DCF Psychotropic Medication Advisory Committee
MINUTES
April 10, 2015 1:00 PM
Value Options® Connecticut 500 Enterprise Drive, Suite 3D (Litchfield Room) Rocky Hill, CT 06067.

Present: Jacqueline Harris, M.D., David S. Aresco, Pharmacist, Patricia Cables APRN; Joan Narad, M.D.; Amy J. Veivia, Pharm. D.; Chris Malinowski, APRN; Jason Gott, Pharmacist; Alana Lee; Margaret Rudin, PhD; Brian Keyes, M.D.; Beth Muller, APRN.; Sherrie Sharp, M.D.; Fredericka Wolman, M.D.; Kristina Stevens, DCF Administrator.

1. The meeting was called to order by Dr. Harris at 1:04PM.

2. The next meeting is scheduled for May 1, 2015 from 1pm – 2:30pm.

3. The minutes of the March 2015 meeting were reviewed and approved with minor changes.

   The expected turnover time for distribution of draft minutes is now set at 7 business days. Every effort will be made to meet this expectation.

4. Dr. Ricka Wolman reported that she will be seeking input from PMAC on the revision of the protocol to request genomic testing. She will present her ideas at a future PMAC meeting possibly May 2015.

5. Kristina Stevens, Administrator, DCF Clinical and Community Consultation and Support Division was welcomed as a guest and introductions were done. Kristina described her role in DCF.
   i. Discussion: System interface issues: A document containing discussion topics previously developed by PMAC was distributed and each topic discussed in detail. The discussions were long and detailed. Key points are noted below.
      a. Issues surrounding medication management and prescribing practices especially in the context of continuity of care were highlighted.
      b. DCF involved vs. not involved children: The level of services available is different for the two populations.
      c. Recommendation was made to develop and implement a treatment plan that would be given to each new provider as a child moved between programs. This would help to resolve communication issues.
      d. Medical information from the primary care practitioner needs to be included in the package of information given to new providers.
      e. The delay in accessing the appropriate level of care in a timely manner was discussed.

      Need to obtain information about the work that has been done by Access Mental Health was raised but tabled for a later PMAC meeting. Recommend DCF worker attend (or via phone) intake and the participation of foster parents whenever possible.
      f. Noted referrals for new intakes or upon discharge from a provider are often missing key information.
      g. Concern that OTC medications are often not included on drug therapy profiles as a part of the provider packages.

      Hospitals: discharge summary missing or lacking key information. Feedback from hospitals is often “we don’t have time”. Generally difficult to get needed information. Medication reconciliation process discussed as well as the accuracy of the data that

is provided. Lack of good communication between the hospital and community provider may be partially due to the much quicker pace of the workflow and/or this issue not being a priority for hospitals. Community providers are usually not contacted during the course of a hospitalization and discharge plans made to former providers without prior contact with the receiving community provider. The impact of hospitalists was also considered, i.e. the hospital treatment being done in isolation from the community providers. Consider asking the Connecticut Hospital Association for assistance in addressing some of these concerns.

h. Need to develop a standard of what is expected for minimum baseline data for youth moving from one provider to the next.
i. Overloaded programs and/or systems severely limits time spent with patients and leads to a “cookie cutter” practice model.
j. Marketing strategies were suggested such as offering presentations on the CMCU protocol and the work of PMAC, and increasing the information on the DCF website. To save scarce resources it was suggested a presentation could be recorded and/or conducted via webinars.
k. Having Narcan available in DCF licensed facilities was recommended. Noted that this is in process.

6. Medication Therapeutic Class Review: Antipsychotics
   I. CMCU data was presented, reviewed and discussed.
      a. The 2011 Medicaid Nine State Psychotropic Medication Use Study data is being used as the benchmark for CMCU data comparison. Noted DCF is well below the benchmarks.
         i. The study showed a total foster care prescribing rate of 13.4% compared to 8.1% for DCF.
         ii. The study showed a rate for ≥4 medications prescribed concurrently of 12.2% compared to 6.7% for DCF.
         iii. The study showed the use of two or more antipsychotic medications as 17.1% compared to 0.09% (DCF did not have any youth on more than two)
         iv. The study showed the use of antipsychotics by children five and younger as 0.2% compared to DCF rate of 0.09%
   II. The 2015 performance measures were presented and discussed: children or adolescents prescribed:
      a. >=2 antipsychotic medications
      b. >=4 total psychotropic medications
      c. Hypnotic medications
      d. Children <=5yrs of age on psychotropic medications
      e. Noted BMI measures are under development
   III. First quarter data relating to these performance measures was presented and discussed.
   IV. Quality of care concerns study/data was presented and discussed.
   V. NCINQ measures were presented and discussed. Note that DCF is meeting all measures except ongoing metabolic monitoring which is recommended but not monitored by DCF.
   VI. The protocol, approved drug list, and maximum dose guidelines with recommended changes were presented, reviewed and discussed.
      a. Recommendation to remove the word “suggested” from the protocol approved.

b. It was decided that the information on the DCF website will be updated as indicated after each PMAC meeting rather than current system of periodic updates.
c. Asenapine considered for the approved drug list. A formulary monograph was presented, reviewed and discussed. Drug administration issues discussed. A maximum dose of 20mg/day was recommended and approved. PMAC voted to approve the addition of this medication for children/adolescents 10-17 years of age.
d. Lurasidone considered for the approved drug list. A formulary monograph was presented, reviewed and discussed. Noted there are currently 3 studies underway involving children. Two studies either have the results pending or not yet published. The third is an extension study that is in process. There is another study involving adolescents with schizophrenia with recruitment now taking place. PMAC voted to defer adding this medication until the above noted data is available.
e. Iloperidone considered for the approved drug list. A formulary monograph was presented, reviewed and discussed. At this time there is no evidence to show safety/efficacy in children and/or adolescents. Noted that recruitment for a dosing study is currently underway. Additional concerns include QTc and orthostasis issues. PMAC voted to not add this medication at this time.
f. Protocol review: No changes recommended. PMAC approved.
g. Long term use safety data: a 2014 article was reviewed. Noted that long term use of this class of medications is acceptable practice despite the availability of support data. PMAC recommended a statement to this effect be placed in the opening comments portion of the protocol.
h. PMAC raised an issue in that once a medication in this class is prescribed it seems that the effectiveness of the medication is rarely assessed resulting in extremely long term therapy that may not be needed. This topic will be placed on the PMAC Oct 2015 agenda for further discussion/evaluation.

7. Trazodone use in males: There are well documented case studies regarding priapism but no incidence data is available at this time. No further actions recommended at this time.

8. Methylphenidate use in children age 5 and under: A 2008 study was presented, reviewed and discussed. Noted children<5 had a 30% greater chance of experiencing an adverse drug reaction (ADR). This includes 11% experiencing disorientation. A reference to this article will be emailed to PMAC members and placed in the final version of the minutes. Reference follows:

   Greenhill LL
   Child Adolesc Psychiatr N Am. 2008; 17(2):347 - 366.

   Greenhill L
   Published correction: J Am Acad Child Adolesc Psychiatry. 2007; 46(1):141
   J Am Acad Child Adolesc Psychiatry. 2006; 45(11): 1284 – 1293.

9. Research results: Melatonin status: presented and discussed. Status has not changed in that there is no FDA regulated melatonin product available in the USA.

10. Recommendation to restart DCF PMAC Newsletter: Approved. A draft newsletter will be prepared. PMAC members were encouraged to ask colleagues to get on the mailing list for the newsletter and/or PMAC minutes by sending their contact information to Dave Aresco.

11. Adjournment: 2:45pm

Respectfully Submitted,
David S. Aresco
Consulting Pharmacist