New PCORI Award

In December 2013, the UPMC Center for High-Value Health Care received a second award from the Patient-Centered Outcomes Research Institute (PCORI) for the project titled, "Amplifying the Patient's Voice: Person-Centered Versus Measurement-Based Approaches in Mental Health." The study is designed to assess the efficacy of Pat Deegan's CommonGround software and other measurement-based strategies. It will involve up to 3,000 adults who have Medicaid as their health insurance and receive medication treatment at one of 14 community mental health clinics across Pennsylvania.

The typical length of an outpatient medication management appointment for people with serious mental health conditions is 15 minutes. These brief interactions with prescribers are often have little time to spend on the member's individual needs and personal recovery. Shared decision making is considered to be a strategy that could improve the interaction, although little is known about its impact on outcomes that matter most to individuals with serious mental illness. This study will compare two evidence-based, technology-supported strategies to determine which works best for persons with serious mental illness and under what circumstances.

The $2.1 million award from PCORI was part of a very competitive process and only 11% of responsive applicants were selected for funding. Principal investigators include Kim MacDonald-Wilson, ScD, Senior Director of Recovery and Wellness Transformation at Community Care; Pat Deegan, PhD, Pat Deegan & Associates; and Greg McHugo, PhD, Associate Director, Dartmouth Psychiatric Research Center.

To read the full press release and an interview with principal investigator, Kim MacDonald-Wilson visit Community Care news.
Was it premature to include DMDD in the DSM-5?

by Boris Birmaher, MD

The recently published DSM-5 includes a new disorder, Disruptive Mood Dysregulation Disorder (DMDD). Children with DMDD have severe temper outbursts and chronic irritability. However, the inclusion of this disorder in the DSM-5 has been controversial and deemed “premature” by some experts because it has many features that overlap with Oppositional Defiant Disorder and there are very few studies validating it.

Moreover, the key symptoms of this disorder, namely, irritability and temper outbursts, are common symptoms in most psychiatric disorders (e.g., ADHD, depression, bipolar, anxiety, PTSD). Thus, the diagnosis of DMDD may conceal the presence of underlying disorders, and potentially delay specific, effective treatments of these disorders.

Also, since the atypical antipsychotics seem efficacious for the management of irritability and anger, a diagnosis of DMDD may lead to increased use of atypical antipsychotics. It is possible, however, that DMDD is not a “disorder” per se, but a “phenotype” associated with more severe psychopathology. Until further research on DMDD is done, it is important to carefully assess youth with chronic irritability because they are at increased risk of developing depression, anxiety, behavioral problems, and suicidality during adulthood.

Youth with these symptoms, especially those who have not responded to usual treatments, often benefit from additional assessment. If you believe a referral may be helpful you can contact our specialized program at pediatricbipolar.pitt.edu or 412.246.5238.
Community Care evaluates the use of multiple psychotropic medications among adult members on a yearly basis. We identified the percentage of adult members receiving five or more psychotropic medications for at least 90 days concurrently for the time period of July 1, 2012 through June 30, 2013.

The rate of psychotropic polypharmacy for adult members receiving at least one psychotropic medication remained unchanged from last year at 0.6%. The most commonly prescribed medication class for these members was antidepressants. Physicians identified as treating five or more members on at least five psychotropic medications concurrently will be contacted by Community Care’s medical directors.

Community Care encourages physicians to review members’ medication regimens and diagnoses for clinical appropriateness. Community Care will continue to monitor the use of multiple psychotropic medications among our adult members.

The US Food and Drug Administration reported that, in rare cases, the Attention Deficit Hyperactivity Disorder (ADHD) medication methylphenidate can cause prolonged and sometimes painful erections (priapism).

The median age of patients taking a methylphenidate product who experienced priapism was 12.5 years (range 8–33 years). In a few patients, priapism occurred after an increase in the dosage of methylphenidate, but priapism has also occurred under other conditions, such as during short periods of time when the drug was stopped temporarily, when there was a longer than typical time between doses, or after stopping the drug permanently.

The agency has ordered changes to drug labels and patient guides for methylphenidate-based products to include the risk information. Physicians should be cautious about switching patients to atomoxetine (Strattera®) because it also has been associated with priapism in young children, teenagers, and adult males.

The FDA has received a few reports of priapism with amphetamine drugs, but these also involved other drugs with known risks for the condition.

Read the complete FDA’s drug safety alert for methylphenidate here.
2013 Provider Benchmarking

Community Care is committed to continuous quality improvement. In 2011, Community Care adopted a new provider benchmarking process that allows for a thorough assessment of rates, the development and implementation of more meaningful interventions, and evaluation of the interventions’ effectiveness. A three-year cycle benchmarking process breaks the levels of care benchmarked into three large groups: adult mental health, child/adolescent mental health, and substance abuse services. Focus on one group occurs each year.

In 2013, Community Care published reports for child/adolescent levels of care. A total of 784 reports were sent to 166 distinct providers. The reports included the following indicators and associated goals:

**Inpatient Mental Health (IMH)**
- 30-day readmission rate; goal is 10% or less, OMHSAS Gold Standard
- 7-day follow-up rate; no goal, OMHSAS Gold Standard is 90% or higher
- 30-day follow-up rate; no goal, OMHSAS Gold Standard is 90% or higher
- Average length of stay (LOS); no goal
- Average time to follow up; no goal

**Residential Treatment Facility (RTF); no goals established**
- Inpatient mental health rate during treatment period
- Percentage of 7-day follow-up
- Median LOS
- Length of stay over 365 days

**Family Based Mental Health Services (FBMHS)**
- Average FBMHS units for episode of treatment; no goal
- Percent of members with inpatient stay during episode; goal is 16% or less

*continued*
In developing indicators for these levels of care, Community Care reviewed past methodologies and revised them as necessary. Interim goals were set to supplement the OMHSAS Gold Standards for the inpatient mental health follow-up indicators. A threshold of 72.6% and 87.5% were established for the IMH 7-day and 30-day follow-up rates, respectively.

This year 77 Quality Improvement Plans (QIPS) were requested from 47 distinct providers in response to the benchmarking rates. A total of 40 provider meetings were held to discuss the benchmarking results in detail through a combination of individual and group meetings. Input was also solicited from providers during group meetings, which are not provider specific but level of care specific, concerning factors that may be driving the rates, as well as feedback regarding future benchmarking. Information gathered at these meetings and collected from the submitted QIPS was aggregated, presented to the various Quality and Care Management Committees, and shared with providers.

Community Care welcomes provider input into the benchmarking process. To share your ideas or comments regarding the provider benchmarking process, please email ccbh_benchmarking@ccbh.com.
Clinical Practice Guidelines

Community Care uses Clinical Practice Guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. These evidence-based guidelines are reviewed at least annually, updated as appropriate, and approved by Community Care’s Quality and Care Management Committee. Community Care has adopted three clinical practice guidelines.

APA Guideline for the Treatment of Patients with Major Depressive Disorder (3rd Edition)
Major depressive disorder (MDD) is the top diagnosis for the Community Care membership; therefore Community Care has adopted the 3rd Edition of the MDD guideline.

APA Guideline for the Treatment of Patients with Schizophrenia (2nd Edition)
Schizophrenia is among the top ten diagnoses for the Community Care membership, therefore Community Care has adopted this guideline for the treatment of patients with schizophrenia.

Because substance abuse disorders account for two of the ten most prevalent diagnoses within the membership, Community Care has adopted this NIDA guideline for the treatment of substance use disorders.

Community Care measures provider adherence to Clinical Practice Guidelines via claims data and record reviews. Providers are notified of the results of these measurements through newsletter articles or Web-based communications. If you have any questions regarding the use of these guidelines, please call us at 1.888.251.2224 and ask to speak to a quality representative.

To obtain a copy of the APA guidelines, contact the American Psychiatric Association, 1400 K Street NW, Washington, DC 20005 or visit the APA website.

To obtain a copy of the NIDA guideline, contact the National Institute of Health, 6001 Executive Boulevard, Room 5213, Bethesda, MD 20892. The guideline may also be obtained via the NIDA website.
STDs and Domestic Abuse
An informational article from the Department of Public Welfare.

Women are more at risk for sexual and physical abuse than men. The Centers for Disease Control and Prevention state that women who are victims of these types of abuse are more likely to have a sexually transmitted disease (STD). HIV/AIDS is one example of an STD. Other STDs can increase the risk of HIV/AIDS. Also, STDs can cause health issues whether or not a person has HIV/AIDS.

Sexual abuse can happen between partners of the same sex or between partners of the opposite sex. Giving a person an STD on purpose is a form of abuse. The abuse may be ongoing if a partner:

- Will not get treated for an STD
- Will not use a condom
- Forces or pressures a partner into sex when there is an STD
- Blames the other partner for cheating and causing the STD

Women risk ongoing health problems from having an STD. These may include:

- Pelvic Inflammatory Disease (PID)
- Problems getting pregnant
- Problems while pregnant
- Damage to reproductive organs
- Passing the STD to a baby during pregnancy or birth
- Passing the STD to a baby during pregnancy or birth

Regular health check-ups can find an STD. To get help for an STD, see a family or health clinic doctor right away. It is legal in this state for a person to get medicine for their partner to also treat the STD. A patient can ask their doctor to provide this service in a way that does not put the patient at risk for more abuse.

Resources
To find the domestic abuse program in Pennsylvania nearest to you, visit http://pcadv.org and click on Find Help or use the Find Help map on the homepage.

- To reach the National Domestic Violence Hotline, call 1.800.799.SAFE. For TTY, dial 1.800.787.3224.
- To reach the National Teen Dating Violence Hotline, call 1.866.331.9474 or text “loveis” to 22522. For TTY, dial 1.866.331.8453.
- For more information on HIV and AIDS counseling and testing, call the Pennsylvania Department of Health AIDS Factline at 1.800.662.6080 or visit their website.