Early Identification & Referral Work Group

July 8, 2015 Work Group Discussion

1. What are the areas of focus/need of this work group?

- Clearly define assessment, intervention, and screening for best practices when identification occurs. Children get missed in identification because of the already narrow view of referral once autism is identified
- Difficult to determine what is and is not an appropriate referral. Second stage needed once a referral is made, including the need for a secondary screening. The result is that the diagnosis process gets bottlenecked because of lack of providers able to officially/legally diagnose for ASD
- M-CHAT needs to be most current version when follow-up is conducted
- Screening, identifying and referring appropriately – providing alternatives between referring and identification – providing intermediate paths between identification and official diagnosis
    - Secondary screenings that are more in-depth to help rule out one diagnosis over another. Utilize STAT-MD (see information below) out of Vanderbilt, and Australia – general PCPs can be certified to use which gives more information)

      Second Stage/Level 2/Intermediate ASD Screens
    - STAT-MD: http://vkc.mc.vanderbilt.edu/vkc/triad/training/stat/physicians/
    - Stone, Wendy L., Elaine E. Coonrod, and Opal Y. Ousley. "Brief report: screening tool for autism in two-year-olds (STAT): development and preliminary data." *Journal of autism and develop ental disorders* 30.6 (2000): 607-612.
    - Stone, Wendy L., et al. "Psychometric properties of the STAT for early autism screening." *Journal of autism and developmental disorders* 34.6 (2004): 691-701.
    - ADEC (Autism Detection in Early Childhood): https://shop.acer.edu.au/acer-shop/group/ADE Dix, Leigh, Rachael Fallows, and Glynis Murphy. "Effectiveness of the ADEC as a Level 2 screening test for young children with suspected autism spectrum disorders in a clinical setting." Journal of Intellectual and Developmental Disability 40.2 (2015): 179-188.
- Coordination between PCPs and early intervention crucial
- PCP may be deterred from screening due to cumbersome billing requirements
- Communication, training, and education to ensure timely care
    - Assessment and intervene early – autism comes in all variations or spectrums that may be difficult to identify and treat beginning at an early age

- Diagnosis is the most challenging piece of effectively treating ASD because once child is referred, the system slows down
- When referrals come through AzEIP, pediatricians discontinue involvement, in varying degrees, in the follow-up process – PCP needs to be included further, including other provider types to encourage collaboration and treatment
- "Watch and wait" a reoccurring problem
- Redefine and clarify "evaluation" and AzEIP's role in AMPM – may be fixed by clarifying front end of the policy
- Education - Parents may be confused in that an assessment is not the same as an official diagnosis. What are next steps following an evaluation, assessment, and diagnosis, and who is responsible for providing each
- AzEIP should not be looked at as the only resource as a guide to obtaining services
- Pediatricians only involved in surveillance
- Lack of identification, inappropriate referral, or appropriate referral that results in long waits and bottle necking
- Communication strategy between provider and families
- Network identification and adequacy
- Clearly defining the assessment
- The interagency workgroup: No ICASS http://www.iwg-autism.org/

2. What do we collectively know about each area of focus?

[Insert]

3. What data do we have/need?

1. What percentage of PCPs are engaging in screening with the hopes of increasing (rural, urban, Pediatrician, family practice, etc.)– 96110 code (very low utilization)
2. physical health v. behavioral health utilization – PT, OT, ST up to age 6

4. What data do we need to obtain?

a. **Sources?**
   i. Screening percentages.
   ii. What other states have done to identify best practices

b. **Who will obtain the data?**