NATIONAL NETWORK of DEPRESSION CENTERS

Ketamine Interest Group

Meeting Minutes

Thursday, May 21st, 2020 @ 2:00pm ET

Co-Chairs:	Mark Niciu (Iowa), Adam Kaplin (JHMI)
Attendees:	Srinath Gopinath (Florida), Robert Meisner (McLean), Sagar Parikh (Michigan), Christopher Schneck (CUAnschutz), Jennifer Vande Voort (Mayo), Peter Zandi (JHU)
NNDC:	Diana Burnett

1. Discussion around starting clinics (ketamine/esketamine) – guided by R. Meisner
2. Ketamine Survey –
    a. Add a "general comment" text box to capture any further concerns or questions
    b. Distribute with task group member list
3. Research in the time of COVID-19
    a. **Iowa**: Suspended IV ketamine at the beginning of the shutdown in March; ramping up again now. Research studies are being allowed only in the context of an existing clinical care visit. Research only visits are not allowed.
    b. **McLean**: Previously doing ~30 ECT patients daily; fewer ketamine but they continued to treat (TMS unknown but continuing). Epidemiologists are predicting a wave of patients upon the Massachusetts Phase 1 reopening. Doctors are bracing themselves for the mental health wave from COVID-19.
4. Aerosolization risk with bag valve masking (with or without HEPA filter) – LMA and ECT
    a. Made the argument to insurance that a rapid pivot for select patients from ECT to IV ketamine or esketamine was in order.
    b. Movement wasn't fast and effort didn't really pan out. Glad the team tried; didn't work – got stuck in bureaucratic "no man's land".
5. COVID-19 Testing for Ketamine/Esketamine Patients?
    a. McLean:
        i. ER: Undomiciled person from a shelter (2 negative tests several hours apart + CXR) – two facilities were presented; patient eventually accepted at a McLean facility
        ii. Not testing asymptomatic patients who are continuing in ECT, ketamine or esketamine protocols

b. Iowa:

i. All asymptomatic in/outpatients for ECT require negative tests within 36 hours. This is problematic for patients in rural areas who travel a distance to come to the medical center.

ii. Every outpatient is screened.

6. Starting a ketamine clinic: Issues – C. Schneck/CUAnschutz

a. Payment

b. Space to monitor the patient for the duration of the post-infusion monitoring

c. Nothing has been protocolized

d. New Chair – Dr. Neill Epperson is very supportive

e. Ketamine or esketamine?

i. Iowa: Intranasal will likely do more good for more people, but both have pros.

ii. McLean: IV Ketamine was easier to get started. They jumped on adding esketamine, but hit the wall on insurance. They do treat via private pay, but it costs thousands per dose.

7. Insurance Companies and Esketamine – R. Meisner

a. One insurance company at a time!

b. Structure of your institution affects your relationship with the insurance company (ie, private vs university)

c. Coverage for observation and monitoring can be difficult.

d. BCBS approving full series of IV ketamine now.

e. Dependent on how the specific institution defines itself legally, and its contractual relationship with each insurance company; plus, the ability to negotiate subcontracts or individual agreements.

f. Dr. Paula Bolton at Partners Hospital can speak to these points of friction.

8. Vistagen Study

https://www.vistagen.com/news-media/press-releases/detail/139/vistagen-submits-ph94b-phase-2a-study-protocol-for

9. 2nd Indication for esketamine – topic for next meeting.

Next Meeting: Thursday, June 18th, 2020 @ 2pm ET