ASD Advisory Committee - Early ID and Referral Work Group

9/29/15 Notes

Participants: Kim Elliott (AHCCCS), Don Fowls (Mercy Maricopa Integrated Care), Janet Holtz (Mercy Care Plan for Rene Bartos), Karie Taylor (DES/AzEIP)

Note-taker: Theresa Gonzales

I. **Updates**
   a. Working on TriCare info- Kim is following up with Dr. Tamsky
   b. Don is looking for data that MMIC might have

II. **Developing Recommendations**
   a. Screening and assessment
      i. Already done a lot in the system; is a covered benefit. Develop tools and work with associations. Need to communicate an easy process to follow and post on AHCCCS website and health plan website so both families and providers know what to do.
      ii. Use simple statements like "screening and assessment is a covered benefit" and "this is how you access." Same for providers: "use M-CHAT."
      iii. Crosswalk of different terms
         1. What is a screening, assessment, etc.
         2. The definitions don't currently exist. More a professional opinion.
         3. Federal regulations definition- EPSDT
         4. Not a perfect match
         5. If I'm a PT could go one way, if licensed professional could go another way. Could include recommendations that different agencies affirm this is what is intended?
      iv. Need protocols and can model out what it could look like. Perhaps form small work team to start modeling out using the TriCare process as a model for mapping the process in Arizona (Kim, Janet or Rene, Karie, Theresa)
      v. It is difficult to explain to families what is needed from a health plan perspective. Need to have steps laid out so providers can also assist.
      vi. Disseminate and use the tool, including crosswalk of terms and walk through. Continue to update.
      vii. Include in multiple places: website, member handbook, provider manuals. Make info consistent and ensures communication is the same across all systems.
      viii. Someone would need to track where it's been disseminated so updates can be made. Or - perhaps it could be a link housed on AHCCCS website.
      ix. If on AHCCCS already but wants DDD, can't use same criteria. Should still start receiving services regardless. Could access services through acute care plan. Other workgroup is working on who can get what services where.

    x. Consider how one becomes eligible in the first place. Apply for AHCCCS, if not enrolled, go to AzEIP (no income level), referral line.

b. Referrals to providers who can diagnose ASD
    i. Part of crosswalk and communication channel. One of the boxes envisioned: "PCP has determined child has autism" and then list out 3 numbers for the RBHAs to make direct referral. But what about when RBHA says they don't do ASD diagnoses?" This is a problem that AHCCCS is addressing.
    ii. Diagnoser can be psychologist, psychiatrist, or developmental pediatrician contracted w/ the RBHA - contractually required to do it. But what about if they're not comfortable doing ASD diagnoses? Anecdotally, we're heard that some child psychiatrists not comfortable… there is a problem if this is so.
    iii. AHCCCS member can use PCP or BHS.
    iv. What about stigma re BHS? Similar on private side too.
    v. How does CRS play into this? Same process.
    vi. Build into flow sheet so easy to understand.

c. Secondary screening prior to formal diagnosis (amended to say it is an another screening)
    i. Folks should be prioritized if higher needs identified. If creating ability to educate and inform re direct access to diagnose, should take out need for secondary screening.
    ii. What about when referred to RBHA? So we have a child with BH issues, regardless if it's not autism, the services need to start. Do we need someone stuck in the middle screening? Not much value added. It's complicated. The screening is there for a reason. Screen and assess and someone who can diagnose decides. The basic process should be laid out. If there are variations can note them but shouldn't be included as part of process.
        1. Recognize it will be a challenge based on system capacity, but shouldn't build another process because of that.
        2. How long does it take to get a diagnosis with someone at MMIC? Not sure but shouldn't be long. Secret shopper found it was quick with MMIC. Typically if there's an obstacle we will hear about it.
    iii. RECOMMENDATION: Remove bottleneck area and do monitoring to make sure it's flowing the way it needs to. Should remove secondary screening altogether from this work group's areas of focus.

d. Communication and coordination between PCPs and intervention providers
    i. Standard format 1-pager easy checklist so all providers can have same info until HIE is in place.
    ii. Address treatment plan and what services are rendered.
    iii. PCP should support families in achieving goals.
    iv. Communicate on BH side. Need a care coordinator to manage kids and provider level of assistance to families.

    v. The form would not only be intervention providers but also PT, ST, etc. All providers should provide info to PCP.
    vi. DDD may already have a form of what services an individual is getting and outcomes as a starting point.
    vii. Another form similar to EPSDT…requirements for how soon it needs to be submitted and reviewed? Yes. Would model a form like DDD and send to health plans. ACTION: Include as an agenda item. DDD adapted it from national trainers. ee to send link to Sharon.
    viii. Need a communication and education plan. Currently have process, but need to review to ensure how to continually remind them. Think about how that would look. Not as simple as throwing it out there. Use list-serves likes Academy of Pediatrics, other associations. Consider having trainings in person ongoing. Until institutionalized, needs to be ongoing.
    ix. Concern: high turn over in provider offices. What about a computer-based training (CBT) with a link for new folks? Can consider. Maybe include as part of enrollment process for relevant providers. MMIC could make a recommendation on the basics to include as some of the principles will apply in integrated model.

III. Action items

- a. Continue to work of crosswalk: flow chart of entry for providers and families (TG to set up meeting w/ Kim, Karie, Rene, Jill, someone from MMIC)
- b. One-pager from Karie on DDD process
- c. Components of a communication plan
- d. Aaron and a team of ASD Committee and work group participants are working on a summary of who provides what, when, and where.
- e. It will be a while before the pilot Dr. Blitz is doing has results.