REVISED: Reducing System Complexity Work Group: August 5, 2015

Participants: Coralyn Lingwall (in place of Sherri Wince, DDD), Ginger Ward (Southwest Human Development), Cynthia Macluskie (Autism Society of Greater Phoenix), Steve Sparks (DBHS), Chris Tiffany (Raising Special Kids), Monica Coury (AHCCCS), Rene Bartos (Mercy Care Plan), Diedra Freedman (Arizona Autism Coalition). On phone: Brian van Meerten (Behavioral Consultation Services of Northern Arizona), Karie Taylor (DES/AzEIP), Jessie Marshall (for Diana Davis-Wilson, Hope Group), Jennie McMillian (NARBHA), Facilitator: Sharon Flanagan-Hyde. Notes taken by Monica Coury.

Sharon gave an overview of last meeting:

- Discussion about eligibility and entry into the system – need for clarity around this for parents and providers
- Need for strong care coordination component
- Need for integrated care model

Brian's slides:

- Look at other models within AHCCCS system
  - Acute plans
  - ALTCS DDD
  - RBHA system for SMI, CRS
- Looks at funding streams: multiple different stakeholders

Discussion around complexity of understanding how to navigate the system.

- Difficulty understanding if someone isn't ALTCS eligible, how to access services; what to do if you aren't ALTCS eligible, understanding role of the RBHA…

Sharon: How do we move the system and make recommendations that can be acted upon?

- One person discussed care coordination for NICU infants at MMC (Maricopa Medical Center)
- Brian discussed his slides were intended to this point – strong care coordination processes exist within the system today
- Rene said this is the direction we are going in – integrated services for SMI. We can't say behavioral vs developmental, etc., and we can't separate mind/body…
- There are multiple breaks in the system. For instance, AzEIPs doesn't diagnose. So PCPs end up just ordering OT, PT, speech…not the right set of services.
- PCPs don't think they can refer people to the RBHAs
- We must look at the whole child instead of as behavioral health vs medical, etc.
- PCP is the one individual responsible for the coordination, but without parent, the PCP couldn't possible meet all the child's goals for care coordination. As a parent, that is who I want driving the bus.
- Clarification from Rene Bartos via e-mail after reviewing initial version of notes: What I was talking about was that I see a problem in that the PCP just puts a diagnosis of "developmental

delay" and then refers to AzEIP and orders ST, OT, PT for months or years without an apparent comprehensive evaluation ever being done to look for neurodevelopmental conditions such as ASD. I am concerned about this. PCPs and therapy providers do not appear to be connecting enough, therapists send in the auth requests, and PCPs are not doing all the best practices I would expect (likely because they are confused about systems). In other words, just prescribing OT, ST, and PT for months or years is not sufficient. We try to do outreach to offices about this concern. I have been going in the direction of authorizing ST, PT, OT particularly for acute children 0-5 and not trying to manage this issue through prior authorization. Trying to ensure children go through the right paths to get hearing and vision tests, evaluation for ASD, referrals to DDD, ALTCS, etc. is important but I have found it is not feasible to try to manage this through prior authorization of therapies.

- Monica: Talked about health home model, requiring health plans to have a specialized ASD care manager and move BH services into the acute plans. Discussed the CMS health home model. Takes some of the burden off of the PCP and puts onus on health plan to have specialized care manager that sees care through entire continuum.
- Discussion about referrals going to DDD that they can't even respond to, or the family isn't engaged, etc.
- Would care manager oversee health care from BH and medical in health home model? Yes.
- One concern re care coordination is one person is just looking at services piecemeal instead of looking at the care as a whole. E.g., therapists don't talk to PCP, and multiple therapies prescribed but no one following up or following through. Another person added that there aren't follow ups or assessments. There isn't a team based model.
- Team approach that puts the family at the center. How can we help families align services better and help family manage and make progress. So beyond care coordination, we have to center the services on the family.
- Need to have options and it doesn't have to be a cookie cutter. For instance, we can't have it all under one roof or under one center. It's a philosophy – of team models.
- Who can diagnose a child for ASD (in rule) and where does under 6/over 6 issue come from (in statute)?
- Question for health plan…how much are you requiring providers to use EHRs and share information with each other? Rene…getting all the systems to talk to each other is a challenge.
- What about ACOs? Similar model to health plans. We just need to collapse the systems.
- If you didn't get through ALTCS DDD, we need to clarify for the health plans what they need to do.
- Creating a map – for health plans, providers, parents. And needs a team that has the technical expertise to serve the population. Not everyone understands the issue or has the expertise. Need to create this.
- We also have a shortage of providers. It's not just an AHCCCS problem, but it's an Arizona problem. Sharon reminded group that there is another work group addressing this.
- Discussion around lack of education around legacy of disjointed system.
- Discussion around qualification of providers.
- Process of referring to the RBHAs, that doesn't work. PCPs really struggle with this.

- Medical care isn't ready to handle all kids with ASD. For instance, neurology, they don't know what to do with kids with ASD. In her case, neurologist wouldn't even acknowledge seizures. Perhaps, a health home model that requires health plan to have a specialized care team with familiarity with ASD.
- Short term need a solution re PCP referrals to RBHA needs to be clarified. Long term, if we have a health home model the PCP will let the health plan know and the care manager will schedule that appointment for a screening or assessment.
- Short term: fix doc-to-doc referrals and then when family walks in or calls RBHA for ASD assessment. How does that work? Fix this.
- Short term: People don't know that they are enrolled with the RBHA. Fix this! Monica explained that everyone is auto enrolled in RBHA serving their GSA once they are AHCCCS eligible. People don't know where to go.
- Issues related to providers focusing on particular areas because that is how they get paid.
- Communication – is really good in Northern Arizona. Billing is also important. If a provider can bill for case management, then provider does that. If you can't bill for a service, it gets tough. Case management is limited in DD, for instance. In a team service model, there are more meetings, etc.
- In AzEIP, we have been talking about when kids need services through BH system, we are trying to build up the team there to help the kids going into AzEIP. IDEA team is supposed to facilitate diagnosis, no matter where diagnosed. AzEIP service coordinator connects that family to the right place for that diagnosis. Issue is they run into same problem re limited number of people that can make diagnosis. Rene suggested improving the process to getting connected to RBHA for that diagnosis, a more direct link for the team. But it is also a capacity issue at the RBHA.
- If you build it, they will come. But we don't want to show a pathway for diagnosis if there is no provider.
- System survey – how many kids should be AHCCCS eligible, how many actually are. How many have and should have an ASD diagnosis (using 1 in 58 numbers). Survey providers as to their comfort level, capacity to serve ASD. 0-3, 3-6, 6-12, 12-18, above.
- Explain to doctors that they have a contractual obligation to see the members in their plan – there are issues with doctors who don't see certain types of patients. We want to support people who are serving the ASD population and want to help make others more comfortable. Dental also is an issue. But sometimes focusing on an area brings this out and helps build that support.
- Can't forget about foster care children in CMDP. They only contract with PCH neurologists and those neurologists don't have a comfort with ASD.
- CRS kids as well…this process is also unclear, especially for the DDD members.
- Families who call customer support at the RBHA are supposed to be guided to the right provider. But a parent said they know families that have done that and they were told we don't cover that. Ask for the supervisor if the customer service rep says we don't cover that. If they say we don't cover, ask for the CMO.
- This goes back to having a model like a cocoon. As a parent, I won't know to call and say I need ABA, or I need this, it's hard for the parent to figure out how to advocate or what to say.

Sharon wrap up:

- Next meeting is full Committee. Have each group talk about key points in terms of where we are in the process. I can put together a few slides to serve as a framework. Will that work? Yes.
- Does it make sense to have a monthly meeting for this group between now and December?
- Do you still want to meet Wednesday 1-3 before the August 12 meeting? Sharon's understanding was this meeting today takes the place of the Wednesday meeting. [Cancel 8/12 meeting from 1-3.]

Other final comments:

- Important to have phone option and great to periodically ask people on phone whether they have questions.
- PCP is key to making this work. We don't have a rep from PCPs on this group. Can we include Susie Cannata with the Arizona Academy of Family Physicians in the work group? Monica said yes.
- Anne Stafford is new Executive Director of Arizona Chapter of the American Academy of Pediatrics. Sharon will reach out to get her on the committee.

Clarification from Brian van Meerten after reviewing initial draft of notes: I do think it is important to note that we discussed that while the knowledge of the system is helpful, if systemic policies and/or administrative practices promote a delay in services (i.e. DDD/ALTCS) a care coordinator will not be effective. Also, I believe somebody brought up that RBHAs have been working to and providing timely diagnoses to promote efficient service delivery. Also, somebody brought up providing incentives for providers that deliver effective services for kids with ASD to reduce the number of providers denying services for various reasons.

Clarification from Rene Bartos after reviewing initial draft of notes: I would also clarify about the overall potential "breaks" in the system. Here is my take on the biggest issues raised on this as a whole:

- PCP referral to appropriate provider to assess for ASD
- PCPs think that referring to AzEIP, ST, OT, PT is adequate
- Lack of referral to Psychologist/Psychiatrists-confusion by PCPs on how to utilize RBHA services for evaluation for ASD and general trend of PCPs not to use RBHAs for diagnosis of ASD
- Shortage of Developmental pediatricians to see AHCCCS members
- AzEIP enrolled-process to ensure eligible children get into DDD
- Once in DDD, process to get ALTCS and what to do if the member does not qualify for ALTCS