Report on barriers, strategies and effectiveness of practices in identification of children between the ages of 1-3 with symptoms of Autism Spectrum Disorder

Information Submitted by DHS Contracted Managed Care Organizations

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The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

This report is published to comply with Minnesota Statutes 256B.69, Subd. 32a.

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I. Executive Summary

This report identifies barriers to providing screening, diagnosis and treatment of young children, ages 1-3 and It documents strategies implemented or being implemented by managed care organizations (MCO) and county-based purchasing (CBP) plans to address barriers to early screening, diagnosis and treatment of children with autism spectrum disorder and other developmental conditions. It includes recommendations from each MCO on how to measure and report on the effectiveness of the strategies implemented to facilitate access for young children to periodic developmental and social-emotional screenings, (as recommended by the Minnesota Interagency Developmental Screening Task Force), diagnosis, and treatment.

The report was developed in response to a legislative mandate (M.S. 256B.69, Subd. 32a) requiring MCOs to annually submit the above information thus allowing the Minnesota Department of Human Services (DHS) to monitor early screening, diagnosis and treatment for young children served by the MCOs.

In the first submission under this mandate DHS started with some basic questions of MCO's to gather this information. The initial process will be built upon each year going forward to provide further analysis and direction for improving timely access to services for very young children with developmental concerns. DHS also used information derived from prior reports on Autism Spectrum Disorder to create this report. The following key questions were asked:

1. What social-emotional and developmental screening tools are being used by Pediatric and Family Practice Clinics for children ages 1-3?
2. In what settings are social-emotional and developmental screenings conducted for children ages 1-3? In which of these settings are screenings reimbursable as health care services?
3. What is the protocol for referral and diagnoses if the screening(s) are positive?
4. What barriers has the MCO identified to providing screening, diagnosis, and treatment to children, ages 1-3?
5. What strategies has the MCO implemented or will be implementing to facilitate access to periodic developmental and social-emotional screening(s), diagnosis, and treatment for young children, ages 1-3?
6. Pursuant to section 6.1.23 (C) (2) of the 2015 Families and Children Contract, what evaluation and assessment, including treatment recommendations are provided to children who do not meet milestones?
7. What are the recommendations of the MCO on how to measure and report on the effectiveness of the strategies implemented or to be implemented on facilitating access to developmental and social-emotional screening, diagnosis and treatment to children, ages 1-3?

For the second year the MCOs met their Families and Children contract obligation by providing the requested information (see Questions One - Seven) and implementing strategies to reduce barriers to accessing screening, diagnosis and treatment for children, ages 1-3 (see Table 5).

II. Legislation

Minnesota Statutes 2012, section 256B.69 PREPAID HEALTH PLANS.

Subd. 32a.**Initiatives to improve early screening, diagnosis, and treatment of children with autism spectrum disorder and other developmental conditions.**

(a) The commissioner shall require managed care plans and county-based purchasing plans, as a condition of contract, to implement strategies that facilitate access for young children between the ages of one and three years to periodic developmental and social-emotional screenings, as recommended by the Minnesota Interagency Developmental Screening Task Force, and that those children who do not meet milestones are provided access to appropriate evaluation and assessment, including treatment recommendations, expected to improve the child's functioning, with the goal of meeting milestones by age five.

(b) The following information from encounter data provided to the commissioner shall be reported on the department's public Web site for each managed care plan and county-based purchasing plan annually by July 31 of each year beginning in 2014:

(1) the number of children who received a diagnostic assessment;

(2) the total number of children ages one to six with a diagnosis of autism spectrum disorder who received treatments;

(3) the number of children identified under clause (2) reported by each 12-month age group beginning with age one and ending with age six; and

(4) the types of treatments provided to children identified under clause (2) listed by billing code, including the number of units billed for each child.

(c) The managed care plans and county-based purchasing plans shall also report on any barriers to providing screening, diagnosis, and treatment of young children between the ages of one and three years, any strategies implemented to address those barriers, and make recommendations on how to measure and report on the effectiveness of the strategies implemented to facilitate access for young children to provide developmental and social-emotional screening, diagnosis, and treatment as described in paragraph (a).

III. Introduction

Autism Spectrum Disorders (ASD) is the fastest growing developmental disability in the United States. Recent estimates from the Centers for Disease Control and Prevention indicate that one in 68 children[1] is now identified with ASD. According to Autism Speaks[2] (2015), ASD and autism are:

> General terms for a group of complex disorders of brain development. These disorders are characterized, in varying degrees, by difficulties in social interaction, verbal and nonverbal communication and repetitive behaviors. With the May 2013 publication of the DSM-5 diagnostic manual, all autism disorders were merged into one umbrella diagnosis of ASD. Previously they were recognized as distinct subtypes, including autistic disorder, childhood disintegrative disorder, pervasive developmental disorder-not otherwise specified (PDD-NOS) and Asperger syndrome.
>
> ASD can be associated with intellectual disability, difficulties in motor coordination and attention and physical health issues such as sleep and gastrointestinal disturbances. Some persons with ASD excel in visual skills, music, math and art.

ASD usually is evident during the first three years of a child's life. Most parents first notice the loss of skills or developmental delays when their child is 15 to 18 months old however experts in the field are now better able to identify ASD in infancy. Even though researchers cannot point to one specific cause for autism research does consistently suggest that early diagnosis and intervention offer the best chance for improving function and increasing the child's progress and outcomes.

During CY 2011–2012 the Department of Human Services along with contractors used a stakeholder engagement process to gather information about access to intervention services and supports for children with ASD and their families. One result of this process was a report to the Legislature in December 2012 titled *A Report on Early Intervention Services for Minnesota's Children with Autism Spectrum Disorders*. The report includes a section of stakeholder responses highlighting key characteristics of effective early intervention services broken down into 11 categories. Three of those categories tie into the information MCOs are required to provide under Minnesota Statute, section 256B.69, Subd. 32a. Included in each section were comments (identified below section name) that link to practices the MCOs have in place or are trying to implement but are encountering barriers as identified in Table 4:

- Early Means Early
  - Early screening and diagnosis is the key to effective intervention
  - More accessible and systematic process for conducting screening and diagnostic assessment
- Individualized to Unique Needs
  - Staff show respect for the unique needs, values, and perspectives of the individual with ASD and his/her family
  - Programs are designed around the specific needs of the individual with modifications that match his/her profile, age, and developmental stage
  - Use individualized motivational strategies and behavioral and developmental support systems

[1] *CDC webpage – Who is affected* http://www.cdc.gov/ncbddd/autism/facts.html

[2] Autism Speaks (2015). What is Autism? Retrieved on July 31, 2015 https://www.autismspeaks.org/what-autism

    - Provide services in the home or in a center, depending on the child and family's needs
- Data Driven with Frequent, Ongoing Assessment
    - Identify best practices to track progress toward positive outcomes for each child receiving early intensive intervention services
    - Frequent assessment of child progress in order to assure the right goals, objectives and treatment strategies to capitalize on the earliest learning window of opportunity

DHS has a number of data sources describing characteristics of children with an ASD but not as much information beyond claims data about the screening process used by each MCO, the barriers they are encountering and the strategies they are using to ensure children have access to appropriate care. The information communicated from the plans allows DHS an opportunity to better understand what is actually occurring and helps to begin an awareness base-line data phase to direct future work to improve early access to screening, diagnosis and treatment, and assure needed services for children who do not meet milestones.

DHS asked MCOs to respond in a narrative format. This report synthesizes most of the information into various tables to quickly show similarities and differences between each MCO response.

IV. Report Questions

Question One: What social-emotional and developmental screening tools are being used by Pediatric and Family Practice Clinics for children ages 1-3?

During report year 2014 the respondents indicated they each had their own list of screening tools. As shown by the 2014 report in Table 1 and 1A they differed from each other with the exception shown in Table 1 where the ASQ-SE was used by six of seven MCOs. None of the tools identified in Table 1 or 1A were used by all of the MCOs.

Table 1 and 1A limit the identification of tools used to Pediatric and Family Practice Clinics. In those settings all of the tools identified by the Minnesota Department of Health for ages 1-3 in Developmental & Social-Emotional Screening Instruments for Young Children in Minnesota were indicated as used by PrimeWest and UCare in the response.

Table 1. Social-emotional and developmental screening tools used by Pediatric and Family Practice Clinics for children ages 1-3

MCO/CBP	Social/Emotional Screening				Parent Report Instruments			
	ASQ-SE	BITSEA	M-CHAT	PCS	ASQ-3	CDR-PQ	IDI	PEDS
Blue Plus			X					
HealthPartners	X	X						
Itasca Medical Care	X							X
Medica	X			X	X			X
PrimeWest	X	X	X		X	X	X	X
South Country Health Alliance	X			X	X	X	X	X
UCare	X	X			X	X	X	X

Table 1A. Social-emotional and developmental screening tools used by Pediatric and Family Practice Clinics for children ages 1-3							
MCO/CBP	Observational						
	BDI-2	Bayley-III	Brigance Early Childhood Screens	DIAL-4	ESI-R	Early Screening Profiles	FirstSTEP Preschool Screening
Blue Plus							
HealthPartners							
Itasca Medical Care							
Medica							
PrimeWest	X	X	X	X	X	X	X
South Country Health Alliance							
UCare	X	X	X	X		X	

Note: For full names of tools in Table 1 and 1A see Developmental & Social-Emotional Screening Instruments for Young Children in Minnesota on Minnesota Department of Health web site.

Question Two: In what settings are social-emotional and developmental screenings conducted for children ages 1-3? In which of these settings are screenings reimbursable as health care services?

Table 2 shows settings where screenings are conducted and reimbursed. All of the MCOs indicated screenings occur in primary care or medical clinics with screenings being reimbursable (see caveat* for UCare). Many of them also pay for screening conducted in association with public health visit or in public health setting. As indicated in Table 2 none of the MCOs pay for screening conducted at school (as this is seen as an education service) or in a day care setting.

Table 2 Key: X – Indicates Plan identified screening setting R – Reimbursable as health care service

Table 2. Settings where social-emotional and developmental screenings are conducted for children ages 1-3 and s where screenings are reimbursable as health care services.									
MCO/CBP	Primary Care / Medical Clinic	Behavioral / Mental Health Clinic	Specialty Clinic	Public Health Clinic	In Home Public Health Nurse Visit	Family Home Visit	LP	School/ Early Childhood Program	Day Care
Blue Plus	X-R		X-R						
HealthPartners	X-R (Well Child)							X	X
Itasca Medical Care	X-R			X (Follow Along)			X-R	X	
Medica	X-R		X-R		X-R			X	
PrimeWest	X-R	X-R		X-R	X-R	X			
South Country Health Alliance	X-R	X-R		X-R					
UCare	X-R*			X-R*					

* UCare reimburses any licensed health care professional that performs complete Child and Teen Checkup (C&TC) visits.
Follow Along Program http://www.health.state.mn.us/divs/cfh/program/cyshn/follow.cfm

Question Three: What is the protocol for referral and diagnoses if the screening(s) are positive?

All of the MCOs identified some type of process for ensuring children with a positive screen are formally or informally sent on to receive some form of further assessment. Within each MCOs protocol there is an indication of whether or not a formal referral is required and if the initiator follows an individual clinic or plan wide referral protocol.

Since each plan provides individualized screening services the majority of plans indicated that whoever conducts the screening would determine where the child should be sent for the follow up assessment. As shown below that follow up assessment may occur in various health care or educational service areas.

Table 3. To whom may a child be referred when a screening is positive.

MCO/CBP	Referral Protocol	Potential Assessment Referral Sources							
	Ref. may or may not be required	Mental Health / Behavioral Health	Pediatric MD	Education / School District	Speech Therapy / Audiology	Occupational Therapy	Physical Therapy	(EIDBI)	Help Me Grow or Early Child-hood Program
Blue Plus	X*								
HealthPartners	X	X			X	X	X	X	
Itasca Medical Care	X	X	X		X	X	X		X
Medica	X	X		X					
PrimeWest	X	X		X	X				X
South Country Health Alliance	X	X		X					
UCare	X	X							

Early Intensive Behavioral and Developmental Interventions (EIDBI) Services

*Blue Plus – Did not identify referral sources.

Below information taken verbatim from submitted MCO responses.

Blue Plus

Individual clinics maintain their own internal referral protocols. However, overall standards work with Blue Cross protocols. Blue Cross does not require referrals, but highly encourages referrals to participating network providers.

HealthPartners

"If a need is defined by the assessment, a provider will refer the child to a specialty provider in the HealthPartners network for a full assessment or follow up services. Services that may be identified include: behavioral health or developmental pediatrics, physical therapy, occupational therapy and speech therapy. As of July 1st, these services

will include Early Intensive Behavioral and Developmental Interventions (EIDBI) Services. Services may require prior authorization.

Many providers also refer to Help Me Grow, the statewide resource for early childhood development.

HealthPartners Medical Group and Park Nicollet are working to incorporate referrals to Help Me Grow and other specialty providers into the clinicians' work flow after a positive developmental or social emotional screen. "

Itasca Medical Care

Through the assessments if they determine a need for further evaluation the clinics make a referral to a pediatric MD who has an interest in Autism, and they are also refer to applicable therapies such as speech therapy, occupational therapy and physical therapy. Clinics also refer to our early childhood program or "Help Me Grow", which acts as an interagency intake referral. The school districts Autism specialist becomes involved and acts as a coordinator to ensure services are established and maintained for the child. Referrals are also made to Behavioral Dimensions, which is a business that provides intensive behavioral intervention. The Itasca County Disability Resource Group, which was established by mothers assists parents in accessing area resources. The group has also created a resource book that includes local, state, and nationwide resources for parents. If problems are identified by the Public Health Follow-Along Program they too make a referral to "Help Me Grow" and also notify the child's primary care provider. In order to receive the diagnosis, for Autism residents of Itasca County need to go to the metropolitan area.

Medica

Medica advises our providers that clinical guidelines are intended to be used to encourage quality patient care, but cannot guarantee specific patient outcome, and should be used only as a reference guide. These guidelines are not intended to replace a clinician's own judgment with regard to the care needed by individual members or to establish protocols for the care of all members.

Medica follows the Institute for Clinical Systems Improvement (ICSI) guidelines for most care and for some care, we also have Medica specific guidelines that go beyond ICSI guidelines. If screening and/or counseling results warrant additional follow-up, providers are advised to proceed as indicated.

Medica also reimburses for autism screenings. Providers are encouraged to use the developmental and social-emotional screening instruments recommended by the Minnesota Department of Health (MDH) as a first line of screening. If there is an autism indication, then providers should use a more specific screening instrument like the Modified Checklist for Autism in Toddlers (MCHAT).

Members have the option to be seen by one of our providers with a specialty in autism services for further evaluation if indicated and to discuss treatment options and receive services. Members can also receive help with coordination of services from a Medica Behavioral Health Care Advocate. The care advocate can assist in coordinating care between the primary care physician and the specialty provider. If a family member were to call in and speak to a care advocate, during the conversation, the care advocate might also suggest that the family work with their school district to access any additional services that might be obtained through the education system, in addition to referring to a behavioral health provider who specialize in autism.

PrimeWest

When a child has a positive screen, the primary care provider or PHN should refer the child for a comprehensive evaluation with a mental health professional specializing in young children and autism spectrum disorders. As soon

as the infant/toddler under the age 3 is suspected of having a delay or developmental disorder, the child should be referred immediately to Early Childhood Education Services. If the child is demonstrating language delays, the child should undergo an audiologic evaluation. The primary care provider/PHN should schedule a follow-up visit within 1 month of the positive screen.

South Country Health Alliance

Typically a referral or prior authorization is not needed for most services. On a C&CT claim, the provider must indicate the referral codes (AV - patient refused referrals, ST - Referral to another provider for diagnostic or corrective treatment or scheduled for another appointment with screening provider for diagnostic or corrective treatment) for at least one health problem identified during a initial or periodic screening service, S2 - patient is currently under treatment for referred diagnostic or corrective health problems, NU - no referral made. If the screening is positive, it depends on what it is positive for so referrals could be made to a Mental Health Professional for an extended diagnostic assessment, other specialty provider, school-based evaluations, or to the county for mental health services.

Ucare

The majority of developmental problems for children 1-3 are first identified in primary care or pediatrician visits. If the pediatrician or primary care physician wishes to refer to a mental health professional, no referral is required for further screening or assessment by a mental health professional. The member may also go directly to the provider of their choice. If requested, UCare would assist a member with a referral based on the needs of the member. If the member or physician would like assistance in finding a provider or obtaining an appointment, they may call 612.676.3300 to speak with a customer services representative who can assist them.

Question Four: What barriers has the MCO identified to providing screening, diagnosis, and treatment to children, ages 1-3?

The top six barriers to screening identified by the plans in report year 2014 remain the same for report year 2015 as indicated in Table 4:

- Lack of understanding of importance of C&TC screen at well-child visits by families
- Lack of knowledge about this condition
- Lack of time to complete a thorough assessment during a well-child visit
- Lack of knowledge of appropriate screening tools
- Lack of specialty trained providers
- Lack of cross-systems referral, data sharing and follow-up

The primary strategy that the health plans are implementing currently is to improve screening of all children by ensuring that all clients receive C&TC Checkups. Table 5 identifies various strategies the plans are implementing, or considering addressing for the barriers identified in Table 4.

Table 4 MCO identified barriers to providing screening, diagnosis, and treatment to children, ages 1-3

MCO/CBP	Barriers
Blue Plus	• Lack of knowledge about condition (parents, practitioners, general public) • Members not understanding importance of screening

Table 4 MCO identified barriers to providing screening, diagnosis, and treatment to children, ages 1-3	
HealthPartners	• Duplication of screens conducted across various settings creating frustration for families and providers as data not shared across systems serving child shortage of children's mental health providers and unknown referral sources • Closing loop between plan and school district when referral is made • Cost of tools for electronic records • Time to complete a thorough assessment
Itasca Medical Care	• Concerns heard "parents deny there is something wrong", "misconception of early signs", and no specialist in rural area • MDs are not informed on Autism • MDs not comfortable making diagnosis • Lack of information about the fact that certain treatment may be provided • Parents unaware of screening opportunity through early childhood education • Takes a lot of time before a medical diagnosis is made as they have to go to the metropolitan area.
Medica	• Screening instruments are not available in the electronic medical record format • Some of tools cost money • Education at primary care level requirements • Reimbursement for these screenings is too low
PrimeWest	• Primary care indicate lack of time to conduct thorough screening when added to other expectations of well child visit • Lack of specialty providers in rural area • Distance to specialty providers can cause transportation challenges • Wait times to see specialty providers (includes metro and rural providers)
South Country Health Alliance	• Knowledge of appropriate screening tools and proper coding • Members not bringing in children for well-child checks or other screening opportunities (i.e. early childhood screening) as recommended
UCare	• Fragmentation: the service system from primary care to mental health professionals is fragmented and often times families are left to coordinate services on their own while trying to deal with the personal and financial stress of the child's condition • Lack of resources and perceived importance: there is inadequate attention paid to the importance of early screening and no single agreed upon approach for providers. In addition, the demand far exceeds the available resources and many providers do not have the adequate equipment. Professionals skilled in the assessment and treatment of children below the age of three are primarily located in the metro area, Duluth and Rochester which results in significant barriers for families accessing treatment. • Inadequate data: while we have data for the number of well child visits, there is inadequate data on the frequency of mental health screens, follow-up visits, and referrals for appropriate treatment. • Family and racial challenges: members that do not read or speak English as their primary language have difficulties understanding the information and the importance of receiving care. Some families have a reluctance to discuss and seek help for the issues due to stigmas surrounding mental health. Families have a tremendous fear about losing custody of their children if they acknowledge having challenges in caring for them at home.

Question Five: What strategies has the MCO implemented or will be implementing to facilitate access to periodic developmental and social-emotional screening(s), diagnosis, and treatment for young children, ages 1-3?

Six of the seven MCOs are using Child &Teen Checkup (C&TC) as a strategy for reducing barriers to screening. In addition to C&TC MCOs are educating providers, communicating with members, and the general public about Autism. One MCO is implementing pay for performance to encourage well care visits and another is providing incentives to families who complete recommended childhood screenings.

Table 5 Strategies MCO has implemented or will be implementing to facilitate access to periodic developmental and social-emotional screening(s), diagnosis, and treatment for young children, ages 1-3.

MCO/CBP	Strategies

Blue Plus	• Commitment to Child and Teen Checkups (C&TC)
	  ○ Provider education
	  ○ Member communication
	  ○ Incenting providers for administering complete screenings
	  ○ Offers financial rewards to families who complete recommended childhood screenings

HealthPartners	• HealthPartners Medical Group ASQ and ASQ-SE Pilot –All Park Nicollet Clinics use the Ages and Stages Questionnaire (ASQ) and ASQ Social Emotional (ASQ-SE) in all pediatric well child visits. HealthPartners Medical Group is currently piloting to conducting the ASQ at ages nine months, 18 months and 24 months, the ASQ-SE at 12 months and 36 months as per the American Pediatric Association recommendations. All HealthPartners Medical Group Clinics will implement using the ASQ and ASQ-SE by 1/1/2016 • Screen at 3 Pilot – Through participation in GenNext Kindergarten Readiness Action Team, HealthPartners Midway Clinic is participating in the ABCD Close the Loop project with St. Paul Public Schools. Through this pilot, all children age three seen at Midway Clinic are being referred to St. Paul Schools for their Early Childhood Screening and connection to other school district resources.
Itasca Medical Care	• IMCare has informed members, providers and the general public about Autism in our newsletters and the local newspaper. Additionally, information about the Follow Along Program was in a newsletter.
Medica	• Specific to Hennepin County, Medica has been actively involved with the CHIP initiative, sitting on the leadership team as well subcommittees. One subcommittee's focus is not only to increase the rate at which children are screened at age three years, but also to close the loop as it relates to communication between clinics and school districts. • As part of this work, a Medica staff person, Sandy Lien, put together a white paper on the issues with early childhood screenings and Child and Teen Checkups recommendations with the help of a Hennepin County staff member, Patricia Anderson. They were subsequently invited to a Generation Next meeting to review what they put together. Generation Next is working to decrease the barriers to screenings at age 3 years of age and Medica will assist in any way we can. • Medica has been attending community meetings that are also working on increasing the rate of early childhood screenings. We will continue to support community, county and state initiatives on increasing social-emotional/mental health and developmental screenings for all children.

Table 5 Strategies MCO has implemented or will be implementing to facilitate access to periodic developmental and social-emotional screening(s), diagnosis, and treatment for young children, ages 1-3.	
	• Medica has been conducting education and providing resources for the screenings. • Medica has, and will continue to place, low scoring clinics on improvement plans where a complete C&TC is not documented. • This year we are providing additional education to our nurse reviewers with a focus on mental health screening for all ages. • Medica will also continue to publically report clinics C&TC review scores. • Medica Behavioral Health has contracts with providers to treat young children in need of mental health services, including services specific to autism.

PrimeWest	Public Health/Social Service
	• PrimeWest Health is a County-Based Purchasing (CBP) organization owned by the 13 counties that make up the PrimeWest Health service area. As such, we are organizationally integrated with county agencies, including county Public Health and Human Services. Public Health is a provider of Child & Teen Checkups (C&TCs) that conducts a developmental and social emotional screen during the C&TC. Both Public Health and Human Services conduct complex case management for PrimeWest Health's Prepaid Medical Assistance Program (PMAP) population. If the member has an elevated screening score, he/she can be referred to complex case management by the Public Health Nurse (PHN). The complex case manager assists the parent in navigating the mental health system to access appropriate services.
	
	Primary Care Providers
	• The PrimeWest Health care management model focuses on a broad continuum of care and comprehensive benefit set and encourages the establishment of a relationship between the member and primary care provider that is supported by PrimeWest Health from birth on. In an effort to obtain regular screening for developmental and social–emotional status, the establishment of a relationship between the member and a provider who can screen for those needs is critical. Selecting a primary care clinic is important because members who select and utilize one tend to stay healthier and have fewer urgent care and emergency room visits. These members also maintain medical history and other information in one location. PrimeWest Health has the screens listed in question 1 available for children ages 0 - 3 and requires that the provider complete these at every well-child visit/C&TC. The American Academy of Pediatrics recommends that children be screened for developmental delays during well-child visits at 9 months, 18 months, 24 months and specifically screened for Autism Spectrum Disorder (ASD) at 18 and 24 months.
	To encourage and support developmental and social-emotional screenings by primary care providers and physical health screening by case managers/care coordinators, PrimeWest Health provides the following:
	  ○ Availability of Minnesota Department of Human Services (DHS) standard and approved screening tools and assessments
	  ○ Education regarding the application and use of the tools
	  ○ Concurrent review with appropriate follow-up if indicated
	  ○ Chart auditing
	  ○ PrimeWest Health Integrated Care Program
	
	Integrated Care Program
	• PrimeWest Health partnered with the local Children's Mental Health Collaborative to develop a program to integrate physical and mental health treatment in the primary

Table 5 Strategies MCO has implemented or will be implementing to facilitate access to periodic developmental and social-emotional screening(s), diagnosis, and treatment for young children, ages 1-3.	
	care setting. The program has been implemented in collaboration with two Alexandria area primary care clinics and several mental health providers. The "New Way of Care" model is composed of five main components; however, each entity has morphed into utilizing varying levels of the model's components and fits the model into their existing clinic/program infrastructure, so no program operates the same as another. 1. Education and training: PrimeWest Health will provide primary care providers with continuing education units (CEUs) in general mental health topics and integrated care system training and will provide clinical training updates. 2. Consultation: PrimeWest Health will set up consultation services in clinics (primarily through interactive visual connection via Internet consultation) with both a child and adolescent board-certified psychiatrist and an adult board-certified psychiatrist. This will include three different levels of service: a. Psychiatrist to primary care provider b. Psychiatrist to primary care provider/patient/family c. Emergency psychiatric consult assessment of patient 3. Screening and triage assessment: PrimeWest Health members will complete a mental health screening prior to seeing a provider. This may result in referral of the member for a diagnostic assessment completed by a mental health professional with recommendations being made for treatment and follow-up. 4. Follow-up/monitoring protocols: Mental health treatment and monitoring protocols will be developed for primary care providers. Monitoring and follow-up will also be available via interactive video. 5. Clinic supervision/consultation: Clinic supervision and consultation will be available for other professionals working with members including school staff, public health staff, social workers, advanced practice registered nurses (APRNs), and triage mental health therapists. From 2012 to 2013, Alexandria Clinic experienced a 38.2 percent increase in growth for referral to the program for the 0 - 5 age group
South Country Health Alliance	• Pay for performance components are built into provider contracts to encourage well care visits for children up to age 15 months. • SCHA allows 6 well child visits during this time period. SCHA has member education and incentive programs to encourage utilization of services. • Every month SCHA's Provider Network sends a list of eligible children for C&TC checkups to the clinics. • South Country is working closely with MN DHS to implement the new EIDBI service and is educating county partners and providers regarding the service benefits, provider enrollment process, and CMDE trainings.
UCare	UCare has a workgroup dedicated to Child and Adolescent measures, including C&TC, which reports up through our Quality Committee. Each year this workgroup implements a number of strategies and interventions to facilitate access to periodic development and social-emotional screening(s), diagnosis, and treatment for young children, ages 1-3. In 2014, some of those activities include: • Handing out C&TC periodicity schedules to members at health resource and screening fairs.

Table 5 Strategies MCO has implemented or will be implementing to facilitate access to periodic developmental and social-emotional screening(s), diagnosis, and treatment for young children, ages 1-3.	
	• Distributing C&TC periodicity magnets at the Metro Action Group to County C&TC coordinators and to the Minneapolis Public School early childhood screening coordinators. • Providing training to Head Start Early Childhood coordinators about the importance of educating families and members on C&TC visits and periodic developmental and social-emotional screening. • Providing telephonic outreach with internal UCare staff to members to remind them about getting their C&TC visit and assisting them with scheduling when needed. • UCare offers *member incentives* to encourage members to receive preventive health visits/screening and providers can participate in our Pay for Performance program to receive incentives for improving preventive health visit rates. • UCare has a dedicated *C&TC chapter* in Provider Manual where we encourage Child and Teen Checkups and link to a variety of resources for C&TC including the Dakota County C&TC billing grid and DHS and MDH C&TC websites. • UCare publishes a provider newsletter (*health lines*) in which articles about C&TC screenings have been written to provide continuing education on C&TC, how to bill for services provided and the additional reimbursement available for screenings. • UCare also includes C&TC performance measures in our Pay For Performance program for primary care providers.

Question Six: Pursuant to section 6.1.23 (C) (2) of the 2014 Families and Children Contract, what evaluation and assessment, including treatment recommendations are provided to children who do not meet milestones?

All of the MCOs, except Blue Plus indicate further assessment by someone other than current contact.

The below responses are verbatim from each MCO.

Blue Plus

All children with Blue Plus have access to comprehensive assessment and treatment planning. This work originates with the Primary Care Physician/Primary Care Clinic.

HealthPartners

As mentioned above, the pediatrician or family practice provider is likely to reschedule the patient/family to do a more in-depth assessment with a specialty provider such as a referral to developmental pediatrics, child psychiatry, child psychology and other rehabilitative services. As of July 1, 2015, children diagnosed with Autism or related conditions will also be referred to EIDBI services and receive a Comprehensive Multidisciplinary Evaluation (CMDE) for assessment of additional services.

Itasca Medical Care

When a child is not meeting critical developmental or social- emotional milestones providers are referring directly to early childhood or the Help Me Grow program. Once they are in the early childhood system, treatment may include speech therapy, physical therapy, occupational therapy, and/or behavioral therapy. Home based mental health services are also available for children who meet criteria. If the child meets criteria and enters into the program, ongoing assessments are conducted by the treatment team.

Medica

Medica asks participating providers to follow the Institute for Clinical Systems Improvement (ICSI) and Medica clinical guidelines. At a minimum, Medica expects providers to conduct surveillance of the child's developmental and social-emotional milestones at each Child and Teen Checkups visit and provide referrals as medically indicated. We also educate providers about Help Me Grow and how to make referrals.

Additionally, in accordance to the Child and Teen Checkups Periodicity Schedule, Medica strongly recommends as best practice that a standardized developmental screening instrument be used at 9, 18 and 24 months and at 3 years. And, if a standardized screening instrument was not used at the 3 year checkup, it is recommended that one be used at the 4 year checkup and at the 5 year checkup if one was not used at the 3 or 4 year checkup. We expect providers to make referrals as medically indicated by the screening(s).

For social-emotional health, Medica strongly recommends as best practice that a standardized social-emotional/mental health screening instrument be used at 6, 12, 18 and 24 months and at every C&TC screening between 3 and 20 years. If a child does not meet the milestones, the family can access services through one of our providers specializing in the treatment of autism spectrum disorders. This may include additional evaluations and a range of treatment services such as, outpatient services, in-home services or day treatment services. Again, we expect providers to make referrals as medically indicated by the screening(s).

PrimeWest

The following are possible treatment recommendations for children who do not meet milestones to have access to appropriate evaluation and assessment, including treatment recommendations to improve child's functioning with the goal of meeting milestones by age five:

- DC 0-3R assessments are diagnostic assessments specifically geared for further mental health evaluation with infants and toddlers
- Behavior and communication approaches
- Occupational therapy
- Sensory integration therapy
- Speech therapy
- Dietary approaches
- Medication
- Complementary and alternative medicine

South Country Health Alliance

For children who do not meet milestones, referrals may be made to a provider for diagnostic or corrective treatment. Referrals may be made to PT, OT, speech, to school-based centers, or to mental health professionals depending on what milestones were not met. One example of a referral may be to a qualified mental health professional for a CMDE for possible eligibility for EIDBI. Referrals are not required to access these services if completed by an in-network provider. Members may also be referred back to the county for assistance in coordinating needed services. South Country ensures access to services and works with in and out of network providers to meet member need in the area of early screening, diagnosis, and treatment of Autism and other developmental conditions. South Country follows the DHS fee schedule and continues to work with DHS and other health plans in the development and implementation of new services, such as EIDBI, to treat our members.

UCare

When children do not meet developmental milestones, the treatment recommendations would be indicated by the screening, evaluation, and assessment guidelines. UCare supports the use of best clinical practices (ICSI best practices and UCare provider resource).

As an integral part of UCare's medical management of members, the UCare Special Health Care Needs (SHCN) program identifies persons with special health care needs, assists identified members with access to care, and monitors their treatment plan for positive behavior change. Through early identification and predictive modeling, UCare can anticipate a member's potential health state and intervene accordingly. The UCare SHCN team reaches out to these members, and parents of members, for proactive case management. This program works to reduce or eliminate barriers for pediatrics with special health care, including social, emotional and developmental needs. UCare offers this program to all members, including children ages 1-3.

As mentioned above, UCare also partners with Community Health Workers (CHWs) from WellShare International to provide telephonic outreach and home visits. These CHWs provide education to parents and responsible parties on how to reduce the barriers mentioned above and help these members navigate the health care system to receive adequate care.

Additionally, UCare utilizes Health Services Management, Inc. to perform Utilization Management and Utilization Review for rehabilitative services including physical therapy, occupational therapy, speech therapy and children's habilitation services.

Question Seven: What are the recommendations of the MCO on how to measure and report on the effectiveness of the strategies implemented or to be implemented on facilitating access to developmental and social-emotional screening, diagnosis and treatment to children, ages 1-3? (Responses as provided by the MCO.)

Blue Plus

A number of current and new strategies should be maintained and implemented to increase awareness of the importance of these screenings.

HealthPartners

Provider education should be implemented so that accurate codes are used and thus encounter data could be used to measure the effectiveness of plan and State efforts.

There are now two distinct codes for early childhood screenings performed at the clinics. The new CPT Code 96127 is designated for social-emotional or mental health screenings, whereas the CPT Code 96110 is for developmental screenings. This distinction was made January 1, 2015, and the MCHP Provider Manual was updated to reflect this change in May 2015. These codes could be used to track the number of screenings taking place and if referrals were made.

Itasca Medical Care

IMCare would recommend working with the Department of Education on this issue as the early childhood programs work with autistic children throughout their school life, but can also start as early as age 0. These educational programs submit data to the MDE. Another consideration is that once a child is diagnosed with Autism they typically obtain disability status and are no longer on a managed care program. If IMCare implements an incentive

program, we could measure the effectiveness by tracking the number of members that are screened early and compare that to previous data that the early childhood program would have.

Medica

It would be helpful if first, a group of key stakeholders (providers, state agencies, school districts, health plans, Generation Next, etc.) formed a task force to address the barriers of getting children between the ages of 1 and 3 years of age screened. Collaboratively, we can then address the systemic issues that create barriers to these important screenings. Once the barriers are lessened or removed and recommendations have been made, it has the potential of increasing the rate of screenings being performed more than just putting measurements in place. The task force can then discuss and make recommendations of how to measure the effectiveness of its efforts.

There may also be other ways to help increase the rate at which children 1 to 3 years of age are screening; it would be good to brainstorm and explore these options.

PrimeWest

1. Number of emergency room (ER) visits for behavior and/or psychiatric diagnosis, pre- and post-
2. Number of hospitalizations for behavior and/or psychiatric diagnosis
3. Number of readmissions within 30, 60, and 90 days for behavior and/or psychiatric diagnosis
4. Length of time between hospitalizations
5. Prescription/medication fill percentage
6. Medication refill percentage
7. Reduction in appointment wait time for the members that were triaged to an adult or child psychiatrist
8. Improved or maintained screening scores
9. Quality of life determination survey
10. Provider satisfaction survey
11. Percent of members accessing mental health treatment post positive screen date
12. Percent of members demonstrating continuous access to mental health services one year post diagnosis of mental health disorder (visits occur minimum of once every 3 months).

South Country Health Alliance

Run a claims report to identify the number of screenings completed. When the coding staff do audits, they could pull samples on the screenings. Providers could be surveyed regarding barriers to accessing screening and treatment for this population.

UCare

UCare's Child and Adolescent workgroup uses the Plan-Do-Study-Act (PDSA) methodology with every intervention. They place a high emphasis on measurement in order to study if the intervention is achieving the intended results and to improve interventions for the following year. We also monitor our HEDIS rates for C&TC on a monthly basis.

V. Conclusion

Even though the MCOs have implemented or will be implementing strategies to overcome barriers for screening, diagnosis and treatment (as required under M.S. 256B.69, Subd, 32a) families are still struggling to access appropriate services. This report identifies current barriers in access and provides preliminary recommendations for further efforts to address barriers in access to early screening, diagnosis and treatment of autism spectrum disorders or other developmental concerns. The results of this data help to identify gaps and provide a road map

going forward for MCO's to work collaboratively. Recommendations include improving public awareness of the importance of early screening, education on ASD, effective screening tools, diagnosis and treatment, workforce development and improved communication and collaboration across educational, medical and human service providers. Analysis of these surveys includes recommendations for expanded education of multi-cultural and linguistic communities about the importance of early screening and understanding of typical and atypical child development and resources available for treatment and recognizes the need to ensure that rural/out-state MN clients have access to the same services as metro families.

As public program providers, managed care organizations and county-based purchasing plans have an important role to play in the development of best practices in policies and procedures for screening, diagnosis, and treatment of young children in Minnesota. It is critical for health plans, policymakers, and the broad community of autism stakeholders to work collaboratively to address early screening, diagnosis and access to effective treatment for children with ASD and related conditions. Support for a Coverage with Evidence Development approach to early identification and treatment of autism, as recommended by the Health Services Advisory Council report (February 2013), is also key so that children with ASD and their families can be assured that they are receiving the right services at the right time and with the most effective use of health plan and public resources.[3]

Addressing the challenge of autism spectrum disorders requires a multi-faceted, multi-agency approach including health, education, social services, community agencies and public and private health coverage. Issues that this report raises and that need further collaborative focus, input and evaluation include how to address:

- Need for consistently applied practices in early social/emotional screening by primary physicians and health care providers
- Need for training of providers in use of screening tools and early indicators of ASD or other developmental/ social/emotional challenges
- Availability of screening tools in the electronic medical format
- Identification of best practices in tools used to identify children early?
- Incentives for providers to consistently implement recommended screening practices and for families to follow- through on screening appointments
- *Addressing the cost of tools so that they are accessible and utilized by providers
- Understanding of appropriate referral sources and resources that are available including education, health care, mental health/behavioral health and human services and need for coordination and collaboration with all services
- How to improve understanding of typical and atypical development in multicultural and linguistic communities and the importance of screening and early intervention and resources available to improve outcomes
- Ensuring services and supports are available for all communities and identifying what can be done to reduce barriers for specific communities (racial, ethnic or geographical)
- Expanding capacity of qualified providers to deliver the services and supports

[3] Autism Spectrum Disorders: A Report to the Minnesota Commissioner of Human Services, Minnesota Department of Human Services, February 2013. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6181-ENG