DCF Psychotropic Medication Advisory Committee

**MINUTES**

**November 7, 2014 1:00 PM**

Albert J. Solnit Children’s Center, Middletown, CT.

Present: Jacqueline Harris, M.D., David S. Aresco, Pharmacist, Patricia Cables APRN; Brian Keyes, M.D.; Allen Alton, M.D.; Aurele Kamm, APRN; Maureen Evelyn Parent Advocate; Renu Kothari, M.D.; Beth Muller, APRN; Joan Narad, M.D.

1. The meeting was called to order by Dr. Harris at 1pm.
2. The next meeting is scheduled for December 5, 2014 from 1pm – 2:30pm; Solnit Center AB conference room. The January meeting will take place the SECOND Friday of the month on January 9, 2015 as the first Friday is the day after a Holiday.
3. The minutes of the October 2014 meeting were reviewed and approved with minor changes. Minutes in the future will be sent within 1 week of the meeting.
4. Announcements: A proposal to have Narcan available at all DCF facilities is being addressed by the DCF Director of Substance Abuse.

DPH is providing free training on the use of long-acting Opioids. CMEs are available. A direct mailing of dates and times was sent to all providers by DPH.

1. New Business: System Interface Issues between DCF and Community Providers: Noted that the goal is excellent quality of care for DCF children. The DCF PMAC should be instrumental in providing suggestions for changes to meet this goal. Concrete, realistic suggestions for change are needed to take back to the practice settings that will improve the health care delivery system. Once a list is developed it will be prioritized and presented to DCF by Dr. Harris.

Dr. Harris encouraged a broad discussion to begin the development of a list of suggestions. A list of examples of system impacts based on PMAC member feedback and comments was distributed as a way to get the discussion started.

There was a very lively discussion hitting on many issues as briefly noted below.

* The value of genomic testing.
* HIPAA training specific to when information CAN be shared between health care professionals.
* The positive and negative effects of an electronic health record.
* Patient acuity: increased acuity in the present compared to recent past.
* Lack of discharge summaries following hospitalization.
* Need for additional information to be included in the discharge summary (“who is this kid?”).
* Silo structure/mentality in the system.
* Lack of availability of services at certain higher levels of care.
* “Bunker” mentality in the system.
* Lack of prescribing practitioner participation in team meetings.
* “Hand off” mentality in the system.
* Who is in charge at team meetings? Sharing information tends to only take place at these once/month (or every other month) meetings.
* Transition of care: new state/federal regulations may help.
* Loss of good caregivers in the mental health field: the legislature has a program for student loan forgiveness to attract people into the field but it is not funded.
* Electronic Health Record: very time consuming to enter the amount of data required such as ht, wt, vitals, etc. This should be done by support staff as in other medical fields.
* Provide access to Link to all providers at DCF facilities to help with access to patient data. Workers should pull data in advance of a meeting and send it to the provider but as of now it is not required and/or considered important.
* Noted response varies greatly from region to region.
* Use those regions that are compliant as a model for regions that are not.
* Build into provider contracts requirements for attendance at mandatory meetings, communications, etc. Providing the resources (dollars) in the contract to fund these requirements is an issue.
* Standardize patient information required for transition of care. This can then be provided to the developers of the new DCF IT system for inclusion (system should be completed in about 18mo). PMAC members are encouraged to send recommended required information to Dr. Harris. Suggested required information:
  + Last progress note
  + Name of provider at last visit and visit length
  + Current medications with directions for use and outcomes especially noting SE’s, ADR’s
  + Response to medications and treatment plan
  + Recent changes in therapy.

1. ADRs: Roll Out ADR Reporting System – Provider Communication, PR Issues: Deferred until December 2014 meeting.
2. Medication reviews: Review recent FDA warnings: Vortioxetine and levomilnacipran: as neither of these new medications are approved for use in pediatrics and are not on the approved drug list the FDA warnings are N/A at this time. At the request of PMAC the following will be presented at the next meeting.

* New FDA warnings (within the past year) for medications on the approved drug list.
* New data for use of methylphenidate in children as young a 4yrs old.
* Availability of pharmaceutical grade melatonin. Possibly Circadian available in the United Kingdom.

1. Category of Medication reviewed: Antihypertensives: the max dose of clonidine recommended: Children >6years 0.4mg/day. No other changes recommended. PMAC requests the reference data for this change be provided at the next meeting. PMAC recommends no other changes in this drug class.
2. CMCU Data Review: Deferred until December 2014 meeting.
3. DUE: ADHD medications: the consultant pharmacists do not as of yet have approval to assist with this as it involves patient records. Additionally ORE has other priorities and staffing up has been delayed. Predict this DUE can begin in May 2015.
4. Adjournment: 2:30pm

Respectfully Submitted;

David S. Aresco