ASD Early Identification and Referral Work Group December 1, 2015

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- How do we define “reduce delays”? AMPM document is unclear about it. It’s a nation wide problem, not just here in Arizona.
- So would the goal of the group be to recommend 45 days?
- 45 days in a life of a three year old is a long time…so 45 days…60 days…?
- Let’s have it as a goal although it will be hard to meet it…it could be best practice
- The next bullet point - AHCCCS should consider pediatricians, pediatric nurse practitioners trained through this pilot program to make an initial diagnosis…to start interim services until a diagnosis is made by a licensed psychiatrist, developmental pediatrician, or pediatric neurologist…
- I think looking at it from health plan standpoint it’s a good way to get them somehow into services…it addresses the notion that you have to get into DDD ALTCS to get services…part of the issue is that everybody is the mind frame that if you don’t get into DDD ALTCS, you don’t get anything…people are focused on will DDD accept this diagnosis…so why don’t we instead put that whole notion away and say anybody who is identified through this program…we then have steps A, B, C, and D…and that is what we’re trying to work on. Once they get a diagnosis then what needs to happen for them to get treatment? So I think this more lined up with what the health plans provide—PT, OT, ST—if it isn’t already going through the AzEIP process…and then for the behavioral…it’s stronger linkages between health plans and the current children’s services within the RBHAs.
- You find this child...I am sending them to you now…do all the best practices within the RBHA…that is how I would look at it and take the DDD part out.
- I think it does come back to the have services available…kids that are AHCCCS eligible… vs those who are ALTCS eligible.
- If they at least got a preliminary diagnosis then the health plan knows about it and can go to behavioral health…at least they can start getting behavioral health services…and they can be checked for other diagnosis such as ADHD and some of those other comorbidities.
- Are you recommending an addition or replacing the section that talks about the pilot?
- I think we need to be clear about what those services are and that you can get certain services started without being in DDD…I guess the other part of it…is that we say something about the health plans will work with this program for preliminary diagnoses to help navigate the children to get those services…so like we find out about them…it’s almost like care coordination…we find out that they are diagnosed and we make sure that they’re referred to one of the RBHA sites that does children services…that is kind of what I am trying to work on right now…
- Will you have this put together by next week and have it in the draft document?
    - Yes…need to put something in where we make it clear that the health plans with work with this program in order to capture that population that is getting an interim diagnosis

  and helping them to navigate so that they can get those interim services such as PT, OT, speech…as well as ensure that they are getting behavioral services that the RBHA can provide.

- I think there will be some input from some of the provider agencies about how that will be coordinated. And you make a really good point that if we do all of this work…of getting kids identified…but if there isn't good communication between the diagnosis provider and the health plan…so that family gets a warm hand-off to what's next…because I do think that is part of the problem…there is no one really doing care coordination except for community based organizations.
- The problem is when doctor tells individuals to refer themselves to the RBHA…they are going to call a phone number…who is on the other end? The person at the RBHA doesn't know that the PCP wants the child to be checked for autism. I think that is big priority—clear connection and process steps for PCPs to follow and the health plans to follow to get the behavioral services.
- Page 6 line 5 – wording is good now.
- I think it is good worded like that… AHCCCS policy on genetic testing basically is that the genetic testing has to change the treatment plan to improve the health of the member.
- Do you think that adding that language to the paragraph would make sense…"genetic testing that has the potential to change the care plan"
- That is already the policy…
- I don't have an issue with the way that it is worded
- I was going to change it, maybe simplified a little bit, "medical assessment including screening for comorbidities and genetic testing as per recommendations by organizations such as"
  - I think to be honest…people a lot times interpret those recommendations in different ways but those of us who do this as our daily work may know the details of medical necessity criteria….so for example it actually says any child with autism, fragile X testing is done… but the other one that was up on the screen…was not cut and dry…the argument for it would be you might as well if you having your blood drawn for fragile X…for a child with autism I typically had been approving both at once…but you could actually say you could make a medically necessity decision for the fragile X and say no to the chromosomal micro array until the fragile X comes back…if you want to be frugal about it…but than you have to consider the transportation of the child and all that…
  - I think in another year this whole chromosomal micro array and fragile X is going to change because now we all want to do whole exome sequencing…..so people would say now it's cost effect to do exome sequencing from the beginning…not sure if there is a clear answer on that yet…and it still is considered experimental by several of the commercial insurances…I'm not approving that… why do have to do two bizzilion tests and you have found nothing so far.. is that going to change the management of the member. ..that is where we run into issues as medical directors.
  - So are you okay with the wording changes for this?
    - Yes.

        - We don't want to get to specific about CMA and fragile X because I think this is going to keep evolving
- The next bullets--"AHCCCS should educate providers… and "Screening for ASD should be accompanied by … and to basically describe how that process works"
    - I don't know because that is not something we include the medical policy manual.
    - [Referring to AHCCCS should educate providers sentence] part of this going to need to be done not by the acute health plans but by the RBHAs. I just don't understand why children that come in…why can they all [those coming in for behavioral referrals] be assessed for ASD and ADHD…why ASD even left out? I don't understand why the focus is on ADHD, OCD…
        - I think the point people were making in terms of AHCCCS should be responsible is because they want it to be in the AMPM
        - Would this be in chapter 400?
            - I think this could be incorporated into that section as best practices for children's care
            - Yes chapter 400 would be a place that it would reasonability fit into the AMPM
            - Is the appropriate language—"standard of care" or "best practice"
                - "Best practice"
- Is the overview document ready yet for the work group to look at?
    - I thought there was something else you wanted to add
    - I think it's good…
    - I think the suggestions I had were things that were based on questions on what if the provider never gets anything from AzEIP? What do we want PCPs to do? It's all the little bugs that they run into and what they need to address those…but it might not belong in the document….it could something we talk through to find what the answers are and then the health plans would provide the care coordination
    - Some of the questions I have written on this document for things like…what if the provider never get anything from AzEIP, what should they do? What do we want PCPs to do regarding the ALTCS process and what do to they do follow up? What if the provider never gets anything from the RBHA after referring for ASD diagnosis? What if the PCP wants behavioral health services for ASD but the member is not ALTCS and doesn't qualify? Where does the PCP send the therapy request, do they send them to DDD or the health plans? This is the stuff that smooths everything out for the kids in real life.
    - So would this be something that you would imagine to be an appendix for this report?
        - I love that because that is what we do all day long
        - The other thing I was thinking of was putting together a list of resources that would include, for the PCPs, these are the kinds of organizations that can help.
        - Maybe a resource page