ASD Workgroup: Building Network Capacity
September 1, 2015
Conducted by phone due to power outage at AHCCCS

Participants: Vickie French, Brian Van Meerten, Arnetta DeCamp, Tyrone Peterson, Danny Kessler, Ann Monahan. Note-taker: Jennifer Carusetta

Who can make diagnosis?

- Question: Is Early ID and Referral work group also looking at issue of who can diagnose, as opposed to who can provide ongoing services? Sharon - Yes, they are.
- Consider bringing a recommendation to full committee that DDD seek a statue change so that diagnoses from Developmental Pediatricians and Pediatric Neurologists would be accepted.
- There are more Pediatric Neurologist than Dev. Pediatricians, but they haven't jumped on bandwagon, even though by training they should be able to ID children with autism.
- Came up in context of Dr. Henry in Nogales, Pediatric Neurologist in her area was go-to person for diagnosis.
- If someone has professional interest, go ahead, but in Phoenix, we see kids who were seen by neurologists all the time, they may make mention of behaviors, but don't pursue the diagnosis – there are a lot more of them than Dev. Ped.
- Don't know what the incentive is for Ped. Neurologists to make the diagnosis.
- Expand, especially in rural areas, but need to ensure they can do a comprehensive diagnosis.
- When DDD requires diagnosis for approved groups, they must include the diagnostic criteria that are a match for this child, and that the behaviors have caused significant impairment in 3 of 5 areas. Most Ped. Neurologists should have the competency to do that, but if they haven't had experience, there is little reason for them to jump into the breach – they are busy with their other work. What's their incentive to add this to their list of diagnoses?
- Would support any opportunities to expand the range of people who make diagnosis.
- This may require a change in statute – now only psychiatrist and psychologist, waivers for Developmental Ped.
- In terms of who is seeing these children, they may be seeing Pediatric Neurologists for other reasons.
- Expand to pediatricians, but may not be statute - but they might provide the data, so the diagnosis may not come from a therapist, but they would provide the info for diagnosis.
- That's still a narrow funnel…
- In rural communities, presumably there is a pediatrician accessible to the treatment team. However, it would be nice to have some way of certifying that this is a pediatrician who has been trained, understands diagnosis, and confirm collected data.
- TriCare will allow pediatricians to do the initial ASD diagnosis, as long as there is follow-up in one year with a qualified diagnoser. This should be allowed for Board Certified developmental behavioral pediatrics, pediatric neurology, child psychology for those who are licensed at the doctoral level.
- What does initial diagnosis then get the child? If that gets intensive treatment (as defined by our recommendations), but then is not confirmed, this is a fairly expensive outlay of resources

- for something that does not actually pan out. I like the idea of that utilizing a group of physicians because presumably, if they are participating in the evaluation, then they have an interest in doing that and have some training. We would need to clarify who that team is. If it is just an occupational therapist that does the assessment, that is not enough. The team would need more depth.
- Model that Robin Blitz is piloting, with a diverse team, vs. TriCare model which is just physicians whose diagnosis is the basis for intervention.
- There is a long list of types of providers who need to be considered when recommendations are made.

New topic – What do we collectively know about each area of focus?

Under "better understand which services are covered, its' a long list of who might be considered once a diagnosis is made, then 2nd bullet point about DDD habilitation – any questions?

- SAARC typically does private insurance/pay- there may be other things to look at like grants - two work group members will research other resources.
- I would like get a better understanding of who can provide services - there is no detail so far besides who can provide the diagnosis. What do we want to capture under this bullet point?
- The national board has a very comprehensive guideline about what services are to entail - the statute says that providers must be licensed behavioral analysts - same for speech, OT, and PT.
- We need to focus on the supervision piece - new codes don't say ABA. We need to be clear on what requirements are based on the services are from DDD. When we talk about who can provide services - all services, early intervention services, etc., we need to drill down on services then expand upon who can actually provide services.
- If there is an agency that does not have an ABA supervisor - there is no requirement for respite or habilitation. We should identify each service and the specifications for providers. Very few BCBAs are doing direct line therapy. This needs to be not just the service, but also the service levels.

New topic – who is providing services, and where, especially in urban and rural areas.

- Who is responsible for what – schools, DDD, … who is responsible for what and when, even hours in the day. Good idea for us to get as much information as possible about what each player is responsible for.
- Funding sources – sometimes a competition, same money to draw from, but some contracts are really collaborating, go into home, comprehensive behavior assessment, RBHA is saying be effective in all settings.
- Who will be responsible for figuring out the who does what when. Another work group member was suggested – Sharon will ask him…

Other observations…

- Transition age group, older teens to adulthood

- Center-based employment
- AHCCCS is trying to figure out how to be creative and keep center-based employment. The reality is we have a ton of kids in center-based employments right now - the HCBS rules have a 5-year transition plan.
- Need to look at employment out in the community, not just center-based employment
- (not primary focus of this work group – Adults with ASD work group addressing this)

Long list of bullet points in terms of the issue of increasing the number and competency of those who can do diagnosis and treatment. What I hope we can do is go up a level from these details to get to strategic level – what will it take to make these increases?

- Big chunk of it is money – going after same employees – minimum wage increases complicate things.
- Dept. of Labor, federal law dictates some of what can be provided for home and community based employment. How do we change it, since this is challenging.
- Need an exemption, pay overtime and drive time, etc., included in 40 hours. Some legal battles are underway, Labor Dept., to Supreme Court, difficult issue – just not enough money to cover needs. How do we maintain network if people are dropping off with no money.
- Think people want to do this work, but rates are now enough so that quality people are always there.
- If we say money is an issue, are we being creative enough to tap into available monies via insurance, other service areas besides AHCCCS.
- How do we make ourselves desirable enough in the community?

Beyond funding – what other issues should we bring to Committee?

- We have many older individuals who require much care, if earlier interventions, spend less in long run – can we do something to shift the money more upfront, early diagnosis, etc.

Other strategies to build the network capacity?

- Can we partner with other organizations? Is there a way we can look at different areas we can partner with? TriCare has asked to collaborate - is there an opportunity to work with them?
- I know we had discussed to trying to recruit high school students to recruit them and train them – earlier recruitment, before career path is formed.

Technology-related

- There is great research on telehealth and videos - will make sure everyone gets the articles that speak to this issue.
- Has anyone heard what is happening with the NODA- diagnosis tool? When they announced it - they announced it as an ongoing study. They wanted to recruit people for it, but the articles had been submitted, but not published. We are open to looking at that information, since it has been developed, and it is out there and it is available

- There is a new app that parents can use to videotape certain predefined activities or behaviors - the app leads a parent through what to videotape. The NODA assessment process is completed in 2-3 weeks at half of the cost of regular testing. There was a pilot in Jan 2015 - I am not sure what has happened since then. Dr. Smith at SAARC could give more details.

What are the barriers that keep providers from participating in the network?

- In previous meetings we talked about how there were health disparities in rural areas - the codes vary among the RBHAs and private insurers. We also need to look at the impact of copays.
- Up here and down south travel is a barrier to direct treatment.
- There are two rates, depending on what the service might be. There are different rates for different services - especially DD services. Actually, there are more than two rates.

We need to go over the data obtained so far.

- The majority of AHCCCS services are provided under habilitation, respite, and care management.
- Lauren sent everyone a handout with AHCCCS, ASD prevalence, screening data.
- One of the other groups wanted the number of ALTCS members by diagnosis age and service year. This group has a very long list of things they would like to know about. At the last full committee meeting, we asked the groups to prioritize the data requests to AHCCCS in light of how long it takes to do a data run.
- We looked at CDC website and found data for Maricopa County only. We are talking about capacity for medical and behavioral health treatment. Can we provide a baseline for what is going on right now?

One thing that might be helpful would be to start thinking about what might be some recommendations that would come out of this workgroup to the full committee in Dec. What information do we need to support these recommendations?

- Training continues to come up when we talk about network sufficiency when it comes to training providers to provide BCB training for attendant care.
- In a perfect world, what would providers like to do to maintain those employees? Training is a component of that. Everybody has thoughts on what good training is - it has been a bone of contention for a long time.
- Documentation and note taking is important, along with making sure documentation and data collection fit with a service. This is something we need to address/recommend.
- As providers of services, we really do have to be very diverse in our funding options. The fear is that there is a lack of want for providers to move in different lines of business because it’s scary. It’s important to talk to providers of these services and not put all our eggs in one basket.
- We need to talk to the Governor’s Office related to improving services to members at risk for ASD or with an ASD diagnosis in terms of network capacity. One of the things we could talk about is the community, taking advantage of natural supports (churches, communities, etc.), not just network sufficiency, particularly on the employment piece - we need to have community

businesses more involved. There is potential for many more community partners who can help us out or even fill holes we have.

We don't do a good job of collaborating with schools. We don't see a lot of collaboration between state agencies (behavioral health, DDD) and schools. What would it take to make improvements?

- Schools need adequate budgets.
- There are policies that prohibit the exchange of services and data. Policies are sometimes interpreted more flexibly, which opens up good possibilities for collaboration in N. Ariz. Often a special education director invites in. We need to provide more flexibility. The RBHAs should allow us to go into schools - this would be really beneficial. This is a decision that the family can help make.
- We are hearing that the schools in greater Phoenix have not allowed any of the ABA therapists into the schools. We are told it is a liability issue - but the ABA therapists are not licensed by the school. This is a great loss when excluded from schools. There is a misinterpretation of the policy - an ABA has liability insurance through other means.
- The schools don't want families to see what is possible in terms of working with families because the families will be asking for it.
- Allowing therapists in the schools could potentially save costs and the collaboration could be beneficial to kids.
- It would be helpful to know what circumstances the therapists are operating under in a school contract and under an AHCCCS contract.
- Our recommendations should include greater collaboration through systems.

Next meeting Tue Sept 29, in Ocotillo room in 801 building

Next full committee Wed Sept 9 in 701.