letters, almost all indicated that the person was never or was no longer their patient. These cases suggest pharmacy billing errors, so DMH provides the information to Medicaid, which pulls the money back until the claim is resolved. A few physicians pointed out there were multiple prescribers due to a residential location or group practice.

Dr. Parks noted that the real value to the project has been engaging physicians in dialogue, helping them to understand the issues, and promoting some ownership of the problem. In addition, Missouri has achieved some cost savings. The quarterly review indicated that while total mental health prescription spending for all medications increased 2.4 percent, spending within the outlier program (those who received letters) had a lower rate of increase of 0.8 percent. And, while the total claims volume increased 0.3 percent, the outlier claims volume decreased 1.7 percent. Finally, the amount price per claim for the total group increased 2.1 percent; the amount price per claim for the outlier group grew 2.5 percent, slightly faster.

Dr. Parks illustrated how Missouri can use the data to learn what drives the increase in cost per medication class. For example, sedative hypnotics increased in cost 7.7 percent during the quarter. This figure represented a 0.8 percent increase in the number of scripts, 1.7 percent increase in the number of new patients, and 6.9 percent increase in cost per medication. In contrast, mood stabilizers increased in cost by 7.1 percent, reflecting an increase of 4.1 percent in the number of scripts, 4.8 percent increase in patients, and 2.9 percent increase in the cost of the medication. So, even though both sedative hypnotics and mood stabilizers showed increases of around 7 percent each, the sedative hypnotic spending was driven primarily by the increased medication cost while the mood stabilizer spending was driven by increased utilization and cost.

Finally, Dr. Parks discussed the project's latest interventions. These efforts include:

- Targeting the top 300 prescribers, who account half of the cost and volume of all edits, by sending them their own letter.
- Activating more indicators.
- Assigning peer review consultants. The availability of peer review will be offered in letters and via cold calling.
- Reformatting individual patient prescribing detail and recommendations for use in the medical record. Physicians reported that they liked the form and wanted to include it in the chart as the medication profile.

To complement the public sector experience, Dr. Frear, Vice President of Clinical Services with Express Scripts, shared his experience in the private sector. Express Scripts is the third largest pharmacy benefit manager (PBM) covering 40 million lives and serving 2,300 clients, including state Medicaid programs, managed care organizations, the Federal government, and large employers. Express Scripts has determined that approximately 5 percent of enrollees use half of the pharmacy budget. The 20 million users of the pharmacy benefit go to 1.7 physicians on average and 1.9 pharmacies per year.

A full service PBM, Express Scripts provides formulary development and management, mail service, retail pharmacy networks, utilization management, and drug utilization review. Dr. Frear noted that the company is dedicated to developing clinically sound formularies based on the independent clinical evaluation. Express Scripts has 18 doctors practicing throughout the U.S. who help put together the formularies.

The company aggressively promotes the use of generic drugs after determining that prescribing generics is the one action that has the most impact on controlling medication costs. Dr. Frear shared that, in the next 3-5 years, another 27 percent of the current drug spend will lose patent protection. If the cost of those medications can drop during that time, perhaps those savings can be spent on

other programs or medications.

In addition to the choice of medications, efficient distribution channels can drive down the cost of medication. While state Medicaid programs typically do not use mail service, managed care clients save if Express Scripts can shave 5-7 percent of the cost by changing the distribution channel to mail service. The savings from mail service benefit the bottom line for both clients and Express Scripts.

Express Scripts does not target every prescribing physician for letter interventions or academic detailing programs. Most prescriptions are written by a relatively small number of physicians. Of the 300,000 physicians in the database, 50,000 prescribe on regular basis. Of those, 5,000 - 10,000 physicians across the U.S. comprise most of the prescription volume. These are the physicians who are likely to receive an intervention.

To see how these interventions were being received, Express Scripts conducted physician focus groups in two cities, St. Louis and Boston. Feedback from the focus groups was:

- Most physicians learn about the non-formulary status of drugs only after prescribing them – from the pharmacy, the patient, or Express Scripts. This feedback suggests that the information must get to the physicians at the time they are making prescription decisions, otherwise the information is retrospective. One strategy is to provide formulary information to patients who then bring it to their doctors.
- While some progress has been made in the area of drug substitutions, physicians consider some drugs to be non-substitutable.
- Physicians do not recall receiving conflicting requests from PBMs.
- Physicians do not consider drug utilization review information received from PBMs to be useful.
- Overall, physicians have negative perceptions of PBMs and negative feelings about the prior authorization process. Physicians perceive PBMs as telling them how to practice medicine.

Dr. Frear suggested that the real opportunity for change lies with educating patients more about their benefits. Physicians are more willing to switch a drug at a patient's request if s/he feels it is clinically appropriate. The challenge is to provide accurate formulary and copay information at the time of proscribing and enable the physician and patient to have a conversation within the typical 15-minute window available for medication consultations. Express Scripts has an extensive web site with different portals available for clients, physicians, and patients to access information. Approximately 150 physicians have signed up to obtain formulary information, while 15 – 20 percent of patients use the web to obtain formulary information.

Dr. Frear also described Express Scripts efforts to reach medical students and educate them about PBMs. The company organized a seminar for third year medical students at Washington University.

The Saturday morning seminar provided clinical and cost prescribing information, presented the FDA rating system and equivalents, and outlined the role and strategies of PBMs. Participants worked on case studies involving generic and therapeutic substitutions developed by pharmacy students. At the conclusion, students indicated that the seminar provided useful and important information. However, given that organizing this seminar was very resource intensive (3-month long negotiation to arrange one seminar for one medical school), Express Scripts is uncertain about the return on investment. The company will explore trying to get information about cost effective prescribing patterns into the curriculum.

Dr. Frear discussed the range of Express Scripts' interventions.

- *Mail services and retail pharmacy.* The company has 48 hours to fill prescription through its mail service, which permits more time for pharmacists to call and ask if it is appropriate to switch to a preferred drug. If the physician responds no, the system tags the order so a repeat call is not made with the refill. As a result, 30 percent of mail service orders achieve some sort of switchover. With retail pharmacy, the opportunity to contact the physician is extremely limited given the quick turnaround time for filling prescriptions. Thus, most of the switchover requests are done retrospectively by mail. Not surprisingly, the retail intervention is only half as effective as the mail service efforts.
- *Prior authorization programs.* In the last year, Express Scripts tripled the number of medications on step therapy and doubled the number of drugs on prior authorization. Prior authorization programs are popular management tools for clients, particularly among state Medicaid programs. However, prior authorization is less accepted for psychotropic medications; many Medicaid Request for Proposals prohibit prior authorizations for psychotropic medications.
- *Step therapy.* The company encourages the use of generics before brand medications. If patients fail with generics, they can receive whatever medication they need as a second step – no questions asked. Dr. Frear commented that this approach is supported by the literature. Any time Express Scripts can increase generic utilization by one percent, it results in a direct one percent decrease for a client's typical drug spend. The company has been able to achieve modest results from encouraging patients to switch to generics (e.g., 7.8 percent switched from an original Selexa prescription). Dr. Frear commented that the system is able to review a patient's history and, if that history suggests the patient is not inclined to or able to use generics, the company will not attempt a switching intervention.
- *Generic sampling.* Express Scripts has provided a great number of generic samples to physician offices, but found the samples did not result in an increase in the number of generic prescriptions written by those physicians.

- *Physician-to-physician contact.* Dr. Frear suggested that face-to-face interaction is effective and may be an educational avenue to pursue further. Physicians will see Express Scripts representatives if they make an appointment, which leads to opportunities for academic detailing. The company also is running an academic detailing program for Massachusetts BC/BS and will have results from that effort in the next six months.
- *Retrospective drug use program.* Similar to the activities occurring in Missouri, Express Scripts sends letters to physicians noting that the patient profile from the last 180 days suggests concerns about coordination or other type of problem. The company also sends information on drug-drug interaction, over utilization, drug disease, drug pregnancy, and addicts. For example, in response to a letter triggered by a lithium nonsteroidal edit, 15 percent of physicians responded that they would modify their practice, 34 percent commented that they would discuss the issue with their patient, and 23 percent responded that the person was not their patient (which flagged problematic data from the network pharmacies). When evidence of problematic data arises, Express Scripts sends the information to the provider relations department and it becomes part of the audit criteria when they go to visit the pharmacy.

Dr. Frear commented that PBMs are not doing a good job educating physicians about their efforts. He referred to a dose consolidation study with a particular state Medicaid program. The study brought together experienced and relatively high volume internal and family physicians for a 90-minute discussion on consolidating multiple lower doses (of either Zyprexis or Risperdal) into a higher dose. While the physicians were familiar with dose consolidation, the majority of “participants reported that the benefits to most of their patients from switching to BID to QD dosing could be clinically minimal and perceived it as an attempt to constrain their ability to practice medicine in their patient’s best interest.” The physicians had this reaction despite hearing evidence that most people can be well controlled with efficient use of those medications. Dr. Frear lamented that programs to date have not been effective in helping physicians understand these clinical implications and the waste of resources by spending twice as much on two 5mg tablets rather than one 10 mg tablet.

Electronic data transmission may be another strategy to help control costs and preserve open formularies. However, physicians have been slow to adopt electronic prescribing; only 5 percent of the physician population uses that approach. Similarly, most physicians are willing to look at the physician portal on a web site, but have not built web consultation into their practice pattern. Express Scripts is a major contributor to RxHub, a database with information from all the PBMs designed to facilitate 2-way communication between physicians and PBMs about prescriptions. However, Dr. Frear noted, it will take years before the hub is utilized the way it could and should be.

Finally, Dr. Frear referred participants to the September/October 2003 edition of *Health Affairs* and the article “Managing Psychotropic Drug Costs: Will Formularies Work?” The article addressed many issues faced by payors and may be of interest to Medical Directors.

Effective Use of LOCUS and Treatment Planning

Co-Section Moderators/Presenters:

*Alan Q. Radke, M.D., M.P.H.
Clinical-Medical Director
Adult Mental Health division
Department of Health
State of Hawaii*

*Neal Adams, M.D.
Medical Director, Adult Services
Department of Mental Health
State of California*

Dr. Adams spoke about his work over the last two year working with counties throughout California on treatment planning. His training involves videos and slides on the principles of treatment planning, practical training and peer learning. Participants have the opportunity to write treatment plans in small groups and receive feedback from the larger group. A premise of the training is that treatment planning is a central part of the treatment process and necessary to ensure quality care; it is not merely an administrative requirement.

Dr. Adams illustrated how two pivotal reports underscored the importance of focusing on patients and their care. The Institute of Medicine's *Crossing the Quality Chasm* and the President's New Freedom Commission on Mental Health *Achieving the Promise: Transforming Mental Health Care in America* strike similar themes: systems are only as good as the effects they have on individual patients and patients must be at the center of any effort to transform systems.

An article in the 2002 edition of *Health Affairs* (see "A User's Manual for the IOM's Quality Chasm Report" by Donald Berwick) addressed the 4 levels within the system of care where interventions can occur to transform the system: (1) experience of patients and communities; (2) microsystems of care (i.e., where care occurs); (3) health care organization; and (4) external environment of care (e.g., policy, financing, regulation). The first level – the patient's experience – is the "north star" which should guide all intervention efforts.

The President's Commission on Mental Health addressed the need to transform the mental health system, stating that "Consumers of mental health services must stand at the center of the system of care. Consumer needs must drive the care and services provided." Indeed, the Commission's recommendations included a call for a plan of care which "will be at the core of the consumer-centered, recovery oriented mental health systems." The Commission added, "Providers should develop customized plans in full partnership with consumers."

Dr. Adams pointed out that current practice around treatment plans does not live up to the

expectations outlined in the Commission's vision for a system transformation. Clinicians cannot distinguish between objectives and interventions. Forms are poorly designed. Few understand the treatment planning process. People may be languishing in mental health systems due to the inability to clearly articulate a plan.

The President's Commission cited one study on the effectiveness of person-centered care. A recent Medicaid demonstration project compared agency-directed and consumer-directed services. The consumer-directed services demonstrated higher client satisfaction, increased number of needs met, and equivalent level of health and safety. Dr. Adams maintained that systems need to be committed to the two key principles of person-centered care and effectiveness.

While the term "person-centered" is used frequently, Dr. Adams wondered if people really understood its meaning. Person-centered means a highly individualized comprehensive approach to assessment and services is used to understand each individual's and family's history, strengths, needs, and vision of their own recovery including attention to the issues of culture, spirituality, trauma, and other factors. Service plans and outcomes are built upon respect for the unique preferences, strengths, and dignity of each person.

Person-centered care involves the following key ingredients:

- Respect for values, expressed preferences and needs of person served
- Coordination and integration of care
- Information, communication and education
- Comfortable and safe
- Emotional support and hopefulness
- Compassion and empathy
- Appropriate involvement of family and friends
- Agreement on goals, tasks, participation and roles
- Relationship with the provider experienced as collaborative, respectful, understanding, encouraging, empathic, trusting, hopeful, and empowering.

Few treatment plans speak to the vision of recovery that consumers have for themselves. Consumers often articulate goals such as manage their own lives, work, be involved with activities and accomplishments, have access to transportation, achieve spiritual fulfillment, develop satisfying relationships with family, peers, and a sexual partner, achieve a high quality of life, pursue education, increase their social opportunities, live in stable housing, and have good health and fun. Yet, most treatment plans are written from the provider's perspective and have goals like "take medication" or "stay out of the hospital." Providers set goals that resemble the lower rungs of Maslow's hierarchy of needs of basic health and safety, emphasize harm reduction, and/or address legal obligations and mandates. Dr. Adams urged that practitioners recognize this tension and engage in dialogue and negotiation with the person served when developing a treatment plan.

Dr. Adams used a pyramid model to depict the steps for building a treatment plan. Beginning with

the tip and representing the final step, the pyramid consists of the following levels:

- Outcomes
- Services
- Objectives
- Goals
- Prioritization
- Understanding
- Assessment

He maintained that the steps in the process, beginning with assessment, must be followed in order to ensure the plan's integrity. If a step is skipped, the person will have problems downstream and the planning process will not succeed. Dr. Adams noted that plan development is an acquired skill that often is not taught in professional training. The plan provides an opportunity for clinicians to think creatively and integrate information about the person served.

Dr. Adams commented that participants in his trainings frequently ask about treatment planning for people who are in denial about their substance abuse. He acknowledged that the recovery model assumes a motivated, voluntary client and the reality is that consumers come to treatment through a variety of channels, some involving coercion. The dilemma is how to convert reluctant, perhaps coerced, participants into participatory partners in their treatment. Ultimately, Dr. Adams suggested, the buy-in occurs when the person sees the value of the plan, plan goals speak to their personal goals, and they have some hope that they can get what they want.

Of course, tension occurs when providing person-centered care. Dr. Adams illustrated the conflict zone which exists between the end points of neglect (letting the client do what he/she wants) and control (getting the client to do what the practitioner wants). The challenge is for practitioners to become more comfortable operating in this conflict zone.

Similarly, practitioners must grow more comfortable with the risk of failure. Intentional care recognizes the dignity of risk and a person's right to fail. When clients take risks, they should not be abandoned to suffer "the natural consequences" of their choices. If a choice results in failure, neither the provider nor the client should be deemed a failure.

Unfortunately, the current system discourages risk taking. The mental health system has bought into the rhetoric around recovery, yet sets up people to fail (through allocation of resources, expectations, disincentives). To truly embrace the vision of recovery and transformation, work flow and system designs need to change.

Dr. Adams outlined the clinical benefits of treatment planning. These upsides include client benefit and improvement, more explicit and purposeful staff and client responsibilities, a tool to overcome scapegoating and fragmentation, resource management tool, identification of realistic caseload size, and maximization of resources. He also pointed out some of the challenges to treatment planning,

including the problem of measurability, conflicting documentation needs/standards, too frequent revisions for clients in chaos, emphasis on crisis management, tendency to blame/scapegoat for client failure, inability to control collateral services, and limited cross training and collaboration.

Finally, Dr. Adams raised the practice implications for treatment planning:

- forces focus on outcomes and goal/success attainment
- reduces burnout and morale problems as clinicians see their efforts have an impact
- creates a sense of shared responsibility within the mental health system and allied agencies
- assigns responsibility at all levels

The policy implications include:

- need to provide time for staff to learn and practice
- moderate interim expectation/demands
- create performance standards based upon recovery expectations
- revise policy and procedure manuals to conform to recovery principles
- reexamine medical necessity and utilization review practices

Dr. Radke followed the session on treatment planning and discussed his experience using LOCUS within two state mental health systems. The Level of Care Utilization System (LOCUS) is a product of the American Association of Community Psychiatrists and Deerfield Behavioral Health. LOCUS is a utilization management tool that also impacts clinical decision-making as it provides data to support decision-making.

The LOCUS framework includes several risk dimensions (risk of harm or danger, level of functioning, co-occurring condition, and stress in the environment) and three risk reduction dimensions (environment impair or support, response or history of response to treatment, and individual's attitude toward treatment). Through these dimensions, a practitioner is able to understand the extent to which a person is engaged in treatment and what could influence their psychiatric condition and create risk for the person.

Dr. Radke relayed his experience with LOCUS in Minnesota. After learning about the tool in early 2001, he decided to pilot the tool at Anoka Metropolitan Region Hospital. At the same time, the hospital Medical Director departed, which provided an opportune time to introduce the tool as Dr. Radke had to assume the hospital Medical Director duties.

Within the hospital, LOCUS was used as part of the admission screening process. The Admission Office used LOCUS as part of its preadmission screen to determine whether a person needed hospital-level care. Then the Admission Team used LOCUS to determine unit placement for the patient. LOCUS was a helpful tool in sorting out the type of treatment needed from the hospital's various units, including specialized co-occurring and behavioral treatment units. In addition, the Admission Officer used LOCUS to coordinate with the referral source. If the patient was not

appropriate for hospitalization, LOCUS helped identify the appropriate level of care and guide the coordination of resources to obtain the right level of care in the community.

LOCUS also was a tool for the utilization management process. The admission authorization process would review whether the patient was properly placed. If a hospital bed was not needed, Minnesota had three other state-operated units in the metropolitan area. Other placement options included a medically monitored transition unit (LOCUS level 5) which offered intense psychosocial rehabilitation for community preparedness; a community unit (LOCUS level 4) which provided wraparound strategies in apartments, more community skills development with a bit more independence and support; and a pre-placement unit (LOCUS level 2), a community program for people who were ready for semi-independent living but could not find housing and did not need to be in a hospital.

The continuing stay authorization process involved LOCUS, as well. The continued stay criteria were based upon LOCUS. If a person was deemed a LOCUS level 4 or less, the continued stay was not granted and the community team would work on transition. The Utilization Management Committee met weekly and discussed the appropriate levels of care. The Medical Director headed this Committee and notified the team's lead physician of the Committee's decision. The Medical Director also sat on treatment teams and provided consultation for patients who seemed stuck in the system. Many problems were solved through this increased communication, which developed higher levels of trust and more willingness to take risks among clinicians, patients, and patient families. Finally, the Utilization Review personnel assured disposition by going back and reviewing the cases.

The discharge process utilized LOCUS, too. Concerns about discharge planning could be initiated by multiple players: the treatment team, Utilization Management Committee, administration, patient advocate, or the courts. More players involved meant more people helping to problem-solve and develop creative solutions, particularly for people who had burned many bridges in the community. Indeed, discharge planning began on or prior to admission. Hospital staff would talk with the county case manager, community mental health center staff, or private provider and discuss the supports and services needed so that the person could be discharged. The Medical Director questioned the reasons for discharge delays, not to second-guess the delay but to learn the rationale and what was being done to change the situation. Utilization Review personnel reviewed LOCUS and discharge plan to provide an objective review and feedback to the discharge team. Given their review of numerous discharge plans, the Utilization Review team was able to share that collective knowledge with treatment teams.

Dr. Radke explained the LOCUS training process used by Minnesota. The Behavioral Health Director and Director of Community Services conducted the initial training in the hospital and communities. They trained everyone in leadership (e.g., nurse managers, department heads) to create an institutional memory for the LOCUS training. The Utilization Review personnel ran the orientation training for all team members from physicians to direct care personnel. Even though direct care personnel would not use LOCUS in their work, it was important they understood the

model. Utilization Review monitoring included just in time training with treatment teams. All treatment center staff were expected to use LOCUS as a tool in treatment planning as a way to organize their thinking. The message was that LOCUS would not take away clinical decision-making, it was a tool to support such decision-making.

Dr. Rake also articulated the additional and unexpected ways Minnesota used LOCUS. These special uses included:

- *Development of treatment pods.* Prior to LOCUS, the hospital had 6 independent inpatient units with little collaboration. Over time, the hospital developed treatment pods in response to the identified needs for varying types of care. Beginning with a medical psychiatric unit and a fragile, multi-system issue patient unit., the hospital added an intensive care unit, behavioral treatment unit, mental illness/substance abuse co-occurring unit, a unit for people who were having difficulty with community placement and needed more psychosocial rehabilitation. Pods were expected to work together and share staff.
- *Creation of community, transition and pre-placement units.* With LOCUS, these units had a better focus and identity.
- *Collaboration with the community mental health center in the metro area.* LOCUS helped community mental health center staff become part of the team that could support patients' transition from hospital back to the community.
- *Integration of mental illness/substance abuse treatment across the continuum of care.* Discussion about co-occurring issues did not occur only in specialized units. Every staff person had to understand the principles of co-occurring care and be able to conduct at least an initial intervention.
- *Needs analysis to begin hospital/community planning.* LOCUS was used to identify gaps within the mental health system and places where resources were being underutilized or over-utilized. LOCUS provides documentation of gaps and objective support for funding requests.

In Minnesota, the pilot project was to be extended to all state hospitals and community mental health centers, but that process was not completed due to budget cuts. The goal was for LOCUS to become the common language of the public mental health system and a tool to support, not supplant, clinical judgment.

Dr. Radke also discussed his more recent experience with LOCUS in Hawaii. Initially used at the state hospital to assist in the discharge process, LOCUS is now being used by Hawaii's Adult Mental Health Division (AMHD) Utilization Management Staff within the central office. Hawaii also uses LOCUS with its purchase of serviced (POS) providers to move patients to lower levels of care. LOCUS can help educate staff, consumers, and families and serve as springboard for transition

planning, particularly when people do not want to risk transitioning to lower levels of care from over-utilized resources like hospital and 24- hour group home beds.

In Hawaii, Deerfield trained all AMHD program and service leaders in a “train the trainer” model with an expectation that the leaders would then train their staff. However, leadership staff had limited experience with the instrument so the training did not take hold. Staff knew what LOCUS was but not how to use it. Thus, statewide training was launched again and directed at all case managers (including POS and CMHC). Currently, LOCUS is required for all initial treatment plans, treatment plan updates, and changes in Levels of Care. While LOCUS was required to be used by October 1, 2003, teams were using the instrument well before that date because it was a practical tool that assisted their efforts.

Hawaii has developed a statewide plan for implementing LOCUS. The plan includes:

- All consumers will have a LOCUS on their initial request for services.
- Any time a treatment plan is modified a LOCUS will be done. This encourages the treatment plan to be dynamic, not a static plan that is rarely revisited.
- At least every 6 months a new treatment plan must be developed using LOCUS.
- Utilization Management will use LOCUS to determine authorization for services.
- LOCUS will be used to monitor or oversee service provision.
- Every program and service has an identified LOCUS level.
- Treatment teams are encouraged to use LOCUS in treatment planning processes.
- LOCUS will allow for integration of care management from hospital to community.

In his summary, Dr. Radke stated that LOCUS is a tool that can be used clinically, for management purposes, and to support accountability. LOCUS provides a decision tree detailing risk domains and risk reduction dimensions that practitioners can integrate with their clinical discussions. The tool provides an objective way for treatment teams to think through a morass of problems and organize their decision-making.

The Symposium concluded with a business meeting where Medical Directors discussed and planned future Council activities. (See separate Medical Directors Council Meeting Minutes.)