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Can 'Nudge' Letters Cut Overprescribing of Psych Meds?

— Peer comparison and threat of review can change prescribing behavior, but approach has some drawbacks

by Shannon Firth, Washington Correspondent, MedPage Today

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WASHINGTON -- Issuing peer comparison letters led to "substantial and durable reductions" in prescriptions for the antipsychotic drug quetiapine, with no evidence of negative impacts on patients, researchers reported.

The study by Adam Sacarny, PhD, of Columbia University's Mailman School of Public Health in New York City, and colleagues assessed the impact of "behavioral nudges" to stem over-prescribing of quetiapine in the Medicare Part D program.

Sacarny discussed the findings at the AcademyHealth Annual Research Meeting. The study, which was published in 2018 in *JAMA Psychiatry,* received the group's 2019 Publication-of-the-Year Award.

The researchers found that over 9 months, the treatment group supplied 11.1% fewer days of quetiapine per prescriber versus the control group (2,456 vs 2,864 days, respectively) for an adjusted difference of -318.7 days (95% CI -374.4 to -263.0, $P<0.001$).

Sacarny's group also found that the difference persisted through 2 years, with 15.6% fewer days supplied in treatment versus control (95% CI -18.1% to -13.0%, $P<0.001$).

However, Sacarny said the i per off, with the treatment group's data "cre suggesting that "over the long run these effects [t forever."

Sacarny's group collaborate re & Medicaid

Services' (CMS) Center for Program Integrity and the Office of Evaluation Sciences (OES).

Study Details

Quetiapine is FDA approved for the treatment of depression, bipolar disorder, and schizophrenia, but is also used off-label for the treatment of Alzheimer's and dementia in older adults. This latter use is "pretty widely discouraged" by the American Psychiatric Association (APA) and the American Geriatrics Society, noted Sacarny, who is an OES member.

However, APA guidelines were revised in 2015 to state that instances in which "dementia-associated symptoms (e.g., aggressive behavior due to paranoid delusions) pose an acute threat to the individual and others, and in these instances antipsychotic medications must be used before formal nonpharmacologic measures can be instituted."

Sacarny's group identified high-volume prescribers by reviewing Medicare Part D data (the "event file") from 2013 and 2014 for quetiapine prescriptions (Seroquel, Seroquel XR, or generic). In all, 5,055 clinicians (48% in family medicine; 18% female), or about 5% of all primary prescribers of quetiapine, who met criteria as high-volume prescribers in 2013 and 2014 were included.

In April, August, and October 2015, prescribers were randomized 1:1 to receive a placebo letter or three peer comparison letters stating that their quetiapine prescribing was high relative to their peers, and was under review by the CMS. The letters noted that recipients may be contacted at a later date regarding further actions.

The study's primary outcome was total quetiapine days supplied by prescribers from the start of intervention to 9 months.

"Secondary outcomes included quetiapine receipt from all prescribers by baseline patients, quetiapine receipt by patients with 'guideline concordant' or 'low value' indications for therapy, mortality and hospital utilization," the researchers explained. Outcomes were followed to 2 years.

They reported that "at the patient level," those in the treatment group received 3.9% (95% CI -5.0% to -2.9%, $P<0.001$) fewer days supply of quetiapine from all prescribers over 9 months. There was a larger decrease among patients with "low value" versus guideline concordant indications (5.9% vs 2.4%, respectively, $P=0.01$ for test effects that were equal for both groups).

"There was no evidence of [illegible]9-month mortality and hospital utilization wer[illegible]roups," the researchers stated.

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Study limitations included the focus only on prescriptions covered by Medicare Part D, and "The letters may have encouraged physicians to reevaluate their prescribing to patients with private insurance, Medicaid, or no insurance coverage. This 'spillover' effect could amplify or dampen the magnitude of our findings, depending on the nature of the spillovers," the researchers noted. Also, letters sent to prescribers who were not high-volume outliers could have different effects.

"Surprising and Strong"

"My takeaway [from the study] is that overuse letters with this kind of strong language can improve the value of prescribing, but these effects are pretty blunt, and so the letters are most likely to be most beneficial when they're really more ... laser-targeted at low-value care," Sacarny said Tuesday.

But he pointed out the impact of using a "surprising and strong" message. He noted that a previous systematic review of peer comparison letters found a much smaller impact on behavior, while a previous study done by his group that included a peer comparison letter to high prescribers found no effects on prescribing outcomes.

The letters are an "exhaustible resource," he warned. "If CMS decided to send these letters every month, I don't think that they would continue to have big effects. I think word would get around that they're just sending lots and lots of letters."

"Blunt Instruments"

Amol Navathe, MD, PhD, of the Leonard Davis Institute for Health Economics at the University of Pennsylvania in Philadelphia, praised the study.

"This is a low-cost, scaleable intervention," said Navathe, who had co-authored an accompanying *JAMA Psychiatry* editorial. "I think that is actually really intrinsically important, because we oftentimes have very complicated, expensive interventions, and then we scratch our heads and say 'Why aren't they being picked up or scaled?'"

The study also highlighted both the intended and unintended effects of peer comparison letters. Such letters are "relatively blunt instruments" that don't specifically target low-value prescribers, Navathe pointed out, and there can be appropriate off-label use of antipsychotics. For example, Seroquel is often used as a sleep aid for patients with dementia.

Navathe added that it was 't impacted by the intervention, but he said he ues among appropriately prescribed patients.

The researchers suggested that primary care physicians "may be able to target 'guideline concordant' patients for whom stopping quetiapine may be clinically justifiable while maintaining access for patients who experience clinical benefits (by continuing to prescribe to these patients or by shifting them to psychiatrists)."

Navathe cautioned that finding and seeing a psychiatrist may be difficult for patients with dementia or other cognitive deficits.

"So the actual impact on the patient, beyond what we're seeing in claims, may actually potentially be more ... I think we need to just be thoughtful about that," he stated.

Beth McGlynn, PhD, vice president for Kaiser Permanente Research, said during a panel discussion Tuesday that one valuable aspect of the study is that the researchers worked upfront with the CMS, which could mean the results will have greater influence going forward.

However, that potential influence could also have drawbacks -- if Congress decides this intervention is good, it could become "the law of the land," McGlynn said. "Keep an eye out for that because ... talk about blunt instruments."

Another concern is that such letters might scare prescribers into simply opting out. Sacarny acknowledged that this was a relevant concern that should be considered in future studies.

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Primary Source
JAMA Psychiatry
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