**MINUTES**
**MHCD INTERIM WORKGROUP**
*August 11, 2003*

***Members Present:*** Kathy Savicki, LCSW; Seth Bernstein; Ann Uhler.

***Staff Present:*** Darren Coffman; Alison Little, MD.

***Also Attending:*** Ralph Summers, MSW, Office of Mental Health and Addiction Services (OMHAS).

## I. Call to Order

The first meeting of the MHCD Interim Workgroup was called to order at 10:00 am in Room 107 of the Meridian Park Hospital Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Darren Coffman noted attendance.

## II. Review of Discussion at June 25, 2003 MHCD Subcommittee Meeting

Darren began the meeting by asking the workgroup to consider what areas of mental health and chemical dependency might be amenable to evidence-based practice guideline development. Seth asked for clarification of the goal of the workgroup, whether it was to make recommendations about best practices to MHOs and FCHPs, or to attach guidelines to the list. Kathy explained that the purview of the HSC is only to make modifications, including attaching guidelines, to the list, and that suggestions are not part of that charge. Ralph stated that his understanding of our task was to identify those areas where the evidence is so strong regarding effectiveness of treatment that a guideline is indicated. He commented that the Balanced Budget Act (BBA) now requires MHOs to have practice guidelines in place. Alison asked for clarification regarding whether any evidence-based changes had to be able to be identified by coding in order to be implemented. Kathy replied that in general, they would indeed need to be identified by coding, but Ralph felt that even without that, a guideline could be useful to the plans to encourage or require a certain practice pattern, which in turn could be audited.

## III. Discussion on Incorporating Evidence-Based Research and Best Practices into MHCD Line Items

### A. What mental health conditions would lend themselves to a guideline?

Darren gave the workgroup a review of the guideline development process that the full Commission had used, using the spine lines and Hepatitis C as examples. Ann gave the

example of rapid detox, which initially OMAP was paying for because they couldn't identify by coding that it was being done. This is a method of detox that occurs in the hospital setting that is very expensive and has been shown to be no more effective than in an outpatient setting. Once she learned it was occurring, a system was put in place to identify it and not pay for it.

Seth suggested a possible guideline for child mental illness, requiring concomitant active therapy with the parent in order for individual therapy with the child to be covered. Ralph pointed out that this would be problematic with the high proportion of OMAP children in substitute care. He gave an example of Daily Structure and Support, which is therapy that is essentially socialization. It can be effective for those with severe and persistent mental illness, as can supported employment. He stated that his office had just completed creating "criteria" for the mental health procedure codes that will serve as definitions of what is expected to be performed. They are due to be published next week. Kathy suggested that the workgroup look at these definitions and pair them with specific diagnoses, as there is good evidence that they are effective in some cases, such as for serious and persistent mental illness. Another example that she felt might be worthy of specific pairing was Dialectic Behavioral Therapy (DBT), which is very effective for borderline personality disorders, as well as trauma disorders.

Kathy brought up the topic of co-occurring diagnoses, and suggested that perhaps a detailed assessment and treatment plan could be required in these circumstances, and that only qualified professionals who could deal with both problems should be able to treat the patient. The problem, pointed out by Seth and others, was that because the systems are not integrated, it is difficult to identify these co-occurring conditions by encounter data. Kathy reported that her group has been successful in accomplishing this assessment, but Ann pointed out that others had not been so efficient. She asked Darren if the Commission had determined which diseases they had decided to focus on for their evidence-based guidelines. Alison responded that she currently is in the process of cross-referencing the list of the top 25% most expensive diagnoses created by Carole Romm, with a list of all available evidence-based research. Ann had thought there was a list of 10. Darren clarified that the list she is referring to was an informal survey of the commissioners, asking what they would like to see more evidence about. Ann stated she was surprised, as 6 of the 10 were related to substance abuse, for example, treatment of Hepatitis C and liver transplants. She suggested that perhaps the workgroup could create guidelines, such as requiring A&D assessments, and attach them to the appropriate physical health lines. Alison asked for, and Kathy provided, an explanation of the quadrant model of co-occurring illness. This model states that there are 4 types of patients; those that have a high level of both mental illness and chemical dependency, those that have a high level of chemical dependency and mild mental health problems, those that have a high level of mental illness and a small problem with chemical dependency, and lastly a group who has mild problems with both. The latter are typically treated in the primary care provider's office. There is good evidence that, for the second and third groups, if both problems are not addressed, the outcome is poorer, and for the first group, the best outcome is achieved by integrated treatment by a team of qualified providers.

## B. What evidence is available on the treatment of chemical dependency?

Ralph brought up the issue of methadone treatment, and wanted to perhaps attach a guideline to the chemical dependency line to emphasize the fact that there is good evidence that this treatment is effective. Alison asked for the workgroup's position on both methadone and buprenorphine. Ralph re-iterated that methadone treatment is effective, and that recently buprenorphine has been shown to be effective as well, although there is much less data to support it. Alison passed out some articles discussing the cost effectiveness of buprenorphine, showing that it is not cost effective at a cost per dose higher than $15. She stated that her understanding was that it is safer than Methadone, and Ann replied that she wasn't sure about that, but that there were 2 advantages to buprenorphine. One is that it doesn't carry the same stigma as methadone, so that there are some addicts who normally would refuse methadone who would agree to treatment with buprenorphine. The other is that it can be dispensed from the physician's office, so will improve access to this type of treatment in rural areas. Ralph stated that buprenorphine will be covered by OMAP effective 10/1, and that it is not a 7 & 11 drug. Alison asked if the workgroup would be interested in developing a guideline around this therapy, and Kathy thought that perhaps it would be reasonable to pair a guideline emphasizing the effectiveness of narcotic replacement therapy in general, and also identifying criteria for when buprenorphine should be used. Ralph concurred. Discussion continued about whether or not drug treatment of CD should be on a separate line, to indicated it's superior effectiveness to counseling alone. Ann indicated that the National Institutes on Drug Abuse (NIDA) publishes a small booklet on evidence-based treatments for chemical dependency.

Kathy asked that 2 issues be discussed in the context of the biennial review. First, she would like to discuss what to do with mental illness in children ages 0-3. Second, she stated that the neurological dysfunction line is problematic, in that multiple different diagnoses are on it, including dementia, developmental delay, traumatic brain injury and Asperger's syndrome. She would like to see a detailed look at what treatments are effective for which diagnoses, and also a delineation of which state agencies are responsible for providing which services. She said that currently, the agencies just fight among themselves because this responsibility is unclear. She would like to see a meeting, possibly organized by Jean Thorne, of all the agencies involved where these issues could be discussed and clarified. Alison asked specifically which agencies were involved. Kathy explained that the disability system, the senior system, and the mental health system all provide different levels of service, some of them overlapping such as case management and nursing. In addition, for those diagnosed as developmentally delayed before the age of 18 (IQ less than 70), special education is involved. Ralph added that especially for traumatic brain injuries, often the justice system is involved. There was debate over whether or not such a discussion was the purview of the HSC, with the conclusion that the Commission should confine its work to the list related aspects of the problem.

## IV. Recommendation for September 24, 2003 MHCD Subcommittee Meeting

Seth stated that he would be willing to summarize the evidence and create a short guideline that could be attached to the list for mood disorders. He suggested that perhaps the other workgroup members could do the same for other diagnoses. Rather than proceeding in this fashion it was asked that staff compile a list of all suggested topics from this meeting (see Attachment 1) to take to the full subcommittee in September for them to prioritize. Kathy would like to see something regarding early psychosis intervention, as the use of a disease management approach has been shown to be effective, and she thought guidelines would be useful. Ann asked if the workgroup would like someone to speak to the subcommittee about evidence-based practices for substance abuse treatment. The workgroup agreed that they would, and Ann said she would arrange it for the next meeting. Before adjourning, Alison passed out 2 more handouts on suggestions that David Pollock had made to Darren. The first were samples of drug algorithms created by the Texas Medication Algorithm Project. The consensus of the group was that they were too complex, and it was premature to look at incorporating this work until it is decided whether Oregon will move forward with something similar, and even then we may want to wait a year after implementation begins to include this in the Prioritized List. It was agreed that further discussion should take place at the full subcommittee meeting. The second was an example of the SAMHSA Model Programs, which is a spreadsheet of all drug abuse prevention programs that have been shown to be effective. Since they were dealing only with prevention, Kathy didn't think they were pertinent to the workgroup's charge.

Seth mentioned that a potential source of huge cost savings was the growing body of evidence from non-drug company sponsored research that anti-depressants are not very effective for the majority of depressed patients. He did not believe that an adequate meta-analysis had been done yet to act on this, but felt it should be looked into. Alison agreed to do so, and asked if there were other similar issues that she should research as well. Kathy felt similar data may exist for ADHD.

There was discussion about having an appendix at the end of the Prioritized List that referenced evidence-based guidelines for mental health conditions.

## V. Public Comment

There was no public comment.

## VI. Adjournment

The MHCD Interim Workgroup meeting adjourned at 12:00 pm. If there is another meeting to be held, it will be scheduled sometime after the Mental Health Care and Chemical Dependency Subcommittee meeting, September 24, 2003.

**ATTACHMENT 1**

# MHCD Services With Potential For Establishing Evidence-Based Guidelines

A. Requirement of concomitant active therapy with parent for coverage of individual therapy for childhood mental illness
B. Daily structure and support for individuals with severe and persistent mental illness
C. Dialectic Behavioral Therapy (DBT) borderline personality and trauma disorders
D. Co-occurring disorders
    a. Substance abuse in physical health conditions, e.g. hepatitis C (after HSC determines which physical health lines to develop guidelines for)
E. Separate chemical dependency line in pharmalogical vs. non-pharmalogical treatment (biennial review)
F. Opiate substitution
G. Treatment of mental illness in children 0-3 (biennial review)
H. Early psychosis intervention
I. Neurological dysfunction lines (biennial review)
J. Texas Medicaid Algorithm Project (post-implementation)
K. Anti-depressant therapy
L. ADHD treatment
M. Appendix to Prioritized List on evidence-based guidelines by condition