ASD Advisory Committee — Building Network Capacity Work Group — 9-29-15

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- Sharon provided an overview of the day's agenda and other work groups' activities.
- A cross-workgroup team is putting together a matrix of the services available and list of providers.
- We heard the RBHAs are providing ABAs and floor time. However, they may provide for limited hours - not 40 hours for kids.
- Well known that there are limitations at DDD – should direct people to RBHAs.
- When families contact the RBHA for diagnosis, they are told the RBHAs don't do that. Why would psychiatrists not be comfortable doing diagnosis?
- We heard in the last meeting that through secret shopper research by AHCCCS, patients can get an appointment within a few weeks through MMIC. At all the other RBHAS, people were not able to get through to get a diagnosis.
- In looking at the matrix, some providers say they do assessments, but not applied behavior analysis functional behavior assessments. It's really about looking at challenging behavior and replacing it with another behavior.
- There is so much confusion out there about the lingo - some families ask for one service but it is known by another term by someone else. What can we do about this as a group?
- The Early Identification group is doing a crosswalk of terminology. We have heard it's easier for AzEIP. AHCCCS and DDD have a hard time finding definitions in their manuals. It's confusing not just for families, but for those doing the work.
- With an integrated benefit plan, everything else gets integrated - policy, resources, network, etc. AHCCCS is headed in that direction a year from now.
- We need to simplify how to become contracted with the AHCCCS and the RBHA. Right now it is an incredibly cumbersome process.
- There is a larger problem of the number of doctors in general - we need to align available skills and need.
- There should be a portal where a practitioner can register with AHCCCS then have a quick approval in conjunction with the RBHA contract process.
- Once a provider is already contracted, it is easier to amend the service listing.
- We have talked about expanding the types of specially trained providers from whom DDD will accept a diagnosis. Are there additional provider categories?
- Pediatric neurologists - what is their scope of practice? They are all capable of doing diagnosis - they don't. There is a fellowship under the Board of Psychiatry and Psychology that should help with this.
- One neurologist in Southern Arizona is doing ASD diagnosis.
- DDD is in the middle of medical management changes - whoever comes in will need to review a change in the policy. But, they are all in favor of expanding the pool.
- We want to increase the number and competency of providers for diagnosis and treatment.

- In licensing, you must show area of interest, CME credits, and explain why training allows you to make diagnosis. There should be some way to do that. We are not sure if that is an AHCCCS or a board issue.
- Providers need to have demonstrated experience and expertise.
- There is an annual survey on credentials; we should tie incentives to completing this survey.
- We should reach out to the universities. We need to bring people into the system earlier.
- Money is an issue. For DDD, even with limited services, rates are always talked about — it becomes a disincentive. We think we are not getting the best of the behavioral analysts - they can go through commercial plans and RBHAs and get better rates. So, there is a pool out there we can't even reach. As a result, people are on a waiting list for things they should not be waiting on.
- We can expand workforce through training. MMIC is interested in online capability. At the RBHA, they are reaching 12,000 providers in a way they have not before. For example, MMIC is disseminating information on autism, best practices, treatments, etc. How do we get info to docs so the index of suspicion is up so they know what to look for and how to treat. These should be palatable so docs will use them in their practice instead of taking an 8-hour training. These could be done in 5-10 minute snippets.
- There are online training modules in various areas for medical training for students. We are not sure if there is a certificate of completion. Whenever you do medical research, you must complete a training on protection of human subjects every two years. You must be able to demonstrate ongoing competency beyond reviewing a website or view videos. This is a model we can use.
- Training institutions - MMIC working with medical students at U of A to engage in what is happening at the RBHA.
- There was a question that came up at the last meeting. The perception is that some families are hesitant to be referred to the RBHA for diagnosis because of the behavioral health stigma. We are not certain that this is very widespread - most families are anxious to get there kids into services.
- What is the scope of the problem with families who contact the RBHA, but can't get an appointment? If this is true, then these things need to be addressed.
- One recommendation might be that the RBHAs or AHCCCS do awareness training and remind providers about what their role is. MMIC is already doing this.
- One thing that will help is value-based contracting. It puts incentives around access - if someone calls, how long will it take to get an appointment?
- Maybe there is some way to measure effectiveness and sustainability.
- Habits have developed over time with block funding. The focus needs to be on the why and not how you get paid.
- Use of technology to support diagnosis and treatment:
  - There is not a set routine that has been recognized and validated. The recommendation should be that we are open to those advancements - SAARC has app that is in process. SAARC also piloted a parent training program to train families to video themselves working with their child, then connect with behavioral analyst over Skype.
  - SAARC would be the people to go to ask. They used the technology in the rural communities.

  - Yuma has a model of connecting services. SAARC was able to partner with a family in a distance arrangement using that technology.
  - MMIC is looking at technology all the time. Looking at the member population - one thing that makes sense is integrated data. Until now, the data has been siloed. One of the advantages of an integrated benefit plan is that as kids get more complicated, having that data available is crucial. An integrated care plan can be supported by different providers who aren't necessarily co-located, so they can share information.
  - MMIC is looking at a program that does this. It interfaces with other technology nicely.
  - How do we leverage use of State's HIE? This allows for the exchange of information.
  - What is the status of HIE? A lot of hospitals and ERs are on it. The idea is that when someone shows up in the ER, an alert goes to appropriate providers to let them know.
  - How do we make good use of the alerts that come through there? These may be especially useful for adults. There was an article in the *Republic* about an adult with a developmental disability who ended up in the general population in jail.
  - How do members best utilize technology?
- With regards to integrated care, we can't leave out long-term care services. The service array needs to be understood by everyone. It should be understood up front what services everyone is providing.
- The idea behind this effort is to get an idea what is being provided by everyone. Who is doing what/where?
- Given the diversity of providers in the network, what are some key outcomes and how can we measure what the network is doing over time?
- We can come up with a handful of practical things that give good information on what we are doing. There are certain clinical and functional features that can be identified in the SMI system. MMIC is really looking at those real life outcomes and trying to define it that way. We can also look at access to care, utilization, member satisfaction, etc. This all adds up to a report card on the system.
- The first key clinical outcome is age of diagnosis.
- We need to ask families how things are going. Have things improved? Families must be included. A lot of times we think we know what someone needs and they really need something else.
- What barriers exist for a referral? There are limited providers and long waiting lists.
- If someone sees red flags, how long does it take to get diagnosis?
- If you are working through the RBHA, how long does it take to get an appointment?
- At school, why does it take so long to get a referral? Some of it is parent-based. We have a kid who wasn't referred until they were four and a half. They were initially referred at two and a half, but other family members said the child was fine, so the parents waited.
- What are the things that influence the decision to make the referral? This is where widespread education that can make an impact.
- More families that come in are worried about autism and their children don't have it. Knowledge in the community has increased.
- More and more frequently parents are referred to developmental psychologists, but there are no developmental psychologists available.
- With technology, one of the issues is privacy and HIPPA - some feel comfortable using Skype, some don't. There is a psychologist in Scottsdale treating patients in England - his technology is

heavily encrypted. MMIC is looking to pilot something so case managers can go into the field and if someone needs to see someone it can happen that way. It's a way to deal with the shortages we face.

- We need to address the reimbursement barriers that keep qualified providers from participating in the network.
- MMIC: This falls in line with value-based purchasing and bundled payments. There are lots of different agencies touching these kids - they are siloed. What are the services and units and costs that go into a child with autism in a year? We can bundle the services in a dollar amount. For a person, dollars can be allocated in the way they need to for the member.
- It seems like the higher cost members and the services that keep people coming back increase the block funding. This hurts agencies with low return rates. There needs to be a way to turn that around to reward agencies that are effective and remain effective.
- That is the other place where reimbursement needs to be worked on - we need to align incentives on high cost people. If payments are bundled to the team - opportunity to improve care at a tremendous savings.
- The tricky part is sometimes there can be an increased payment for certain services. This may incentivize agencies that are diversifying their contracts. They should not just have all their eggs in one basket.
- We need to look at the payment methodology to support what members need instead of anything else. The system can get focused on what the costs are for a provider to provide services. The focus should be on the member - what does it cost to treat the member and what should be reimbursed? A public system should not be forced to pay someone's higher overhead. In the AHCCCS world, that is the approach.
- Is there a way to do a comparison of rates for services around the country to see how far off we are? What's standard? What do other systems do? Some states have integrated agencies to address some of these issues. (Dr. Fowls will look at Missouri, New York and Kentucky.)