

# Informed Decision-making:

## What Works



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# A Note of Caution

# Polypharmacy Rates Depend on Your Metric

Study	Sample	Definition	Interval	Rate
Olfson et al., 2002, JAACAP	1996 Med Expend Panel Survey (MEPS)	> 1 Classes	16 mos	<b>23%</b>
Zito et al., 2008, Peds	TX Foster Care 2004 N=500	$\geq$ 3 Classes	30 days	<b>41%</b>
Constantine et al., 2010, Clin Therap.	FL Medicaid 2002-07	> 2 APAs	> 60 days	<b>7%</b>
dosReis et al., 2011, Peds	“Mid Atlantic State” Medicaid 2003	$\geq$ 2 APAs	> 30 days	<b>19%</b>
PFK Data	OH 2010 N=26, 487	> 3 Classes	> 60 days	<b>2.2%</b>
Beacon	OH Medicaid 2011	$\geq$ 3 Classes	Oct 2008	<b>22%</b>

# Interventions for appropriate use of medications

- *Demand side interventions*
  - Cost sharing for patients
    - Co Pays
- *Supply side interventions*
  - Education (eg CME, detailing, etc.)
  - Profiling (eg DUR)
  - Cost sharing (eg time or money)

# Demand Side: Co-Payments

- Process
  - DRA allows up to \$3 copay (41/50 States)
  - Imposed on providers/can be waived
- Benefits/Challenges
  - Impairs care seeking + adds to other use
  - Increased costs of admin
- Consider when public demand is high

# Supply Side Interventions



# Evidence for the Effectiveness of Techniques To Change Physician Behavior

Wally R. Smith

*Chest* 2000;118;8S-17S  
DOI 10.1378/chest.118.2\_suppl.8S

- Study objectives: To understand the theory and results of how to improve physician performance, as part of overall health-care quality improvement.
- Design: Review.
- Measurements and results: No unifying theory of physician behavior change tested among physicians in practice. Mixed results are found for almost all interventions reviewed. ***Multiple interventions yield better results.***
- ***Conclusions: The answer to the question of what works to improve an individual physician's clinical performance is not simple.***
- Multiple tools will likely be necessary and should be chosen carefully.

# Robert Penfold, Ph.D.

- New drug diffusion patterns related to:
  - Marketing dollars
  - Key clinicians/communities
- Evidence moderates use of new agents over time
- Clinician social networks very important



# Clinician Education

- Process
  - Providing continuing medical education
- Benefits/Challenges
  - Accepted part of practice
  - Moderately expensive
  - Little evidence of effect
- Recommended for setting expectations

# Drug Utilization Review

- Drug Utilization Review Process
  - Flagging prescriptions as inappropriate retrospectively
  - Sending letters and/or educational material to the physicians
- Benefits/Challenges
  - Automated process at low cost
  - Clinicians ignore letters
  - Not linked to specific patient for whom the prescription was written.
  - Imply concern for money over patient
- Recommended
  - Possible pay for performance considerations

# Academic Detailing

- Process
    - Trained, objective, colleagues present to clinicians (one-on-one or in small groups)
    - Review evidence and personal patterns
  - Benefits/Challenges
    - Highly effective at changing prescribing practices.
    - Expensive
  - Recommended for:
    - Expensive but uncommon conditions
    - Expensive but outlier prescribers
-

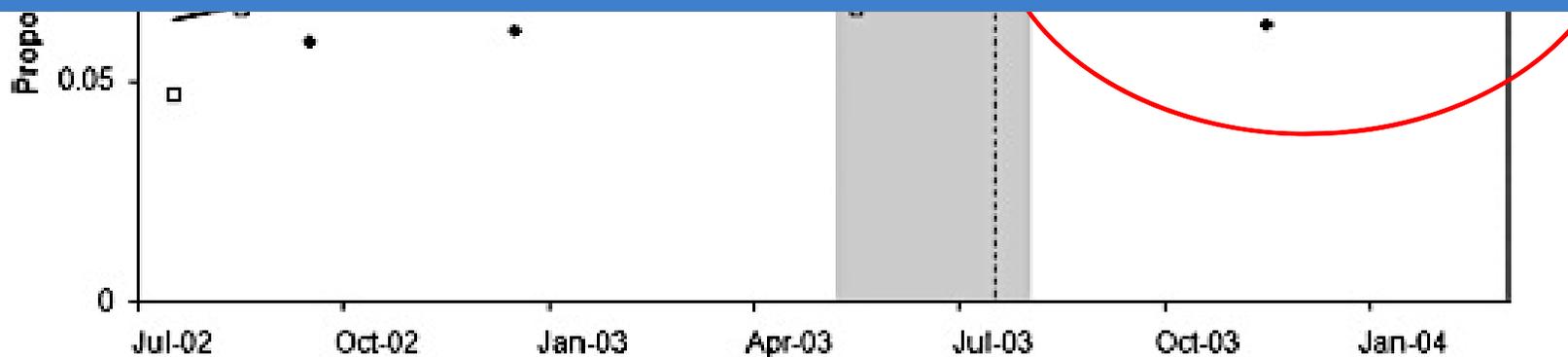
# Prior Authorization

- Process
  - Review of all prescriptions of a type or name
  - Clinicians required to call or fax
- Benefits/Challenges
  - Costly/resented (49 min/staff/PA at MCO)
  - May reduce use for high need patients
- Consider

# Unintended Impacts of a Medicaid Prior Authorization Policy on Access to Medications for Bipolar Illness

Christine Y. Lu, PhD,\*† Stephen B. Soumerai, ScD,\* Dennis Ross-Degnan, ScD,\* Fang Zhang, PhD,\*  
and Alyce S. Adams, PhD\*‡ *Medical Care* • Volume 48, Number 1, January 2010

“This study contributes to a growing body of literature suggesting that PA policies may have unanticipated and unintended impacts on treatment when applied to antipsychotic agents, compared with other medication classes.”



## Use Of Atypical Antipsychotic Drugs For Schizophrenia In Maine Medicaid Following A Policy Change

Patients initiating AAs during Maine's policy experienced a 29 percent greater risk of treatment discontinuity than patients initiating AAs before the policy took effect; no change occurred in a comparison state. AA spending was slightly lower in both states. **Observed increases in treatment discontinuities without cost savings suggest that AAs should be exempt from PA for patients with severe mental illnesses.**

# Second Opinion

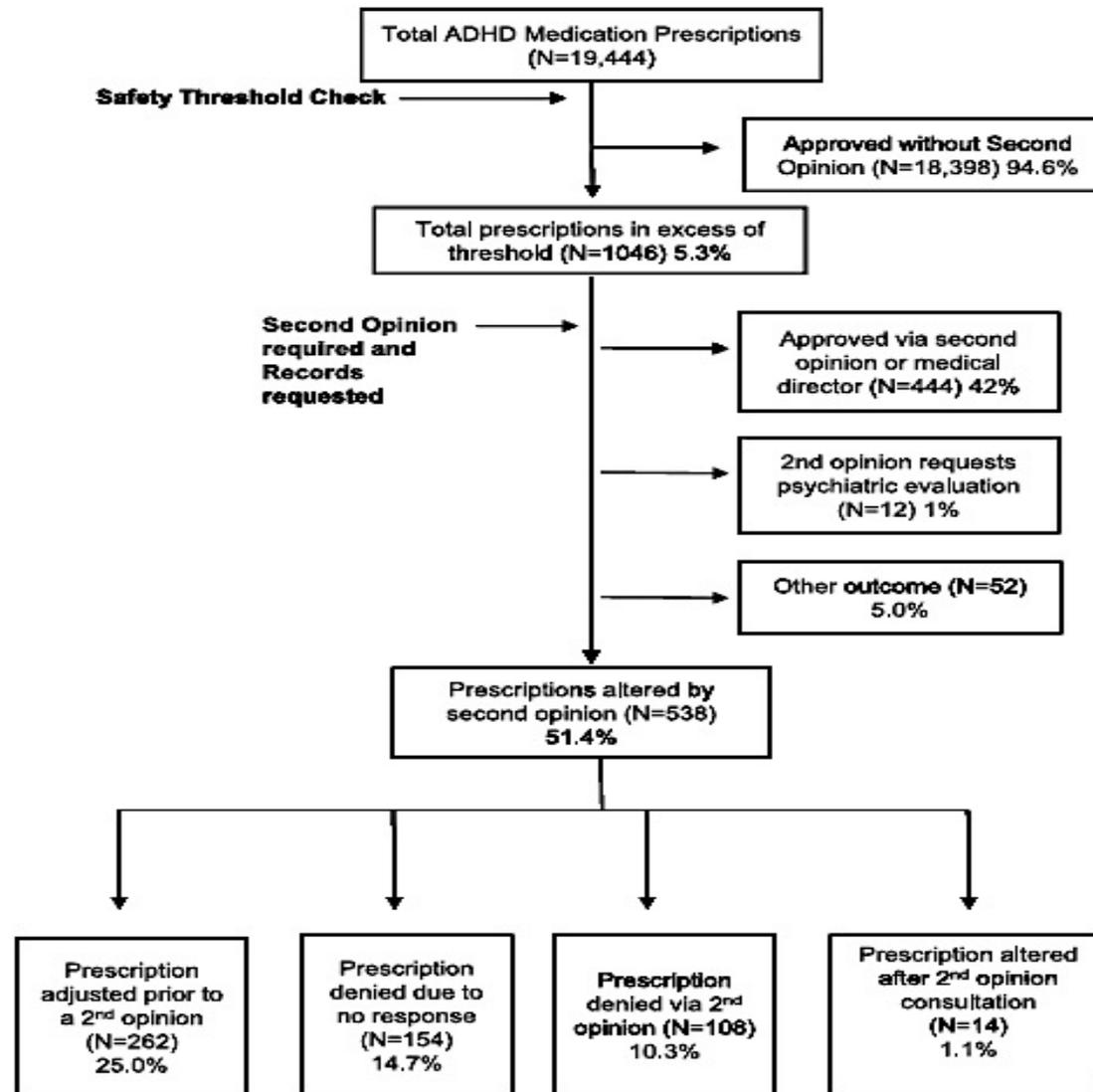
- **Process**
  - Prescribing outside guidelines requires pre-authorization for approval
  - Pre-authorization process conducted by medical team
- **Benefits/Challenges**
  - Not for all prescribing or clinicians
- **Recommended for high risk populations**

# Second Opinions Improve ADHD Prescribing in a Medicaid-Insured Community Population

JEFFERY N. THOMPSON, M.D., M.P.H., CHRISTOPHER K. VARLEY, M.D.,  
JON McCLELLAN, M.D., ROBERT HILT, M.D., TERRY LEE, M.D., ALAN C. KWAN, B.A.,  
TAIK LEE, M.A., AND ERIC TRUPIN, Ph.D.

- A work group developed safety thresholds and review process
- Thresholds approved by the community and advisory work group.
- Second opinions and were reviewed over time as new drugs came on the market and second-opinion outcomes were aggregated.

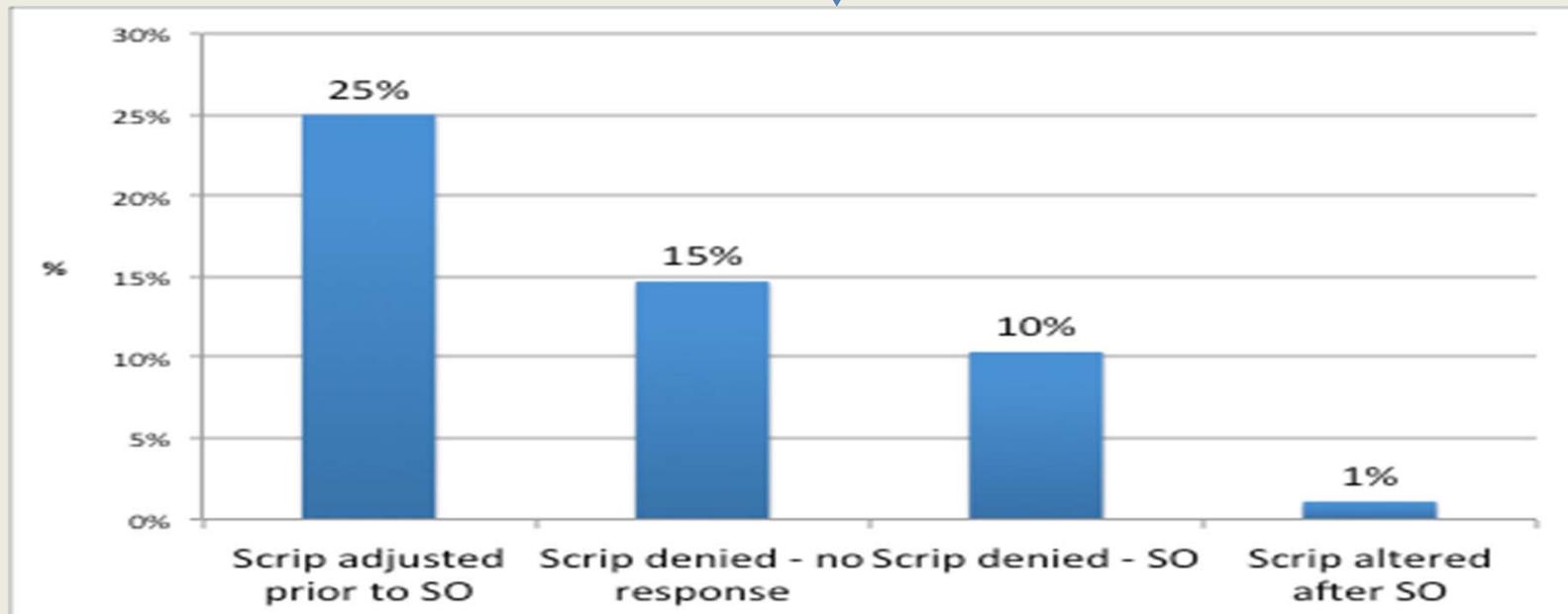
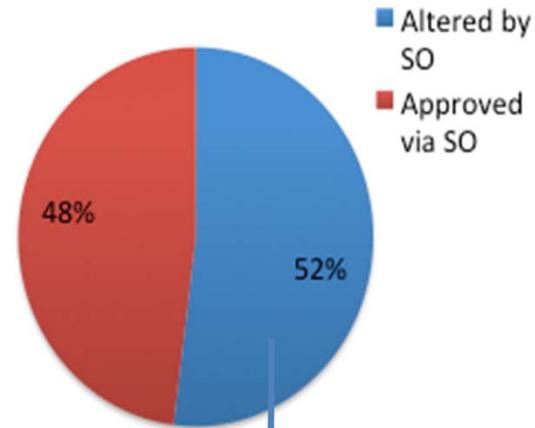
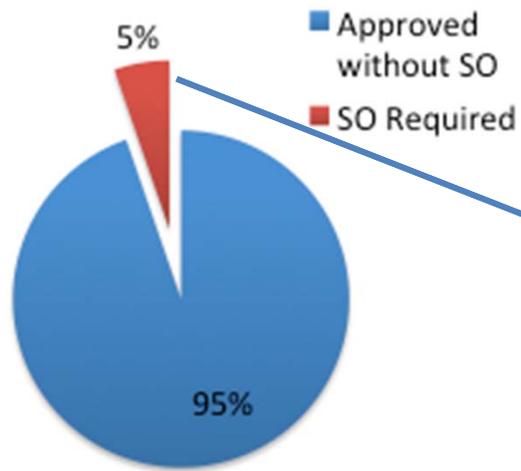
# Results of Second Opinion



**Fig. 1** Results of second opinions in prescriptions over safety thresholds.

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# Results of Second Opinion Program in Washington State

- Adjustments to primary care physician (52%), psychiatrist (50%), nurse practitioner (54%), and physician assistant written (51%) prescriptions.
- **Savings of \$1.2million**, with **538** fewer patients exceeding safety thresholds.
- This was a **10:1** return over administrative costs
- Overall Medicaid expenditures still increased because of higher unit costs and newer brands entering the market.

# Discussion

