MINUTES

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
February 19, 2003

Members Present: Donalda Dodson, RN, Chair; Kathy Savicki, LCSW; Carole Romm, RN; David Pollack, MD; Seth Bernstein; Gary Cobb.

Members Absent: Robert George, MD; Ann Uhler; Muriel Goldman; Bruce Piper.

Staff Present: Darren Coffman and Kathleen Weaver, MD.

Also Attending: Anita Miller, Office of Mental Health and Addiction Services (OMHAS)

I. Call to Order

Donalda Dodson called the meeting to order at 8:45 a.m. in Room 107 of the Meridian Park Hospital Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Darren Coffman noted attendance.

II. Approval of Minutes

The minutes from December 18, 2002 were approved as written.

III. Review of Recommended Coding Changes to Prioritized List Due to HIPAA

Darren Coffman presented the Subcommittee with a draft mapping of codes currently appearing on the 50+ MHCD lines and how they would appear using the crosswalk of OMAP unique codes of the form BAxxx and ECCxx provided by the Office of Mental Health and Addiction Services (OMHAS). The lines were broken into six categories and assigned to various Subcommittee members for review. The subcommittee proceeded to review the comments associated with lines related to personality disorders, anxiety disorders, and eating and other miscellaneous mental health disorders. See Attachment A for a table of the line items reviewed. Items indicated in bold are new recommendations that will be taken to the Health Services Commission (HSC) in May or June. Of the boldface items, those shown in strikethrough text will be deleted from the indicated lines and those not in strikethrough text will be added. No changes are being recommended to those items not shown in boldface type. Attachment B lists the specific codes associated with the services associated with the columns in Attachment A. Line items related to chemical dependency, psychotic disorders, and mental health disorders of childhood will be reviewed at the next subcommittee meeting.

Kathy Savicki said that a question had arisen recently on the coverage of hospital services for conditions that are not paired with hospital CPT codes on the Prioritized List. Darren Coffman indicated that the problem lies in the fact that the HSC declared hospital services to be ancillary services and therefore are automatically covered if the condition appearing on an inpatient claim is in the funded region of the list. Hospital facility charges are paid either by DRG codes or by revenue center codes paired with ICD-9-CM codes and therefore the current structure of the Prioritized List cannot exclude coverage of anything other than the professional component of a hospitalization for a covered condition. This issue will be taken to the HSC for consideration.

In addition to the changes to the list reflected in Attachment A, the following recommendations will also be taken to the HSC:

- Remove electro-convulsive treatment (ECT), represented by CPT codes 90870 and 90871, from all but the lines for severe depression and mood disorders.
- Restore CPT codes 90882, ENVIRONMENTAL MANIPULATION, and 90887, CONSULTATION WITH FAMILY, PER HR, to all line items that they were previously deleted from as a result of the recommendations of the Mental Health Lines Workgroup which met during the Winter of 2002.
- Add HCPCS codes T1013, SIGN LANGUAGE/ORAL INTERPRETER, 15 MINS, and T1016, CASE MANAGEMENT, 15 MINS, to all lines including outpatient mental health services.
- Delete the following codes from all mental health lines on which they currently appear:

  90845 PSYCHOANALYSIS
  90865 NARCOSYNTHESIS
  90875 PSYCHOPHYSIOLOGICAL THERAPY
  90876 PSYCHOPHYSIOLOGICAL THERAPY
  90880 HYPNOTHERAPY
  90885 PSYCHIATRIC EVALUATION OF RECORDS
  90889 PREPARATION OF REPORT
  90899 PSYCHIATRIC SERVICE/THERAPY UNSPECIFIED

IV. Health Services Commission Update

Darren Coffman reported on the changes that have taken place with the Oregon Health Plan since the December 18, 2002 meeting and those that are due to take place effective March 1, 2003. These include but are not limited to:

- Eliminate funding for 24-hour mental health crisis services
- Eliminate the Medically Needy program
- Eliminate services for long-term care clients in survivability levels 14-17
- Eliminate cost-based reimbursement for Type A and B hospitals
- Reduce reimbursement for prescription drugs to average wholesale price (AWP) minus 17%

- Eliminate prescription drugs, outpatient mental health and chemical dependency services, durable medical equipment, and the remaining dental services for the OHP Standard population (March 1)

Dr. Kathy Weaver reported that the HSC heard a presentation from Dr. Mark Helfand of the OHSU Evidence-based Practice Center at their January 23, 2003 meeting and plans to conduct a evidence-based review of select services on the Prioritized List in a manner similar to that undertaken by the Health Resources Commission for prescription drugs.

The subcommittee feels that major changes are going to be made to the Oregon Health Plan and would like to make sure that certain principles are used in guiding that process. They drafted a list of such principles as shown in Attachment C and asked that Donalda Dodson and Kathy Savicki take these to the March 6th HSC for consideration.

V. Other Business

Kathy Savicki asked for an update on the reimbursement for subacute detox services. Anita Miller reported that Ralph Summers has indicated that the necessary language has been added to the contracts to include this as a covered service. She is not aware of any additional outstanding issues (e.g. rules needing to be filed).

VI. Public Comment

No public comment was received.

VII. Adjournment

Donalda Dodson adjourned the meeting at 10:35 a.m. The next Mental Health Care and Chemical Dependency Subcommittee meeting is scheduled for March 28, 2003, 8:30 a.m.–10:30 a.m. in Room 107 of the Meridian Park Hospital Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon.

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Donald Dodson, RN, Chair

ATTACHMENT A

Changes to MHCD Line Items Resulting from HIPAA Crosswalk Review

Line	Condition	Outpatient[1]	75+min	Multi-fam group therapy	Med mgmt[2]	Activity therapy/ Training	Resi-dential[3]	Comm support	Respite	Crisis intervention	Hospital[4]
145	Anorexia nervosa*	X	X	X	X	X	X	X	X	X	X
376	Bulimia nervosa*	X	X	X	X	X	X	X	X	X	X
432	Functional encopresis	X	~~X~~	X	X	X	X	X	X	X	X
458	Eating disorder NOS*	X	?	X	X	X	X	X	X	X	X
514	Simple phobia	X		X	X	X	X	X	X	X	**P**
515	Social phobia	X		X	X	X	X	X	X	X	**P**
571	Sexual dysfunction	X	X	X	~~X~~	X	~~X~~	~~X~~	~~X~~	X	**P**
664	GID, paraphilias	X	X	X	~~X~~	X	~~X~~	~~X~~	~~X~~	X	**P**
730	No effective tx	E									
245	Acute Stress Disorder	X		X	X	~~X~~	~~X~~	X	X	X	**P?**
375	Anxiety Disorders	X		X	X	X	~~X~~	X	X	X	~~X~~
423	Chronic Depression	X		X	X	X	~~X~~	X	~~X~~	X	~~X~~
434	Psych Factors Aggravating Phys Condition	X		X	X	X	~~X~~	X	~~X~~	X	**C**

[1] Outpatient – X = standard outpatient therapy; L = limited outpatient therapy (no interactive psychotherapy); E = evaluation only
[2] Medication management – X = full coverage; L = limited coverage (no direct observation)
[3] Residential services – X = full coverage; S = short term only
[4] Hospital services – X = full coverage; P = partial hospitalization; C = initial inpatient consultation
* Line includes nursing facility care
Boldface type indicates changes agreed upon at the 2/19/03 subcommittee meeting

Line	Condition	Outpatient[1]	75+min	Multi-fam group therapy	Med mgmt[2]	Activity therapy/ Training	Resi-dential[3]	Comm support	Respite	Crisis intervention	Hospital[4]
460	Chronic Organic MH Disorders*	L		X	X	X	X	X	X	X	~~P~~
513	Somatization Disorders	L		~~X~~	X	~~X~~	**X**	X	~~X~~	X	~~P~~
615	Factitious Disorders	L	X	~~X~~	X	~~X~~	**X**	X	~~X~~	X	~~P~~
616	Hypochondriasis	L	X	~~X~~	X	~~X~~	X	X	~~X~~	X	~~P~~
267	Adjustment Disorders	X		X	X	X		X	X	X	**P**
304	PTSD~~*~~	X		X	X	X		X	X	X	X
305	OCD	X		X	X	X	~~X~~**?**	X	~~X~~	X	**PC**
339	Panic Disorder/ Agoraphobia	X		X	X	X	~~X~~	X	X	X	X
425	Borderline Personality	X		~~X~~	X	X	**S**	X	X	X	X
426	Identity Problem	X		X	~~X~~	X	~~X~~	~~X~~	~~X~~	~~X~~	~~P~~
427	Schizotypal Personality	X		X	X	X	**S**	X	X	X	X
475	Stereotypy/Habit Disorder	X		X	X	X	~~X~~	X	~~X~~	X	~~P~~
663	Other Personality Disorders	X	X	X	X	X	~~X~~	X	X	X	**P**
707	Anti-Social Personality	L		X	~~X~~	X	~~X~~	~~X~~	~~X~~	X	**X**

[1] Outpatient – X = standard outpatient therapy; L = limited outpatient therapy (no interactive psychotherapy); E = evaluation only
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[4] Hospital services – X = full coverage; P = partial hospitalization; C = initial inpatient consultation
* Line includes nursing facility care
Boldface type indicates changes agreed upon at the 2/19/03 subcommittee meeting

ATTACHMENT B

Detailed Procedure Code Listings For Service Categories Appearing In Attachment A

The following codes represent standard outpatient therapy as referenced in Attachment A. Those codes shown with an (^{L}) are included in the limited outpatient codes which exclude interactive psychotherapy as treatment and those indicated with an (^{E}) are included in a package which include evaluation services only.

90801^{L}	PSY DX INTERVIEW PER HOUR
90802	INTAC PSY DX INTERVIEW PER HR
90804^{L}	PSYTX, OFFICE, 20-30 MIN
90805^{L}	PSYTX, OFF, 20-30 MIN W/E&M
90806^{L}	PSYTX, OFF, 45-50 MIN
90807^{L}	PSYTX, OFF, 45-50 MIN W/E&M
90810	INTAC PSYTX, OFF, 20-30 MIN
90811	INTAC PSYTX, 20-30, W/E&M
90812	INTAC PSYTX, OFF, 45-50 MIN
90813	INTAC PSYTX, 45-50 MIN W/E&M
90846^{L}	FAMILY PSYTX W/O PATIENT PER HR
90847^{L}	FAMILY PSYTX W/PATIENT PER HR
90853^{L}	GROUP PSYCHOTHERAPY PER HR
90857	INTAC GROUP PSYTX PER HR
90882^{L}	ENVIRONMENTAL MANIPULATION
90887^{L}	CONSULTATION W/FAMILY PER HR
96100^{L}	PSYCHOLOGICAL TESTING, PER HR
H0002^{L}	BEHAV HEALTH SCREEN, TX ADMIT, 15 MINS
H0004^{L}	BEHAV HEALTH COUNS/THERAPY, 15 MINS
H0031^{L}	MH ASSESSMENT, NON-PHYSICIAN, 15 MINS
H0034^{L}	MEDICATION TRAINING/SUPPORT, 15 MINS
T1013^{L}	SIGN LANG/ORAL INTERPRETER, 15 MINS
T1016^{L}	CASE MANAGEMENT, 15 MINS
99201^{L,E}	OFFICE/OUTPATIENT VISIT, NEW
99202^{L,E}	OFFICE/OUTPATIENT VISIT, NEW
99203^{L,E}	OFFICE/OUTPATIENT VISIT, NEW
99204^{L,E}	OFFICE/OUTPATIENT VISIT, NEW
99205^{L,E}	OFFICE/OUTPATIENT VISIT, NEW
99211^{L,E}	OFFICE/OUTPATIENT VISIT, EST
99212^{L,E}	OFFICE/OUTPATIENT VISIT, EST
99213^{L,E}	OFFICE/OUTPATIENT VISIT, EST
99214^{L,E}	OFFICE/OUTPATIENT VISIT, EST
99215^{L,E}	OFFICE/OUTPATIENT VISIT, EST
99241^{L}	OFFICE CONSULTATION
99242^{L}	OFFICE CONSULTATION
99243^{L}	OFFICE CONSULTATION
99244^{L}	OFFICE CONSULTATION
99245^{L}	OFFICE CONSULTATION
99271^{L}	CONFIRMATORY CONSULTATION
99272^{L}	CONFIRMATORY CONSULTATION
99273^{L}	CONFIRMATORY CONSULTATION
99274^{L}	CONFIRMATORY CONSULTATION
99275^{L}	CONFIRMATORY CONSULTATION

The following codes represent psychotherapy sessions of 75+ minutes in duration as referenced in Attachment A. Those codes indicated with an (^{H}) are only to be included on lines with inpatient hospital, partial hospital, or nursing facility care services.

90808	PSYTX, OFFICE, 75-80 MIN
90809	PSYTX, OFF, 75-80, W/E&M
90814	INTAC PSYTX, OFF, 75-80 MIN
90815	INTAC PSYRX, 75-80 W/E&M
90821^{H}	PSYTX, HOSP, 75-80 MIN
90822^{H}	PSYTX, HOSP 75-80 MIN W/E&M
90828^{H}	INTAC PSYTX, HOSP 75-80 MIN
90829^{H}	INTAC PSYTX, HSP 75-80 W/E&M

Detailed Procedure Code Listings For
Service Categories Appearing In Attachment A (Cont'd)

The following code represents multi-family group therapy as referenced in Attachment A.

90849	MULTI-FAMILY GRP THERAPY PER HR

The following codes represent medication management as referenced in Attachment A. The single code shown with an (^{L}) is included in a limited group of services without direct observation.

90862^{L}	MEDICATION MANAGEMENT, 30 MIN
H0033	ORAL MED ADMIN, DIRECT OBSERV, 15 MIN

The following codes represent activity therapy and training & education services as referenced in Attachment A. The single code shown with a (^{T}) indicates the single code associated with training & education services only.

G0176	ACTIVITY THERAPY FOR MH COND, 15 MINS
G0177^{T}	TRAINING/EDUCATION FOR MH COND, 15 MIN

The following codes represent behavioral health residential treatment as referenced in Attachment A. The single code shown with an (^{S}) indicated the single code associated with short term residential treatment.

H0017	BEHAV HEALTH, RESIDENTIAL, PER DIEM
H0018^{S}	BEHAV HEALTH, SH TERM RES, PER DIEM
H0019	BEHAV HEALTH, LNG TERM RES, PER DIEM

The following codes represent community psychiatric supportive treatment as referenced in Attachment A.

H0036	COMMUNITY PSYCH SUPPORTIVE TX, 15 MIN
H0037	COMMUNITY PSYCH SUPPORT TX, PER DIEM

The following codes represent respite care as referenced in Attachment A.

H0045	RESPITE CARE, NOT IN HOME, PER DIEM
S5151	UNSKILLED RESPITE CARE, PER DIEM
T1005	RESPITE CARE SERVICES, 15 MINS

The following codes represent crisis intervention as referenced in Attachment A.

S9484	CRISIS INTERVENTION MH SERV, PER HR

The following codes represent nursing facility care services as referenced in Attachment A.

90816	PSYTX, HOSP/PH/NH, 20-30 MIN
90817	PSYTX, HOSP/PH/NH, 20-30 MIN W/E&M
90818	PSYTX, HOSP/PH/NH, 45-50 MIN
90819	PSYTX, HOSP/PH/NH, 45-50 MIN W/E&M
90820	DIAGNOSTIC INTERVIEW
90823	INTAC PSYTX, HOSP/PH/NH, 20-30 MIN
90824	INTAC PSYTX, HOSP/PH/NH, 20-30 W/E&M
90825	EVALUATION OF TESTS/RECORDS
90826	INTAC PSYTX, HOSP/PH/NH, 45-50 MIN
90827	INTAC PSYTX, HOSP/PH/NH, 45-50 W/E&M
99301	NURSING FACILITY CARE
99302	NURSING FACILITY CARE
99303	NURSING FACILITY CARE
99311	NURSING FAC CARE, SUBSEQ
99312	NURSING FAC CARE, SUBSEQ
99313	NURSING FAC CARE, SUBSEQ
99315	NURSING FAC DISCHARGE DAY
99316	NURSING FAC DISCHARGE DAY

Detailed Procedure Code Listings For
Service Categories Appearing In Attachment A (Cont'd)

The following codes represent hospital services as referenced in Attachment A. The single code shown with a (^{P}) indicated those codes associated with partial hospitalization. Those codes indicated with a (^{C}) are associated with an initial inpatient consultation.

90816^{P}	PSYTX, HOSP/PH/NH, 20-30 MIN
90817^{P}	PSYTX, HOSP/PH/NH, 20-30 MIN W/E&M
90818^{P}	PSYTX, HOSP/PH/NH, 45-50 MIN
90819^{P}	PSYTX, HOSP/PH/NH, 45-50 MIN W/E&M
90820^{P}	DIAGNOSTIC INTERVIEW
90823^{P}	INTAC PSYTX, HOSP/PH/NH, 20-30 MIN
90824^{P}	INTAC PSYTX, HOSP/PH/NH, 20-30 W/E&M
90825^{P}	EVALUATION OF TESTS/RECORDS
90826^{P}	INTAC PSYTX, HOSP/PH/NH, 45-50 MIN
90827^{P}	INTAC PSYTX, HOSP/PH/NH, 45-50 W/E&M
99217	OBSERVATION CARE DISCHARGE
99218	OBSERVATION CARE
99219	OBSERVATION CARE
99220	OBSERVATION CARE
99221	INITIAL HOSPITAL CARE
99222	INITIAL HOSPITAL CARE
99223	INITIAL HOSPITAL CARE
99231	SUBSEQUENT HOSPITAL CARE
99232	SUBSEQUENT HOSPITAL CARE
99233	SUBSEQUENT HOSPITAL CARE
99234	OBSERV/HOSP SAME DATE
99235	OBSERV/HOSP SAME DATE
99236	OBSERV/HOSP SAME DATE
99238	HOSPITAL DISCHARGE DAY
99239	HOSPITAL DISCHARGE DAY
99251^{C}	INITIAL INPATIENT CONSULT
99252^{C}	INITIAL INPATIENT CONSULT
99253^{C}	INITIAL INPATIENT CONSULT
99254^{C}	INITIAL INPATIENT CONSULT
99255^{C}	INITIAL INPATIENT CONSULT
99261^{C}	FOLLOW-UP INPATIENT CONSULT
99262^{C}	FOLLOW-UP INPATIENT CONSULT
99263^{C}	FOLLOW-UP INPATIENT CONSULT
H0035^{P}	MH PARTIAL HOSPITALIZATION, <24 HRS

ATTACHMENT C

Proposed Principles for Revising OHP

1) **Keep Prioritized List of Health Services but modify by moving the funding line higher.**

2) **Elevate preventive and other critical lines for this population.**

3) **Incorporate concepts from Access Proposal as formulated by the Oregon Health Council Access Subcommittee.**

4) **Decrease available treatment options within each line.**

5) **Add emphasis on level of acuity/severity/impaired function.**

6) **Emphasize vulnerability rather than poverty level.**

7) **Keep managed care.**

8) **Given severity of funding situation, should consider also applying this to OHP categorical population (OHP Plus).**

MINUTES
MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
March 28, 2003

Members Present: Donalda Dodson, RN, Chair; Kathy Savicki, LCSW; Carole Romm, RN; David Pollack, MD; Seth Bernstein.

Members Absent: Robert George, MD; Ann Uhler; Muriel Goldman; Bruce Piper, Gary Cobb.

Staff Present: Darren Coffman.

Also Attending: Anita Miller, Office of Mental Health and Addiction Services (OMHAS).

I. Call to Order

Donalda Dodson called the meeting of the Mental Health Care & Chemical Dependency Subcommittee (MHCD) to order at 8:45 a.m. in Room 107 of the Meridian Park Hospital Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Darren Coffman noted attendance.

II. Approval of Minutes (February 19, 2003)

The Minutes from the February 19, 2003 meeting were approved as written.

III. Continuation of the Review of Recommended Coding Changes to Prioritized List Due to HIPAA

Darren Coffman first led the Subcommittee through a review of the work completed at their February meeting on the placement of procedure codes for the treatment of personality disorders, anxiety disorders, and eating and other miscellaneous mental health disorders. Attachment A represents the results of that review reflecting the following changes:

- Do not pair 75+ minute therapy for lines 458 (Eating Disorder NOS), 571 (Sexual Dysfunction), 615 (Factitious Disorders), 616 (Hypochondriasis), 663 (Other Personality Disorders), and 664 (Gender Identification Disorder, Paraphilias)
- Leave medication management paired on line 571 (Sexual Dysfunction)
- Do not pair residential treatment with lines 305 (Obsessive Compulsive Disorders), 513 (Somatization Disorders), 514 (Simple Phobia), 515 (Social Phobia), and 615 (Factitious Disorders)

- Do not pair partial hospitalization with lines 267 (Adjustment Disorders), 305 (Obsessive Compulsive Disorder), 514 (Simple Phobia), 515 (Social Phobia), 571 (Sexual Dysfunction), 663 (Other Personality Disorders), and 664 (Gender Identification Disorder, Paraphilias)
- Pair all hospital services (instead of just partial hospitalization) with lines 245 (Acute Stress Disorder) and 460 (Chronic Organic Mental Disorders)
- Do not pair any hospitalization services with line 707 (Anti-social Personality)

All other changes previously noted in the minutes of February 19, 2003 will continue to be recommended.

Attachment B shows the continuation of the work on the pairing of appropriate services for the remainder of the mental health and chemical dependency (MHCD) lines on the Prioritized List. This included the line items in the general categories of psychotic disorders, mental health disorders of childhood, and chemical dependency. Staff is to contact specialists in child psychiatry at OHSU to make sure that the decisions indicated in Attachment B for rumination disorder, reactive attachment disorder, and PICA are appropriate.

All of the changes to the Prioritized List that result from these revised condition/treatment pairings using the HIPAA crosswalk provided by OMHAS will be forwarded to the HSC for incorporation into the list to go into effect on October 1, 2003.

IV. HSC Update

Darren Coffman gave a brief update on the Health Services Commission (HSC). He reported that Representatives Westlund, Bates, and Kruse came to the HSC meeting on March 6th. They summarized where things stood with the restructuring of the Oregon Health Plan (OHP). They would like the HSC to go ahead with plans to "squeeze" the Prioritized List by eliminating less effective services from within the line items. The legislature will likely be ready to come back to the HSC in mid-April with possibly more assignments as the blueprint for the future of the OHP becomes clearer. What is clear is that the Prioritized List is going to be a key component of whatever is done, as the savings that it achieves is needed now more than ever. It appears that there is consensus that MHCD should be provided to the mandatory populations and furthermore that there is a strong desire to have MHCD services provided for whatever package can be afforded for an optional Medicaid population.

Mr. Coffman continued by noting that most, if not all, of the principles for the OHP restructuring identified at the February subcommittee meeting are a part of the discussions taking place. He assured the subcommittee that it will continue to be a part of the process as the HSC becomes aware of the role that it will be asked to play.

V. Update on Early Detection and Treatment of Psychosis

Kathy Savicki introduced Tamara Sales, also from Mid-Valley Behavioral Healthcare Network, to give the Subcommittee an update on their program for early detection and treatment of psychosis. Ms. Sales reported that implementation of the programs guidelines has been underway for about two years. There are indications that their efforts are resulting in fewer hospitalizations and a return to work/school activities. A researcher has just been hired to help improve on the quality of their data and to work on further analysis.

The guidelines in use are based on those implemented in Australia, with the exception that treatment in the prodromal (pre-psychotic) phase is not being provided – a person must experience symptoms for 72 hours in order to be considered as having an ongoing psychosis. The primary goal of the program is to reduce long-term disability due to schizophrenia and bipolar disorder. A total of 120 people have been provided with services since the program began, with 16 enrolled as of December 2002. Ages of the individuals range from 15 to 30.

A public health approach that provides community education to providers, school personnel, and the media is used to raise awareness of the early symptoms of psychosis. Also, outreach to individuals needing treatment is conducted in order to establish a relationship with that person. A physician may go to the person's home if necessary. Family education is also a key component of the treatment. Protocol stipulates that polypharmacy be avoided – treatment starts with short-term benzodiazapines and low-dose anti-psychotics (which are then tapered up). Medication is usually continued for 2-5 years, but there is debate over the appropriate length.

About 60% of their clients are in OHP Standard, although some are now applying for disability in an effort to be provided services under OHP Plus. With the recent cuts in OHP Standard and other funding sources, they are seeking a four-year funding grant from the Robert Wood Johnson (RWJ) Foundation. OHSU is also applying for a NIH grant to replicate a study done in Maine in which a handful of kids were treated in the prodromal phase with none going on to develop a psychoses. Such a grant would be used to expand this program to include what appears to be a preventive service.

VI. OMHAS Issues

No issues were raised at this time.

VII. Other Business

No other business was identified at this time.

VIII. Public Comment

No public comment was given.

IX. Adjournment

Donalda Dodson adjourned the meeting at 10:30 am. The next Mental Health Care and Chemical Dependency Subcommittee meeting will be scheduled at a later date.

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Donald Dodson, RN, Chair

ATTACHMENT A

Revised Condition/Treatment Pairings on MHCD Lines Originally Reviewed at 2/19/03 Subcommittee Meeting

Line	Condition	Outpatient[1]	75+min	Multi-fam group therapy	Med mgmt[2]	Activity therapy/ Training	Resi-dential[3]	Comm support	Respite	Crisis intervention	Hospital[4]
145	Anorexia nervosa*	X	X	X	X	X	X	X	X	X	X
376	Bulimia nervosa*	X	X	X	X	X	X	X	X	X	X
432	Functional encopresis	X		X	X	X	X	X	X	X	X
458	Eating disorder NOS*	X		X	X	X	X	X	X	X	X
514	Simple phobia	X		X	X	X		X		X	
515	Social phobia	X		X	X	X		X		X	
571	Sexual dysfunction	X		X	X	X				X	
664	GID, paraphilias	X		X		X				X	
730	No effective tx	E									
245	Acute Stress Disorder	X		X	X			X	X	X	H
375	Anxiety Disorders	X		X	X	X		X	X	X	
423	Chronic Depression	X		X	X	X		X		X	
434	Psych Factors Aggravating Phys Condition	X		X	X	X		X		X	C
460	Chronic Organic MH Disorders*	L		X	X	X	X	X	X	X	X

[1] Outpatient – X = standard outpatient therapy; L = limited outpatient therapy (no interactive psychotherapy); E = evaluation only
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* Line includes nursing facility care

Line	Condition	Outpatient[1]	75+min	Multi-fam group therapy	Med mgmt[2]	Activity therapy/ Training	Resi-dential[3]	Comm support	Respite	Crisis intervention	Hospital[4]
513	Somatization Disorders	L			X			X		X	P
615	Factitious Disorders	L			X			X		X	P
616	Hypochondriasis	L			X		X	X		X	P
267	Adjustment Disorders	X		X	X	X		X	X	X	
304	PTSD*	X		X	X	X		X	X	X	X
305	OCD	X		X	X	X		X		X	C
339	Panic Disorder/ Agoraphobia	X		X	X	X		X	X	X	X
425	Borderline Personality	X			X	X	S	X	X	X	X
426	Identity Problem	X		X		X					P
427	Schizotypal Personality	X		X	X	X	S	X	X	X	X
475	Stereotypy/Habit Disorder	X		X	X	X		X		X	P
663	Other Personality Disorders	X		X	X	X		X	X	X	
707	Anti-Social Personality	L		X		X				X	

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* Line includes nursing facility care

ATTACHMENT B

Condition/Treatment Pairings on MHCD Lines Reviewed at 3/28/03 Subcommittee Meeting

Line	Condition	Outpatient[5]	75+min	Multi-family group therapy	Med mgmt[6]	Activity therapy/ Training[7]	Resi-dential[8]	Comm support	Respite	Crisis intervention	Hospital[9]
162	Schizophrenia*	X	X	X	X	X	X	X	X	X	X
163	Major Depression, Recurrent**	X	X	X	X	X	X	X	X	X	X
164	Bipolar Disorders**	X	X	X	X	X	X	X	X	X	X
189	Major Depression, Mild/Single Episode	X	X	X	X	X	X	X	X	X	X
190	Other Psychoses	X	X	X	X	X	X	X	X	X	X
390	Paranoid Disorder*	X	X	X	X	X	X	X	X	X	X
459	Dissociative Disorders	X	X	X	X	X	X	X	X	X	X
617	Conversion Disorder, Adult	X		X	X	X		X		X	C
92	Rumination Disorder	F		X						X	X
146	Reactive Attachment Disorders	X	X	X	X	X	X	X	X	X	X
191	ADHD	X		X	X	X		X	X	X	C
246	Separation Anxiety Disorder	X		X	X	X		X		X	
268	Oppositional Defiant Disorder	X		X	X	X	X	X	X	X	C
269	Tourette's/Tic Disorders	X		X	X	X		X		X	C

[5] Outpatient – X = standard outpatient therapy; L = limited outpatient therapy (no interactive psychotherapy); F = therapy involving family only; E = evaluation only
[6] Medication management – X = full coverage; L = limited coverage (no direct observation)
[7] X = activity therapy and training & education for MH condition; T = training & education for MH condition only
[8] Residential services – X = full coverage; S = short term only
[9] Hospital services – X = full coverage; P = partial hospitalization; C = initial inpatient consultation
* Line includes nursing facility care (physician services only)
** Line includes nursing facility care (physician services only) and electro-convulsive therapy (ECT)

Line	Condition	Outpatient[5]	75+min	Multi-family group therapy	Med mgmt[6]	Activity therapy/ Training[7]	Resi-dential[8]	Comm support	Respite	Crisis intervention	Hospital[9]
374	Conduct Disorder, Child	X		X	X	X	X	X	X	X	C
431	Conversion Disorder, Child	X		X	X	X		X		X	C
433	Avoidant Disorder	X		X	X	X		X		X	
569	Impulse Disorders	X		X	X	X	X	X	X	X	C
633	PICA	X		X		T					C
186	Tobacco Dependence										
188	CD Abuse & Dependence†	X	X	X	X						X
264	Substance-Induced Delirium				X						X
424	Substance-Induced Delusions/Intoxication*	X	X	X	X						X

[1] Outpatient – X = standard outpatient therapy; L = limited outpatient therapy (no interactive psychotherapy); F = therapy involving family only; E = evaluation only
[2] Medication management – X = full coverage; L = limited coverage (no direct observation)
[3] X = activity therapy and training & education for MH condition; T = training & education for MH condition only
[4] Residential services – X = full coverage; S = short term only
[5] Hospital services – X = full coverage; P = partial hospitalization; C = initial inpatient consultation
* Line includes nursing facility care (physician services only)
† Coverage is to include the A&D treatment program (H2035), sub-acute detoxification (H0012), and case management (H0006)

MINUTES

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
June 25, 2003

Members Present: Donalda Dodson, RN, Chair; Kathy Savicki, LCSW; Carole Romm, RN; David Pollack, MD; Seth Bernstein; Gary Cobb; Ann Uhler.

Members Absent: Robert George, MD; Muriel Goldman; Bruce Piper.

Staff Present: Darren Coffman; Laura Lanssens.

Also Attending: Ralph Summers, MSW, Office of Mental Health and Addiction Services (OMHAS); Kim Burgess, Washington County Health & Human Services; Joe Hromco, PhD, Tuality Valley Centers; Doris Cameron Minard, National Association for the Mentally Ill (NAMI); Diane Lund, Oregon Health Forum (OHF).

I. Call to Order

Donalda Dodson called the meeting to order at 8:39 a.m. in Room 104 of the Meridian Park Hospital Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Members and guests introduced themselves to those in attendance.

II. Approval of Minutes

The approval of the March 28, 2003 minutes was deferred until the next meeting.

III. Process for Incorporating Evidence-Based Research into Prioritized List

Dr. Eric Walsh explained that he came to today's meeting to open a dialogue with the subcommittee on their willingness to advise the Health Services Commission (HSC) on how to most effectively spend limited resources on mental health and chemical dependency (MHCD) services. In particular, this could include identifying those services that are ineffective or potentially harmful which the state should not pay for.

Dr. Walsh reported that the HSC formed the Evidence-Based List Task Force, which he chairs. This task force held their second meeting last week where they developed a process using evidence-based research to help determine which new and established physical health services should be covered on the Prioritized List of Health Services.

There are many things already on the Prioritized List that we don't know whether they are truly effective or not, we only think that they are. This process will not remove such

services from the list just because their effectiveness is unknown. However, more scrutiny can be given to newer technologies. The task force is recommending that the HSC wait until evidence exists as to their effectiveness on any of a list of accepted sources of evidence-based research.

The HSC will be working with the OHSU Evidence-based Practice Center as the Commission refines this process. The HSC will also consult with the Health Resources Commission (HRC), as the HRC is often coming across information on the effectiveness of specific drugs for certain conditions that the HSC might want to include in a guideline. This will not result in a duplication of effort as the HRC only compares drugs within a drug class on their overall effectiveness across all indications of use.

Dr. Walsh used the treatment of benign prostatic hypertrophy (BPH) as a condition for which the HSC has already developed a guideline and could act as a template for more. Ann Uhler pointed out that the MHCD Subcommittee had also developed a guideline for smoking cessation, where medication was found to be more successful if used in combination with counseling.

Dr. Walsh said that the Evidence-Based List Task Force looked for existing evidence-based research on the most common services provided under the Oregon Health Plan (OHP). One item that came as a surprise was information of bypass surgery for peripheral claudication. This is a very common procedure and very expensive. However, while this procedure is certainly accepted as standard of care, the evidence indicates that it does not prolong life nor does it prevent the amputation of limbs any better than conservative treatments. During the task force's search of evidence they also came across studies of mental health services, such as a review from the Cochrane Collaborative on the treatment of schizophrenia. Dr. Walsh sees the introduction of new and expensive antipsychotic drugs that are then used for off-label conditions where the evidence for effectiveness is unknown. He asked for consultation from the subcommittee on whether they thought that the process developed by the task force could be used for MHCD conditions. Furthermore, he would like the subcommittee to provide consultation when physical health conditions involved MHCD co-morbidities.

Kathy Savicki said that she had done a cursory look at the websites and could not find anything on co-occurring disease. She did find some summary articles from Dartmouth and one by Pat Mastik on mental health treatments for kids made it clear that the accepted levels of evidence are lower than in the physical health arena. Ann Uhler said that different sites on evidence-based research were available for chemical dependency, including the National Institute on Drug Abuse (www.nida.nih.gov) and TIPs (Treatment Improvement Protocols). Dr. Walsh noted that the number of variables involved the difficulty in defining outcomes make it harder to conduct a controlled study for MHCD treatments.

Ralph Summers noted that Oregon is one of six states working with the National Association of State Mental Health Program Directors in identifying how best to move towards the use of best-supported practices in mental health treatment.

Some areas of service that might be considered for review include the treatment of schizophrenia (a guideline was published by NICE in March), the use of Lithium vs. Depekote, and the substantial utilization of Neurontin. Kathy Savicki cautioned that the subcommittee should make recommendations for a services placement on or off of the Prioritized List or the creation of a guideline, but should forward on to OMAP or OMHAS any potential management strategies for medication usage. Similarly, if evidence is found to support a particular care model, that information should be passed along to the MHOs.

A question was asked of whether guidelines for physical health services could include direction on the use of MHCD treatments. Ann Uhler indicated that a study was done on the savings expected on physical health care with the inclusion of alcohol & drug treatment in the benefit package. She also said that a meta-analysis exists that lists the physical health conditions that are impacted by alcohol and drug treatment. Staff will attempt to locate these materials prior to the next meeting.

IV. HSC Update

Darren Coffman gave a brief update on the work of the Health Services Commission (HSC) since the last subcommittee meeting. He noted that Dr. Walsh had provided a good report on the work of the Evidence-Based List Task Force. A second task force of the HSC had their first meeting in May, the Line Zero Task Force. This task force is being chaired by Dr. Dan Mangum. It was created to look at services that are covered by OHP that are not associated with a particular line item on the Prioritized List. These are primarily diagnostic, and to a lesser degree, ancillary services.

The task force had discussions in four general areas:

- Imaging services - The task force is considering recommending the exclusion of the coverage of PET scans for treatment management in following patients who are undergoing therapy. The use of PET scans for initial diagnosis and staging was thought to be of more worth.
- Incontinence supplies - The task force wants to explore tying stricter limits to individual diagnoses as compared to the current limit of 360 units/month for any diagnosis.
- Transportation services – The task force will hold off on this topic to see whether current efforts to capitate health plans for this services or set up brokerages come to pass, which may help to control costs.
- Emergency Department (ED) visits – The task for will review a list of diagnosis codes determined to be inappropriate for ED visits that was developed at CareOregon. It is thought that reimbursing ED visits with those diagnoses at a

lower rate would encourage an increase in the use of urgent care clinics see these patients in a more cost-efficient manner.

The Line Zero Task Force will hold its next meeting on July 24, 2003, just after the Health Outcomes Subcommittee and just prior to the full commission meeting.

V. Workplan for Remainder of 2003

An interim workgroup meeting will be scheduled in late July or early August to discuss what mental health and chemical dependency conditions should be looked at first in reviewing best practices and evidence-based research on treatment effectiveness. Those line items with the highest cost will be given the most consideration. The workgroup is to include subcommittee members Kathy Savicki, David Pollack, Ann Uhler, Seth Bernstein, Carole Romm and include participation by Ralph Summers and staff members Darren Coffman and Alison Little.

There is already underway an effort by the MHO Rate Finance Committee to look at ways to manage the high cost of prescription drugs. The subcommittee does not want to interfere with that process but would like to be kept informed of its progress.

VI. OMHAS Issues

OMHAS Issues were not discussed at this time.

VII. Other Business

Kathy Savicki will present on diagnostic services for the 0-3 age group at the next meeting.

Darren Coffman indicated that he had received a reply from Dr. Nancy Winters at OHSU on appropriate services for mental health conditions affecting infants. She agreed with the treatment options listed for reactive attachment disorder from the March meeting. Dr. Winters had a question of whether community support and/or respite care might be needed in a diagnosis of pica, but the subcommittee noted that there would be a co-occurring disorder in such a case and those treatments would be covered on a higher line. Also, based in Dr. Winters comments, it became apparent to the subcommittee that the title of the line for rumination disorder should be changed to coincide with a change in DSM-IV-TR terminology.

VIII. Public Comment

No public comment was received.

IX. Adjournment

Donalda Dodson adjourned the meeting at 10:35 a.m. The next Mental Health Care and Chemical Dependency Subcommittee meeting was tentatively scheduled for Wednesday, September 25, 2003 from 8:30 am – 11:30 am pending member availability at a location to be determined.

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Donald Dodson, RN, Chair

MINUTES
MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
September 24, 2003

Members Present: Donalda Dodson, RN, MPH, Chair; Kathy Savicki, LCSW; David Pollack, MD; Gary Cobb; Ann Uhler; Carole Romm; Seth Bernstein, PhD; Bob George, MD.

Members Absent: Muriel Goldman; Bruce Piper.

Staff Present: Darren Coffman; Alison Little, MD.

Also Attending: Ralph Summers, MSW, Department of Human Services/Office of Mental Health & Addiction Services (DHS/OMHAS); Steve Gallon, Northwest Frontier Addiction Technology Transfer Center/OHSU.

I. Call to Order

Donalda Dodson, Chair called to order the meeting of the Mental Health Care & Chemical Dependency Subcommittee (MHCD) at 8:30 a.m., in Room 107 of the Meridian Park Hospital Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Darren Coffman noted attendance.

II. Approval of Minutes

The June 25, 2003 MHCD Subcommittee Minutes were reviewed and a minor correction was requested on page 2. In the fourth paragraph, third sentence down the name *Pat Mastik* is changed to Pat Mrazek.

The August 11, 2003 Interim Workgroup Minutes were reviewed and a minor changed was requested on page 2, second paragraph, first sentence. **Delete** "…*and that only qualified professionals who could deal with both problems should be able to treat the patient".* The sentence should read as follows: "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."

Both sets of minutes were corrected and sent electronically to the MHCD members for their approval.

III. HSC Update

Donalda informed the Subcommittee that a guest speaker was attending; hence she was going to alter the agenda. Introductions were made, then the committee heard a presentation by Steve Gallon of OHSU about best practices in alcohol and drug treatment. Steve Gallon first asked for clarification of what the Subcommittee's task was, and what they would like to accomplish. Kathy Savicki stated that the Health Services Commission is looking for ways to use evidence-based research to shape the benefit package for the health plan with an emphasis on cost containment. They would like to identify what in the literature could be applied to the Prioritized List. Donalda added that there are 3 possibilities: one is that the literature supports that an intervention truly is a best practice, another is that there is no evidence either to support or refute effectiveness, and lastly, there may be evidence that an intervention is NOT effective.

Carole Romm asked if the intention was to consider the strength of the evidence, as is done on with physical health. Kathy Savicki stated that there is an awareness that evidence may be different in mental health than physical health, and that this Subcommittee is considering including the strength of the evidence.

David Pollack stated that there are 3 different kinds of practice; values driven practice, emerging or promising practice and evidence based practice. There are 6 types of practice that have been identified that can be labeled evidence-based. In general, they are not tied to a particular diagnosis, but are types of treatment, for example, supported employment and treatment of co-occurring illness. There has recently been an attempt to link those evidence-based practices to levels of care. He asked whether the Commission intended to limit itself to evidence-based treatment, or consider promising treatments as well.

Kathy Savicki reported that she was recently at a meeting in Washington DC which referenced the National Registry of Effective Programs. They use rigorous criteria when rating an intervention evidence-based, but also identify model programs and promising programs. It is part of the Center for Substance Abuse Prevention (CSAP), which is part of Substance Abuse and Mental Health Services Administration (SAMHSA). The current listings are for CD prevention; they are beginning to incorporate MH prevention and both MH and CD treatment models.

Steve Gallon then proceeded to speak, explaining that in 1999, the National Institute on Drug Abuse published a small book called Principals of Effective Drug Abuse Treatment, which describes 13 principles of treatment. They appear to be common sense, however many health systems do not take them into account. They include the following:

- No single treatment is appropriate for every individual (individualized treatment)
- Treatment needs to be readily available
- Treatment tends to multiple needs of the individual

- Treatment plans ought be assessed frequently, and case management should be available
- Treatment needs to be available for an adequate period of time (90 days is minimum)
- Behavior therapy and counseling are critical components
- Medications must be available and reimbursable
- Co-occurring illness should be treated in an integrated fashion
- Medical detox is only the first stage of recovery, and assessment of the effectiveness of detox should not be based solely on recovery rates
- Treatment doesn't need to be voluntary to be effective
- Drug use during treatment should be monitored continually and should not be criteria for termination from treatment
- Treatment programs should provide assessment for infectious diseases
- Recovery is a long term process and frequently requires multiple episodes of care

There was concurrence among the group that the goal of treatment need not be abstinence, but could be harm reduction, but that this in not an option in this country, despite good evidence that strict abstinence is not required.

Steve Gallon continued with material developed by William Miller. There are 5 practices that he feels warrant an evidence-based moniker, even though they have not been tested in randomized controlled trials. These are:

- Brief interventions by a primary care provider are effective early on in the course of disease
- Social skills training is effective (life skills relevant to their drug use)
- Motivational enhancement (research is not solid, assessed in alcohol but not drugs) – assess readiness for change and target intervention to the appropriate level
- Community reinforcement – assuring that patient has access to other community services (legal aid, marriage counseling, etc)
- Behavioral contracting (patient and therapist make agreements)

There was discussion and agreement that all of these principles are consistent with the chronic care model, that dissemination of information about the desired practice was essential, and that implementation of best practices is extremely expensive.

Steve Gallon continued. There are seven gold standard elements of treatment endorsed by NIDA and NIAAA, which all have manualized approaches and lots of clinical trials:

- Cognitive behavioral interventions - Structured interventions that link thinking process with behavior
- Community reinforcement (case managed access to community resources), with and without the use of contingency management (i.e., voucher for clean urine)

- Contingency management - clients have opportunity to earn rewards for appropriate behavior (can be done in the absence of community reinforcement)
- Motivational Enhancement Therapy – stages of change model (treatment plans consistent with client's readiness for change)
- 12 step facilitation – orients the client to 12 step program before first meeting
- Pharmacotherapy – antabuse, methadone, buprenorphine, naltrexone
- Systems treatment – family therapy, couple intervention, etc

It was requested to attach a copy of Hester and Miller, 1995, Effective Treatments of Alcohol and Drug Dependency to the minutes (see Attachment 1).

There was discussion about the role of spirituality in treatment, and about how to incorporate these best practices into the List, possibly through guidelines. Darren Coffman commented that to date, guidelines have been prescriptive, which would be difficult in mental health. There was acknowledgement that institution of best practices would be cost effective in the long term, but would increase expense in the short-term. The passage of Senate Bill 267 was also mentioned, and the fact that all programs related to reduction in crime must demonstrate that they are using their funds to support programs that have an evidence basis to them.

Ralph Summers noted that case management would be a managed care only encounterable service for chemical dependency effective October 1. Kathy Savicki pointed out that the actuaries predict the increased costs of medical care based on new technologies, and expressed concern that they may be less skilled in anticipating future developments and costs in the delivery of behavioral health services. She wondered whether these issues could be addressed in the HSC's work with the actuary on rate setting models. Darren Coffman stated that he thought it unlikely that the actuary for the Health Services Commission would reach the kind of detail she was referring to. Alison Little asked what services are currently not being covered. Kathy Savicki replied that it wasn't a matter of types of treatment not being covered, but a matter of insufficient intensity and length of treatment. Carole Romm asked if adoption of the 7 gold standards and attaching them to the list was a good idea.

There was concern that codes were not specific enough to accomplish what was desired. Ann pointed out that all the research is based on individual treatment, while Oregon almost exclusively uses group treatment. The idea of a pilot project was discussed which would incorporate the best practices to determine their cost before extending it to the whole list. Carole suggested that one site could serve as a model. Ralph stated that it was inappropriate to incorporate all these practices in one site at one time, and that it would take a long time to do so. He cautioned against any proposal that would require more money from the legislature. Carole recommended that the state change their audit mechanism to incorporate these best practices. Ralph replied that OMHAS already was. Ann cautioned that these evidence-based principals have not been tested on special populations.

Darren Coffman shared that House Bill 3624 encourages the Commission to incorporate cost-effectiveness into the prioritization of services. Ralph gave the example of daily structure and support, which has little evidence of effectiveness but high cost. He recommended shifting utilization from one service to another, and there was concurrence among the group to use best practices to determine what services are paid for. Darren clarified that the absence of evidence may be used to remove services from the list IF there is another service for which there is evidence of effectiveness that is less costly. There was discussion of the coding of Daily Structure and Support, and of use of treatment guidelines on various lines.

IV. OMHAS Update

Due to time constraints, Ralph Summers forewent his update.

V. Prioritization of recommendations from August 11, 2003 MHCD Evidence-based Workgroup regarding MHCD Services amenable to Guidelines

The subcommittee had made a commitment to prioritize a list of treatments attached to the Evidence-based Workgroup minutes at their last meeting. However, Donalda Dodson felt that direction was needed from the full Commission before proceeding.

VI. Review of Evidence-Based Research on Specific Diseases

A. ADHD

Alison Little handed out evidence based research from the British Medical Journal and the Canadian Coordinating Office of Health Technology Assessment on Attention Deficit Hyperactivity Disorder, which shows that medication is effective but behavioral therapy is not. Bob George explained that behavioral therapy is necessary because without it, children don't continue on their medication. Kathy Savicki noted that this assessment suggested that treatment could all be done in the primary care office, and others noted that most of it already is. She pointed out that the guidelines would also suggest limiting codes on this line, possibly eliminating family therapy. Bob George disagreed, saying he thought it was important to include this in order for the child to continue on the medicine and receive effective treatment. Kathy Savicki commented that this evidence didn't seem to support this view. Bob George stated he had concerns about the structure of one of the studies, and expressed concern that managed care organizations are limiting what medications can be used. There was also discussion of the denial of medication based on off-label use, and the role of the FDA. David Pollack countered that the managed care organizations are in the position of having inadequate information about the patient they are making decisions about, and conflicting opinions from different psychiatrists about what medication is appropriate.

B. Depression

Alison Little passed out an article that had been sent to the Subcommittee by Seth Bernstein, which showed that 80% of the effectiveness of anti-depressants could be explained by the placebo effect. She also passed out a practice guideline from the Agency for Healthcare Research and Quality, which dealt with the evidence around medications for depression. David Pollack clarified that the understanding in the psychiatric community is that medications are effective in treating depression, counseling is as well, the 2 combined are probably more effective, and that medication may not be very effective for cases of mild depression or mood disorder. Seth Bernstein discussed the first article, suggesting that coverage of anti-depressants might not be the best use of mental health dollars. David Pollack referenced the ARC study, which shows that newer antidepressants are no more effective than the older ones, and that the only difference was due to adherence, which was also minimally different between the two groups. There was consensus that this Subcommittee was not going to deal with medications, since the Health Resources Commission is doing this work. Darren Coffman clarified that the HRC is forbidden to look at mental health drugs, but that the Health Services Commission is going to look at some drugs. David Pollack is trying to develop some programs to deal with mental health drugs in a variety of different ways that will be allowed by the legislature.

C. Schizophrenia

Alison Little next distributed the NICE (National Institute for Clinical Excellence) guideline for schizophrenia, pointing out an audit tool at the end that detailed the various aspects of treatment. It was noted that every other page was missing, and Alison Little promised to send the full guideline by email. Ralph pointed out that effective October 1, new codes would be available which correspond to proven treatments for adults with severe mental illness, such as supported employment.

VII. Recommendations for Next Steps

There was discussion of what the next steps should be, whether a guideline should be attached to the list or not. Donalda Dodson felt that guidance from the full Commission was necessary, as these guidelines are significantly different from guidelines the Commission has used before. What the Subcommittee is proposing are more suggestions than mandates, and deal more with treatment than diagnosis. Bob George cautioned against using a guideline created in another country with a different structure of health care delivery and finance. He suggested using the American Psychiatric Association's guideline, and the need for expert review. Alison Little clarified that the Commission's directive is to move away from expert review and focus more on evidence. Kathy Savicki stated that specialty society guidelines generally look more like consensus statements than evidence-based reviews. Bob George was concerned that presence of a guideline posed a risk from a legal point of view, in that when a guideline exists, deviation from that guideline can be grounds for malpractice. There is also peril

in relying only on what has been proven to be effective in clinical trials, citing treatment of children as an example. Kathy Savicki pointed out that the schizophrenia guideline has ratings of the levels of evidence, and that very few of them received an A rating. There was discussion of the need to keep a guideline updated. Darren pointed out that most bodies that create such guidelines have an automatic update process.

IX. Public Comment

There was no public comment.

X. Adjournment

Donalda Dodson adjourned the meeting at 11:30 a.m. The next Mental Health Care and Chemical Dependency Subcommittee meeting will be held on November 12, 2003, in Room 105 of the Meridian Park Hospital Health Education Center, from 8:30 am to 10:30 am.

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Donald Dodson, RN, MPH, Chair

MINUTES
MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
November 12, 2003

Members Present: Donalda Dodson, RN, MPH, Chair; Kathy Savicki, LCSW; David Pollack, MD; Gary Cobb; Ann Uhler; Carole Romm, RN; Seth Bernstein, PhD; Bob George, MD.

Members Absent: Muriel Goldman; Bruce Piper.

Staff Present: Darren Coffman; Alison Little, MD.

Also Attending: Ralph Summers, MSW, Department of Human Services/Office of Mental Health & Addiction Services (DHS/OMHAS); Casadi Marino.

I. Call to Order

Donalda Dodson, Chair called to order the meeting of the Mental Health Care & Chemical Dependency (MHCD) Subcommittee at 8:40 a.m. in Room 105 of the Meridian Park Hospital Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Darren Coffman noted attendance.

II. Approval of September 24, 2003 Minutes

There were multiple corrections to the minutes. Due to the extensive nature of these, it was agreed that they would be emailed to Alison Little after the meeting, and formal approval of the minutes will occur at the next meeting.

III. HSC Update

Darren Coffman informed the Subcommittee that the focus of the upcoming Health Services Commission meeting will be how to incorporate cost-effectiveness information into the evidence-based medicine process. He also informed the Subcommittee that Dr. Som Saha, a prospective commissioner with expertise in cost-effectiveness analysis, would be attending the meeting. Donalda Dodson stated that a presentation was given at the last meeting by a health economist who described the skills needed, and recommended that the Commission obtain such expertise.

IV. OMHAS Update

Donalda Dodson introduced the topic by explaining that it was her understanding from the last meeting of the Subcommittee that there were activities occurring in the Office of Mental Health and Addiction Services (OMHAS) that pertain to, and may overlap, the Subcommittee's charge of incorporating evidence-based medicine for mental health diagnoses into the Prioritized List. Because of that, she asked Ralph Summers to update the Subcommittee on the activities of his office, and David Pollack to update them regarding his work with mental health drugs and evidence-based medicine in mental health. She also reported that when she presented a summary of the Subcommittee's September meeting to the full commission, there appeared to be a lack of understanding, and more interest in more concrete recommendations.

Ralph Summers indicated there were a number of items that he wanted to briefly update the Subcommittee on. A few weeks ago, a public psychiatry conference was held which was focused on rational prescribing, the Texas Medication Algorithm Project and provider profiling regarding mental health drugs. The following week, the Governor's Council on Alcohol and Drug Abuse held a summit meeting that represented a team model to help inform the annual plan that has to be submitted to the Governor's office. One session was focused on evidence-based medicine, and that will be shared with the Subcommittee once it is written. It included a presentation by Dennis McCarty from OHSU. It was agreed that the slides from his presentation would be sent to the Subcommittee as well.

Senate Bill 267 directs the Department of Corrections, the Oregon Youth Authority, the Department of Human Services and the Commission on Children and Families to assure that in the coming biennium, 25% of the services purchased are evidence-based practices or programs, with the percentage increasing to 50% in the following biennium and 75% in the third biennium. The legislation was promoted by the judicial subcommittee. OMHAS is in the process of assembling a stakeholders group to implement this mandate, which should be in place by January.

In addition, there are two specific tasks that the agency is working on. First, a Resources for Recovery grant from the Robert Wood Johnson Foundation for planning and technical assistance regarding alcohol and drug services. This grant is designed to identify what can be done in the context of a residential stay to increase effectiveness, and secondly, what can be done in the context of both the community and residential treatment to increase the effectiveness of transitions.

Secondly, there is a budget note requiring OMHAS to include psychiatric children's services at the state hospital, as well as psychiatric residential and day treatment services for children, into local original managed care environments. The goal is to create a complete continuum of services under one management umbrella so there are fewer incentives to shift responsibility.

Ralph Summers also reported that there is still no answer from CMS regarding the waiver amendment. He pointed out that this is a somewhat unique situation, since the proposed benefit package is more comprehensive than the one currently in place. Due to the complexities of implementation, the department has made the decision to not implement any sooner than 60 days after approval is received from CMS, and to only begin implementation on the first of the month.

David Pollack added there are two additional initiatives. One is a pilot program for supported employment for adults with severe and persistent mental illness. The other is an Expert Committee on Medical and Psychiatric Practice, which is charged with addressing the problems with the state hospital system.

Bob George asked if it was true that 2 children's units had been closed. David Pollack answered no, and explained that 2 adolescent units were consolidated down to one with a census of 19. Ralph Summers added that a year and a half ago, the young children's unit at the state hospital was closed, and a secure inpatient unit for children in Portland was opened. Additional children's residential beds were added as well. Bob George expressed concern about the way children's care was being managed, and after discussion, it was agreed to put this item on the agenda for the next meeting. To be discussed would be intensive mental health services and drug management of children, along with A&D services for kids and mental health for children from 0-3 years of age.

V. Discussion of HSC's Comments on Work Done So Far on Incorporation of Evidence-Based Research into MHCD Line Items

David Pollack proceeded to discuss two additional initiatives that his office is undertaking. The first is TMAP, the Texas Medication Algorithm Project, which is a prospective introduction of evidence-based algorithmic approaches to treatment guidelines for psychosis, depression and bipolar disorder. In addition, the project includes a standardized progress note, as well as a curriculum of education for consumers. He then gave a power point presentation about the second initiative (see attached slides). The content is summarized as follows:

The cost of all mental health medications in the last calendar year was approximately $12 million per month or $144 million per year. The same amount was spent on all other mental health services. The top 10 most expensive medications accounted for $103 million of the total drug costs. The first 2 are atypical anti-psychotics and the third is Neurontin. 31% of all medication expenses are for mental health medications.

The goals of this initiative are to maintain access to mental health medications, increase quality of care and contain costs. To accomplish this, the proposed interventions are voluntary (as involuntary interventions --a formulary or Preferred Drug List -- are prohibited by the legislature) and emphasize quality improvement. Regarding system focused strategies, the recommendation is to do bulk purchasing, and to include all fee-for-service patients in some kind of management of their pharmacy benefit. For the

strategy of increasing accountability, the goal is to do provider profiling and academic detailing. This is hampered by inadequacy of the information system (~30% of prescriptions do not have the prescriber identified).

Regarding the medication specific strategies, there are two areas of focus; one is quality improvement and the other is cost-effectiveness. In the first arena, this includes ensuring an adequate time of treatment with one medication before it is changed, adhering to psychiatric medications, limiting polypharmacy (2 or more atypical anti-psychotics or 4 or more mental health medications of any kind), limiting the number of psychiatric prescribers, ensuring appropriate dosing and limiting off-label use. The cost-effectiveness strategies include dose consolidation, pill splitting, and use of the least expensive medication that is appropriate. When any of these issues are identified on the provider profile, the plan is to send a letter to the provider informing them of the issue and making recommendations, and possibly to facilitate a change in prescription. This would come from the local MHO or FCHP medical director. For those who don't respond, peer-to-peer consultation from a psychiatrist and/or doctor of pharmacy would occur.

Data was then reviewed from the prior year. Two-thirds of the cost of prescriptions can be attributed to primary care providers (PCPs), and more than two-thirds are written by PCPs. Only 9% (psychiatrists) and 11% (PCP) of all SSRI prescriptions were for generic fluoxetine. Regarding anti-psychotics, the most cost-effective medications are Geodon, Risperdal and Seroquel, and they currently comprise over 60% of all the atypical anti-psychotic prescriptions. Of all mood stabilizers, Neurontin is prescribed most often (28%). A slide looking at duplication of anti-depressants indicates a fairly low frequency of that occurrence, however 20% of all patients receiving an atypical anti-psychotic were on two or more for more than 60 days. A total of 22,000 patients received their anti-psychotics from a PCP, and 15,000 received them from a psychiatric prescriber. 19% of patients receive 4 or more mental health medications. Estimated cost-savings from the cost-effectiveness measures are $1 to 4 million just for pill splitting and dose consolidation. By using the most cost-effective medications (Geodon, Risperdal, Seroquel, Lithium, fluoxetine), up to $17 million could be saved.

David Pollack concluded his presentation by stating that the initiative described above will be implemented first. OMHAS is in the process of finalizing an RFP for an outside consulting company to assist with the project. Once a consultant is chosen, or if it is determined that the department will do the project alone, it will commence. On the other hand, TMAP will take at least a year to implement.

VI. Recommendations for Next Steps

There was extensive discussion about whether or not to formally present this information to the Health Services Commission. It was agreed that the evidence-based issues confronting the Subcommittee are related to systems of care, and ways to deliver a whole range of services that are embedded in a single line. Given that, there is little

that the Subcommittee can make formal decisions about that will directly affect the List. Ultimately, it was decided to hear a presentation on TMAP at a future Subcommittee meeting and have Eric Walsh attend. In addition, David Pollack will meet with him individually.

The Subcommittee will report to the Commission that evidence-based work is occurring within OMHAS in the form of several different projects. It makes less sense for the subcommittee to develop a set of recommendations around evidence-based practice than it does for other key organizations that are currently engaged in these activities to do so. This is because the format of the List does not address those areas where evidence-based practices are applicable. In the course of the Subcommittee's involvement in the other projects that are currently ongoing, they will watch for opportunities for the Health Services Commission to support the ongoing initiatives in evidence-based medicine.

VII. 2004 Biennial Review

This subject was not discussed.

VIII. Other Business

There was no other business

IX. Public Comment

There was no public comment.

X. Adjournment

Donalda Dodson adjourned the meeting at 10:35 a.m. The next Mental Health Care and Chemical Dependency Subcommittee meeting will be held on January 21, 2004, 8:30 a.m. to 10:30 a.m. At this time a venue has not been reserved.

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Donald Dodson, RN, MPH, Chair