ASD Advisory Committee

November 18, 2015

AHCCCS Gold Room

- Review of agenda, group norms, charge to Committee, State of Arizona intentions
- Updates – ASD Services Chart; "crosswalk" of terms used in different ways by different agencies; flowcharts for families and providers that map out screening, assessment, and diagnosis process; and components of Communications Plan under development.
- Discussion of first draft of recommendations — Sharon requests additional feedback and clarification:

Systems-Level Changes

- Let health plans decide where coordinators should be located – incentivize the providers to have someone in provider's office or have it be at the health plan
    - Some comments expressing preference that coordinator be on site but have something at the plan if not available on sight at provider
    - If asking acute care plans to be responsible for coordinators, the plans should decide where they should be; whether to have within network, in office, or have them at the health plan
    - One participant said we should not prescribe in the recommendation
    - Health plans should recruit providers that have care coordination
    - Suggestion: Not be so specific in the recommendation. Not sure want to say "assign a care coordinator" vs. "have access to care coordination
    - One participant said incentivizing by health plan is critical or else it won't happen
    - Primary care level doctors don't have enough time to coordinate care – clarification to that comment is that there would be a separate person coordinating the care
    - Comment re option for the practice that wants to have the coordinator. For those who can't, it should be available to them through the health plan.
    - Emphasize paying for care coordination in page 2 in Value-Based Purchasing section.
    - Question re how does commercial insurance do it. Response by one is that payors do both and so we want to allow multiple options.
    - One participant desired someone with clinical background like a Physician's Assistant who can provide coordination.
    - Line 22: Quality of care coordinator is a category that is part of monitoring quality of care coordination process.
    - Clarify wording of lines 22-35.
    - Clarify line 27 to include DDD targeted.

- Clarify: if you don't qualify for services through DDD and/or ALTCS.
- Clarification question re are we only talking about coordinator on site at pediatrician's office or can it include a multi-specialty clinic, behavioral health home…Response is wherever that person's medical home is.
- Emphasis that there are different models of integration.
- Clarify line 36 — DDD is the MCO home for ALTCS members (children and adults); non-ALTCS DDD members (DDD targeted) and acute enrolled AHCCCS members receive ASD services through their acute health plan.
- Line 36: change "should be" to "is"
- Take out language re more intense needs on line 37.
- Key point is that acute plans contract for integrated physical and behavioral health services. Is there consensus around that? Sharon sees heads nod yes.
- Health plans need to know who is DDD targeted versus ALTCS. Placement in document questioned. Sharon said could look for place to rearrange that.
- Incentives sentence ending on line 26: add — legislation needed to have coordination between school, health plans, and behavioral health.
    - One parent disagreed and said parents can sign privacy releases to allow for this. No others spoke up in favor and several seemed to want more information as to purpose of legislation.
- Line 31. Adding phrase "or could be integrated in the acute plan." Participants unclear as to the origin of this suggestion and Sharon could not provide additional information.
- Sharon: this is the section talking about recommendations on how the Committee wants this system to look in the future. Going toward a model similar to SMI – each acute plan would contract for BH. Clarification that RBHAs currently contract with the physical health providers. Participant clarified that the recommendation is that the acute plan contracts with the BH provider. Each acute plan could contract for BH services and for EPSDT services needed by individuals with ASD. Sharon explained that is how she heard it. Medical home in acute plan is preferred because members with ASD have so many complex medical needs.
    - Clarification from participant: does that include at-risk? Pediatric and adult?
    - Think about how to operationalize. How to ID members? Claim? Referral? Be thoughtful of how to approach.
    - Another: this is a tricky area. One view is the acute plan manages. But this person's approach is that it takes specialty network.

- Could have different approaches: 1) Use acute plans to manage acute health care needs and have specialty plans to manage more difficult members. This is why the SMI plan works. 2) Combine the 2. It takes a whole different skill set and expertise to manage members w/ complex special needs vs. healthy population.
- Another participant said people felt more comfortable with acute plan as the home for non-ALTCS and DDD as ALTCS home plan.
- Another comment: agrees that especially with pediatric population, families are more comfortable with medical home in pediatric setting. How do you integrate or combine the BH elements? At a first step, allow the plans to contract out for those services. Can be also part of value-based purchasing.
- Don't want RBHAs pointing to acute plan and acute plan point to RBHA. We want one plan in charge.
- Sharon: We need to reach agreement on this.
- In workgroup meetings, people said the community is more comfortable with the health plan than with the behavioral health system. People also feel more comfy with DDD for individuals eligible for ALTCS.
- One participant says it is different when the care team is led and shaped by developmental pediatrician. So I think the home has to be the acute plan because the steward of the ship is the pediatrician. Most families I know value that.
- Sharon: Let's do a thumbs up if you support a recommendation that the driver of the ship is acute plan. In other words, the medical home is the primary care provider through the acute care plan.
- Sharon: does anyone want to speak against that model? One participant said it's not a one size fits all. And that we could miss other important psycho-social aspects if housed in acute plan.
- One participant said that an ASD specialist and pediatric specialist will be more likely to recognize the psycho-social needs.
- Concern that if medical home was in BH, general medical needs might be overlooked.
- One participant concerned re implementation – how to identify who gets the integrated care. Is it by diagnosis?
- One participant said the moment is when my child's pediatrician refers my child to developmental pediatrician who send report back that says: child is either at-risk or child has ASD and next steps identified. Then the PCP contacts the health plan and says we need to move this kid.

- One participant: I know integration is the goal. Still struggling with what that looks like.
- One participant explained that the integration comes from the acute plan. Communication incentivized by the plans so they can communicate and share information with all providers. There is now a wall between behavioral health and physical health. Integration would allow wall to be pourous.
- One participant explained integration is at the health plan/administrative level but allows the health plan discretion to develop different models of care that incorporate integration – co-located practices, virtually integrated practices, models where the health plan connects providers
- One participant struggling with transitions of care for young adults.
- One question why not put members with ASD in ALTCS DDD. Explained that most kids are in the acute system.
- Clarification: ALTCS is a program for individuals at immediate risk of institutionalization under the federal requirements.

Value-Based Purchasing (VBP)

- What are the definitions of family centered care? One participant said there are well agreed upon thoughts on this. Reference those in the definition with this recommendation in line 13.
- One participant would like the consumer to also be a judge of quality.
- Timeliness is an excellent standard to incentivize.
- Request for explanation of VBP. Example: Arrangements between provider and health plan based on something the plan is seeing a need for. For example, individuals with Serious Mental Illness (SMI) and use of ER. Health plan would enter into arrangement with provider to better manage member, get member in for routine visits and if there's a drop in ER use, the provider will get savings. Also, Pay for Performance (PFP) standards that trigger bonus payments for timeliness is an example.
- Pay for performance is a good system in theory but hard to accomplish with autism. Problem is that a good outcome for one child may not be a good outcome for another so how do you measure value.
- Sharon: workgroup said paying for quality, understanding that outcomes are different. Participant responded that achieving standards as opposed to outcomes might be the way to go.
- Should be standards of care that everyone agrees on…comprehensive evaluations, screening for comorbidities, family centered care, family choice. Those providers who don't meet these standards then are not eligible for this value-based purchasing model.

- But the system does not provide adequate reimbursement for comprehensive evaluations and services. Eliminates competent providers.
- One comment (from an observer, not a Committee member) said the parents should have a greater say in what services they would want to purchase with dollars. Can this be considered? Sharon said that it has not come up as a concept in previous meetings, and too late in process to introduce consideration of such a different model.
- One comment re aligning incentives across providers. 5 or 6 providers rowing in the same direction and work toward a common goal, i.e., preventing homelessness, successful employment, avoiding incarceration. And if those outcomes are impacted, then reward. Don't want to shift risks and costs.
- We don't want to see facility-based providers shifting risks to lower cost providers. This is a general recommendation as opposed to getting more specific. Recognize goal of aligning providers with a shared goal.

Understanding the Current System

- Correction that ASD is autism spectrum disorder, not autistic…
- Question re CRS. Sharon: this group has not addressed this. Sharon is tossing this to the workgroup.
- Line 35 – Autistic Disorder is term used in DSM IV that DDD uses and ASD is term in DSM V. We don't want to get crosswise with DDD. Wherever this term is in law, code, etc., it needs to be changed to proper term today.
    - Sharon: clarified that the recommendation is that DDD use the term per the current DSM.
    - DDD said this is just a label, but we are looking for a full picture. DDD concerned that it takes a long time to change legislation.
    - Sharon clarified: this is the recommendation from the group. In early Committee meetings, it was agreed that the group would set aside concerns about things taking a long time. The goal is to make recommendations that reflect how the Committee wants things to be long-term.
    - One comment said the laws should match to the current DSM instead of putting the terms in.
    - DDD concern that this may open up to increased caseload and fiscal analysis has to be conducted.
    - One clarification: the "at risk of institutionalization" criteria is not changing.
    - Sharon: The issue is that Autistic Disorder is not a term currently used and the Committee is recommending changing to align to current term ASD across all agencies, in codes, rules, and policies.

Accessing the Current System

- Page 3, line 7. Referred and eligible for DDD are separate. Can be referred and be in the process and still be in acute. Have 2 bullets: 1) Not referred to DDD 2) Not eligible for ALTCS
- Page 3, lines 15-36. The health plan needs to be cocoon for member even if they don't get into DDD.
- Make the process clear to PCP. Emphasize that if member needs something there are services available through the health plan.
- Comment again to emphasize that not getting into ALTCS DDD does not mean you cannot access services.
- There is a lot of RBHA language. Is that because right now…people in acute have to go through the RHBA? Sharon said yes because some recommendations are for longer term changes — how the Committee wants the system to be set up — and at the same time, we want people to understand the current system, so we want people to know to go to RBHA.
- Instead of RBHA, can we use "public behavioral health system" — RBHA is not a term families understand.
- What constitutes a delay? Line 24. Sharon said she will send that to the workgroup for definition.
- Add a glossary to the recommendations.
- The study – one comment that St. Luke's Health Initiatives should be paid by AHCCCS to conduct comprehensive study of services and gap analysis.
- Clarification: Are RBHAs contracting with the developmental pediatricians? It is allowed. One participant said I had a contract with the RBHA and the Medical Director of the RBHA had to approve referrals and I never got a referral.
- DDD and health plan should align provider network. One request for clarification. One response said there is a lot of choice and would help if health plan contracts with same providers, especially with PT, OT, speech. One health plan did some root cause analysis and found that when someone asks the health plan for authorization, DDD has already authorized. One comment said they were hoping it would align DDD and health plan so if you lose your ALTCS eligibility, you don't lose your provider. Sharon said we can incorporate both.

ASD Diagnosis

- Changing the Arizona Administrative Code so DDD can expand beyond psychiatrist and psychologist to developmental pediatrician and pediatric neurologist. Sharon saw heads nodding in the room and there is agreement to this.
    - Second potential recommendation: expand to allow pediatricians and developmental pediatric nurse practitioners per PCH "Early Access to Care – Arizona" pilot (Dr. Robin Blitz) that is training 12 people, to also allow to

diagnose. Sharon noted that Dr. Blitz provided additional information that is in shared Dropbox.

- One question re pilot program – are those providers going to actually diagnose? One response said yes but only those pediatricians that have been trained.
- Sharon clarified that workgroup wants to expand the actual Rule (AAC) and not just DDD policy.
- One person said licensed behavioral health counselor says she can diagnose ASD. One response said that there is huge range in training and would be surprised if BH counselors could make this diagnosis.
- To the second recommendation: we need more information about the pilot and data. Concern re putting pediatrician on the spot; stress related to diagnosis could disrupt relationships in the family's medical home.
- Sharon: So, I am seeing there may not be consensus as to this second recommendation.
- One comment: not sure. Asked the DDD reps what they felt in their discussions with Dr. Blitz. DDD response is they are not sure about this pilot – comfort level is not there.
- One comment: In Boston, kids can be screened and then receive services while they wait for a formal diagnosis. Can we talk about that?
- Comment: Pipeline for getting kids services is one of the problems this committee was asked to look at and getting that diagnosis is key to resolving that. I am in agreement with Dr. Blitz that specially trained people should be able to make the diagnosis but we do NOT have enough information on Dr. Blitz' program yet.
- Could Dr. Blitz present to the Committee on the training? Sharon will contact her re availability.
- Sharon: I am hearing consensus is not achieved around letting specially trained pediatricians and pediatric NPs to make diagnosis, but consider Dr. Blitz program as a preliminary screening that triggers the start of services, so it would serve as an interim assessment.
- Participant says interim assessment is critically important.
- One participant wondered what insurance companies are going to recognize for this pilot program, because if private insurance won't cover services for diagnosis made by someone in pilot program, DDD will be paying for services denied by private insurance.
- This program also helps workforce development and gets interim services started…you don't need to get into DDD to get services. So this will let the acute plans start services for the member.

- One other potential recommendation: comprehensive multi-disciplinary plan coordinated at the medical home; diagnosis using current DSM criteria, etc., as stated on the slide.
    - One comment: yes, supports.
    - One person calls into question chromosomal microarray…including this may not be acceptable to everyone…do we need to be this specific?
    - One comment: geneticists recommend this; support leaving this level of specificity in. Also, chromosomal microarray is not expensive.
    - Another support
    - Another support that this is part of evaluation
    - Important to highlight that this should not slow things down.
    - Need to highlight other co-morbidities
    - Another said co-morbidities are important for pediatricians to evaluate as part of a checklist.
- Line 12: question — Who would do that? Sharon said this was not addressed. One response said published in a standard of care.
- Clarify AHCCCS makes ALTCS eligibility determination, not DDD. One person said there is a question as to how that process works.

Primary Care Provider Education

- Enhance relationship with professional associations and AHCCCS, as well as health plans.
- Page 4, Line 12: Who would do that? Take it back to the workgroup.
- Issue: if have DDD Targeted member, how to get into ALTCS? Different answers. DDD helps process. Require the referral to AHCCCS. How to accomplish that?
- Providers don't have a good understanding about the documentation that DDD needs.
- Include CDC recommendations re screening and diagnosing for autism.
- This isn't about screening, it's about ensuring PCPs know the common comorbid conditions with autism so they have a check list and know what to look for.
- Could be both. AHCCCS plans and DDD work with professional organizations to education providers on:
    - ID and evaluation
    - Comorbid conditions
- Should be a standard of care in the manual.

ASD Services

- Define habilitation and rehabilitation. How are they different?
- Cost shifting between organizations created that issue. Who pays for what and not let member get stuck in between. Eliminate payment discrepancies. Move it all to acute health plan.
- Why do therapies require prior authorization (PA)? Eliminate PA for therapies. Huge administrative burden for all.
- DDD/ALTCS: What services are covered under habilitation versus rehabilitation?

- Based on review, should have access to medically necessary services.
- Parent/guardian should also include caregiver

Workforce Development

- Lack of speech therapist across the board. Will be a challenge to increase numbers.

Evidence-Based Practice Definition

- Looking at circles, the center is really the individual's treatment. Change center to say Person-Centered Plan.
- Change Family's to Family/Caregiver
- Specify how evidence-based practice fits into that.
- Are circles equally weighed priorities? Yes, that was the intention of the workgroup.
- Rationale: Recognizing that each individual is unique.
- Consider prioritizing, for example, best available research.

Evidence-Based Modalities

- Page 5, lines 28-29 – make clear that the care coordinator is responsible for ensuring that the evaluation takes place, not for ensuring the evaluation outcomes.

Adults with ASD

- Coordinate with DES for WIOA. Information received from a participant after the meeting: "WIOA is a Federal Law passed in July 2014 and effective July 2015. Unfortunately AZ is still figuring the implementation out but all of the services, except those provided by schools, are housed and coordinated @ DES. This is one of the major reasons I remain adamant that DDD remain the agency responsible for providing care for all DDD eligible individuals, not just those who are DDD/ALTCS eligible. These WIOA benefits begin @ age 14 with pre-vocational transition planning. It is DDD's responsibility to coordinate with the other DES agencies to make sure all DDD members eligible for WIOA services get them." PowerPoint presentation copied to Dropbox.
- The U of A Sonoran UCEDD (University Center for Excellence in Disabilities Education, Research and Service reported: Over the last year, a group of multi-stakeholders, including members of the Arizona Developmental Disabilities Network, have been working diligently to prepare an action plan for Employment First to be launched in the state. Employment First supports the belief that employment, must be a primary focus for all persons including those with disabilities.
  Listed below are some of the accomplishments achieved or pending related to Employment First:
    - The Employment First Strategic Plan was finalized in August and formally presented at the Arizona Department of Education's Fifteenth Annual Transition Conference during the session *AZ Employment First: Job Opportunities Builds Success*.
    - The Division of Developmental Disabilities has announced an Employment Services Manager will be recruited to coordinate and implement the Employment First Strategic Plan goals and action steps. The position will also support the Division's initiatives to provide technical support assistance and

training, developing employment policy/procedure, and developing new employment services.

- The Council is implementing a new webinar series and will be presenting information to the general public on Employment First in the near future.

Oral Health

- Need online resources

Tracking ASD Utilization

- Need to determine what to track.

Information about Resources

- AZ Autism Coalition has a website that could be used: azautism.org
- Could update.
- Needs to be a nonprofit.
- Could work with Autism Society. New Jersey did that with nonprofits collaborating. Was not a government website.

ASD Advisory Committee Meeting

Session 6

November 18, 2015

Agenda

- Review of group norms, charge, and intentions
- Updates on work underway
- Draft recommendations, with changes & additions
- Next steps before final Dec. 16 Committee meeting

Group Norms

- Help create an environment that allows all to speak freely and without concern:
  - Listen with an open mind and a collaborative mindset.
  - Speak concisely and respectfully.
  - One person speaks at a time, as called upon by the facilitator.
- The full Committee focuses on the overall goals—details and tactics will be handled by workgroups.
- Stay focused on the topic at hand and self-monitor to avoid tangents.
- When expressing agreement with other speakers, don't use up time repeating what has been said.
- Work towards consensus on recommendations.

Charge to Committee

- Articulate a series of recommendations to the State for strengthening the health care system's ability to respond to the needs of AHCCCS members with or at risk for ASD, including those with comorbid diagnoses.
  - Focus on individuals with varying levels of needs across the spectrum, including those who are able to live on their own and those who may require institutional levels of care.
  - Address early identification of ASD and the development of person-centered care plans.

State of Arizona Intentions

- Break down silos in health care.
- Drive value-based purchasing efforts that reward quality over quantity.
- Bring together behavioral health and physical health.
- Reduce burdens on families of children with special health care needs in the CRS program.
- Coordinate care for people with behavioral health needs that interface with the justice system.
- Align care for dual-eligible members.

Update: ASD Services Chart

Cross-workgroup team is developing a well-organized document to answer the question:

Who provides what services and when for AHCCCS members with ASD?

Update: Early ID & Diagnosis

Early Identification & Referral Workgroup, in collaboration with AHCCCS staff, is creating:

- "Cross-walk" of terms that are used in different ways by different agencies
- Flowcharts for families and providers that map out the screening, assessment, and diagnosis process
- Components of a Communications Plan about early identification and diagnosis for multiple audiences

Draft Recommendations

This is a preliminary draft for initial discussion. Additional content will be added by the workgroups, and we'll make additions and edits based on our conversation today.

Systems-Level Changes

- Integration
- Choice
- Care Coordination
  - Where should the care coordinator be located? At the acute health plan? At the PCPs office? Both options?
- Question: Does the Committee want to include the medical home concept in the recommendations?

ASD Diagnosis

- Change Arizona Administrative Code R6-6-302 so that acceptable documentation of autism by DES DDD is expanded beyond licensed psychiatrist or psychologist to include developmental pediatrician and pediatric neurologist.

Potential Recommendation

- Add pediatricians and developmental pediatric nurse practitioners with extensive training, experience, and credentials.
- Phoenix Children's Hospital Developmental Pediatrics developed "Early Access to Care-Arizona" program—12 pediatricians from non-metro areas in an intensive 6-month training program, with regional assessment teams to support diagnosis and entry into early intervention.
- Second cohort (Maricopa County) staring in Jan. 2016.
- Details added to Dropbox.

Potential Recommendation

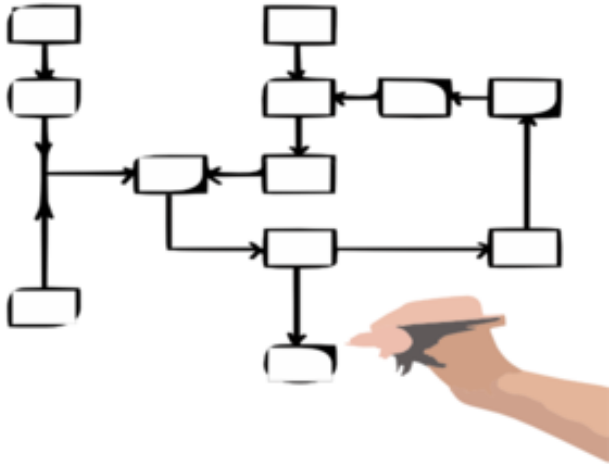
- Comprehensive multidisciplinary assessment and plan:
  - Coordinate in the medical home.
  - Diagnosis should be made using current DSM criteria.
  - Medical assessment should include recommended testing for Fragile X and a Chromosomal Microarray, as recommended by American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychology (AACAP), and American Academy of Neurology (AAN).
  - Speech and language assessment.
  - Psychological assessment (cognitive and adaptive skills).
- Provides a comprehensive profile of child's and family's strengths and needs in multiple domains and informs comprehensive treatment plan.
- Must not hinder or delay the initiation of services.

Value-Based Purchasing

- What are appropriate outcomes measures for ASD in a Value-Based Purchasing model?

Understanding the Current System

- Communications Plan
- Family and Provider Flow Charts



Accessing the Current System

- Comprehensive study of available services
- Document services in a database

Primary Care Provider Education

- Check for co-morbid conditions.
- Encourage use of American Academy of Pediatrics clinical reports, “Identification and Evaluation of Children With ASD” and “Management of Children with ASD”—both reaffirmed by AAP Council on Children with Disabilities in 2014.

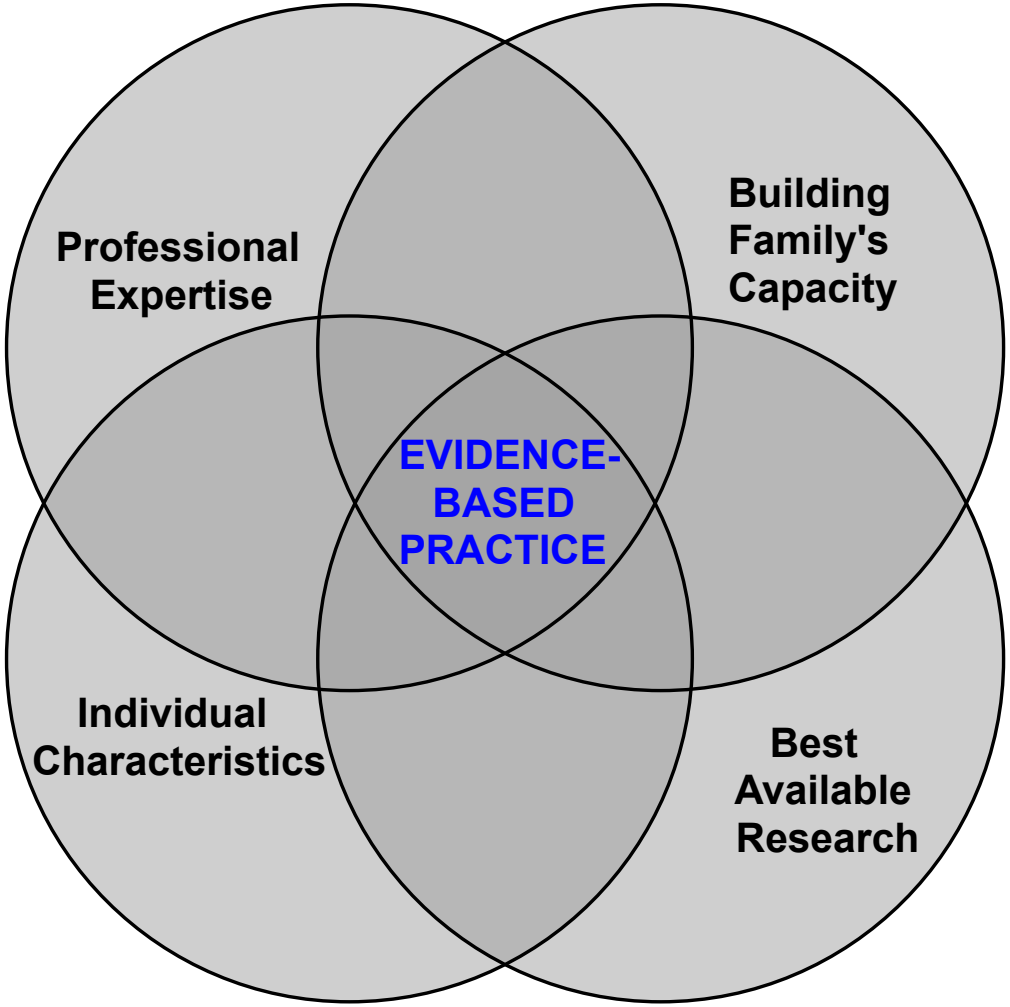
ASD Services

- Eliminate distinction between habilitation and rehabilitation.
- Focus on building the capacity of the parent/guardian when delivering OT, PT, ST, and feeding therapy.

Workforce Development

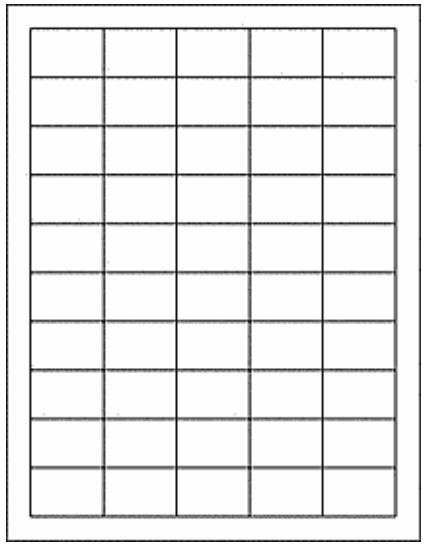
- Create an ASD Workforce Development Consortium.
- Increase use of online training.

Evidence-Based Practice Definition



Evidence-Based Modalities

Create and maintain a matrix showing the latest large systematic reviews of ASD treatments.



Adults with ASD

- State agencies should incentivize providers to build the infrastructure for member-directed services that are needed to support the coming “tidal wave” of adults with ASD.
- Recommendations under development on:
  - Residence options
  - Employment options
  - Social issues and social connections
  - Community awareness
  - Supportive services

Oral Health

- Online training
- Office-specific storyboard to help prepare an individual with ASD for a dental visit

Tracking ASD Utilization

- Define the data needed to monitor utilization of covered services by AHCCCS members with ASD.

Information about Resources

- Create a website with comprehensive links to information needed by:
  - Families and adults with ASD
  - Primary care providers
  - Providers of ASD diagnoses and services
  - State agencies
- Provided printed copies of resources for those without easy Internet access.

Next Steps before Dec. 16

Facilitator will assist each Work Group, through in-person meetings, teleconferences, and e-mails, to revise draft recommendations and add appendices.

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