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INTRODUCTION

In 2011, the U.S. Government Accountability Office (GAO) reported rates of psychotropic prescriptions for foster and non-foster children in Medicaid fee-for-service in five states. Massachusetts exhibited the highest rate of behavioral health medication (BHМ) utilization with 49.3% of all Medicaid children being prescribed a psychotropic medication, and 39.1% of children in foster care prescribed these medications.1

In 2012, the U.S. GAO reported a higher prevalence of BHМ regimens with ≥5 medications in foster care children. Antipsychotic use in children covered by Medicaid was twice as likely compared to those privately insured.2

The Massachusetts Medicaid (MassHealth) Pharmacy Program, in collaboration with the Department of Children and Families and the Department of Mental Health implemented the PBHMI in November 2014. Proactively requests prior authorization (PA) for specific medications or combinations of BHМs prescribed to members less than 18 years of age.

A multidisciplinary therapeutic class management (TCM) workgroup consisting of child/adolescent psychiatrists, pharmacists, and a social worker, retrospectively reviews complex cases. Interventions include telephonic prescriber outreach by a child/adolescent psychiatrist to discuss opportunities for regimen simplification, drug interactions or toxicity, and to encourage evidence-based practices.

METHODS

Population Selection

MassHealth members identified as candidates for a peer-to-peer outreach call based upon PBHMI TCM workgroup review during the time period of September 1, 2015 through August 28, 2016 who had continuous coverage throughout the TCM review and no third party liability (TPL). The highest likelihood of prescriber acceptance.

Primary Outcome

Case data was utilized to collect the types of interventions, number of peer-to-peer consultations conducted, and suggested medication recommendations. Pharmacy claims and subsequent PA submissions were analyzed to assess medication regimens prior to workgroup intervention, as well as changes to the medication regimen after the peer-to-peer discussion.

Secondary Outcomes

An anonymous and voluntary survey was faxed to prescribers who participated in a peer-to-peer to assess prescriber satisfaction.

OBJECTIVES

Primary Objective: To determine the impact of the PBHMI telephonic peer-to-peer outreach program in modifying prescribing trends by assessing the rate of acceptance, modified acceptance, or rejection of medication interventions suggested by the workgroup.

Secondary Objectives: To assess the impact of prescriber type and medication class on peer-to-peer outreach outcomes. Additionally, to assess prescriber satisfaction with the peer-to-peer outreach process.

DISCUSSION

Peer-to-peer outreach calls conducted by the TCM workgroup resulted in a medication regimen recommendation acceptance rate of 31.4%, modified acceptance rate of 44.3%, and rejection rate of 24.3%.

Recommendations made during a peer-to-peer were more likely to be accepted or modified by a non-child/adolescent psychiatrist than a child/adolescent psychiatrist. Recommendations were more likely to be rejected by a child/adolescent psychiatrist than a non-child/adolescent psychiatrist (Figure 2; P=0.4106).

Antipsychotics were recommended more frequently during a peer-to-peer, accounting for 26.8% of recommendations.

Recommended changes for regimens containing a benzodiazepine had the highest likelihood of prescriber acceptance.

All recommendations (N=6) were accepted (P=0.0758).

CONCLUSION

The results of this analysis suggest a peer-to-peer outreach program is associated with increased awareness and implementation of evidence-based medicine in a pediatric population treated with behavioral health medications.

The type of prescriber and medication class being recommended for change may have an impact on the likelihood of recommendation acceptance.

Full results anticipated in May 2017.

REFERENCES

CONCLUSIONS/Acknowledgments

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