

## ASD Advisory Committee — Evidence-Based Treatment Work Group – 9/20/15

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### Defining evidence-based

All are comfortable with the language in California Trailer bill for evidence-based practice

### Communication to parents

We need to improve how we communicate our information to parents

### Potential Recommendations

- What recommendations are we going to make to the ASD Committee regarding evidence-based treatment?
  - I would be okay if children go to licensed professionals for social thinking
  - Under your license you cannot use a CPT code to do something that is not covered under that CPT code
  - As a licensed psychiatrist I could use various therapies including cognitive behavioral health therapy, and could bill such therapy under different CPT codes depending on which individuals are present at the therapy.
    - Social cognitive thinking tools can be used during play therapy to address things like anxiety
  - We can agree that it's OK if they are operating within their scope of their practice using tools that are available to them. I'm just not comfortable to recommend such therapies as evidence-based.
  - As long as we include something similar as Appendix C (Missouri document)—that is a step in the right direction. I think that has to be part of what we do moving forward
  - Evidence-based practice is the integration of three things: best available research, clinical expertise, and patient preference.
  - There is a reason why we want to talk about distinctions between evidence-based treatments and emerging treatments. In order for something to be considered evidence-based it needs to include a meta-analysis that shows this treatment is effective and proven.
  - Not everybody is going to be happy with this perspective.
  - ABA doesn't account for individual differences.
  - There are different opinions around the table
    - I think there is more of a consensus around a diagram of equal weight for best available research, clinical expertise, and patient preference
  - We are going to put a matrix together that includes the best available information re ASD treatment. We want to give families the best picture re treatment options.

- Stopgaps are in place - Health plans have processes in place for certain things that will need prior auth. And other that will not need such process.
- At times, therapies that are used without considering whether they are working. Example: 8 years of occupational therapy and no improvement in handwriting. How do we make sure that interventions get data to show improvement – that’s time you could be doing something else.
- Delivery system is constantly looking for prior auth, therapists keep sending in, by the time you know it they have had many visits, but no one is looking at the whole plan to see if it is helping.
- Doctors just sign off, don’t evaluate
- Who is responsible? Theoretically, the doctor, but are they responsible for looking at data related to the request?
- Have the health plan take more of a role, talking through the options, making sure it’s working
- Not sure I like the health plans doing this, rather the providers
- Health plans could provide some monitoring, and care coordination, providers speaking to each other.
- How realistic is it for PCPs to come to planning meetings?
- Some are sending care coordinators to IEP meetings – but that’s a minority
- From the cost perspective, care coordinators can make sure the provider had the history, make sure family could connect, followed through. It makes a difference
- Is this evidence-based practice? Some concerns will be addressed by other committees
- Evidence-based designation must be assessed annually
  - We need a committee that makes annual recommendations on evidence-based practices. The committee should include a variety of expertise/professionals who are licensed including speech pathologist, medical doctors, etc. who can make recommendations based on their expertise.
  - The committee should also include family members
  - Do we have a committee like that in the state (AZ) right now for any of the medical programs?
    - AMPM (AHCCCS Medical Policy Manual) Committee reviews specific guidelines that AHCCCS created
  - I like that if we can have some group with expertise from a variety of professional backgrounds and families
  - I would like to make sure that this review committee will include expertise from all the services that ASD members utilize
- In terms of harvesting from other states, what’s the best process?
  - Ex: Minnesota plan – described each unit, initial assessment, providers who can diagnose, what is the treatment plan, requirements, some things we can look at, also Missouri plan – don’t need to create something new – we can use existing things as model
  - Going back to update of Appendix C in the Missouri report, what would you recommend for AZ in terms of categories – there is not always consistency, some call it evidence-based,

others call it established, others moderate strength of evidence – how to pull together for recommendations for the full committee? Do we want to say this is what we recommend?

- Do we want this Committee to make recommendations for other providers outside the AHCCCS system?
  - I think the information we are producing will benefit people outside of AHCCCS
  - As soon as the ASD associations get ahold of our recommendation, they will share it with parents and providers outside of AHCCCS
  - Having a document that is internal to AHCCCS means they will have the responsibility for keeping it up. If another organization housed it, it might not get updated appropriately.
  - I thought our charge was to make recommendations for AHCCCS?
    - Yes it is [full committee agrees]
    - It's hard navigating the AHCCCS website
      - Someone from AHCCCS said that they are working on the website
  - We can create a document with all of the recommendations but it will be up to AHCCCS to decide to incorporate it into the AMPM.
  - Recommendation document should be posted on the AHCCCS site and every year a group of people who are experts should review the recommendations, and make changes based on new research
- What would it take for health plans to use this document?
  - AHCCCS can put these recommendations in the health plans contracts so that health plans will cover the recommended treatment
  - Rehab services are currently covered under the plan
  - Anything under EPDST should be covered regardless by Medicaid plans
- For AHCCCS and DDD, habilitative and rehabilitative are words that create issues
  - States that health plan will cover all medically necessary treatments for kids, but it doesn't really address the issue of Chapter 300 and use of rehabilitative, and what health plans think they need to cover.
  - At this point, erring on side of approving, hearing from DDD the opposite of what had been recommended, denying it and then appeal, now saying don't do this, but they are not set up over there to do prior auth. If they want to delegate to health plans, need to figure out how that looks in the contract.
  - Is one of our recommendations where services should be housed?
  - We need to define medical, behavioral, etc.
  - There is a lot of overlap among the work groups with recommendations, recs for physical and behavioral integration, like SMI, there is movement, many work groups are agreeing. This will bubble up at next full committee meeting.
- As facilitator – there is no mandate that this workgroup come up with a list of what this group considers evidence-based. Based on what I have heard over the past few months, you could talk about being medically necessary, with team interdisciplinary review, asking is this working, medical necessity is the doorway in rather than a list.

- Perhaps this is where we can compromise, maybe an appendix for what is available in the literature for all approaches.
- Anything on that list, a medical professional can say, why don't you try this path.
- Health plans have policies which show gradations of evidence-based, then they create a policy that goes over all that, shows what they consider medically necessary, and what codes are to be used – that's why medical plans have a medical director, there may be times when there are exceptions, individual needs something different
- What you're saying goes back to p. 56 of MO document, three intersecting circles, combination of best practices, expertise, individual characteristics, without any one having more weight – is everyone comfortable with this?
- This is why we wanted to distinguish between evidenced-based treatments and evidence-based practice.
- Yes – everyone is comfortable.
- There is a continuum, we find things, new treatments become standard of care, change can be rapid.
- Need to be open-minded enough to consider treatments for kids, not all will need ABA in a certain way.
- But at some point we need to put some weight on meta-analysis and what has been learned.
- As facilitator, there are differences of opinion about how to do these weights, some are more comfortable with meta-analyses, but studies of some treatments haven't been done. I hear more consensus around equal weighting of three factors.
- Sometimes I might deny treatment, but get more info about individual involved, then approve
- This may not be a deep, dark line, but some are established and some are emerging, and what we are saying is that AZ families have access to whatever is medically necessary and works, whether from established or emerging.
- Are we in agreement to include a matrix that includes what is the best known science at present?
- Yes and we need to be sure we are looking at the child and family
- Evidence may make it easier to try certain things first, without preauth
- Aug Com devices are an example with not enough evidence to put in best practices, but may work for some.

### **Role of Pediatricians**

- There was an AZ AAP white paper on autism at some point – we should take a look at this.
- It's one thing to have PCP best practices in effect, but often how these are reinforced is through performance improvement projects, things where health plan looks to ensure doctors are doing this, other times look to see if things on plan are accomplished, need overall plan for member.
- In terms of recommendations we need to make sure that we have as few barriers as possible. It needs to be built into best practices.

- How do we ensure that physicians follow our recommended best practices?

### **Reevaluation is essential**

- Story about why need for reevaluation – family had ABA for a year, but many seizures a day, ABA not effective, but once seizures were under control, ABA was helpful, wasted a lot of money on year of treatment.

### **Comorbid Conditions**

- Recommendation re diagnosis - I want to make sure that ASD children are treated for comorbid conditions. PCP needs to make sure that ASD children are treated for comorbid conditions. This could be part of an annual evaluation.
- Maybe our recommendations should be age appropriate
- We should create recommendations for physicians (medical and behavioral providers) that includes a checklist for different comorbidity issues

### **Feeding Issues**

- Another big area is feeding issues. I see a lot of PCPs just order nutritional supplements, other things may be necessary, seeing a specialist, addressing swallowing issues, etc.
- We need to develop a recommendation re nutrition and feeding issues for ASD children
- It's important for parents to have something in terms of nutrition/eating recommendations

### **Oral Health**

- Are there any guidelines on oral health for ASD?
- Huge issue
- In some instances, children were treated for behavior when they actually had serious dental problems
- Recommendation would be they get regular dental care, but dentists don't feel like they can deal with special needs, don't do a good cleaning, just look in and say "you're good," can't deal with sensory issues.
- Example: kid who could not get a MD exam, because of terrible experience with dentist, strapped down, extracted 4 teeth, not properly sedated – are there guidelines for dentists and how they deal with these patients?
- Routine checklist should include how are dental visits going
- Concept from Sidney Rice, used storyboard to show, prepare ahead for visit to her office, can this be done with dental offices, prepared for what they face?
- Autism Speaks has a dental packet – SAARC has something too, I think.
- A.T. Still has an entire special needs setup
- Wouldn't it be good to develop a manual that has some specificity – by practice, since if it differs from general story, it can get in the way if it differs from individual's expectations.
- Could be a program to help a dental practice makes a video.

- What happens when they need to be put under for treatment? Coverage and who will pay is an issue.
- Need balance – sometimes kids are overly sedated, sometimes so dentist could get them through more quickly – should be in best practice guidelines
- This is something that should be part of routine check-up checklist for providers
- We should also include something about dental sedation best practices
- There are issues with dentists over-using sedations in order to see more patients during the day

#### **Other Issues**

- Genetic testing is an important area to consider.
- Prescribing authority is another area.